
AAPA Mission

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

AAPA Vision

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

AAPA Values

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

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

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

Excellence and Equity
We commit to the highest standards and seek to eliminate disparities and barriers to quality health.

Last updated January 24, 2018
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3) Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
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AAPA BYLAWS

AAPA BYLAWS

ARTICLE I Name.

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

ARTICLE II Purpose and Mission.

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

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

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

ARTICLE III Membership.

Section 1: Eligibility. Membership in this Academy shall be open to all individuals wishing to participate in promoting the purposes of the Academy. Specifically, membership shall consist of individuals who are cognizant of their obligation to the public and who meet the requirements for membership as defined by AAPA’s Articles of Incorporation, these Bylaws, and such other of AAPA’s rules and policies that may be established from time to time. Membership in the Academy is an honor that confers upon the individual certain rights and responsibilities. Adherence to the AAPA Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15 – page 180), AAPA’s Articles of Incorporation, these Bylaws, and AAPA’s rules and policies, and generally acting in a manner that is consistent with AAPA’s purposes, is a condition of membership.

Section 2: Classes of Membership. The membership shall consist of fellow, student, affiliate, sustaining, physician, honorary, associate, retired, and such other members as may be recognized by the Academy.
Section 3: Fellow Members. A fellow member shall be a PA who is a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy. Fellow members must satisfy such continuing medical and/or medically related educational requirements as may be prescribed by the Academy. Non-clinical fellow members will not be required to maintain continuing medical education (CME). Fellow members shall have the privilege of voting and be eligible to hold office.

Section 4: Student Members. A student member is an individual who is enrolled in an ARC-PA or successor agency approved PA program. Except as otherwise provided in these Bylaws with respect to the election of the Student Director, student members shall not have the privilege to vote or hold office. Notwithstanding the preceding sentence, one student shall be elected by his/her peers to sit on the Board of Directors and this Student Director shall have and enjoy all rights and privileges of any other member of such Board.

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

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

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

Section 8: Associate Members. Associate members shall consist of representatives of businesses engaged in selling products or services to PAs or individuals employed by government agencies who do not qualify for any other membership category. Associate members are not entitled to the privileges of the floor, to vote, or to hold office.

Section 9: Honorary Members. Honorary membership may be conferred by the Academy upon non-PAs who have rendered distinguished service to the PA profession. Honorary members shall have all the rights and privileges of the Academy with the exception of voting, holding office, and/or chairing commissions or work groups. All honorary members shall be exempt from the payment of dues.

Section 10: Retired Members. A retired member shall be a PA who is a former fellow member who has chosen to retire from the profession, and opts to be classified as a retired member. Retired members shall be entitled to privileges of the floor, but shall not be entitled to vote or hold office.

Section 11: Applications for Membership. All applications for membership shall be in a format approved by the Membership Department of the National Office. There shall be issued to each member a certificate of membership in such form as may be determined by the Membership...
Department of the National Office; title to such certificate shall remain at all times with the Academy.

Section 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.

Section 13: Non-Discriminatory Policy. AAPA will remain non-discriminatory in granting membership.

Section 14: Annual Meeting. There shall be an annual meeting of those members who are entitled to vote for Directors, to be held during the Academy’s annual conference, or at such other time and place as may be determined by the Board of Directors. Notice of the place, date, and time of the annual meeting shall be given to those members who are entitled to vote for Directors at least 30 days but not more than 60 days before the meeting date. Notice may be delivered by electronic means.

ARTICLE IV Constituent Organizations.

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

ARTICLE V Student Academy.

Section 1: Purpose. The Student Academy of the AAPA is the national representative body of the AAPA student members and, as such, while embracing all AAPA policies and purposes, the Student Academy further strives to serve students.

Section 2: Assembly of Representatives. The Student Academy shall have an Assembly of Representatives (“AOR”), which shall represent the interests of AAPA student members. The AOR shall be composed of representatives of the student members as set forth in the Student Academy Bylaws and policies. The AOR is responsible for determining the process for election of the student delegates to the AAPA House of Delegates in accordance with Article VI, Section 2.

Section 3: Student Director. The Student Director of the Academy shall be elected in the manner set forth in the Student Academy Bylaws and policies, and in accordance with the requirements of North Carolina law.

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).

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

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

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

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

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

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

c. **Duties of House Officers.**

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

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

iii. The Second Vice Speaker will assume the duties of the First Vice Speaker in the absence of the First Vice Speaker, or in the event of vacancy in the position of First Vice Speaker.

iv. The Second Vice Speaker shall be responsible for verification of the credentials of the delegates, for compiling the records of all general meetings of the House of Delegates, and for submitting such records to the Secretary-Treasurer of the Academy for filing with the Academy’s books and records.
d. Resignation or Removal of House Officers. Any House Officer may resign at any time by giving written notice to the Speaker, the President of the Academy, or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any House Officer may be removed from his or her position at any time, with or without cause, by the affirmative majority vote of the House of Delegates. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the House Officer. Vacancies in these positions shall be filled in accordance with Article VI, Section 3 and Article XIII, Section 10 of these Bylaws.

Section 4: Meetings of the House of Delegates.

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

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

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

d. Mail and Electronic Voting. Mail and electronic voting of the House of Delegates will be permitted for any House business. Mail and electronic votes will be called for by the Speaker of the House when directed by: (i) a simple majority of the House Officers; (ii) a two-thirds affirmative vote of the Board of Directors; or (iii) a call from 25 percent of delegates currently credentialed. Additionally, mail and electronic votes will be called for by the Speaker when there is a vacancy in an elected office of the House during the time period between regularly scheduled House elections. The House Officers and Academy staff shall determine the procedures for voting on issues requiring a mail or electronic ballot, subject to the requirements of the North Carolina Nonprofit Corporation Act.

ARTICLE VII  Board of Directors and Officers of the Corporation.

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

a. To grant charters to chapters, recognize specialty organizations, establish affiliation with caucuses and special interest groups, and establish Academy commissions or work groups as may be in the best interests of the Academy, taking into consideration any recommendations of the House of Delegates thereon;
b. To appoint or remove the Chief Executive Officer (CEO) pursuant to the affirmative vote of a two-thirds (2/3) majority of the Directors;
c. To direct the activities of the Academy’s national office through the CEO;
d. To provide for the management of the affairs of the Academy in such a manner as may be necessary or advisable;
e. To establish committees necessary for the performance of its duties;
f. To establish, regularly review, and update the Academy's management plan to attain the goals of the Academy;
g. To call special meetings of the House of Delegates as provided under Article VI, Section 4;
h. To report the activities of the Board of Directors for the preceding year to the House of Delegates and members at the Academy’s annual meeting;
i. To establish the amount and timing of Academy membership dues and assessments;
j. To review and determine, on no less than an annual basis, how to implement those policies enacted by the House of Delegates on behalf of the Academy that establish the collective values, philosophies, and principles of the PA profession. If it determines that implementation of one or more such policies will require an inadvisable expenditure of Academy resources, or is otherwise not presently prudent or feasible, the Board shall, at its earliest convenience, report to the House the reasons for its decision.

Section 2: Dual Roles with AAPA Constituent Organizations. Members of the AAPA Board of Directors may not hold elected voting positions in the Academy’s constituent organizations. Directors may hold elected or appointed non-voting positions in the Academy’s constituent organizations.

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

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

Section 5: Duties of Officers of the Corporation.

a. The President shall be the chief spokesperson for the Academy. The President shall report to the House of Delegates and the members at the annual meeting of the Academy with an account of the activities of the Board for the past year and its recommendations for the House of Delegates.
b. The President-elect shall succeed to the office of President at the expiration of the President’s term or earlier should that office become vacant for any reason.

c. The Vice President is the Speaker of the House of Delegates and shall represent the House of Delegates to the Board of Directors and shall perform such other duties as shall be assigned by the Board of Directors.

d. The Secretary-Treasurer shall:
   i. be responsible for adequate and proper accounts of the properties and funds of the Academy;
   ii. give a full report to the membership at the annual meeting;
   iii. deposit or call to be deposited all monies and other valuables in the name and to the credit of the Academy with such depositories as may be designated by the Board of Directors;
   iv. oversee disbursement of the funds of the Academy as may be ordered by the Board of Directors;
   v. render to the Board of Directors, whenever it may request it, an account of all the transactions as Secretary-Treasurer, and of the financial conditions of the Academy;
   vi. oversee the maintenance of the records of the Academy including the records of the Board of Directors and of the House of Delegates;
   vii. execute the general correspondence;
   viii. attest the signature of the Academy Officers;
   ix. cause the corporate seal to be affixed on documents so requiring; and
   x. have such other powers and perform such other duties as may be prescribed by the President or the Board of Directors.

e. The Immediate Past President shall perform such other duties as may be assigned by the President or the Board of Directors.

Section 6: Meetings of the Board of Directors.

a. Regular and Special Meetings. The Board of Directors shall hold such regular meetings at such time and at such places as designated by Board policy, but in no event shall there be fewer than two such meetings in any calendar year. Regular meetings of the Board may be held without notice. Special meetings shall be called by the Secretary-Treasurer at the request of the President or upon written request to the President of at least 20 percent of the members of the Board then in office. The object of such special meetings shall be stated in the meeting notice, and no business other than that specified in the notice shall be transacted at the meeting. Notice of a special meeting shall be provided not less than two (2) days before the meeting.

b. Quorum. A majority of the membership of the Board then in office shall constitute a quorum for the purposes of transacting business.

c. Manner of Acting. The affirmative vote of a majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except as otherwise provided by law, by the Articles of Incorporation, or by these Bylaws. Each Director shall have one (1) vote on all matters submitted to a vote of the Board of Directors. No Director voting by proxy shall be permitted.

d. Teleconferencing. To the extent permitted by law, any person participating in a meeting of the Board of Directors may participate by means of conference telephone or by any means of communication by which all persons participating in the meeting are able to hear one another, and otherwise fully participate in the meeting. Such participation shall constitute presence in person at the meeting.

e. Action by Unanimous Written Consent. Any action required to be taken at a meeting of the Board of Directors or any action which may be taken at a meeting of the Board
Section 7: Chair of the Board. The Board of Directors may elect a Chair of the Board from among its members. The Chair of the Board shall have such duties and responsibilities and may be elected according to such procedures as may be determined by the Board from time to time.

Section 8: Executive Committee. The Executive Committee of the Board of Directors shall consist of the President, Vice President, President-elect, Immediate Past President, Chair of the Board, and Secretary-Treasurer. The Executive Committee shall be empowered to act for the Board of Directors on emergency matters only. Actions of the Executive Committee shall be reported to the Board of Directors no later than the Board’s following meeting. All such Committee actions must be reviewed and ratified by the Board of Directors and shall be included in the official Board minutes.

Section 9: Resignation or Removal of Directors and Officers of the Corporation. Any Director or Academy Officer may resign at any time by giving written notice to the President or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any Director-at-large, Student Director, or Academy Officer (excluding the Vice President) may be removed from office at any time, with or without cause, by the affirmative majority vote of those members entitled to elect them. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the Director or Officer. Vacancies in these positions shall be filled in accordance with Article XIII, Section 10 of these Bylaws. Removal of the Vice President/Speaker shall be done in accordance with Article VI, Section 3 of these Bylaws pertaining to House Officers.

ARTICLE VIII Chief Executive Officer.

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

ARTICLE IX Judicial Affairs.

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

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

Section 3: Anyone may in good faith refer charges against any Academy member or 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 – page 180), 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 – page 180), 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 or temporary permit currently revoked as the result of a final adjudicated disciplinary action for violation of their professional practice statutes or regulations, then their AAPA membership shall be automatically revoked.

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

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

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

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

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

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

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

a. Receiving applications from potential candidates seeking nomination for the positions of president-elect, secretary-treasurer, and directors-at-large;

b. Evaluating all candidates seeking nomination according to the qualification criteria set forth in these Bylaws and according to such other selection guidelines as may be established by the Board of Directors;

c. Endorsing a single or multiple slate of candidates for each nominated position.

Section 2:  Composition; Method of Election or Appointment.  The Nominating Work Group is composed of seven (7) members of which five (5) are elected by plurality vote at the House of Delegates annual meeting. Two members are appointed by the Board of Directors. Nominating Work Group candidates should pre-declare their candidacy; however, write-in candidates, and nominations and self-declarations from the House floor will be accepted at the time of elections. The House of Delegates shall determine procedures for the election of non-Board appointed members to the Nominating Work Group.

Section 3:  Eligibility and Qualifications. Nominating Work Group members may not run for any of the positions they are evaluating for the upcoming election. Additionally:

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

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

c. A candidate must have accumulated at least three distinct years of recognized leadership experience in the past five years through service to the AAPA; an AAPA constituent organization; an AAPA affiliated organization; and/or a healthcare-related professional or community organization. Examples include, but are not limited to: service in the AAPA House of Delegates; the PA Foundation; PAEA; a local hospice support organization; a hospital board.
   a. Recognized leadership experience must be earned in, at least, two major areas of professional involvement.
   b. Recognized leadership experience includes a board member or organization officer; an elected or appointed representative; or a chair of a commission, committee, work group or task force.
   d. Any calendar year or Academy year in which the candidate served in more than one area of professional involvement shall be counted as one distinct year of experience.
   e. With the exception of the Board-appointed members, a Nominating Work Group member cannot hold any other elected office or commission or work group position in AAPA during the time of service on the Nominating Work Group.

Section 4:  Term of Service.  The term of service for members of the Nominating Work Group shall be two (2) years. Terms shall be staggered. Individuals appointed to temporarily fill a vacancy shall be eligible to run for the vacated seat. The unexpired term the appointee previously filled shall not be counted as a filled term for purposes of determining work group tenure.
Section 5: Vacancies. Nominating Work Group vacancies shall be filled in the following manner:

a. Board-appointed Member. The Board of Directors shall appoint a replacement member to fill the remainder of the unexpired term.

b. Elected Members. The House Officers shall appoint a temporary replacement member. The temporary appointees shall serve until replaced by the House of Delegates in the following manner: (1) the position shall be declared open for election at the next House of Delegates election and shall be filled by appropriate election process; and (2) upon completion of the election, the temporary appointee shall continue to serve until the newly elected work group member takes office at the next change of office.

ARTICLE XII Rules of Order.

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

ARTICLE XIII Elections.

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

Section 2: Term of Office. 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. Eligible members, as described in Section 6 of this Article, shall elect a new President-elect from the candidates proposed and any candidates that self-declare. The elected
candidate will take office immediately and will serve the remainder of the un-expired term.

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

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

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

**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 or work group, (c) any Chapter, (d) any officially recognized specialty organization, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers.

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

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

Section 5: Each 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 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.
SR-1000  HOUSE OF DELEGATES STANDING RULES

SR-1100  PHILOSOPHY OF PARLIAMENTARY PROCEDURES AND STANDING RULES

The purpose of parliamentary procedure is to facilitate the orderly transaction of business and promote cooperation and harmony in deliberative bodies. Embodied in parliamentary procedure are the following fundamental principles.

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

It is the obligation of the Speaker to preside over the House and to always govern in accordance with the above principles. Attaining the will of the majority of the House must always be the ultimate goal of the Speaker. In that process, the House shall recognize that the motive should outweigh the form by which it is achieved. The Speaker must recognize the right of the House to challenge and reverse any decision made by the Speaker with regards to execution of procedure and the interpretation of its decisions.

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

1. North Carolina Statutes
2. Articles of Incorporation
3. Bylaws of the Academy
4. Standing rules of the House of Delegates

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

SR-1200  POLICY MANUAL

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

SR-1210
Terminal policy is defined as policies that either have a set period during which they are in effect, or have no current or future policy value. The House of Delegates authorizes the House Officers to delete terminal
policies, as they occur. The Speaker shall give an accounting of all terminal policies, so removed from the AAPA Policy Manual, in the Speaker’s Annual Report.

SR-1215
Transitory and/or temporary measures (i.e., those to be carried out before the next House meeting) will not be included in the published AAPA Policy Manual.

SR-1220
Policies and policy papers adopted by the House shall expire five years after adoption unless revised, referred, or reaffirmed.

SR-1225
AAPA Policy Definitions

There are two vehicles utilized to articulate policy:

1. Policy statement
2. Policy paper

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

(1) Policy Statement
A policy statement is a relatively short, concise statement setting forth Academy policy on a particular topic. Policy statements cover fundamental issues of mission, typically involving questions of Academy direction, values, priorities and philosophies/principles that guide other decisions. Policies may also include philosophical decisions that may affect or recommend allocation of resources, activities, and relationships among the Board, House of Delegates, commissions, work groups, constituent organizations, and staff departments. The House of Delegates determines policy that establishes the collective values, philosophies, and principles of the PA profession. A policy statement brought to the House floor for approval or review may be amended on the floor of the House.

(2) Policy Paper
A policy paper presents Academy policy and supporting information on a particular topic. It is differentiated from a policy statement by its supporting information citing data from a variety of sources and may include a bibliography. The House of Delegates approves policy papers. A policy paper brought to the House floor for approval or review may be amended on the floor of the House.

In addition to those documents noted above, the following two types of non-policy documents are utilized to guide the Academy and its components:

(1) Procedure
(2) Rules

Procedure: These documents outline the mechanisms and procedures to handle routine transactions and normal operations. Procedures are matters of form, process, method and application of other policies. The Board of Directors, House Officers, commissions, work groups and staff are responsible for determining procedure.

Rules: Regulations that guide or prescribe everyday conduct. Each functional unit is responsible for establishing its own rules of conduct. (i.e., House Standing Rules, Board Manual, and the staff handbook).
SR-1300  ANNUAL REPORTS

SR-1305
Academy officers, commissions, work groups, and task forces as appropriate, may submit annual reports to the House of Delegates.

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

SR-2000  HOUSE OF DELEGATES - GENERAL

SR-2100  Duties and Responsibilities

SR-2105
Without prejudice to the duties and responsibilities confirmed by statute, by the Articles of Incorporation, or by the Bylaws, the House of Delegates of the Academy shall be solely responsible for the setting of policies that establish the collective values, philosophies, and principles of the PA profession. The House of Delegates may: (a) make recommendations to the Board for granting charters to chapters, official recognition to specialty organizations, and affiliation with special interest groups (b) make recommendations to the Board for the establishment of Academy commissions and workgroups. In addition the House of Delegates shall: (a) vote on amendments to the Bylaws on behalf of its members (b) establish such rules of procedure as may be necessary for carrying out the activities of the House, and (c) establish such committees of the House of Delegates as necessary to fulfill its duties.

SR-2110
The power to amend Bylaws shall be vested with the Board of Directors and the House of Delegates.

SR-2200  Composition

SR-2205
The voting membership of the House of Delegates shall consist of the immediate past and current House Officers, delegates elected by fellow members of chapters, one delegate elected by fellow members of each officially recognized specialty organization and affiliated caucus, Student Academy delegates elected by a process outlined in the Student Academy Policy and Procedures.

SR-2210
Each chapter shall be entitled to two (2) delegates. Additional delegates will be apportioned among the chapters according to the number of the Academy fellow members within the jurisdiction of each chapter as of January 31 of each year. When the number of fellow members within a chapter’s jurisdiction exceeds 220, it will be apportioned a third delegate. An additional delegate will be apportioned for each 300 additional members within a chapter’s jurisdiction thereafter. The Constituent Relations Work Group will define such jurisdiction. For apportionment purposes, each AAPA member shall be required to signify annually in which chapter s/he wishes to be counted.

SR-2215
The Student Academy shall be entitled to one delegate for each 850 Student Academy members as of January 31 of each year.

SR-2220
The term of office for delegates to the House shall be July 1 through June 30.
SR-2225
One delegate from each represented body will be designated as chief delegate in a manner prescribed by that organization.

SR-2230
All eligible chapters, caucuses, and specialty organizations shall submit an official notification of delegates elected to the appropriate staff member at the national office by July 1 of the year the delegate takes office. The process for the identification of delegates shall be established by staff with the approval of the House Officers. Chapters, caucuses, and specialty organizations that fail to meet this deadline may not be eligible to participate in meetings of the House of Delegates unless granted exception by the House Officers not later than two weeks prior to any meeting of the House.

SR-2235
A delegate must be a fellow member or student member in good standing of the Academy.

SR-2240
The voting body will be those delegates currently apportioned and eligible to vote.

SR-2245
Upon notification from the appropriate body of AAPA that a constituent organization of the AAPA has had its charter, recognition, or affiliation agreement revoked, the Credentialing Committee will remove that constituent organization from the list of eligible delegations and any delegates credentialed to that delegation will be notified that they will not be seated until their constituent organization is brought into compliance with AAPA policy.

SR-2250
Current members of the Academy’s Board of Directors, current chairs of commissions, work groups, and task forces, past presidents of AAPA, and past speakers of the House of Delegates shall be advisory members of the House of Delegates and shall have the right to speak and debate.

SR-2300 Meetings and Rules of Order

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

SR-2310
Each delegate eligible to vote is entitled to one (1) vote. No proxy or absentee votes may be cast.

SR-2315
Official observers are representatives from organizations with interests and goals consistent with those of the AAPA and who desire communication with the AAPA House of Delegates. The House grants official observer status by approval of a resolution for an organization to become an official observer. Official observers are recognized by the Speaker for the privilege of the floor. At the discretion of the House Officers, official observers may receive some or all of the published materials of the House as deemed relevant to their interests.

SR-2320
The organization currently granted official observer status in the House of Delegates is the
Physician Assistant Education Association (PAEA).

SR-2325
The House Officers may grant provisional official observer status to organizations as outlined in SR-1400.3.4. Permanent observer status must be ratified by the House.

SR-2330
Official guests are the invited visitors of the House Officers or Board of Directors. They do not receive published House materials, nor automatically have the privilege of the floor. Official guests must request the privilege of the floor for consideration by the Speaker.

SR-2335
The Speaker may extend the privilege to speak to any Academy member, national office staff member or with prior advanced recognition of the Speaker, an officially recognized visitor or observer. The privilege to speak may be extended to other non-Academy members by a majority vote of the delegates present and voting.

SR-2340
In the absence of any provisions to the contrary in the Bylaws, or Standing Rules, all meetings of the House of Delegates shall be governed by the parliamentary rules and usages contained in the current edition of The Standard Code of Parliamentary Procedure.

SR-2345
Persons who have a potential conflict of interest in the matter under consideration must publicly disclose that information before initially testifying at any hearing or meeting of the House.

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

SR-2350
Delegates will receive a copy of AAPA Conflict of Interest and Disclosure Policies and shall complete the disclosure form at the start of each leadership year, or prior to beginning service in the HOD if the appointment does not align with the leadership year. Delegates shall update their disclosure forms as soon as they are aware of any new potential conflict.

At the start of each leadership year, the Credentialing Committee will receive a copy of the AAPA Conflict of Interest and Disclosure Policies and instruction on implementation of the policy.

The Credentialing Committee, with the aid of governance staff, will evaluate the disclosure forms in accordance with the AAPA Conflict of Interest and Disclosure Policies and determine whether a particular transaction, relationship or other arrangement may constitute an actual, potential or perceived conflict of interest, and if so, how to resolve the matter.

Prior to any convening of the HOD, the Credentialing Committee will provide a written report to the Speaker if there is a delegate who has disclosed a relationship that requires mitigation. The report should contain the name of the delegate(s), the relationship disclosed and the mitigating action. The Speaker may choose to amend the mitigating action.

The Speaker will provide a compliance report to the Board of Directors’ Internal Affairs Committee that will include confirmation that all delegates have submitted a disclosure form and a copy of the Credentialing Committee report, including any Speaker amendments.
SR-2355
The chairpersons of all commissions, work groups, and task forces of AAPA shall have the privilege to make the following motions regarding any resolution upon which their respective commission or work group is the sponsor:

- Amend
- Postpone to a certain time (postpone definitely)
- Postpone temporarily
- Refer to committee
- Division of a question
- Withdraw a motion
- Make a parliamentary inquiry

SR-2400 Order of Business

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

SR-2410 The agenda for the meetings of the House of Delegates shall be determined by the House Officers and published in the House materials.

SR-2500 Officers

SR-2505 The elected officers of the House of Delegates are a Speaker of the House, who shall serve as vice president of the Academy, a first vice speaker, and a second vice speaker.

SR-2510 Each House Officer elected will become a delegate at large during the term(s) as a House Officer, plus one additional year as an immediate past House Officer. The delegates at large shall be accorded all the rights and privileges of elected delegates.

SR-2515 The Speaker presides at all business meetings. The first vice speaker assumes the duties of the Speaker in the event of the temporary absence of the Speaker. The second vice speaker assumes the duties of the Speaker in the event of the temporary absence of the Speaker and the first vice speaker. The second vice speaker keeps the records of all meetings of the House.

SR-2520 The sergeant-at-arms, with the oversight of the second vice speaker, is responsible for the verification of the credentials of delegates.

SR-2525 The Speaker shall report all activities and actions of the House of Delegates to the Board of Directors at its next meeting.

SR-2600 Elections

SR-2605 At each annual meeting of the House of Delegates, there shall be elected from the House of Delegates a Speaker of the House who shall also serve as vice president of the Academy, a first vice speaker of the House,
and a second vice speaker of the House. Each shall be elected by a majority of votes cast. No absentee or proxy vote shall be cast.

SR-2610
In the event that no majority is obtained by a House office candidate, a run-off ballot will be between the two candidates receiving the highest plurality of votes. Write-in candidates are not permitted.

SR-2615
The names of candidates for the offices of Speaker, first vice speaker, and second vice speaker shall be placed in nomination either at the time of call for nominations from the Governance Commission or from the floor of the House of Delegates during the annual meeting. The call for nominations from the floor shall take place at a time designated by the House Officers.

SR-2620
All candidates for a House Officer position must be credentialed delegates and must meet all criteria outlined in Article XIII, Section 3 to be eligible. It is highly recommended that candidates have recent AAPA House of Delegates, Board of Directors, reference committee, commission, work group, or task force experience.

SR-2625
The names of candidates for the offices of Speaker, first vice speaker, and second vice speaker shall be read before the House of Delegates. All candidates whose names are placed in nomination must consent to such nomination. The voting membership of the House of Delegates shall consist of delegates present at the time of elections who are apportioned and eligible to vote.

SR-2630
The term of office of the House Officers shall begin July 1 or in the event that the election of the House Officers occurs later than July 1, the new House Officers will take office at the close of the meeting during which they were elected.

SR-2635
In the event of a vacancy in the office of Speaker, the first vice speaker shall assume both the duties and the office of the Speaker. In the event of a vacancy in the office of first vice speaker, the second vice speaker shall assume the duties and the office of first vice speaker. A vacancy in the office of second vice speaker shall be filled by an electronic vote of eligible delegates who will elect from a list of candidates prepared by the House Elections Committee. An electronic vote to fill a vacancy in the office of second vice speaker will only be called for if the remaining term is greater than three (3) months prior to the annual meeting.

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

SR-2640
The procedures for the election of House Officers shall be the responsibility of the Governance Commission. One member of the Governance Commission shall serve on the House Elections Committee to oversee House elections.

SR-2645
Five (5) members of a seven (7) member Nominating Work Group shall be elected by the House of Delegates at the annual meeting. The Board of Directors shall appoint the final two members. Nominations for this work group shall be made either at the time of call for nominations from the Governance Commission or from the floor of the House of Delegates. Member of the Nominating Work Group shall be fellow members of the
Academy and shall meet such eligibility requirements as stated in the Bylaws. Elections for members of the Nominating Work Group shall be held at the time of election of House Officers. The term of office for elected members of the Nominating Work Group shall be a two (2) year staggered term. The voting membership of the House of Delegates shall consist of apportioned delegates present at the time of elections. Members shall be elected by a plurality vote. The House of Delegates shall determine procedures for the election of non-Board appointed members to the Nominating Work Group *Bylaws Art XI, Sect 2 & 3.*

**SR-2650**
The qualifications for candidates for the Nominating Work Group shall be found in Article XI, Section 3 of the AAPA Bylaws.

**SR-2655**
If a complete, unopposed slate of candidates is presented for House election, a simple majority of delegates seated shall be required to immediately elect the slate of candidates.

**SR-2700 Resolutions**

**SR-2705**
Resolutions are defined as expressions of policy establishing the collective values, philosophies, and principles of the PA profession. Resolutions may further be defined as proclamations of importance to the profession such as expressions of congratulations, commendation, or condolence.

**SR-2710**
Non-Bylaws resolutions may be submitted by (a) the Board of Directors, (b) any commission, work group, or task force, (c) any chapter, (d) officially recognized specialty organizations, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers. 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 eligible to submit resolutions for consideration.

**SR-2715**
The House Officers shall create guidelines for resolution submission. Resolutions must be submitted in the approved format. Sponsors of resolutions may obtain endorsement of their resolutions by other delegations.

**SR-2720**
Sponsors of resolutions shall submit the financial impact of the proposed resolutions.

**SR-2725**
Resolutions calling for changes in the Bylaws must comply with Bylaws Article XIV. Amendments to the Bylaws to be considered at the annual meeting must be received in the national office at least three (3) months prior to the convening of the House of Delegates. Amendments to the Bylaws to be considered for electronic vote must be received 150 days or greater prior to the convening of the House of Delegates. Other resolutions must be received in the national office at a time to be determined and published by the House Officers.
SR-2730
A resolution may be referred for further study. A resolution referred for study, will become the property of the receiving body. That body will report back to the House of Delegates:

- The referred resolution with a recommendation to accept or reject, or
- With an amended or substitution resolution, as long as the resolution proposed deals substantially with the intent of the original resolution.

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

SR-2800 House of Delegates Committees

SR-2805
The Standing Rules Committee shall be appointed annually by the House Officers to review the Standing Rules and make recommendations concerning the Standing Rules to the House of Delegates. The Standing Rules Committee shall be composed of, the sergeant-at-arms, and at least two volunteers with House experience. The second vice speaker shall serve as advisor to the Standing Rules Committee.

SR-2810
The House Elections Committee will be responsible for conducting all elections in the House. The committee will also be responsible for confirming the qualifications for candidates for the House Officers and for the Nominating Work Group. The committee will consist of three members: one member from the Governance Commission, one member from the House, and the chair of the Tellers Committee. The members are appointed by the Speaker of the House in conjunction with the chair of the Governance Commission. The Governance Commission must approve the procedures for election of House Officers. The House Officers must approve the procedures for election of the Nominating Work Group.

SR-2815
The Credentialing Committee will be responsible for credentialing all delegates under the direction of the first vice speaker.
The Credentialing Committee shall be composed of the sergeant-at-arms who shall act as the chair, the staff advisor to the House of Delegates, and at least 3 other fellow or student members appointed by the House Officers.

The duties of the Credentialing Committee shall include:
1. Confirming that each delegation and delegate is in compliance with current academy policy in regards to credentialing.
2. Notifying delegations or delegates that are out of compliance and providing needed information so that the delegation/delegate can become credentialed.
3. Staffing the credentialing desk at the HOD annual meeting. The committee will be responsible for collecting any certificates signed by the president, secretary, secretary/treasurer or chief delegate of a constituent organization when there is a change in the status of any delegate from that previously submitted. In addition, the committee will verify the names of credentialed delegates and distribute a delegate ribbon and any other materials needed for the meeting.
4. Collecting a disclosure form from each delegate. The committee will review the disclosure forms and notify the Speaker of any potential conflicts of interest.
SR-2900 House Awards

SR-2905
The House of Delegates will present an award for outstanding service annually. The House Officers shall determine the criteria, award, and recipient.

SR-3000 IN-PERSON MEETING RULES

SR-3100 In-Person Meeting General

SR-3105
A majority of the total number of delegates who are apportioned and eligible to vote shall constitute a quorum at any meeting of the House of Delegates. Once a quorum has been validated, a vote by a majority of the seated delegates shall constitute action of the House. Exceptions to action by majority vote are specifically delineated in AAPA Bylaws or policy or in the Standard Code of Parliamentary Procedure.

SR-3110
Except as provided for in SR-2710 and SR-2355 of these House of Delegates Standing Rules, only seated delegates may introduce business, make motions, or vote.

SR-3115
The House may meet in an open meeting to which any registered conference attendee, Academy member or officially recognized visitor or observer may be admitted. Other individuals may be admitted at the discretion of the Speaker. However, no one under 18 years of age will be admitted during any session of the House, formal or informal, except at the discretion of the Speaker of the House. Notice of meetings of the House of Delegates shall be given to each delegate at least 30 days before in-person meetings. By a majority vote of the delegates present and voting, an open meeting may be moved into a closed meeting. By a two-thirds vote of the delegates present and voting, an open meeting may be moved into an executive meeting. A closed meeting shall be restricted to fellow and student members of the Academy and to such persons as the delegates determine. An executive meeting shall be limited to the voting membership of the House.

SR-3120
The sergeant-at-arms and tellers shall assist persons not seated in the House of Delegates in requesting the privilege to speak and confirm the membership of those individuals not wearing a badge.

SR-3125
Debate on a motion and discussion on an issue shall include input from proponents and opponents. The Speaker may limit the length of time allotted for debate on a particular topic. A delegate who has not spoken is privileged over one who has already discussed the motion. Each speaker shall be limited to five minutes on initial presentation, and three minutes on any subsequent presentation. The Speaker may call on individuals to provide information as expert witnesses whose testimony shall be limited to the provision of information. A motion to vote immediately must be presented formally. When attempting to end the debate, a delegate may not precede the motion to vote immediately with testimony.

SR-3130
The Speaker shall appoint a parliamentarian and a sergeant-at-arms. The parliamentarian answers any questions about parliamentary procedure that arise during House proceedings and advises the presiding officer. The sergeant-at-arms preserves order during the House of Delegates meeting, maintains security of the floor and in cooperation with the chair of the Tellers Committee, supervises the tellers in controlling access to the floor, and provides support to House Officers and delegates. The sergeant-at-arms is a member of the Standing Rules Committee and chairs the Credentialing Committee.
SR-3135
The chair of the Tellers Committee and the sergeant-at-arms will coordinate the activities of tellers during the House of Delegates. All materials and other handouts must be approved by the Speaker or his/her designee, and will be distributed to the delegates from the sergeant-at-arms desk.

SR-3140
The Standing Rules of the House of Delegates may be amended or suspended by two-thirds (2/3) vote of seated delegates. The Standing Rules remain in effect unless acted upon by the House.

SR-3145
Roll call voting of the House of Delegates will be permitted after appropriate motion, second, and passage by a three-fourths (3/4) vote of the delegates who are seated. The procedure for a roll call vote will be determined by the Speaker.

SR-3150
In order to conduct the business of the House of Delegates with clarity and good order, communications devices should not be audible in the House of Delegates room. Placing these devices in a quiet mode is acceptable with the caveat that any cell phone conversations be conducted outside the doors of House of Delegates during House of Delegates activities.

SR-3200 Resolutions

SR-3205
Late resolutions shall be defined as those resolutions that have been submitted after the deadline outlined in SR-2725, but prior to the convening of the House. Sponsors who wish to submit late resolutions must notify the Speaker of their desire to do so prior to the opening session. A Resolutions Review Committee consisting of the reference committee chairs and at least one House Officer will review each late resolution and report to the House whether or not it believes each late resolution should be accepted for consideration. If there is any objection from the floor, a two-thirds (2/3) vote of the delegates present and voting is necessary to accept the late resolution for consideration.

Any resolution to amend the Bylaws must comply with Article XIV of the Bylaws.

Emergency resolutions shall be defined as those resolutions submitted after the convening of the House. Emergency resolutions are to be submitted under “additional new business” and distributed to the delegates for review. Emergency resolutions require an 80 percent vote of delegates present and voting for consideration. Resolutions of condolence will not be considered emergency resolutions, and will instead be acted upon per Standing Rule SR-3225.

SR-3210
Resolutions submitted for consideration by the House shall be numbered and assigned to a reference committee or the consent agenda by the Speaker. Until the resolution is accepted by the House of Delegates, it may be withdrawn by the sponsor. If there are no objections to considering the resolutions, they will be referred to the appropriate reference committee or placed on the consent agenda. Objections to a resolution can only be based on whether the resolution is in order. Resolutions brought to the House by a body receiving a referral from a previous House cannot be objected to or withdrawn. After acceptance of the resolution they become the property of the House of Delegates which then has the sole right to any action on the resolutions.

SR-3215
The general consent agenda shall contain: the policies from the five-year review process under the jurisdiction of the House of Delegates as well as any properly submitted resolutions selected by the Speaker. Any
objection from the floor to the placement of an item on the general consent agenda will result in the item being assigned a resolution number and being referred to a reference committee.

SR-3220
Resolutions adopted by the House of Delegates that are expressions of philosophy shall become official Academy policy.

SR-3225
Resolutions of Condolence
Resolutions of condolence will not require introduction as part of the standard resolution process. Resolutions of condolence should be submitted prior to the convening of the House. Resolutions of condolence submitted prior to the House will be included with the Speaker’s report. Once the House convenes, all resolutions of condolence must be given to the sergeant-at-arms prior to the final general session. Resolutions of condolence shall automatically be accepted by the House without further comment, debate or vote. At the end of the House, the names will be read and they will be honored with a moment of silence. The House Officers will insure that the Academy maintains an appropriate historical archive of these resolutions. Resolutions of condolence will not be considered by the House as emergency resolutions.

SR-3230
Special Resolutions
Special resolutions of congratulations, recognition, or other special resolutions deemed appropriate by the House Officers shall be introduced as a part of the Speaker’s report and will not require introduction as a part of the standard resolution process. Upon inclusion in the Speaker’s report, these resolutions shall automatically be accepted by the House without further comment, debate, or vote. The House Officers will insure that the Academy maintains an appropriate historical archive of these resolutions.

SR-3235
Delegates are encouraged to review, discuss and evaluate each resolution before the opening of the AAPA House of Delegates. AAPA resources may be used to facilitate these activities as long as their use allows for the representation of all points of view and does not conflict with AAPA policy (BA-2500.1.5, BA-2500.1.6).

SR-3300 Reference Committees

SR-3305
Reference committees shall conduct hearings during the annual meeting of the House of Delegates for the purpose of hearing testimony on resolutions that have been accepted for consideration by the House.

SR-3310
At the conclusion of reference committee hearings each committee shall write and submit to the House a report containing a summary of the testimony and reference committee research on each resolution and a recommendation for House action on each resolution.

SR-3315
Any motion offered by a reference committee does not require a second.

SR-3320
Reference committees are appointed by the House Officers. Each reference committee shall be composed of at least five Academy fellow/student members. The chair of each reference committee shall be a credentialed delegate.
SR-3325
The House Officers shall publish guidelines for reference committees.

SR-3330
Reference committee reports will proceed as follows:
- All recommendations of the reference committee will be placed on the reference committee consent agenda.
- The Speaker will entertain requests for extraction of individual resolutions from the reference committee consent agenda. A resolution will be extracted upon the request of any seated delegate.
- The House will vote immediately to accept the reference committee consent agenda once all requests for extraction have been heard.
- A vote to accept the reference committee consent agenda will be a vote to accept the recommendations of the reference committee on each consent agenda resolution.
- Extracted resolutions will then be reported out by the reference committee, considered and voted upon individually.
- Amendments suggested in reference committee reports will be considered first order amendments and will not require a second.
- When a resolution with a proposed reference committee amendment is extracted, second order amendments will not be allowed.

SR-3400 Conference Committees

SR-3405
The Resolutions Review Committee shall be convened as necessary to review late or emergency resolutions as provided in SR-3205.

SR-3410
The Tellers Committee assists the sergeant-at-arms in facilitating the activities of the House of Delegates. The Tellers Committee chair is appointed by the Speaker of the House. Duties include: 1) securing the House floor; 2) monitoring the activity on the House floor; 3) distributing materials in the House; 4) facilitating votes on the House floor; 5) conducting roll call votes; 6) assisting those not seated in the House to request the privilege to speak; 7) confirming the delegate status and other eligibility criteria for House Officer candidates.

SR-4000 VIRTUAL MEETING RULES

SR-4100 Virtual Meeting General

SR-4105
Any action taken in a virtual House meeting format shall have the same authority as any action taken during an in-person meeting.

SR-4110
Notice of House of Delegates meetings, other than those held in-person, shall be given to each delegate at least 5 days in advance of the meeting.

SR-4115
Virtual meetings and or electronic voting in the House of Delegates will be permitted for any House business. Virtual meetings and or electronic voting will be called for by the Speaker of the House when directed by (1) a majority of the House Officers; 2) a two-thirds affirmative vote of the Board of Directors; or 3) a call from twenty-five (25) percent of the delegates who are apportioned and eligible to vote. The House Officers and
Academy staff shall determine the procedures for voting on issues requiring an electronic ballot, subject to the requirements of the North Carolina Nonprofit Corporation Act.

If 25% of delegates eligible to vote object to voting on a particular resolution electronically, it will be deferred to the annual meeting. The options for online voting will be yes, no, or abstain.

SR-4120
1. For an electronic vote, receiving responses from a majority of delegates who are eligible to vote shall constitute a quorum.
2. A resolution requiring an electronic vote shall be decided by a majority of the votes cast. Except for a resolution to amend the Bylaws, which requires a 2/3 vote to pass.

SR-4125
Electronic discussion on resolutions will be posted for review by delegates for a minimum of 5 days prior to a virtual meeting.

SR-4130
The procedure for posting, discussion and voting will be outlined by the House Officers. Only the business stated in the notice will be transacted during the electronic discussion and voting.

SR-4135
Any delegate submissions or changes to the order of delegates must be submitted 48 hours prior to the established virtual meeting time.
HA-2000.00   ACADEMY/ORGANIZATION

HA-2100.0   HOUSE ACADEMY

HA-2100.1.0   Educational Philosophy

HA-2100.1.1
AAPA should provide ongoing educational experiences that are focused on diversity and health care disparity issues.

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

HA-2100.2.0   Leadership

HA-2100.2.1
The House of Delegates encourages the AAPA Board of Directors to provide face to face opportunities for volunteer PA leaders to conduct business successfully on behalf of the profession.
[Adopted 2010, reaffirmed 2015]

BA-2200.00   ACADEMY/ORGANIZATION – DEFINITION

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

BA-2300.00   CONSTITUENT ORGANIZATIONS

BA-2300.1.0   Constituent Organizations, General

BA-2300.1.1
AAPA defines the following positions as officers of a constituent organization: President, President-elect, Vice President, Secretary and Treasurer, and/or Secretary-Treasurer. This policy does not require any constituent organization to have a particular office.
[Adopted 2012, amended 2016]

BA-2300.1.2
The time when AAPA constituent organization officers may take office may be either January or July 1. However, constituent organizations are encouraged to have a standard term of office for their elected officers beginning July 1 and continuing through June 30.
BA-2300.1.3
AAPA believes that all constituent organizations should adopt a code of ethics. In an effort to maintain one standard of ethical behavior for the profession, constituent organizations are strongly advised to utilize the *Guidelines for Ethical Conduct for the PA Profession* (Policy Paper 15 – page 180).

BA-2300.1.4
AAPA strongly encourages all constituent organizations to have a diversity contact/committee.

BA-2300.1.5
AAPA recommends all constituent organizations include a federal liaison position on their Government Affairs Committee or comparable body to coordinate national PA legislative efforts.
[Adopted 2012, amended 2016]

BA-2300.1.6
AAPA assists constituent organizations in maintaining active status.

BA-2300.1.7
At the annual meeting of the House of Delegates, the appropriate work group will present a report providing the status of all constituent organizations.

BA-2300.1.8
Constituent organizations may not deny any form of membership to a fellow member of the AAPA unless the individual’s fellow membership has been revoked for reason of an ethical or judicial nature by the AAPA or by a constituent organization through a process consistent with AAPA policies.

**BA-2300.2.0**  Chapter Rules

BA-2300.2.2
All officers (as defined in BA-2300.1.1) of a chapter must be and remain fellow members or student members in good standing of the AAPA for the duration of their term in office. Additionally, all chapter officer positions, if filled, must be filled with fellow members or student members of AAPA.

BA-2300.2.4
AAPA members who belong to more than one chapter may vote on AAPA issues in only one chapter.

**BA-2300.3.0**  Relationship to AAPA

BA-2300.3.1
A chapter of AAPA is an independent chartered PA organization that abides by the terms of the charter agreement.
BA-2300.3.2
The chapter retains the right to pursue individual goals and initiatives without interference from AAPA, provided that the chapter is consistent with the terms of the charter agreement.

BA-2300.3.3
All fellow members of a chapter must be fellow members of AAPA. Chapters may amend their bylaws to create alternative membership categories, which may include chapter members who elect not to join AAPA or are ineligible for AAPA fellow membership. Non-fellow members of chapters may be active in chapter affairs but may not participate in issues relating to AAPA, such as voting for delegates, submitting resolutions, or representing the chapter in the AAPA House of Delegates.

BA-2300.3.4
Each chapter in a state, the District of Columbia or a U.S. territory in which a PA program exists should provide at least one seat to a student member on their Board of Directors. AAPA encourages these constituent organizations to formally confer full voting privileges in their bylaws to these student board members. The physical location of a PA program should determine the state or constituent organization of student service.

BA-2300.4.0  Chartering Guidelines

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

Chapter applications shall be provided to the appropriate work group for review. The appropriate work group may make a recommendation to the Board of Directors. If the chapter’s application is approved by the Board of Directors, a charter will be issued to the chapter.

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

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

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

BA-2300.4.2
Chapters with a revoked charter will be ineligible to receive AAPA staff resources or financial support with the exception of assistance that may be required to comply with AAPA policy.
BA-2300.4.3
The appropriate work group shall review the charter of each chapter on a five-year cycle and make recommendations to the Board of Directors for its consideration.

**BA-2300.5.0  Specialty Organizations**

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

Specialty organizations provide valuable information and insight about their specialty to AAPA membership and leadership. Specialty organizations are not chartered, but remain an integral part of the complex framework that assures AAPA the maximum amount of knowledge and understanding of all issues involving PAs in that specialty. Specialty organizations strengthen the PA profession through interactions with their medical and professional counterparts. These relationships allow specialty organizations to partner with AAPA to effectively address challenges such as reimbursement, clinical practice, and regulation.

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

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

Specialty organization applications shall be provided to the appropriate work group for review. The appropriate work group may make a recommendation to the Board of Directors. If the specialty organization is approved by the Board of Directors, a recognition agreement will be issued to the specialty organization.

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

Recognized specialty organization meeting the requirements set by this policy may be represented in the House of Delegates in accordance with AAPA Bylaws.
Recognized specialty organizations that fail to abide by the terms of the recognition agreement may have their recognition referred to the appropriate work group for review. The work group may recommend to the Board of Directors revocation of the recognition until the specialty organization meets the agreement’s terms. Delegates for specialty organizations that have had their recognition revoked will not be seated in the House of Delegates.  

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

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

**BA-2300.5.5**
All officers (as defined in BA-2300.1.1) of a recognized specialty organization are required to be and remain fellow members or student members in good standing of AAPA for the duration of their term in office. All officer positions of a specialty organization, if filled, must be filled with fellow members or student members of AAPA.  

**BA-2300.5.6**
AAPA specialty organizations are encouraged to involve PA students in their leadership activities and encouraged to confer full voting privileges upon student board members in their bylaws.  

**BA-2300.5.9**
The appropriate work group shall review the recognition of each specialty organization on a five-year cycle and make recommendations to the Board of Directors for its consideration.  

**BA-2300.5.10**
Specialty organizations with a revoked recognition agreement will be ineligible to receive AAPA staff resources or financial support with the exception of assistance that may be required to comply with AAPA policy.  
[Adopted 2016]

**BA-2300.5.11**
The specialty organization retains the right to pursue individual goals and initiatives without interference from AAPA, provided that they are consistent with the terms of the recognition agreement.  
[Adopted 2016]
BA-2300.6.0 Caucuses

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

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

Caucus applications will be reviewed by the appropriate work group. The appropriate work group may make a recommendation to the board of directors. If approved by the board of directors, an affiliation agreement will be issued to the caucus.

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

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

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

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

BA-2300.6.5
All officers (as defined in BA-2300.1.1) of a caucus must be and remain fellow members or student members in good standing of AAPA for the duration of their term in office. All caucus officer positions, if filled, must be filled with fellow members or student members of AAPA.

BA-2300.6.7
AAPA caucuses are encouraged to involve PA students in their leadership activities and encouraged to confer full voting privileges upon student board members in their bylaws.
The appropriate work group shall review the recognition of each caucus on a five-year cycle and make a recommendation to the Board of Directors for its consideration.


A caucus retains the right to pursue individual goals and initiatives without interference from the AAPA, provided that they are consistent with the terms of the affiliation agreement.

[Adopted 2016]

Caucuses with a revoked recognition agreement will be ineligible to receive AAPA staff resources or financial support with the exception of assistance that may be required to comply with AAPA policy.

[Adopted 2016]

**BA-2300.7.0 Special Interest Groups**

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

Special interest group applications will be reviewed by the appropriate work group. The appropriate work group may make a recommendation to the Board of Directors. If approved by the Board of Directors an affiliation agreement will be issued to the special interest group.

An affiliated special interest group shall:

- Maintain a minimum of five (5) AAPA fellow members as supporters
- Sign an AAPA affiliation agreement
- Abide by the terms of the affiliation agreement

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

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


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


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

[Adopted 2016]
BA-2300.7.4
A special interest group with a revoked affiliation agreement will be ineligible to receive AAPA staff resources or financial support with the exception of assistance that may be required to comply with AAPA policy.
[Adopted 2016]

BA-2300.7.5
The appropriate work group shall review the affiliation of each special interest group on a five-year cycle and make a recommendation to the Board of Directors for its consideration.
[Adopted 2016]

BA-2400.00 ACADEMY/ORGANIZATION – GOVERNANCE

BA-2400.1.0 General

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

BA-2400.1.2
The Board of Directors has sole authority for policies regarding the management of the organization, including, but not limited to, management of the organization’s property, business, financial affairs, and judicial affairs. It is responsible for setting the strategic direction of the organization.
[Adopted 2017]

BA-2400.2.0 Student Academy

BA-2400.2.1
AAPA grants the Student Academy the right to operate as a subsidiary unit representing AAPA student members. In so doing, the Academy reserves the right to monitor the Student Academy’s adherence to AAPA’s Bylaws and policies. Accordingly, the Student Academy will submit a revised copy of its governing documents, within thirty (30) days of each revision, to the AAPA Judicial Affairs Commission for review.

BA-2400.2.2
The Student Academy of the AAPA is the national representative body of AAPA student members and, as such, while embracing all AAPA Bylaws and policies, the Student Academy further strives to serve students (Bylaws, Article V, Section 1). The Student Academy retains the right to address student concerns and issues, provided that the Student Academy adheres to its responsibility to follow the Bylaws, policies and procedures of AAPA in the process.

BA-2400.2.2.1
Policy statements and policy papers relating to the collective values, philosophies and principles of the PA profession which are adopted by the Assembly of Representatives must be reviewed and approved by the HOD prior to being officially recognized as AAPA policy.
BA-2400.2.2.2
Student Academy members are represented and provide input to AAPA through the Student Academy Board of Directors student delegation to the House of Delegates, the student director of the AAPA Board of Directors, and the student members of AAPA commissions and/or work groups.

BA-2400.2.3
The Student Academy shall receive input from AAPA through an advisor designated by the AAPA Board of Directors. Such input would provide additional insight into AAPA, its policies, goals, objectives, and functions, as well as provide additional opportunity for guidance to the Student Academy. The advisor shall sit as a non-voting *ex officio* member of the Student Academy Board of Directors. The advisor shall attend meetings of the Student Academy Board of Directors and other meetings necessary to fulfill the duties of the position.

BA-2400.3.0 Commissions, Work Groups, and Task Forces

BA-2400.3.1.0 Commission
A commission is a permanent group that carries out the volunteer work of the Academy. Each commission is defined by a set of charges. The primary focus of these charges is policy formulation and implementation.

Each commission has a chair and an even number of members, allowing for an overall odd number of group members to facilitate majority voting. In addition to overseeing the responsibilities of the commission, commission chairs oversee the activities of work groups and task forces that exist beneath the umbrellas of appropriate commissions.

BA-2400.3.2.0 Work Group of a Commission
A work group is a leadership body that exists beneath the umbrella of a commission and has a technical role related to the scope of practice of that commission.

Each work group has a chair and an even number of members, allowing for an overall odd number of group members to facilitate majority voting. A work group chair reports to the chair of the appropriate commission.
[Adopted 2010, reaffirmed 2015, 2016]

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]
BA-2400.3.4
All commission and work group members who are PAs shall be members of a constituent organization.

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-2400.4.0 Commissions and Work Groups—Charges

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

- Explore the question “Do PAs increase access to care?” by examining available published data, identifying examples of PAs increasing access, determining how they were successful, and looking for gaps in healthcare access to consider how PAs can better meet patients’ needs. The commission will socialize its ideas and generate conversation through Huddle and other means in order to spread great ideas and provide questions for further research by the PA academic community.
- Develop research questions and potential methodologies that explore the relationship between different approaches to recertification, competency and quality of care, providing direction to the research community with the goal of facilitating expansion of available evidence.
- Support the Board Task Force on Full Practice Authority as required.
- Support AAPA Research and the FY17 Operating Plan by providing ad hoc feedback on survey development, refining research questions, and evaluating external requests for research support as required.
- Consider different ways AAPA can support the PA research community with access to PAs or AAPA research data and propose an optimal support model that minimizes survey fatigue and is ethical in the handling of PA data.
- Review and provide comments on AAPA policies as required.
- Collaborate with other commissions, organizations and staff, as needed, to ensure complimentary cross-organization strategy, research and planning processes.
[Adopted 2014, amended 2015, 2016]

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

- Advise staff regarding the impact of new healthcare models and value-based healthcare delivery on PAs, and serve as a resource on PA payment policy.
- Provide assistance and oversight for the electronic health record work group’s efforts to assure PA inclusion in all electronic health information technologies related to healthcare.
- Make themselves available to interact with the payer community, as necessary, as part of AAPA’s efforts to increase PA visibility in the payer claims process.
- Assist with designing and drafting interstate compact language.
- Review and provide feedback and support for the uniform application.
- Identify current and/or emerging barriers to practice and discuss options to eliminate the barriers.
• Provide advice and counsel on next steps for decoupling of maintenance of licensure and maintenance of certification.
• Provide advice on AAPA’s federal (congressional and regulatory) priorities.
• Assist in recruiting PAs to participate in the Academy’s key contact program and the grassroots advocacy information network (GAIN).
• Review and provide comments on AAPA policies as required and will develop policy recommendations to put forward in the House, as appropriate.
• Collaborate with other commissions and staff, as needed, to ensure complimentary cross-organization strategy, research and planning processes.

[Adopted 2014, amended 2015, 2016]

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

Annual Conference
• Working with staff, support decision making regarding the mix of educational content for the annual conference and help to develop/recruit sessions. This process should take into account the AAPA Strategic Plan, AAPA’s national QI initiatives, optimal models of PA practice, the use of innovative educational methods, ways to provide enhanced learning opportunities, the integration of PI-CME and self-assessment, and the development of new skill sets needed by faculty as they transition from didactic lecturers who deliver content to facilitators of learning.
• Participate in conference proposal grading, review comments provided by the Conference Proposal Graders, curate the CME content, and finalize the conference program.
• Working with staff, develop strategies to engage conference attendees before, during and after the annual conference to promote continuous learning and reinforce content. This will include recommendations for “repackaging” educational content to extend its impact beyond conference attendees.

AAPA’s CPD and Education Strategy
• Advise education staff on elements of AAPA’s overall education program and strategy. This includes making recommendations regarding the mix of specialty vs. primary care focused content produced, clinical vs. nonclinical topics covered, and traditional vs. innovative learning methods employed across AAPA’s educational offerings.
• Identify, read, and help staff apply learning from documents and articles about trends in adult professional learning and innovative instructional design.

General
• Collaborate with other commissions, organizations and staff, as needed, to ensure complimentary cross-organization strategy, research and planning processes.
• Review and provide comments on AAPA policies as required.

[Adopted 2014, amended 2015, 2016]

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

Clinical Guidelines
• Establish criteria to be used when evaluating potential AAPA participation in external opportunities for developing clinical guidelines.
- Review requests for AAPA participation in external opportunities for developing clinical guidelines, recommend whether AAPA should participate, and assist with recruitment of subject matter experts to represent AAPA.
- Make recommendations to the Board regarding requests for AAPA endorsement of clinical guidelines.

**Clinical External Representation**

- Establish criteria to be used when evaluating potential AAPA participation in external clinical outreach opportunities, taking into consideration the broad effect on PA practice and resources (staff/funding) available.
- Review requests for AAPA participation in external clinical outreach opportunities and provide a recommendation on AAPA’s participation.
- Assist with recruitment of subject matter experts to represent AAPA.

**Emerging Clinical Public Health Issues**

- Establish criteria to be used when evaluating potential AAPA participation in emerging clinical health issues opportunities, taking into consideration the broad effect on PA practice and resources (staff/funding) available.
- Review requests for AAPA participation in emerging clinical public health issues opportunities and provide a recommendation on AAPA’s participation.
- Assist with recruitment of subject matter experts to represent AAPA.

**General**

- Review and provide comments on AAPA policies as required.
- Collaborate with other commissions, organizations and staff, as needed, to ensure complimentary cross-organization strategy, research and planning processes.

[Adopted 2014, amended 2015, 2016]

**BA-2400.4.5 Judicial Affairs Commission:**

- Implement the AAPA judicial affairs procedures as approved by the Board of Directors in the Judicial Affairs Procedure Manual and other related policies.
- Collaborate with other commissions, staff, and AAPA Counsel as needed, to provide guidance on ethics-related issues, and ensure organizational compliance and consistency of policies and procedures.
- Carry out other charges as may be directed by the Board of Directors.

**Policy Review**

- Review and provide comments on AAPA policies assigned to it by the House Officers as part of the five year policy review process and develop policy recommendations to put forward in the House of Delegates, as appropriate.
- Review proposed AAPA Bylaws resolutions prior to the House of Delegates and propose technical changes and conforming amendments to the proposal or existing Bylaws as deemed necessary or desirable.
- Collaborate with other commissions, organizations and staff, as needed, to ensure complimentary cross-organizational strategy, research and planning processes.

BA-2400.4.6  
The role of the Governance Commission is to:

- Review all AAPA governance documents to ensure they are not in conflict and reflect best practices in governance/association management. Make recommendations to improve effectiveness and efficiency of operations and transparency.
- Review policies related to membership privileges and responsibilities to ensure they are consistent with related Bylaws.
- Serve in an advisory capacity to the Nominating Work Group and Constituent Relations Work Group.
- Collaborate with the Student Academy to review and revise Student Academy governing documents to ensure adherence with AAPA’s Bylaws, policies and best practices.
- Collaborate with the Judicial Affairs Commission as indicated in the JAC Manual.
- Review and provide comments on AAPA policies assigned to it by the House Officers as part of the five year policy review process and develop policy recommendations to put forward in the House of Delegates, as appropriate.
- Collaborate with other commissions, organizations and staff, as needed, to ensure complimentary cross-organizational strategy, research and planning processes.
- Collaborate with other commissions, staff, and AAPA Counsel, as needed, to ensure organizational compliance and consistency of policies and procedures.

[Adopted 2010, amended 2015, 2016, 2018]

BA-2400.4.7  
Nominating Work Group (of the Governance Commission):

1. Evaluate and endorse the candidates for the Board of Directors that best meet the anticipated needs of the BOD, as identified by the BOD annually.
2. Proactively educate AAPA membership on the endorsement process.

[Adopted 2010, reaffirmed 2015, amended 2016]

BA-2400.4.8  
The role of the Constituent Relations Work Group (of the Governance Commission) is to:

1. review constituent organization applications and make recommendations to the Board of Directors
2. seek opportunities for AAPA to enhance and advance constituent organization relations
3. oversee the constituent organizations awards program
4. carry out other activities as may be requested by the Governance Commission or Board of Directors

[Adopted 2010, amended 2015, 2016]

BA-2400.5.0  Board of Directors

BA-2400.5.1  
The AAPA Board of Directors may provide interim approval of policy for which they do not have specific guidelines from the House between meetings of the House with the following restrictions:

1) The Board of Directors may not alter or amend the function of the House of Delegates.
2) The item receiving interim approval by the Board of Directors must be presented to the House of Delegates for final approval at its next regular meeting.
3) A complete report, justifying the need for interim approval will be communicated by the Speaker to all delegates within forty-five (45) days of the Board of Directors action. 


BA-2500.00 ACADEMY/ORGANIZATION – OPERATIONS

BA-2500.1.0 Academy Rules

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

BA-2500.1.2
The AAPA logo is copyrighted and registered by the U.S. Patent and Trademark Office and may not be altered in any way without permission. Any contemplated use must have prior Academy approval. 

BA-2500.1.3
AAPA stationery should be used only in an official capacity on behalf of the AAPA. 

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

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

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

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

BA-2500.2.2
AAPA shall recognize those AAPA Fellow and Sustaining Members who have distinguished themselves among their colleagues through the distinguished fellows program.
[Adopted 2007, reaffirmed 2012, amended 2016]

BA-2500.2.3
AAPA may recognize excellence and significant contributions to the PA profession through its Awards Program. The Awards Program is overseen by the appropriate work group of the AAPA.

BA-2500.3.0 Information on the Profession

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

BA-2500.4.0 Strategic Goals

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

BA-2500.4.2
AAPA works toward establishing a culture of leadership excellence in the Academy by endorsing and supporting the importance of personal and professional leadership development for PAs.
See: Leading AAPA Towards a Culture of Leadership Excellence (Policy Paper 19 – page 207)

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.

BA-2600.00 ELECTIONS

BA-2600.1.0 Rules and Regulations for Election of Officers and Directors at Large - Elections/Voting
BA-2600.1.1
AAPA supports an electronic means of balloting for the officers and directors at large of AAPA. The protection of confidentiality shall be of the highest concern in the balloting process. Also, anonymity will be respected to the extent possible in order to ensure the security of our balloting process.

BA-2600.1.2
Self-declaration of candidacy for elected office on the Board of Directors of the AAPA, excluding the House Officers, must occur by a date determined by the Board of Directors and the date must be publicized to the general membership.

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

BA-2600.1.4
Receiving a plurality of the votes cast will elect a candidate.

BA-2600.1.5
The term of office for officers and directors at large will begin July 1.

BA-2600.1.6
At the first Board of Directors meeting of the leadership year, the Board of Directors will determine the election process schedule, which will be posted on the AAPA website within two weeks.
[Adopted 2016]

BA-2600.2.0 Rules and Regulations for Election of House Officers - Nominations

BA-2600.2.1.0 Qualifications for Office

BA-2600.2.1.1
House Officers
a. A candidate must be an officially designated delegate listed on the official delegate roster for the upcoming House of Delegates.
b. All candidates for House office must be seated delegates and must be fellow members. It is highly recommended that candidates have recent AAPA House of Delegates, reference committee, Board of Directors, commission, work group or task force experience.

BA-2600.2.2.0 Elections/Voting

BA-2600.2.2.2
The term for the House Officers and the Nominating Work Group will begin July 1.
BA-2700.00 NOMINATING WORK GROUP

BA-2700.1.0 Responsibilities

BA-2700.1.1
a. Receive applications from potential candidates
b. Prepare a single or multiple slate of candidates for the following elected positions:
   • president-elect,
   • secretary-treasurer (in even numbered years),
   • directors at large (2 in even numbered years and 3 in odd numbered years).
c. Provide a list of endorsed candidates to the Governance Commission

BA-2800.00 JUDICIAL AFFAIRS COMMISSION

BA-2800.1.0 Complaints

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

BA-2800.1.3 Complaints Against Academy-Recognized PA Organizations

See: Judicial Affairs Procedure Manual 1 (page 297)

BA-2800.2.0 Challenging a General AAPA Election

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

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

BA-2800.2.3
   1. The Judicial Affairs Commission will investigate any challenged general election and will report its findings and recommendations to the Board of Directors
2. If the election is challenged while in progress, it will continue unless a recommendation from the Judicial Affairs Commission and a decision by the Board of Directors is made to stop the election and declare it void.

3. If the election is challenged after the announcement of election results, the new officers will assume their elected office and remain in office until a recommendation from the Judicial Affairs Commission and a decision is made by the Board of Directors. Any board member (as determined by the Judicial Affairs Commission) involved in a challenged election will not participate in the Board of Directors deliberation and decision on the election challenge.

4. If the Judicial Affairs Commission finds that the illegal votes cast or the illegal practices engaged in could have changed the election results, then the Board of Directors will void the election. If the Judicial Affairs Commission finds that the illegal votes cast or the illegal practices engaged in could not have changed the results of the election, then the Board of Directors need not void the election.

5. This entire process must be completed, and members notified of action taken within eight weeks of the challenge. If necessary, the Board may approve a single four-week extension.

BA-2800.2.4
Challenging a House Election

Any election conducted by the House of Delegates may be challenged by any seated delegate by

- Rising to a point of order or inquiry.
- Bringing their concerns to the Judicial Affairs Commission.

If any election conducted by the House of Delegates is challenged while the House of Delegates is in session, it may be declared void by a majority of delegates present and voting is repeated.

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

BA-2800.3.0 Adjudication Procedures for the Discipline or Removal (Impeachment) of Elected Officials of the Academy
See: Judicial Affairs Procedure Manual 1

HP-3000.00 PROFESSION

HP-3100.0.0 GENERAL

HP-3100.1.0 Professional Title

HP-3100.1.1
AAPA affirms "physician assistant" as the official title for the PA profession.

HP-3100.1.2
AAPA shall adopt “asociado médico” as the official Spanish translation for physician assistant.
AAPA believes that, whenever possible, PAs should be referred to as “physician assistants” and not combined with other providers in inclusive non-specific terms such as “midlevel practitioner”, “advanced practice clinician”, or “advanced practice provider”.
[Adopted 2008, reaffirmed 2013]

HP-3100.1.3.1
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” to reflect the unique position of PAs in the healthcare system.
[Adopted 2008, reaffirmed 2013]

HP-3100.1.3.2
AAPA encourages that “PA Surname” be established as the recommended address for PAs, unless a more suitable formal address is appropriate, such as military rank or academic role.
[Adopted 2016]

HP-3100.2.0 Definition

HP-3100.2.1
PAs practice medicine in teams with physicians and other health care professionals.

HP-3100.2.3
AAPA opposes any regulations, guidelines or payment policies that differentiate between PAs on the basis of length of educational program or academic credentials granted, if those PAs otherwise meet all criteria for fellow membership in the Academy.

HP-3100.3.0 Role

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.

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

AAPA shall request that the various uniformed services peacetime and wartime missions should reflect, as closely as possible, the broad-based medical training and skills of PAs in accordance with the current accreditation standards for PA education.
HP-3100.4.0  Governing Bodies

HP-3100.4.1
AAPA believes that sustaining public trust in the PA profession is the responsibility of PAs. Therefore, the governing bodies of AAPA, PAEA, NCCPA, and ARC-PA should be comprised of a majority of PAs. These organizations will continue to value the involvement of other stakeholders in medicine, healthcare, and the public through consultative and advisory relationships.
[Adopted 2016]

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

HP-3200.00  PROFESSION – PA EDUCATION

HP-3200.1.0  Initial Education

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

HP-3200.1.2
AAPA believes the ability of PAs to practice and be reimbursed should not be compromised regardless of the degree awarded upon completion of entry level PA education.

HP-3200.1.3
AAPA recognizes that PA education is conducted at the graduate level and supports awarding the masters degree for new PA graduates.

HP-3200.1.4
AAPA opposes the entry-level doctorate for PAs.
[Adopted 2010, reaffirmed 2015]

HP-3200.1.5
AAPA recognizes that PA education exists based on unique mission-driven and geographical needs in a variety of educational institutions and models.
[Adopted 2006, reaffirmed 2011, 2016]

HP-3200.1.6
PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers
(Policy Paper 38 – page 302)
[Adopted 2017]
HP-3200.2.0 Continuing Education

HP-3200.2.1
AAPA recognizes the concept of continuing professional development (CPD) as a means to maintain competence and ensure the delivery of high quality care. CPD is a process that includes ongoing identification of learning needs, development of a learning plan, acquisition of new knowledge and skills, application to practice, personal reflection and reassessment.

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


HP-3200.2.2
AAPA reviews and approves for Category 1 CME credit educational activities which serve to develop, maintain, or increase the knowledge, skills and professional performance of a PA. These may include live presentations, enduring material programs, and other educational activities. AAPA stipulates that the following activities meet the requirements for Category 1 CME credit for PAs:

- those approved for Category 1 credit by the American Medical Association (AMA) (i.e. activities sponsored by providers accredited by the Accreditation Council for Continuing Medical Education (ACCME))
- those approved for Category 1-A credit by the American Osteopathic Association (AOA)
- those approved for prescribed credit by the American Academy of Family Physicians (AAFP)
- accredited programs of the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), or the Physician Assistant Certification Council of Canada (PACCC)
- those approved for credit by the European Union of Medical Specialists/European Accreditation Council for Continuing Medical Education (UMES/EACCME)


HP-3200.2.4
AAPA endorses the policies of the Accreditation Council on Continuing Medical Education (ACCME) on commercial support of continuing medical education (CME) and applies those standards to its own review process.


HP-3200.2.6
AAPA encourages PAs to actively participate in the development and sharing of the knowledge regarding effects of the environment on the health of their patients and the larger community.

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

[Adopted 2010, reaffirmed 2015]
AAPA supports development of strategic alignments that would promote reasoned societal momentum, valuing the best available science, to address critical issues of environmental impact on health.

AAPA supports legislative and regulatory actions that decrease the impact of anthropogenic waste and emissions as a means of decreasing exposure to toxic substances and environmental insults.  
[Adopted 2010, reaffirmed 2015]

AAPA encourages PAs to recognize and understand the public health effects of globalization and climate change.  
[Adopted 2015]

**HP-3200.3.0 Program Accreditation and Curriculum**

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

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.  

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

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

AAPA shall continue to educate and serve as a resource to students, programs, and graduate PAs on issues concerning reimbursement for physician services provided by PAs.  
HP-3200.3.7
AAPA recognizes the important role of the PA in the areas of medical specialization, but feels that education in the specialty areas must be concurrent with or after education in general medicine as described in the Accreditation Standards for Physician Assistant Education of the Accreditation Review Commission on Education for the Physician Assistant.

HP-3200.4.0 Postgraduate Education and Certification

HP-3200.4.1
Accreditation and Implications of Clinical Postgraduate PA Training Programs (Policy Paper 2 – page 93)
[Adopted 2005, amended 2010, 2016]

HP-3200.4.2
Specialty Certification, Clinical Flexibility, and Adaptability (Policy Paper 16 – page 191)
(Adopted 2017)

HP-3200.4.3
AAPA opposes any NCCPA requirement that PAs must practice for a identified time in a given specialty practice as a precondition for specialty certification.
[Adopted 2010, reaffirmed 2015]

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

HP-3200.5.0 PA Education Funding

HP-3200.5.1
AAPA shall actively promote the participation of PAs in National Health Service Corps scholarship and loan repayment programs.

HP-3200.5.2
AAPA recognizes the vital importance of scholarship dollars to the continued growth and survival of the profession.

HP-3200.5.3
AAPA believes it is sound public policy to strengthen the U.S. health care workforce by providing federal and state government support for PA education. Such support includes expanded student loans and scholarships including National Health Service Corps scholarships and loan repayment programs; and federal grants and faculty development initiatives; and other forms of assistance including
research. Grants to PA programs should include investments to expand high quality clinical education sites where PA students can train and function with interprofessional teams. Government funding for PA education to maintain and expand PA education and faculty training will help assure the highest level of health care delivery in the United States. Government funding for research on best practices in education will ensure that effective educational outcomes will lead to high quality, safe health care delivery.
[ Adopted 2008, amended 2013]

HP-3200.5.4
AAPA supports legislative initiatives, as well as, state and federal programs that support PAs in primary care specialties (as defined by the federal government) and that may serve to incentivize PAs to select primary care specialty areas of practice.
[ Adopted 2010, amended 2015]

**HP-3200.6.0 Recruitment and Retention**

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.

HP-3200.6.2
AAPA supports efforts to help US military veterans become PAs.
[ Adopted 2011, amended 2016]

HP-3200.6.3
*Affirmative Action in PA Education* (Policy Paper 23 – page 231)

**HP-3200.7.0 Program Faculty**

HP-3200.7.1
AAPA encourages institutions of higher education that sponsor PA education to establish the Master’s Degree as the terminal degree for tenure and promotion of PA program faculty.
[ Adopted 2006, reaffirmed 2011, 2016]

**HP-3300.00 PROFESSIONAL PRACTICE**

**HP-3300.1.0 Clinical**

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.
HP-3300.1.2
PAs are encouraged to identify key factors that may lead to violence in all ages and to be familiar with and initiate appropriate interventions, including but not limited to, all legally required notifications to address these situations when occurring within their practice setting and/or the community. Interventions may also include innovative and multidisciplinary efforts.

HP-3300.1.3
AAPA encourages and supports the incorporation of health promotion and disease prevention into PA practice, through advocacy of healthy lifestyles, preventive medicine, and the promotion of healthy behaviors that will improve the management of chronic diseases to reduce the risk of illness, injury, and premature death. Preventive measures include the identification of risk factors, e.g. family history, substance abuse, and domestic violence; immunization against communicable diseases; and promotion of safety practices.

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

HP-3300.1.5
AAPA encourages all PAs to take an active role in the screening, prevention, management, and referral of patients for oral health disease.
[Adopted 2011, reaffirmed 2016]

HP-3300.1.8.0 Organ Donation

HP-3300.1.8.1
PAs knowledgeable in the area of organ and tissue transplantation should become actively involved with educating the public and other health professionals.

HP-3300.1.8.2
AAPA encourages PAs to be familiar with criteria for identifying potential organ/tissue donors and to be involved where appropriate in the “request” for donation and subsequent acquisition of organ/tissue donation as is medically indicated.

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

HP-3300.1.9.1
Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources
(Policy Paper 28 – page 258)
[Adopted 2006, amended 2011, 2016]
HP-3300.1.9.2  
AAPA encourages PAs to identify and utilize reliable and accurate consumer health information on specific disease states to encourage patient adherence and improve health education. Health education information should be evidence based and appropriate to the patient’s culture and level of literacy. Provision of such resources is consistent with AAPA efforts to promote health literacy.  
[Adopted 2010, amended 2015]

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

**HP-3300.1.11.0  Obesity**  
HP-3300.1.11.1  
AAPA encourages PAs to become educated about the prevention and management of being overweight and obese for both adult and pediatric populations, and to take an active leadership role in educating their patients and the public about the health risks of being overweight and obese. PAs are encouraged to address the issues of healthy weight and regular physical activity as critical components of health promotion/health maintenance for adults and children in their care. Additionally, PAs are encouraged to be proficient in identifying and treating obesity-related disease states and comorbidities. PAs themselves are encouraged to maintain a healthy weight in order to set the best example for their patients.

AAPA encourages the PA profession to combat the epidemic of childhood obesity within their clinical practices and to collaborate with public health organizations and federal agencies to meet the goals of improved nutritional education in schools, expanded physical education and exercise programs, and healthier eating habits in the home.  
[Adopted 2014]

**HP-3300.1.12.0  Addictions**  
HP-3300.1.12  
PAs should attempt to identify patients with addictive disorders and appropriately refer them for treatment.  

**HP-3300.1.13.0  Antimicrobial Resistance**  
HP-3300.1.13.1  
AAPA believes that PAs should be aware of antimicrobial resistance in their clinical practice. AAPA strongly recommends that PAs educate their patients regarding antimicrobial resistance, including the prudent use of antibiotics and the importance of preventive measures (e.g. pneumococcal vaccine), and not accommodate patient demands or expectations for unneeded antibiotics.  

HP-3300.1.13.2  
*Antimicrobial Resistance* (Policy Paper 18 – page 204)  
HP-3300.1.13.3
AAPA encourages the development and dissemination of educational programs on antimicrobial resistance for PAs and PA students. Such programs should address the scope of the problem, contributing causes, specific local issues, and the role each individual can play in controlling and preventing further antimicrobial resistance.

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

HP-3300.1.14
Complementary and Alternative Medicine (Policy Paper 14 – page 178)

HP-3300.1.15
Immunizations in Children and Adults (Policy Paper 6 – page 126)

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

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

HP-3300.1.18
AAPA believes evaluation of mental health and appropriate diagnosis and treatment of mental illness and consideration of patients’ mental health are essential to overall patient well-being and improved health outcomes. As per the World Health Organization’s definition, AAPA also believes that optimal health is composed of physical, mental and social well-being and not merely the absence of disease or infirmity.
[Adopted 2006, amended 2011, reaffirmed 2016]

HP-3300.2.0 Non-Clinical

HP-3300.2.1
AAPA values the involvement in the Academy of PAs who, although not practicing clinically, remain involved in positions related to health care delivery, including, but not limited to, health professional education, health care administration, health care policy or regulation, or serving in an elected capacity in government.
AAPA encourages PAs to seek election to Federal, state, and local office.  
[Adopted 2012, amended 2017]

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

The Importance of PAs in Executive Leadership (Policy Paper 37 – page 297)  
[Adopted 2017]

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

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

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

AAPA encourages PAs to provide care for medically underserved populations and/or practice in medically underserved areas.  

Direct to Consumer Advertising (Policy Paper 22 – page 228)  

AAPA believes PAs should continually work towards acquiring the knowledge, skills and attitudes needed to provide culturally competent care for patients with a wide variety of cultural attributes.  
[Adopted 2006, amended 2011, reaffirmed 2016]

PAs have an ethical and legal obligation to use appropriately trained medical interpreters for their patients with limited ability to speak or understand English.
See: Use of Medical Interpreters for Patients with Limited English Proficiency (Policy Paper 17 – page 202)  

**HP-3300.3.0 Environmental Health and Awareness**

HP-3300.3.1  
AAPA encourages PAs to acquire the knowledge and skills necessary to recognize the influence that environment has on the health of individuals and their communities.  
[Adopted 2010, reaffirmed 2015]

HP-3300.3.2  
AAPA supports continued educational efforts to keep the PA profession informed on issues of environmental health in publications and through continuing educational opportunities.  
[Adopted 2010, reaffirmed 2015]

**HP-3300.4.0 Society for the Preservation of Physician Assistant History**

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

**HP-3400.00 PROFESSION – HEALTH CARE SYSTEMS**

**HP-3400.1.0 General**

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 is committed to the concept of team-based collaborative practice between the PA and physician to achieve the highest level of quality, cost effective care for patients and continued professional growth and lifelong learning.  

HP-3400.1.2  
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.  

HP-3400.1.3  
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-3400.2.0  Utilization**

HP-3400.2.1  
AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality health care. 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.


HP-3400.2.2  
AAPA shall promote optimal utilization of PAs. This includes providing information on credentialing, cost-effectiveness, scope of practice, reimbursement, and other relevant data.


HP-3400.2.3  
*PAs as Medicaid Managed Care Providers* (Policy Paper 9 – page 137)


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.


**HP-3500.00  PROFESSION – REGULATION/CERTIFICATION**

**HP-3500.1.0  General**

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  Certification

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]

HP-3500.2.5
AAPA opposes any requirement that PAs take a closed-book, proctored exam in a specialty area for maintenance of certification.

[Adopted 2016]
HP-3500.2.6
AAPA opposes any requirement that PAs take multiple examinations during a 10-year recertification cycle.
[Adopted 2016]

HP-3500.2.7
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]

HP-3500.3.0 Regulations/Rules

HP-3500.3.1
AAPA believes that regulations governing the federal rural health clinic program should permit PAs to function as employees, owners, or independent contractors. Rural health clinic program regulations should be flexible and rational, allowing certified rural health clinics to address ongoing changes in the health care market in a timely and cost effective manner.

HP-3500.3.2
PAs as Medical Review Officers (Policy Paper 7 – page 133)

HP-3500.3.3
Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs (Policy Paper 3 - page 102)
[Adopted 2012, amended 2017]

HP-3500.3.4
Guidelines for State Regulation of PAs (Policy Paper 4 – page 113)

HP-3500.3.4.1
AAPA supports uncoupling maintenance of certification requirements from maintenance of license and prescribing privileges in state laws.
[Adopted 2016]

HP-3500.3.4.2
AAPA endorses the Federation of State Medical Board’s (FSMB) Maintenance of Licensure (MOL) Guiding Principles:

- Maintenance of licensure should support PA’s commitment to lifelong learning and facilitate improvement in PA practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders.
- Maintenance of licensure should not compromise patient care or create barriers to PA practice.
- The infrastructure to support PA compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.
[Adopted 2016]
AAPA believes:

• The authority for establishing MOL requirements is strictly within the purview of state legislative or PA regulatory authorities.
• Testing should not be part of the MOL process.
• AAPA strongly encourages all state constituent organizations to advocate for legislation to adopt MOL processes consistent with the FSMB guiding principles and Academy policy.

[Adopted 2016]

AAPA opposes the inclusion or sharing of PA state practice acts with any non-PA healthcare professions.

[Adopted 2017]

AAPA supports license portability for PAs through various modes, including a Uniform Application for State Licensure for PAs, development and deployment of an interstate PA licensure compact and enhancement of the Federation of State Medical Boards’ Federation Credentials Verification Service.

[Adopted 2016]

AAPA opposes unsolicited lobbying by the NCCPA.

[Adopted 2017]

Legal/Contractual

AAPA opposes the use of non-compete clauses in PA’s employment contracts. These covenants violate a PA’s right to practice his or her profession, negatively impact various aspects of patient care and access to care, and ultimately put financial interests ahead of patient and community care.

[Adopted 2009, reaffirmed 2014]
HP-3600.1.4
AAPA believes it is vital to track the volume and quality of medical, psychiatric and surgical services provided by PAs to assess the impact of those services on patients and on the health care system. To facilitate that effort, AAPA supports the enrollment, recognition of, and direct payment to, PAs by public and private third party payers and health care organizations.  
[Adopted 2011, amended 2016]

HP-3600.1.5
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.  

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

HP-3600.1.7
AAPA supports legislation to remove barriers to reimburse PAs that provide hospice care.  
[Adopted 2015]

HP-3600.1.8
AAPA believes in gender based equity in income for PAs having comparable responsibilities within the same specialty. AAPA encourages additional research on gender based disparities in income.  
[Adopted 2011, reaffirmed 2016]

HP-3700.00 PROFESSION – ETHICS/BEHAVIOR

HP-3700.1.0 General

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

HP-3700.1.2
Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15 – page 180)  

HP-3700.1.3
PA Impairment (Policy Paper 8 – page 135)  
HP-3700.1.3.2
AAPA shall support in principle the chemically dependent PA who has acknowledged his/her illness, engaged in a recovery program, and persists in a lifestyle compatible with ongoing recovery.

HP-3700.1.4
End-of-Life Decision Making (Policy Paper 12 - page 157)

HP-3700.1.5
Guidelines for the PA Serving as an Expert Witness (Policy Paper 5 – page 120)

HP-3700.1.6
False or Deceptive Health Care Advertising (Policy Paper 30 - page 268)

HP-3700.2.0 Disciplinary Process

HP-3700.2.1
AAPA believes that Academy members have an obligation to disclose what they believe in good faith to be unethical or unprofessional conduct, without reprimand or retaliation.

HP-3700.2.3
AAPA will follow judicial review processes that encompass confidentiality, due notification, fair and equitable process, and an appeal procedure that protect the rights of the members involved.

HP-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.
[Adopted 2017]

HP-3700.3.0 International

HP-3700.3.1
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.


HP-3700.3.2  
*Licensure Eligibility for PAs Trained Abroad* (Policy Paper 21 - page 222)

**HP-3700.4.0 Continued Competence**

HP-3700.4.1  
AAPA recognizes life-long learning provides opportunities to improve competence, supports preparedness for certification/licensure and increases the vitality and efficiency of a practice by providing learning opportunities which are intended to improve performance in practice as measured ultimately by patient outcomes.

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


HP-3700.4.2  
*Professional Competence* (Policy Paper 10 – page 140)

HP-3700.4.3  
*Competencies for the PA Profession* (Policy Paper 27 – page 254)

**HP-3800.00 PROFESSION – QUALITY ASSURANCE**

**HP-3800.1.0 General**

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

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

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

AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the relationship, if any, between taking the NCCPA recertification test and patient outcomes, safety and satisfaction.
[Adopted 2016]

AAPA believes that patient and family-centered care is beneficial to patients, family members, and healthcare professionals.

PAs should help educate patients, families, providers and institutions of the value of the patient- and family-centered care.

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

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

**HP-3800.2.0 Liability/Risk Management**

AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed. The goals of a fair medical liability insurance system include:

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

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

**HP-3800.2.2 Acknowledging and Apologizing for Adverse Outcomes** (Policy Paper 31 – page 271)
HP-3900.00  PA Health

HP-3900.1.1
AAPA believes that all PAs should use the standard and transmission-based precautions recommended by the Healthcare Infection Prevention Control Advisory Committee (HICPAC) and the Centers for Disease Control and Prevention (CDC) for preventing the spread of infectious diseases and healthcare associated infections. AAPA believes employers should establish procedures to ensure that standard precautions, transmission-based precautions, and other applicable infection control measures are enforced and that educational programs covering proper infection control procedures are available for all health care workers. Employers should ensure that timely post-exposure counseling and prophylaxis, in accordance with relevant CDC and OSHA guidelines, are available to health care workers after an exposure.
[Adopted 2006, amended 2011, 2016]

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

HX-4000.00  EXTERNAL POLICY

HX-4100.00  HUMAN RIGHTS

HX-4100.1.0  General

HX-4100.1.1
AAPA believes that patients have the right to be free of all forms of seclusion and physical and chemical restraint that are not medically necessary. Seclusion and restraint should not be used as a means of coercion, discipline, convenience, or retaliation. Seclusion and restraint should only be used according to accepted medical standards for the purpose of protecting the patient or others and to improve a patient's functional well-being and only if less intrusive interventions have been determined to be ineffective.

HX-4100.1.2
AAPA encourages all of the nations' correctional facilities to seek accreditation through on-site evaluation using the National Commission on Correction Health Care’s (NCCHC) Standards for Health Services in Jails and Standards for Health Services in Prisons.

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

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

HX-4100.1.3
AAPA opposes all forms of sexual harassment and gender discrimination.
HX-4100.1.4
AAPA supports equal rights for all persons and supports policy guaranteeing such rights.  

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

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and
(2) should instead demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

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


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

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

HX-4100.1.8
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.

HX-4100.1.9
A PA, as a member of a health care profession, should not participate in an execution. Participation in an execution includes, but is not limited to, the following actions: (1) prescribing or administering medications or substances that are part of the execution procedure; (2) monitoring vital signs on site or remotely (including monitoring electrocardiograms); (3) attending or observing an execution as a PA; and (4) rendering technical or professional advice regarding execution.

In a case where the method of execution is lethal injection, the following actions would also constitute participation in the execution: (1) selecting injection sites (2) starting intravenous lines as a port for an injection device (3) prescribing, preparing, administering, or supervising lethal injection drugs or their doses or types (4) inspecting, testing, or maintaining lethal injection devices and (5) consulting with or supervising lethal injection personnel.
The following actions do not constitute participation in an execution: (1) certifying death, provided that the condemned has been declared dead by another person who is legally authorized to declare death in that jurisdiction (2) witnessing an execution in a totally non-professional capacity (3) witnessing an execution at the specific voluntary request of the condemned person, provided that the PA observes the execution in a non-professional capacity (4) relieving the acute suffering of a condemned person who is awaiting execution, including providing medication at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.


HX-4100.1.10
AAPA respects the racial, ethnic, and cultural diversity of all people. The Academy's commitment to diversity values all individuals. When differences between people are respected everyone benefits. Embracing diversity celebrates the rich heritage of all communities and promotes understanding and respect for the differences among all people.


HX-4100.1.11
AAPA believes that PAs should provide culturally effective care, which is defined as the delivery of care to a diverse population within the context of appropriate knowledge, understanding, and appreciation of all cultural distinctions leading to optimal health outcomes.

[Adopted 2006, reaffirmed 2011, 2016]

HX-4100.2.0 Disabilities

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


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


HX-4200.00 HEALTH PROMOTION

HX-4200.1.0 General

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.


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

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

HX-4200.1.4
AAPA recognizes the U.S. Preventive Services Task Force recommendations as unique and innovative in the field of preventive medicine and supports their utilization as one resource in the practice of preventive medicine.

HX-4200.1.5
AAPA endorses exclusive breastfeeding when possible, for about the first 6 months of life, followed by breastfeeding with complementary food introduction until at least 12 months of age.

HX-4200.1.6
AAPA recognizes the significant public health implications of substance abuse, to include both non-medical use of prescription drugs and illicit substance use, and encourages PAs to take an active role in eliminating substance abuse. AAPA supports the education of all PAs in the early identification, treatment and prevention of substance abuse.
[Adopted 2005, reaffirmed 2010, amended 2015]

HX-4200.1.6.1
The AAPA encourages student and graduate PAs to recognize the crises of pain management and opioid abuse. The AAPA encourages student and graduate PAs to work towards a solution to these crises at the local, state, and national levels through advocacy, collaboration and education for students and practicing PAs about responsible opioid prescribing.
[Adopted 2016]

HX-4200.1.6.2
AAPA supports increased access to opioid treatment programs for patients with opioid use disorder, and therefore recommends identification and removal of obstacles to full PA utilization in such programs.
[Adopted 2016]

HX-4200.1.7
AAPA strongly recommends that PAs promote and educate about the physiological and psychological benefits of physical activity and encourage everyone to establish a lifetime commitment to a regular physical activity routine.
[Adopted 2005, reaffirmed 2010, amended 2015]

HX-4200.1.8
AAPA believes that timely access to ongoing prenatal care is essential to optimizing pregnancy outcomes. PAs should be aware of programs within their communities that provide access to culturally competent care and promote a full range of preconception and pregnancy support services.
[Adopted 2006, reaffirmed 2011, 2016]

HX-4200.1.9
*Routine Vaccination for Human Papillomavirus* (Policy Paper 32 – page 274)
HX-4200.2.0  Infectious Disease

HX-4200.2.1
AAPA supports needle/syringe exchange programs and legal access to sterile injection equipment as effective public health measures for reducing the transmission of bloodborne pathogens. In particular, AAPA endorses

- Establishment of needle/syringe exchange programs by public health departments and other organizations to support the use of sterile needles/syringes by individuals who inject drugs and other substances;
- Government funding to support access to sterile needles and syringes;
- Amendment of state paraphernalia laws and needle/syringe prescription and dispensing laws to allow legal access to and possession of injection equipment; and
- PA involvement in direct patient education and counseling regarding the attainment of sterile needles/syringes either through established exchange programs, or by prescription or over-the-counter in states where allowed.


HX-4200.2.2  

HX-4200.2.3
AAPA supports increased focus on addressing the Hepatitis C epidemic. This will include: alignment with Centers for Disease Control and Prevention (CDC) recommendations and supports the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts.
[Adopted 2017]

HX-4200.3.0  Alcohol

HX-4200.3.1
AAPA advocates responsible behavior concerning alcohol use and encourages public education efforts regarding its potential for abuse.

HX-4200.3.2
AAPA supports legislation that encourages states to impose minimum mandatory sanctions against convicted drunken drivers and that encourages states to establish comprehensive alcohol-traffic safety programs which would help to assure stronger laws, stringent enforcement, and effective rehabilitation programs.

HX-4200.3.3
AAPA supports the following recommendations to reduce under-age access to alcohol and to save lives:
1. That it be illegal for individuals under the age of 21 to drive with any measurable amount of alcohol in their bodies.
2. That retailers and individuals be held accountable/liable for negligently providing alcohol to a minor.
3. That advertisers promoting alcoholic beverages be required to provide balanced time for the promotion of responsible alcohol use.

HX-4200.4.0 Tobacco

HX-4200.4.0.1 Nicotine Dependence (Policy Paper 36 – page 289)
   [Adopted 2016]

HX-4200.5.0 Organ Donation

HX-4200.5.1 AAPA supports multi-organ and tissue donation.

HX-4200.5.2 AAPA supports the concept that organs and tissue for transplantation should be made available based on need, rather than ability to pay.

HX-4200.6.0 “Conversion or Reparative’ Therapy

HX-4200.6.1 AAPA opposes any treatment directed specifically at changing sexual orientation or gender identity.

HX-4200.6.2 Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression (Policy Paper 39 – page 317)
   [Adopted 2017]

HX-4300.00 SAFETY

HX-4300.1.0 General

HX-4300.1.1 AAPA encourages and supports accurate and appropriate labeling of foods, dietary supplements, herbal preparations over-the-counter and prescription medications, cosmetics, and personal care products that clearly illustrate ingredients, potential health hazards, indications for usage adverse reactions and contraindications.

HX-4300.1.2 AAPA encourages its membership to be aware of medical consequences of toxic waste.

HX-4300.1.3 AAPA is opposed to the use of tanning beds by adolescents and young adults under 18 years of age.
HX-4300.1.4
AAPA encourages state chapters to pursue and support legislation to restrict the use of tanning beds by individuals under 18 years of age.
[Adopted 2012, reaffirmed 2017]

HX-4300.1.5
PAs should educate patients of all ages about the dangers of tanning and the importance of full skin exams yearly.
[Adopted 2012, reaffirmed 2017]

HX-4300.2.0  Motor Vehicles

HX-4300.2.1
AAPA encourages all citizens to follow the manufacturer's guidelines regarding the use of all safety features on motorized vehicles.

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

HX-4300.2.3
AAPA and its chapters actively encourage all states to enact mandatory seatbelt legislation for both front and rear occupants of a vehicle. AAPA supports effective motor vehicle passenger safety programs for children including enforcement of child restraint laws and enactment of belt-positioning booster seat laws in all states. AAPA also supports booster seat loaner programs and encourages PAs to discuss motor vehicle passenger safety with their patients.

AAPA supports further research on the safety of seatbelts in school busses.

HX-4300.2.4
AAPA supports legislation that bans the non-emergent use of hand-held telecommunication devices while operating a moving vehicle.
[Adopted 2011, reaffirmed 2016]

HX-4300.2.5
AAPA supports national and state legislative initiatives to require mandatory drug and alcohol screening by law enforcement officials of all drivers in fatal and serious injury motor vehicular crashes.
HX-4400.00  VIOLENCE

HX-4400.1.0  General

HX-4400.1.1
AAPA believes that PAs should be familiar with social and cognitive skills that foster nonviolent conflict resolution. In addition, PAs should support the incorporation of age-appropriate school and community-based curricula that recognize racial, ethnic, and cultural diversity and that teach the skills of non-violent conflict resolution.

HX-4400.1.2
PAs are encouraged to address bullying as a component of violence prevention. AAPA encourages appropriate public and private funding agencies to support research on cyberbullying, bullying behavior and anti-bullying intervention.

HX-4400.1.3
AAPA will seek to develop pro-active, collaborative working relationships with groups committed to preventing pediatric and adolescent violence by utilizing programs that reflect multifaceted, multidisciplinary approaches to effectively address the problem of children’s violence in our communities and schools.

HX-4400.1.4
AAPA supports the right of access to medical care and opposes all acts of violence and intimidation and reprisal directed against PAs, other health care providers, patients and their respective families. AAPA opposes violence directed against medical facilities as an infringement of the individual’s right of access to medical care.

HX-4400.1.5
PAs support missing children awareness activities for parents and children alike. AAPA supports the promotion of patient education and prevention on issues dealing with missing children such as abuse, runaways, and kidnapping.

HX-4400.1.6
AAPA supports efforts in the prevention, early recognition, reporting, and management of children who are victims of child abuse, including neglect, emotional, physical and/or sexual abuse. PAs should be familiar with the risk factors, clinical presentations, as well as, short and long-term consequences related to child abuse.

AAPA supports the use of community resources in the management of child abuse, including appropriate local and state reporting agencies.

HX-4400.1.7
AAPA recognizes that abuse and violence are a public health epidemic in the United States.
AAPA supports medical care of abused and battered individuals which emphasizes linkages with community-based programs and referral agreements whenever possible.

AAPA encourages its members to participate in community-based efforts to increase the awareness of the epidemic of child, intimate partner, and elder abuse.

AAPA encourages its members to recognize that a relationship exists between substance use disorders and abuse of individuals.

AAPA supports the development of educational programs addressing prevention, early recognition, reporting, treatment and the appropriate referral to prevent abuse.


HX-4400.1.8
PAs are encouraged to be familiar with multi-disciplinary educational resources and public health & safety efforts directed at pediatric and adolescent violence prevention. AAPA believes that access and availability of reliable information in these areas can enhance the efforts of PAs to address the problem of violence as it relates to the pediatric and adolescent population.


HX-4400.1.9
AAPA supports a national commitment, including legislative and other local, state, and national efforts that have the expressed purpose of reducing the risk of violence by and against children and improving the physical, psychological, socioeconomic and cultural status of children.


HX-4400.1.10
AAPA supports public and private efforts that strive to decrease the incidence and effect of family violence.


HX-4400.1.11
AAPA believes that all PAs should be knowledgeable about the spectrum of elder abuse and neglect. PAs should be aware that the problem is likely to be encountered in their medical practices. In addition, PAs should be cognizant of barriers to the proper identification and management of elder mistreatment.

[Adopted 2006, reaffirmed 2011, 2016]

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


HX-4400.1.13
PAs should be aware of community resources for identifying and aiding the victims of human trafficking. AAPA should support legislative efforts to decriminalize the victims of human trafficking.

[Adopted 2015]
HX-4400.2.0 Weapons

HX-4400.2.1
AAPA opposes the proliferation of chemical, biological, radiological, and nuclear weapons and agents and supports the immediate pursuit of global nuclear disarmament. AAPA supports the continued education of its membership and the public at large of the public health and medical ramifications of chemical, biological, and nuclear warfare and terrorism.

HX-4400.2.2
AAPA supports policies and educational programs that will effectively reduce homicide, suicide and other violence that occurs through the use of firearms. As AAPA represents the diverse membership of PAs, AAPA supports:

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

HX-4400.2.3
Proliferation and Dispersal of Anti-personnel Weapons (Policy Paper 34 – page 282)
[Adopted 2012, reaffirmed 2017]

HX-4400.3.0 Terrorism

HX-4400.3.1
AAPA supports continued research and development to ensure the following:

- to improve understanding of the epidemiology, pathogenesis, and treatment of the diseases caused by chemical, biological, radiological, and nuclear agents
- new and more effective medical countermeasures such as vaccines, pharmaceuticals, and antidotes
- enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes
- to improve the detection and defense capabilities against chemical, biological, radiological, and nuclear agents.

HX-4500.00 TECHNOLOGY

HX-4500.1
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.
HX-4500.2
**Telemedicine** (Policy Paper 35 – page 285)
[Adopted 2015]

HX-4500.3
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]

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

HX-4500.5
AAPA supports a patient-centered health care system in which there is an open exchange of information for patients with their health care professionals, hospitals, and other agencies providing care for those patients through mutually interfacing health information technology (H.I.T.) systems.

HX-4500.6
**Scientific Integrity and Public Policy** (Policy Paper 25 – page 242)

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

HX-4500.8
AAPA believes that genetic testing for the presence of or susceptibility to disease should be available to the public only through the services of a qualified health care provider.
[Adopted 2008, reaffirmed 2013]
HX-4600.00 ACCESS TO CARE

HX-4600.1.0 General

HX-4600.1.1 Informed teams that include patients and their providers should make health care decisions. AAPA opposes any intrusion into the provider-patient relationship that inhibits the provider's ability to deliver appropriate and necessary medical services.

HX-4600.1.2 AAPA supports the free exchange of information between the patient and provider and opposes any intrusion into the provider-patient relationship through restrictive informed consent laws, biased patient education or information, or restrictive government requirements of medical facilities.

HX-4600.1.3 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.

HX-4600.1.4 AAPA recognizes the unique needs of underserved populations and encourages PAs to provide care to all patients.
AAPA supports the development of programs and elimination of barriers to care for all patients. Any incentives offered by government or private entities promoting more equitable and accessible care should be available to all health care practitioners.

HX-4600.1.5 AAPA believes that PAs should endorse and support policies and programs that address the elimination of health disparities and commit to activities that will achieve this goal. AAPA supports forming “strategic partnerships” with other organizations that will help advance the elimination of health disparities.

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

HX-4600.1.6.1 Health Disparities: Promoting the Equitable Treatment of All Patients (Policy Paper 33 – page 277)
[Adopted 2011, amended 2016]

HX-4600.1.7 Improving Children’s Access to Health Care (Policy Paper 20 – page 220)
Comprehensive Health Care Reform (Policy Paper 1 – page 92)

HX-4600.1.8
AAPA opposes actions that limit or restrict patient access to care based on personal or religious beliefs.
[Adopted 2006, reaffirmed 2011, amended 2016]

HX-4600.1.9
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.

HX-4600.1.10
AAPA believes PAs should advocate and facilitate care for veterans of the uniformed forces of the United States and their families including National Guard and Reserve Forces. AAPA supports education for all PAs regarding the medical and psychosocial needs of all veterans and their families. AAPA encourages PAs to be aware of the services and resources in their communities that assist veterans and their families to obtain the most up to date care.
[Adopted 2008, reaffirmed 2013]

HX-4600.1.12
AAPA supports the continuity of care that comes from providing hospice medicine to our patients.
[Adopted 2015]

HX-4600.2.0 Rural Health Care

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

HX-4600.2.2
Rural Health Clinics (Policy Paper 13 – page 174)

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

HX-4600.2.4
AAPA supports and takes steps to ensure the continuation of the rural health clinic (RHC) program to meet the goal of improving access to care in rural medically underserved areas.
HX-4600.2.5
AAPA supports retention of the original requirement that rural health clinics utilize PAs to provide access to primary care medical services.

HX-4600.2.6
AAPA should make it a priority to promote the PA profession to patients and leaders of healthcare facilities in underserved communities to improve access to care and reduce health disparities.

**HX-4600.3.0 Workforce**

HX-4600.3.1
AAPA believes that health plans, payers and provider networks should list PAs in their provider directories. PAs should be specifically included on the list of providers to allow patients the option of seeking care from a PA.

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

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

HX-4600.3.4
AAPA urges all federal, state, local and privately funded programs to include and recruit PAs in all healthcare scholarship and loan repayment programs.

HX-4600.3.5
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]

**HX-4600.4.0 Public Health Crisis/Disaster Response**

HX-4600.4.1
*The PA in Disaster Response: Core Guidelines* (Policy Paper 11 – page 145)
HX-4600.5.0  Prescription Medication

HX-4600.5.1
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 PAs and other appropriate health care practitioners to samples of prescription drugs from pharmaceutical manufacturers.

HX-4600.5.2
AAPA supports prescription drug benefit plans that are universal, mandatory for all beneficiaries, integrated into the basic benefit package, are not a financial hardship to beneficiaries, include catastrophic coverage, have a defined, comprehensive benefit, and permit health care prescribers to select medications using appropriate medical judgment that includes consideration of cost effectiveness, safety, and efficacy.

HX-4600.5.4
AAPA believes that information technology software should enable PAs to write appropriate, legal electronic prescriptions that comply with all state and federal guidelines. Therefore, AAPA encourages all electronic prescription software companies to incorporate the required parameters to facilitate efficient electronic prescribing by PAs and to ensure that PAs remain in compliance with both state and federal laws and rules.
[Adopted 2012, reaffirmed 2017]

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

HX-4600.5.6
AAPA advocates for legislative and/or regulatory changes to remove legal and regulatory barriers to prescribing, dispensing, or distributing naloxone for secondary administration for the reversal of opioid overdoses.
[Adopted 2012, amended 2017]

HX-4600.5.7
State chapters are encouraged to collaborate with public health agencies, addiction treatment organizations, local and state medical societies, patient advocacy organizations, and other entities to seek legislative and/or regulatory changes to remove barriers to the prescribing, dispensing, or distribution of naloxone for secondary administration for the reversal of opioid overdoses.
[Adopted 2012, amended 2017]

HX-4600.5.8
AAPA shall actively engage in efforts to educate health care advertisers about PA prescribing authority and practices. AAPA shall encourage health care advertisers to avoid such language as "only your doctor can diagnose" or "only your doctor can prescribe."
HX-4600.5.9
AAPA believes that safe and affordable prescription medications should be available for all patients. Reimportation of pharmaceuticals from countries such as Canada is not a long-term solution to the problem of costly medications in the United States. AAPA encourages pharmaceutical manufacturers to find ways to reduce the cost of their products and to expand their programs of assistance to those who cannot afford medication, particularly the uninsured. All health plans and government agencies should negotiate medication prices with suppliers and manufacturers.

HX-4600.6.0 Reproductive

HX-4600.6.1
AAPA opposes attempts to restrict the availability of reproductive health care.

HX-4600.6.2
AAPA supports over-the-counter nonprescription status of emergency contraception pills.

HX-4600.6.3
AAPA encourages its members to work with schools and parents within their communities to establish programs for reproductive health education in schools.

HX-4600.6.4
AAPA supports equitable and confidential access to sex education, family planning education, and birth control options.

HX-4600.6.5
AAPA believes all PAs should advocate responsible sexual behavior including education on methods to prevent unintended pregnancy and sexually transmitted infections.
[Adopted 2005, reaffirmed 2010, amended 2015]

HX-4600.7.0 Marijuana

HX-4600.7.1
AAPA believes that additional clinical research should be conducted on the therapeutic value and efficacy and safety of cannabinoids. AAPA urges that marijuana’s status as a federal Schedule I controlled substance be reviewed to facilitate and allow the conducting of clinical research.
[Adopted 2009, reaffirmed 2014, amended 2016]

HX-4600.7.2
AAPA recommends that in any state where medical marijuana laws exist, PAs are included as healthcare providers that can authorize or recommend the use of marijuana for patients. AAPA believes effective patient care requires the free and unfettered exchange of information on treatment options and that discussion of marijuana as an option between PAs and patients should not subject either party to criminal sanctions.
[Adopted 2016]
HX-4600.7.3
AAPA supports continued education programs and public health based strategies relating to the abuse of marijuana, and addressing and reducing the use of marijuana.

AAPA supports public health based strategies, instead of incarceration, when dealing with persons in possession of marijuana.
[Adopted 2016]

HX-4600.7.4
AAPA discourages the use of marijuana by women who are planning to become pregnant, are pregnant, or breastfeeding and shall treat and counsel women on cessation of marijuana.
[Adopted 2016]

HX-4600.7.5
AAPA discourages the use of marijuana by those persons under the age of 21 and discourages the use of marijuana by adults who are in the presence of persons under the age of 21.
[Adopted 2016]

HX-4600.7.6
AAPA supports legislation that requires labeling and child-proof packaging of marijuana and marijuana related products and that limit advertising to adolescents.
[Adopted 2016]

HX-4600.8.0 Immigrant Health

HX-4600.8.1
AAPA recognizes that policies disrupting families and communities living in the United States have significant negative physical and mental health implications, in particular when minor children are involved. Thus AAPA supports alternatives to mass deportation of immigrants and reiterates its support of the historical duty of PAs to deliver high quality-care to all patients regardless of their immigration or citizenship status.
[Adopted 2017]

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

HX-4700.00 QUALITY OF CARE

HX-4700.1.1
Quality Incentive Programs (Policy Paper 26 – page 244)

HX-4700.2.0 Care in Emergency Departments

HX-4700.2.1
AAPA believes overcrowded emergency departments (ED) threaten access to emergency care for all patients.
HX-4700.2.2
AAPA is opposed to the practice of boarding admitted patients in the ED as it threatens the safety and quality of care of all ED patients.

HX-4700.2.3
AAPA recommends that hospital industry leaders develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring and enforcement of these standards.

HX-4700.2.4
AAPA supports regulatory oversight that requires reporting of boarding information to CMS, and that CMS make the data publicly available, and that CMS ultimately develop a quality measure on boarding.

HX-4700.2.5
AAPA recommends hospitals allocate staff so that the staffing ratios are balanced throughout the hospital to avoid overburdening the emergency department staff while maintaining patient safety.

HX-4700.3.1
The Role of In-Store or Retail Based Convenient Care Clinics (Policy Paper 29 – page 265)
[Adopted 2017]

HX-4700.4.0 Medical Home

HX-4700.4.1
AAPA actively supports and encourages inclusion of PAs without restriction in the Advanced Trauma Life Support (ATLS) course provided by the American College of Surgeons and, upon successful completion of course requirements, provision of documentation to PAs as ATLS providers.

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

A medical home provides coordinated and integrated care that is patient- and family-centered, culturally appropriate, committed to quality and safety, and is cost-effective. This care is provided by a team led by a 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.
HX-4800.0    Temporary Placement

HX-4800.1
AAPA defines family as any person or persons who play a significant role in an individual’s life. This may include persons not legally related to the individual. AAPA recognizes that PAs are obligated to follow state and federal laws regarding family, however, AAPA encourages PAs to acknowledge, respect and consider any non-legally or non-genetically related family members.
[Adopted 2010, reaffirmed 2015]
The American health care system requires coordinated and systematic reform in order to meet the needs of the population, ensure quality, and control costs.

AAPA is not an advocate for any specific structure of health care reform and financing. The guiding principles must include access for all patients; evidence based care; equitable distribution of care and resources; and a payment mechanism that is portable and sustainable for individuals, families, and society.

Patients should retain a choice of providers, have access to a variety of health services, and should be satisfied with the type and quality of care offered by the providers and the health care system without restrictions due to pre-existing and other arbitrary condition-based exclusions. All providers, allopathic, osteopathic, and alternative, should be held to the highest professional standards of evidence-based care and medical ethics.

AAPA and the PA profession are committed to working with federal and state legislatures and all involved parties to plan and implement a fair and comprehensive reform of the United States health care system.

AAPA sets forth the following principles to direct its efforts on health care reform.

AAPA believes the primary goal of comprehensive health care system reform is to ensure access to quality, affordable, and cost efficient health care for all patients.

AAPA supports a health care system that will provide basic services to all patients.

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

AAPA supports reform that confronts the limits of care and resources and encourages the use of evidence-based medicine and the utilization of comparative-effectiveness information.

AAPA supports the optimal utilization of primary care in a reformed health system.

AAPA supports an emphasis on health promotion and disease prevention in health care reform.

AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed and encourages health care professionals to apologize for adverse outcomes without increasing risk.

AAPA endorses system reform that enhances the relationship between the patient and the clinician.

Additionally, AAPA believes that a long range solution to the Medicare physician payment system must be part of health care reform.
Accreditation and Implications of Clinical Postgraduate
PA Training Programs

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

- AAPA recognizes that advanced training in the clinical setting is a core facet of the professional identity formation and continuing medical education for every PA throughout his or her career.
- AAPA recognizes that advanced training in the clinical setting, the generalist foundation of entry-level PA education, and generalist model for PA certification together position the PA profession as one of the most flexible and adaptable professions in modern healthcare. This flexibility and capacity to adopt and adapt to dynamic changes in healthcare delivery make PAs invaluable assets within the U.S. healthcare workforce to improve access and improve the quality of patient-centered care for patients, families, and communities.
- AAPA believes clinical postgraduate PA training programs represent one of many innovations created by the PA profession to support continuing professional development and lifelong learning, foster interprofessional and collaborative care, advance workforce development and explore novel educational approaches to optimize healthcare delivery. Since 1971, clinical postgraduate PA training programs have provided a relatively small number of interested PAs with diverse opportunities to gain advanced clinical skills and experience in the workplace, building upon the generalist medical education offered to all PAs through entry-level PA education. Similar to the impetus of physician shortages that led to the birth of the PA profession, many of the early clinical postgraduate PA training programs arose to address provider shortages that resulted from duty-hour restrictions of medical residents.
- AAPA supports a PA-led accreditation model for clinical postgraduate PA training programs.
- AAPA believes a PA-led, national accreditation model for clinical postgraduate PA training programs should be efficient, foster continuous quality improvement, and support data collection and dissemination of program processes, impact, and outcomes.
- AAPA believes greater investment in research infrastructures is needed to support knowledge generation, dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs.

Background
Task Force Composition, Collaboration with the Commission, and Guiding Principles
In November 2015, a Task Force on Accreditation of Postgraduate Training Programs was convened by the AAPA Commission on Continuing Professional Development and Education to support their efforts in reviewing and revising the current AAPA policy HP-3200.4.1 regarding the accreditation of postgraduate physician assistant training programs as described in the position paper entitled “Maintaining Professional Flexibility: Issues Related to Accreditation of Postgraduate Physician Assistant Programs.” Responsible review of the policy called for assessment of the current landscape and investigation of issues impacting the PA profession related to clinical postgraduate PA training. The task force was comprised of a diverse group of experienced healthcare professionals and clinical administrators, primarily PAs but also inclusive of members from allopathic medicine, osteopathic medicine, and healthcare administration. The task force primarily focused its review on clinical postgraduate PA training programs and considered issues beyond accreditation, since a previously existing national accreditation model for postgraduate PA training programs was put in abeyance after the last amendment of this policy paper.

To frame discussions and ensure broad perspectives were addressed throughout the process, the following guiding pillars were established: leadership, evidence, quality, impact on the PA profession, adoption and adaptation. The rationale for these pillars is built upon the following observations and best practices. Scaling of transformative change will occur when leaders envision, encourage, and support innovation that supports all stakeholders, namely PAs and the patients, families, and communities they serve. Additionally, clinical postgraduate PA training experiences that facilitate leadership development among PAs are considered critically important to the future of healthcare innovation and the PA profession. Empiric evidence should be foundational to decision making, understanding that there will likely be gaps in existing data and inherent barriers to high quality research for postgraduate clinical training models. Evidence from other healthcare professions or healthcare workforce populations from large employers may be valuable; however, the unique attributes of the PA profession should be acknowledged in attempting to generalize evidence from other professions. Expert opinion balanced with stakeholder input will likely represent the most practical approach to this review and revision process. Recommendations that encourage better, more consistent data collection and reporting for future years should be considered. A prioritization of future research should be made for investigations or observational studies that relate to optimizing quality of care, increasing access to care, and supporting optimal health for patients and communities. Careful consideration should be given for any guidance or policy recommendations that addresses structured or formalized regulatory oversight, because of its potential macro-level impact on PA practice. The careful consideration of potential long term effects of recommendations on PA practice and the practice environment should be weighed carefully, as well as the appropriate authority and rights of states in the licensure, regulation, and monitoring of PA practice. Scaling of transformative change will occur when adoption and adaptation respect and influence the cultures of the different settings in which care is delivered. This observation can be easily
identified in the creation, evolution, and scaling of the PA profession since its inception nearly fifty years ago in the United States. Clinical postgraduate PA training represents a voluntary permutation of advanced training in the clinical setting that is limited to a very small percentage of the overall PA population. These disciplined, educational innovations have often evolved to meet regional and unique workforce development needs and opportunities. Task Force recommendations should respect the autonomy and unique needs of the different healthcare settings and training programs, including facets related to employers, specialty, state/region, stage of development of the learner, or regional maldistribution or shortage of physicians or other healthcare practitioners.

**Methods, Findings and Recommendations**

*Data Collection and Stakeholder Engagement*

During the period of review, deliberation and formulation of recommendations by the task force from November 2015 through February 2016, data and feedback were collected by stakeholder engagement and through systematic review of the relevant published literature. The task force reports that data gathering and engagement of stakeholders was not meant to be all inclusive or represent a census activity; rather, this data collection paired with analysis of systematic review served to better inform discussions of the task force which subsequently led to formulation of expert opinion recommendations. Stakeholders engaged included practicing and retired PAs (including those with clinical administrative roles), current or recent participants in a clinical postgraduate PA training program, PA educators, PA students, patients and families cared for by PAs, physicians and physician executives across multiple primary care and specialty areas (primarily from academic health centers or teaching hospitals), and hiring managers within large healthcare employers. Feedback was gathered from leaders within the AAPA and PAEA. Feedback was gathered from the chair of a committee convened by the Accreditation Review Commission on Education for the Physician Assistant to reevaluate accreditation for postgraduate PA training programs. Systematic review identified approximately thirty disseminated works on postgraduate training that were critically appraised, summarized, discussed, and prepared for submission to a peer reviewed clinical journal. Finally, the task force presented its preliminary findings and recommendations during a panel session held for attendees of the AAPA Leadership and Advocacy Summit held in Arlington, Virginia in early February 2016. Participants of this summit also had the opportunity to provide feedback and pose questions which were taken back to the task force for discussion.

**Highlights of Findings from Data Collection and Stakeholder Engagement**

- Clinical postgraduate PA training programs prepare only a small number of PAs each year, compared to the number of students graduated from PA programs annually.
- There were 58 clinical postgraduate PA training programs identified in the United States, and most lasted 12 months with a range of 12 to 18 months.
Clinical specialties represented by programs identified included acute care medicine, cardiology, cardiothoracic surgery, critical care and trauma, emergency medicine, family medicine, general surgery, hematology and oncology, internal medicine and hospital medicine, neonatology, obstetrics and gynecology, orthopedic surgery, otolaryngology, pediatrics, psychiatry, urgent care, and urology.

Despite a previously existing voluntary accreditation process administered by the ARC-PA, the task force was unable to gather summary data through requests or identify comparable, readily accessible data across publicly accessible platforms on program effectiveness, trainee demographics, or longitudinal outcome data.

There were eight programs from the 58 identified that reported having accreditation at one point through the voluntary model previously operated by the ARC-PA and subsequently placed in abeyance.

Clinical postgraduate PA training does not appear to result in increased salary compensation (compared to PAs without this voluntary training), but evidence suggests completion of such a program favorably improved hiring process and improved the confidence levels of PAs completing the training.

PA professional organizations generally support clinical postgraduate PA training as an optional activity for structured advanced training in the clinical setting for PAs who have an interest in pursuing such training at any stage in their careers.

The vast majority of PAs who completed a clinical postgraduate PA training program, based a single national survey study, would recommend postgraduate PA training to others.

Numerous individuals from various stakeholder groups felt varying vernacular for describing these types of programs (e.g. postgraduate training program, residency, fellowship, etc.) was both confusing and problematic.

Themes gathered from feedback from a sample of physician executives overseeing clinical operations (e.g. clinical chairs, section chiefs, service line directors primarily in academic medical centers in different parts of the United States within the following specialties: dermatology, emergency medicine, family medicine, hospital medicine, internal medicine with and without intensive care, oncology, otolaryngology with head and neck surgery, and surgery) included these:

- Experience gained through a clinical postgraduate PA training program was valued by physician leaders in some but not all specialties
- Physicians in some specialty areas preferred to orient and train their own PAs because of the highly variable care models used within their teams (e.g. dermatology, intensive care, emergency medicine with trauma)
- Several physician leaders commented on clinical postgraduate PA training was unnecessary and unlikely to impact a large segment of PA practice because of high market demand for PAs and satisfaction with employers of new graduates
Physician leaders identified key skills or behaviors that were ideal or observed favorably in PAs hired that had completed clinical postgraduate PA training: better understanding of systems based practice, experience with clinical research and administrative skills, greater appreciation for interprofessional practice and multidisciplinary care, greater assimilation into the institution’s overall culture, improved leadership competencies, better understanding of the care continuum (e.g. across settings and points of care transition) and importance of continuity of care.

The vast majority of physician leaders did not believe clinical postgraduate PA training programs would create practice barriers for those not trained in postgraduate programs (e.g. recruitment issues, credentialing or licensure barriers, employer mandates, expectations from physician specialty organizations).

A small number of physician leaders described potential advantages for employment opportunities in some specialties for PAs who complete clinical postgraduate training programs (versus those who do not) if ongoing growth in the number of entry-level PA programs continues and pushes supply over demand.

Factors described by physician leaders related to factors favorably impacting hiring practices did not include completion of a clinical postgraduate PA program (e.g. most common factors described were high level of motivation, strong desire to excel, willingness to learn, ability to receive and proactively gather feedback, flexibility, interest in pursuing scholarly or administrative opportunities, and professional experience prior to entry-level PA training).

The vast majority of physician leaders reported that a national process for recognizing / certifying / accrediting clinical postgraduate PA training programs was very important.

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

- Trainees perceive improvements in their abilities to establish a diagnosis, to recognize disease, to think critically, and generate a differential diagnosis.
- Some programs appear to help trainees develop teaching skills, promote professionalism, increase pool of available and qualified PA faculty and overcome barriers to retention.
- Limited study in critical care demonstrates clinical postgraduate PA (and APRN) training positively impacted patient care and enhanced the training of other healthcare professionals in critical and intensive care settings.
Limited study in emergency medicine demonstrated that the vast majority program faculty surveyed felt PA students had sufficient training from entry level PA education for emergency medicine practice and more than half did not see a need for clinical postgraduate PA training.

Limited study reported improved recruitment and retention of PAs in rheumatology through a specialty postgraduate PA training program.

Several studies did not reveal salary differences for PAs who had completed clinical postgraduate training compared those who had not.

Limited study revealed most PA students are aware of opportunities for clinical postgraduate training but few chose to complete such training.

Feedback from informal interviews and small focus groups with stakeholders revealed the following themes. Please note some feedback may be representative of only a small number of individuals or may represent perspective of a single participant. In the cases of student and patient interviews, convenience samples available to task force members were utilized. Closed online discussion groups were also leveraged to solicit feedback and facilitate discussion.

- Professional organization leaders and most PAs felt clinical postgraduate PA training should remain voluntary and available only to those PAs who want to pursue it.
- Employers and hiring managers saw greater confidence as a key benefit of clinical postgraduate PA training.
- Interest among clinical year PA students in postgraduate training varied widely across three sites examined (e.g. one in Southeast, one in Northeast, one in Midwest) from 5% in one class, to 20% in one class to 50% in one class.
- Many students were unsure what completing clinical postgraduate PA training would mean for their careers in the long-term.
- Hiring managers and some postgraduate program directors felt a well-designed, structured clinical onboarding process can be equally effective as a formal postgraduate training program in terms of bringing newly hired PAs to practice readiness and efficiency.
- Most postgraduate PA program directors felt the former accreditation process was cumbersome and disconnected from important elements of workplace based training.
- The pursuit of accreditation among programs that had sought accreditation was most often reported as a requirement for institutional support.
- Among postgraduate PA program directors interviewed that had not sought accreditation, the most common reasons for not applying for accreditation included: the process was too onerous, accreditation was not important to the institution, and/or there was insufficient staff effort to carry out required elements of the application process.
None of the patients interviewed in focus groups had any knowledge if their provider was trained in a postgraduate PA training program; general consensus of patients was that if the provider was compassionate and addressed their needs, it was unimportant.

Many PA hiring managers conveyed concern about any steps that increased specialization requirements for practice entry; some who oversaw blended workforces of PAs and APRNs cited difficulties in meeting patient needs or inability for some APRN providers to see certain types of patients that were common in the service lines they were assigned or ask to periodically cover.

Most PA hiring managers said the supply of graduates from clinical postgraduate PA training programs was so small, it would never meet workforce needs; many said a year of experience was viewed equivocally as completion of a clinical postgraduate PA training program.

Many PA hiring managers cited a lack of evidence documenting any measureable benefits of postgraduate training that they could take to their executive leaders to justify changes in hiring practices (e.g. medical error rates, efficiency, patient engagement, clinical quality, or unnecessary costs related to practice patterns or utilization).

A small sample of PA hiring managers representing large employers (e.g. > 250 PAs in a single organization or health system) preferred hiring new or inexperienced PAs because they felt they were easy to assimilate into their institution’s culture or practice standards.

Several hiring managers and PAs reported concern over online only programs available to APRNs that were described as clinical fellowships or residencies, citing the main value of postgraduate programs comes from experiential elements.

Several hiring managers who were also involved with pharmacist workforce hiring (all in teaching hospitals) stated that pharmacists without a pharmacy practice residency (and/or specialty residency) were not or were rarely considered for employment opportunities within their institutions.

The vast majority of PA and physician stakeholders as well as leaders involved with the Association of Postgraduate PA Programs described the need for and importance of a national model for evaluating and recognizing these programs. Representatives from the Department of Veterans Affairs even cited concerns about the availability of ongoing funding for such programs (or continuation of pilot project funding) without such recognition. The Task Force endorses a national model for evaluating, supporting ongoing quality improvement, and monitoring outcome measures from clinical postgraduate PA programs.

The Task Force summarizes what we view as key elements and considerations for an optimal national model:

- The process should be PA-led and involve individuals with extensive and current experience in clinical practice.
• The current standards used for evaluation of entry level PA programs are viewed as largely inappropriate for adaptation for assessment and recognition of postgraduate training, over more contemporary models applicable to workplace based training and assessment, professional identity formation and entrustability

• Accreditation through a single, national process is recommended with attention to high quality data collection, analysis and reporting

• Standards should ensure the trainee is positioned for active learning, an appropriate blend of didactic and experiential curricular activities, healthy duty-hours, and reasonable compensation and benefits

• Standards should ensure programs include PA faculty or directors, and standards should ensure sufficient administrative effort is protected to support effective program oversight

• Standards should require the collection and reporting of patient care and quality oriented outcomes of care for trainees

• The application process and requirements for assessment and reporting should be more efficient and streamlined than the previously existing model

• Standards should place greater emphasis on standardizing trainee protections, institutional resource requirements, data collection and reporting, and quality improvement requirements versus on curricular standardization

Summary

Clinical postgraduate PA training programs represent one of many innovations created by the PA profession to support continuing professional development and lifelong learning, foster interprofessional and collaborative care, advance workforce development and explore novel educational approaches to optimize healthcare delivery. Since 1971, clinical postgraduate PA training programs have provided a relatively small number of interested PAs with diverse opportunities to gain advanced clinical skills and experience in the workplace, building upon the generalist medical education offered to all PAs through entry-level PA education. Similar to the impetus of physician shortages that led to the birth of the PA profession, many of the early clinical postgraduate PA training programs arose to address provider shortages that resulted from duty-hour restrictions of medical residents. Advanced training in the clinical setting is a core facet of the professional identity formation and continuing medical education for every PA throughout his or her career. Advanced training in the clinical setting, a generalist foundation for entry-level PA education, and generalist model for certification together position the PA profession as one of the most flexible and adaptable professions in modern healthcare. This flexibility and capacity to adopt and adapt to dynamic changes in healthcare delivery make PAs invaluable assets within the U.S. healthcare workforce to improve access and improve the quality of patient-centered care for patients, families, and communities. The development of an efficient, PA-led, national model for accreditation, continuous quality improvement, and reporting on outcomes is needed. Greater investment in research infrastructures is needed to support knowledge generation,
dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs.
Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
(Adopted 2012, amended 2017)

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

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

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

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

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

Definition of PA

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

All states currently require that a PA

- be a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies and/or²
- pass the initial exam given by the National Commission on Certification of Physician Assistants (NCCPA),
- be licensed to practice as a PA.

Federally employed PAs must meet the first two criteria, but are typically not required to be licensed as federal agencies are not governed by state laws. Many states require current certification for licensure. In some instances, employers may require current certification as a condition of employment.³

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

**PAs as Members of the Medical Staff**

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

In the majority of states, the organized medical staff and hospital governing boards decide which types of practitioners will be granted medical staff membership. Medicare’s Conditions of Participation for Hospitals, as well as the Joint Commission Medical Staff Standards⁵ allow PA medical staff membership. The Medicare Conditions of Participation for Hospitals clearly state that, in addition to MD and DO members, “In accordance with state law, including scope-of-practice laws, the medical staff may also include other categories of physicians…and non-physician practitioners who are determined to be eligible for appointment by the governing body.”⁶ The Medicare surveyors’ manual further specifies that hospitals can appoint PAs to the medical staff.⁶ State law should be consulted; as the makeup of medical staff membership is occasionally dictated there.

On occasion, PAs have been erroneously categorized as allied health professionals or under nursing structures. PAs, by definition, are providers of medical care and, as such, are not part of the allied health field or nursing profession. The National Commission on Allied Health, convened by an act of Congress in 1992, defined an allied health professional as “a health professional (other than a registered nurse or PA)….” The federal Bureau of Health Professions also uses this definition for allied health and classifies PAs as medical providers.⁷

PAs should not be combined with other providers in non-specific, 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.⁸
Medical staff membership language might state:

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

**Credentialing PAs**

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

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

As applied to PAs, these criteria might include:

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

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

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

**PA Privileges**

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

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

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

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

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

**Expanding Privileges**

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

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

**Specialty and Subspecialty Privileges**

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

AAPA is committed to lifelong learning and encourages advanced educational opportunities (such as Pediatric Advanced Life Support (PALS) or Advanced Trauma Life Support (ATLS)), as well as verification of specific course completion. However, AAPA does oppose specialty certification as a 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.

**Duration and Renewal of Appointments**

Duration of appointments and privileges should be the same for physicians and PAs. The renewal/reappointment 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 accreditation standards from the Joint Commission specifically require a fair hearing and appeals process for addressing adverse decisions made against medical staff members and others holding clinical privileges. The process should include PA peer reviewers.

**Corrective Action**

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

**Quality Assurance**

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

**Continuing Education**

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

**Committees**

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

**Discrimination**

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

**EMTALA Provisions**

The Emergency Medical Treatment and Labor Act of 1986 (EMTALA) regulations require that hospital bylaws identify who is considered “qualified medical personnel” for the following areas: medical screening exams, 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 bylaws provisions to the extent allowed by state law in disaster or emergency situations.

Conclusion

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

Endnotes


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

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 non-physician 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.”


“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


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.”


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

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.

42 CFR §489.24(a)(1)(i)

42 CFR §489.24(b) Definitions

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.”

The EMTALA regulations allow “qualified medical personnel” other than physicians to order the transfer of emergency patients. If a PA certifies transfer of an unstable patient to another emergency department, the law requires that the PA first consult with a physician before ordering the transfer.
Subsequently, the physician must co-sign the order within a timeframe specified in hospital policy.

See 42 CFR § 489.24 (e)(ii)(C): “If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.”

Guidelines for State 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, 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. Re-entry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

Because of the high level of responsibility of PAs, it is reasonable for licensing agencies to conduct criminal background checks 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.

**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. The degree of collaboration of the practicing PA should be determined at the practice level in accordance with the practice type and the experience and competencies of the practicing PA. State law should not require a specific relationship between a PA, 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 specialty or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to assure that the patient’s treatment is consistent with the standard of care.

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

**PA Practice Ownership and Employment**

In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs may be employees of the same hospital, health system, or large practice. In some situations, the PA may be part or sole owner of a practice. PA practice owners may be the employers of physicians.

To allow for flexibility and creativity in tailoring healthcare systems that meet the needs of specific patient populations, a variety of practice ownership and employer-employee relationships should be available to 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 respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

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

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

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

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

Title and Practice Protection

The ability to utilize the title of “PA” or “asociado médico” when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state as a PA. The title may also be utilized by those who are exempted from state licensure but who are credentialed as a PA by a federal employer and by those who meet all 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 with PAs be full voting members of the board.

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

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public’s right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high-risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public. Licensee profiles should contain only information that is useful to consumers in making decisions about their healthcare professional. Healthcare professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

**Discipline**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A PA may offer an expert opinion several times in one legal proceeding or in several separate proceedings. Expert testimony offered by the PA in previous cases and proceedings is often reviewed and compared by attorneys and other experts. All testimony should be truthful and consistent.

**Guideline 5:** The PA should testify truthfully and consistently, recognizing his or her testimony may be subject to peer review.

Custom and rules governing compensation for legal witnesses vary. The PA should be fairly compensated for time spent preparing, appearing and testifying as an expert witness.

**Guideline 6:** The PA should not accept a contingency fee — compensation based on the outcome of a case in which testimony is given — or derive personal, financial, or professional favor in addition to compensation.
Summary of Academy
Guidelines for the PA Serving as an Expert Witness

The PA should have current experience and ongoing knowledge in the areas of clinical practice about which he or she is testifying.

The PA should objectively evaluate the facts and provide an opinion. The PA’s review of medical facts should be thorough, fair and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant. The expert should champion what he or she believes to be the truth, not the cause of one party in a dispute.

The PA’s testimony should reflect an evaluation of performance considering generally accepted standards, neither condemning performance that clearly falls within generally accepted practice standards nor condoning performance that clearly falls below these standards. The PA should examine the relationship of an alleged substandard practice to the outcome and acknowledge, when necessary or uncertain, that a deviation from a practice standard is not always causally related to a bad outcome. The PA should make a clear distinction between medical malpractice and the occurrence of unavoidable complications, which do not arise from negligence.

The PA should identify testimony about customary practice and testimony about innovation.

The PA should offer testimony recognizing it may be subject to peer review. Testimony given should be truthful and consistent.

The PA expert witness should be fairly compensated for time spent preparing, appearing and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given, or derive personal, financial or professional favor in addition to compensation.

Recommended Reading

AAPA. “Guidelines for Ethical Conduct for the PA Profession,” May 2013.
Testimony may be given at the request of either party in a lawsuit. Testimony may be given by affidavit, at a deposition, transcribed and then used in court by either party, or testimony may be given directly in court. There are several types of medical testimony.

When a PA has a prior relationship, such as treating or providing a consultation for the patient, there is a duty to assist that patient in legal matters pertaining to the medical care. RS Toth, *Legal Medicine: Legal Dynamics of Medical Encounters*, American College of Legal Medicine; Mosby (St Louis) 1988. An example of this is treating a patient who was involved in an automobile accident or job-related injury and later testifying about the observed injuries or extent of disability. In this circumstance, the PA may testify voluntarily or, less frequently, may be compelled by subpoena to give factual testimony. The testimony may be given in person or in writing.

In contrast, a non-treating PA may provide expert opinion testimony in a malpractice case about a standard of care -- possessing and using that degree of skill and learning which is customarily expected of practitioners acting under the same or similar circumstances. During litigation, a general standard of care is applied to the facts of a case by the introduction of expert witness testimony. See Toth.

Time spent preparing for and giving testimony, possible future court appearances and compensation for these services should be agreed upon with the attorney before undertaking these activities.

During testimony, a factual (percipient) witness may be asked to give an opinion and in doing so offers expert testimony without being called as an expert witness. Similarly, a PA performing chart review as an expert consultant in a legal matter may be called upon to give an expert opinion. To understand your situation and to prepare adequately for testifying you should ask the attorney who wants your services or testimony to specify the request in writing. This may be a letter, contract, or, less often, a formal notice (a subpoena) to compel your testimony. A subpoena, citation or other court order may be issued, if only to help the attorney follow legal procedures should you not be available or qualified to testify.

Whether compelled or testifying voluntarily and regardless of your intent to provide only factual testimony or consultation, you still may be asked to give an expert opinion. An attorney should advise you on the best course of action.

There sometimes are exceptions for having to give expert, opinion testimony. There may be insufficient information on which to base an opinion. Also, a practitioner who treats a patient may refrain from giving an expert opinion on the standard of care in a malpractice case if the injury is alleged to have occurred before the practitioner's care and someone else is alleged to have caused the injury.

Legal jurisdictions have rules about expert opinion, qualifications of experts, applicable fees and types of testimony. Local custom in the medical and legal communities may dictate fees that are appropriate.
Testimony given by a PA expert may cover one or several areas such as clinical practice and procedures, professional standards, conduct and ethics, scope of practice or statutes and regulations relating to practice. In civil and criminal proceedings, PA experts may also offer testimony such as cause of injury or disability, extent of temporary or permanent disability, and medical findings in assault or abuse cases.

The Federal Rules of Evidence define an expert witness as anyone "...qualified as an expert by knowledge, skill, experience, training, or education." (Rule 702) Although most cases in which a PA might testify will be conducted in state courts, which are governed by the particular state's rules of evidence, Federal Rules of Evidence will be cited here to offer generic illustration. There are expert witnesses representing every type of human activity (accountants, engineers, homemakers, mechanics, nurses, physicians, etc.).

The legal definition of negligence has four elements: (1) that the PA owed a legal duty to the patient. A PA owes each patient the duty to possess and use on the patient's behalf that degree of knowledge, skill, and care usually exercised by reasonable practitioners under similar circumstances. This duty creates a standard of care for various medical acts. (2) That the PA breached the duty, failed to comply with the standard of care. (3) That the patient sustained actual damages, such as physical impairment, emotional injuries and/or financial consequences. (4) That the PA's breach of duty proximally caused the patient's injuries. All four elements must be satisfied for a finding of negligence. Expert witness testimony is often needed to support any or all of these elements. Expert opinion testimony often defines the standard of care in malpractice cases. KM Leonetti, in The Professional Liability Handbook: A Basic Guide for Physician Assistants, AAPA (Alexandria), 1990. RS Toth, Legal Medicine: Legal Dynamics of Medical Encounters, American College of Legal Medicine; Mosby (St Louis), 1988. MD McCafferty and SM Meyer, Medical Malpractice Bases of Liability, McGraw Hill (Colorado Springs), 1985.
Immunizations in Children and Adults

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

AAPA recognizes the importance of child and adult immunization programs and the need to educate individual PAs and the public about these programs. To that end, AAPA makes the following recommendations:

- PAs should be aware of current medical guidelines and recommendations for immunization of infants, children, adolescents, and adults. Providers also should be aware that patients in high-risk groups, such as the chronically ill, immunosuppressed, asplenic, or elderly, may need to be on different immunization schedules than the general population.
- Individual PAs and their practices, in cooperation with public health agencies, should promote public information campaigns to increase awareness of the importance of immunizations and allay fears or doubts about potential adverse effects.
- PAs should be immunized against vaccine-preventable diseases for which health providers are at high risk, including annual influenza vaccination. This not only protects PAs, but also protects patients by preventing provider-to-patient transmission.
- PAs need to educate patients and their families about the safety of our national immunization program, dispel unsubstantiated fears about vaccination, and promote public confidence in vaccines for the continued protection of all against vaccine-preventable diseases.
- PA students should have all appropriate immunizations prior to their clinical experience.
- PAs working in primary care should develop systems within their practices to promote optimum immunization of their patients. These systems might include devices such as personal immunization records for patients to carry with them and a way to easily locate each patient’s immunization record in his or her medical chart. High-risk patients should be identified and special programs implemented to optimize vaccine coverage, such as mailing a flu vaccine reminder to all high-risk patients every fall.
- PAs working in specialty practices in hospitals and offices should recognize patients who are at high risk for vaccine-preventable diseases. They should coordinate efforts with the patients’ primary care providers to insure that these patients are adequately immunized and that the primary care providers have complete immunization records.
• PAs should support the development of and participate in state and local immunization registries. Effective immunization registries have demonstrated an ability to prevent fragmentation of care, incomplete immunizations, and unnecessary over-immunization of patients because of lack of communication between various providers and programs. An objective of Healthy People 2020 is to enroll 95% of children under the age of six in population-based immunization registries.¹

• All private and public payers should provide coverage for recommended child and adult immunizations as recommended by the CDC.

Introduction

The immunization of infants, children adolescents, and adults against vaccine-preventable diseases is one of the most important medical advances of the 20th century and among the most valuable health care investments that can be made. In the 20th century, the development of effective vaccines has led to a 97% or greater reduction in reported cases of diphtheria, measles, mumps, pertussis, poliomyelitis, rubella, and tetanus in the United States.² Recent economic analyses found that routine vaccination of children born from 1994 to 2013 will prevent about 322 million cases of disease and over 700,000 early deaths, for a societal cost savings of over 1.3 trillion dollars.³ Given their proven benefit in reducing morbidity, mortality and health care costs, age-appropriate immunization programs for children and adults should be part of the medical practice of all PAs.

Childhood Immunizations

Despite great successes at controlling once common childhood diseases, such as poliomyelitis, diphtheria, measles, mumps, rubella and tetanus; significant gaps remain in vaccination coverage in the United States. The U.S. Department of Health and Human Services’ Healthy People 2020 initiative has set vaccination coverage goals of 90 percent universally recommended vaccines among young children ages 19 to 35 months including those for diphtheria tetanus and pertussis (DTaP), haemophilus influenzae type B (Hib), hepatitis A and B, measles mumps and rubella (MMR), polio, varicella, pneumococcal conjugate vaccine, and rotavirus.¹ Recent national coverage estimates showed that HP-2020 targets of 90% were met for poliovirus, MMR, HepB, and varicella, but not DTaP, Hib, HepB birth dose, PCV, HepA, rotavirus, and the combined vaccination series.⁴

Vaccination rates remains lower among children living below the poverty level, in non-Hispanic black children, and those living in high-risk geographic areas, such as rural, underserved, and low socio-economic regions. These surveys continue to reveal immunization rates well below the national average and/or targeted goal rates.⁴
Gaps in the system of childhood immunizations are not new. Barriers to immunization that have been identified include: lack of knowledge about immunizations, fears about vaccine safety, logistical problems that limit access to immunization services, provider lack of knowledge regarding indications for and contraindications to immunization, fragmentation of patient care causing incomplete immunization records and missed opportunities.  

**Adolescent Immunization Programs**

Vaccination of adolescents is an important and effective way to protect preteens, teens, their friends and family members from vaccine-preventable diseases such as tetanus, diphtheria, pertussis (TDaP), and cancers caused by human papillomavirus (HPV). The advisory committee on immunization practices (ACIP) and the Centers for Disease Control and Prevention (CDC) recommend that adolescents routinely receive tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (TDaP), meningococcal conjugate vaccine, and HPV vaccine. Healthy People 2020 goals for 80% vaccination coverage among adolescents aged 13-15 were achieved or nearly achieved in recent years for TDaP and meningococcal conjugate vaccine, however were lagging for complete coverage for the 3-dose HPV vaccine among females.  

**Adult Immunization Programs**

Adult immunization programs do not receive the same priority as efforts to immunize children, despite the fact that most deaths from vaccine-preventable disease occur in adults. Between 50,000 and 90,000 adults die each year from vaccine preventable diseases such as pneumococcal infection, influenza and hepatitis B.  

Despite availability and effectiveness of vaccines current immunization rates fall below those recommended in Healthy People 2020. In addition to deaths from pneumococcal pneumonia, flu and hepatitis B; each year adult deaths occur due to inadequately immunized children. A majority of the US cases of tetanus and diphtheria today occur in adults who were inadequately immunized as children. Furthermore, the recent resurgence in measles, mumps and rubella; seen primarily among unimmunized preschool children, also occurred in a significant number of young adults. Most vaccine failures in adults occurred among those who did not have a primary response to the MMR vaccine administered in childhood. Waning immunity does not seem to be an important factor. It is now strongly recommended that everyone born since 1956 receive a two-dose measles immunization. Because mumps and rubella have shown similar, though less pronounced, epidemiologic patterns of reemergence, the vaccine of choice is MMR.
Unfortunately, adult vaccination coverage estimates for the four vaccines included in Healthy People 2020 (influenza, pneumococcal, herpes zoster, and among healthcare providers, hepatitis b) remain below target levels. The Centers for Disease Control and Prevention (CDC) recommends vaccinations from birth through adulthood to provide a lifetime of immunity. But while childhood vaccination rates are relatively high, most adults are not vaccinated as recommended per the adult schedule. PAs are encouraged to follow the most up-to-date vaccine schedule from CDC.

**Improving Vaccination Rates**

The CDC recommends that institutions develop standing orders and reminder systems to help improve vaccination rates among adults. Overcoming the low immunization rates among adults will require better reimbursement and a sustained, cooperative effort in both the public and private sectors to educate providers, patients, and policymakers about indicated vaccine uses and the need for effective delivery.

More widespread immunization strategies include new methods of vaccine delivery (nasally administered sprays) and new combination vaccines. Nasal administration of the influenza vaccine would reduce the expense associated with intramuscular vaccination and would be more practical, especially amongst pediatric patients (over five years of age). The immunization action coalition (IAC) continues to promote a national immunization registry as a national goal in Healthy People 2020, specifying that 95% of children from birth to age six should fully participate in an operational, population-based immunization registry.

**Challenges**

Challenges to immunization programs for adults are similar to those in children. Challenges for assuring access and availability of vaccines include: 1) Unprecedented Vaccine Delays, 2) Diminished Number of Vaccine Suppliers, 3) Disparities in Geographic and Socioeconomic Populations, and 4) Erosion of Insurance Coverage for Immunizations.

Adult immunization rates are lower than pediatric immunization rates in part because adult immunizations are largely voluntary, have inconsistent insurance coverage (or other financial barriers), while children are subject to public health policies and school mandates requiring immunizations before school entry. Barriers for adult immunization include:

- Lack of healthcare provider familiarity with current vaccine guidelines;
- Lack of awareness among both patients and providers of potential risks involving vaccine preventable disease;
- Lack of resources to maintain an adequate supply of vaccine
- Or lack of infrastructure within healthcare systems to achieve high immunization rates in adults.
Influenza Vaccination of Health Care Personnel

Influenza transmission and outbreaks in health care facilities are well documented. Health care workers (HCW) acquire influenza from their patients or transmit the disease to patients, staff and their contacts. Because HCW provide care to patients at high risk for complications of influenza, HCW should be considered a high priority group when expanding influenza vaccine use. In 2010 the Infectious Disease Society of America (IDSA) supported universal immunization of health care workers against influenza by health care institutions through mandatory vaccination programs. It was felt that this was the most effective means to protect patients from the transmission of seasonal and pandemic influenza by health care workers.9

Vaccine Safety

PAs need to educate patients and their families about the safety of our national immunization program, dispel unsubstantiated fears about and promote public confidence in vaccines for the continued protection of infants, children, adolescents, and adults against vaccine-preventable diseases.

Summary

The results of inadequate immunizations among infants, children, adolescents, and adults are unnecessary deaths, avoidable hospitalizations and the associated costs, and life-long disabilities caused by the sequelae of potentially preventable diseases. Safe, effective vaccines are available but underutilized, and patients who routinely see health care providers are not often educated about recommended immunizations. Healthcare providers should be familiar with the latest immunization schedule. They should make clear, evidence-based vaccine recommendations for all eligible patients and immunize at all opportunities including well, sick and follow-up visits.

Recommendations

AAPA recognizes the importance of child and adult immunization programs and the need to educate individual PAs and the public about these programs. To that end, AAPA makes the following recommendations:

- PAs should be aware of current medical guidelines and recommendations for immunization of infants, children, adolescents, and adults. Providers also should be aware that patients in high-risk groups, such as the chronically ill, immunosuppressed, asplenic, or elderly, may need to be on different immunization schedules than the general population.
- Individual PAs and their practices, in cooperation with public health agencies, should promote public information campaigns to increase awareness of the importance of immunizations and allay fears or doubts about potential adverse effects.
• PAs should be immunized against vaccine-preventable diseases for which health providers are at high risk, including annual influenza vaccination. This not only protects PAs, but also protects patients by preventing provider-to-patient transmission.
• PAs need to educate patients and their families about the safety of our national immunization program, dispel unsubstantiated fears about vaccination, and promote public confidence in vaccines for the continued protection of all against vaccine-preventable diseases.
• PA students should have all appropriate immunizations prior to their clinical experience.
• PAs working in primary care should develop systems within their practices to promote optimum immunization of their patients. These systems might include devices such as personal immunization records for patients to carry with them and a way to easily locate each patient’s immunization record in his or her medical chart. High-risk patients should be identified and special programs implemented to optimize vaccine coverage, such as mailing a flu vaccine reminder to all high-risk patients every fall.
• PAs working in specialty practices in hospitals and offices should recognize patients who are at high risk for vaccine-preventable diseases. They should coordinate efforts with the patients’ primary care providers to insure that these patients are adequately immunized and that the primary care providers have complete immunization records.
• PAs should support the development of and participate in state and local immunization registries. Effective immunization registries have demonstrated an ability to prevent fragmentation of care, incomplete immunizations, and unnecessary over-immunization of patients because of lack of communication between various providers and programs. An objective of Healthy People 2020 is to enroll 95% of children under the age of six in population-based immunization registries. 10
• All private and public payers should provide coverage for infant, child, adolescent, and adult immunizations as recommended by the CDC.

Bibliography


The Federal Government requires mandatory drug and alcohol testing as a safety precaution for more than seven million transportation workers, such as bus drivers, railroad workers, airline mechanics, and flight crews. Extensive rules governing alcohol and drug tests were issued by the U.S. Department of Transportation (DOT) in 2001. The rules were developed to protect workers’ rights and the integrity of the program through validity testing of the specimens. Validity testing was added to the program as a safeguard after lab mistakes resulted in innocent workers being labeled cheaters or drug abusers and being fired from their jobs. Regulations governing all aspects of the drug and alcohol testing programs are published in the Federal Register and in specific publications of the DOT. One part of these regulations, the definition of the Medical Review Officer, has had a negative impact on the health care delivery systems of companies and transit agencies that employ PAs.

The role of a Medical Review Officer (MRO) is mandated through 49 Code of Federal Regulations (CFR) subpart g, and defined in 49 CFR 40.3. According to these regulations, a medical review officer is “a person who is a licensed physician and who is responsible for receiving and reviewing laboratory results generated by an employer’s drug testing program and evaluating medical explanations for certain drug test results.” To qualify as an MRO, the individual must (a) be licensed as a physician (doctor of medicine or osteopathy) in any jurisdiction in the U.S., Canada, or Mexico; (b) possess basic knowledge in controlled substance abuse disorders (including knowledge of alternative medical explanations for laboratory confirmed drug test results), issues related to adulterated and substituted specimens, and the dot regulations; (c) receive qualification training as an MRO; and (d) receive at least 12 continuing medical education units every three years that are relevant to performing MRO functions.¹

Federal law requires eight basic responsibilities of an MRO: (1) acting as an independent gatekeeper and advocate for the accuracy and integrity of the drug testing process; (2) providing quality assurance review of the drug testing process; (3) determining whether there is a legitimate medical explanation for confirmed positive, adulterated, substituted, and invalid drug test results from the laboratory; (4) providing medical review of the employees’ test results but not necessarily establishing a doctor-patient relationship with the employees whose tests are reviewed; (5) investigating and correcting problems where possible and notifying the appropriate parties (HHS, dot, employers, service agents); (6) ensuring the timely flow of test results to employers; (7) protecting the confidentiality of the drug testing information; and (8) performing all functions in compliance with dot regulations.² PAs are not mentioned in these federal regulations and therefore they may not function as MROs, even if the role is allowable within state guidelines.

AAPA believes that the medical knowledge and training necessary to ensure competence as an MRO are not limited to licensed physicians. As practitioners trained in the medical model to provide physician services,
PAs have the background necessary to perform successfully the duties of an MRO. The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) is the accrediting body for PA educational programs.

According to the ARC-PA’S published accreditation standards for PA education, PA education must include clinical laboratory medicine and pharmacology, providing knowledge of the basis of laboratory analysis and an understanding of actions and interactions of pharmaceutical and non-pharmaceutical drugs. Many PAs receive training in drug abuse problems and all must be trained in patient counseling. PAs are qualified to obtain a complete medical history and to integrate that information with a physical examination and other biomedical data, such as laboratory test results, to reach an accurate diagnosis. PAs are also trained to respect patient confidentiality, which is an important aspect of any successful anti-drug program.

PAs who work in occupational medicine and other specialties and settings may perform pre-employment physicals, evaluate and treat work-related injuries, ensure safety in the workplace, and determine ability to return to work after illness, injury, or when taking prescribed medications. These PAs may routinely screen and evaluate drug testing results and follow appropriate chain of custody procedures for programs other than those of DOT. PAs, given additional education provided in MRO training seminars currently not open to them, would be very competent MROs and would contribute significantly to the success of DOT anti-drug programs.

References
1. 49 Code of Federal Regulations 40.121.
2. 49 Code of Federal Regulations 40.123
PA Impairment

AAPA defines PA impairment as any physical, mental or behavioral condition that interferes with the ability to safely engage in professional activities. Performance of clinical and professional activities while impaired puts patients at risk and may be indicative of an acute and/or chronic illness and/or progressive substance use disorder.

PAs have a responsibility to protect patients and the public by recognizing their own impairment and identifying and assisting impaired colleagues who are unable to practice with reasonable skill and safety to patients because of impairment.

PAs recognizing their own impairment should report concerns confidentially to an appropriate supervisor.

In determining an appropriate course of action, PAs reporting impaired colleagues should refer to state laws and should seek the guidance of impairment committees established by state or local level professional societies and constituent organizations and chapters.

Constituent chapters of AAPA should establish impairment committees to assist PAs. The principal goals of the PA impairment committees should be to enhance recognition of impairment behaviors, to encourage early referral for appropriate treatment, to promote effective long term monitoring for impaired PAs, and to serve as advocates for the restoration of suspended practice privileges once an individual has satisfactorily completed a program of rehabilitation. These committees and any peer review processes that they implement must be confidential in nature, protecting the identity of the impaired PA and any records maintained on that individual. This may not be possible in states where law requires mandatory reporting. The committees are also encouraged to refer to the AAPA document, "Developing an Impairment Committee: A Guide for AAPA Constituent Chapters" and to establish communications with similar committees maintained by state medical societies.

PAs should recognize impairment in physician supervisors and other health providers and should seek assistance from any or all of the resources mentioned above to encourage these individuals to obtain treatment.

PA continuing education and student programs through the Physician Assistant Education Association should include components for education and prevention as well as identification and treatment of impaired practitioners/PAs.

AAPA encourages research in the area of PA impairment, particularly in the type and impact of external factors adversely affecting PAs, including workplace stress, litigation issues, and restructuring of the health care delivery systems.

Except in the case of suspensions necessary to protect patients from immediate harm, AAPA urges that no adverse actions be taken against the practice privileges of PAs alleged to be impaired without suitable
due process proceedings.

AAPA endorses the establishment of support networks for recovering impaired PAs.
**PAs as Medicaid Managed Care Providers**  

**Background**

Financed jointly by the federal government and states, Medicaid is the nation’s health care lifeline for certain low-income residents -- families, primarily women and children; and the aged, blind and disabled. Medicaid is a state-administered program and each state has some degree of flexibility in determining guidelines regarding eligibility and services. While federal law mandates who is eligible for coverage and the broad categories of services that must be provided, each participating state designs and administers its own program by (1) setting certain income and asset eligibility requirements; (2) selecting which optional groups and services to cover; and (3) determining the scope of mandatory and optional services.

Nationally, from 2001-2004, Medicaid costs increased by just under 10 percent per year. Current projections by the Centers for Medicare and Medicaid Services Office of the Actuary suggest that program costs will rise at a rate of 7.9 percent annually until 2017. If that projection holds, program costs will increase from $339 billion in 2008 to $674 billion. That rate of increase is substantially higher than the expected rate of growth for the U.S. economy in general.¹

To constrain rising health care costs, states have turned to mandatory enrollment of some or all Medicaid beneficiaries in managed care delivery plans -- arrangements that limit a beneficiary’s choice of providers and hospitals. In many cases, these managed care plans are prepaid a fixed amount per enrollee. This financing arrangement has demonstrated the ability to lower service utilization, which in turn can hold down costs. Through managed care, many states have expanded coverage to the uninsured working poor. As compared with fee-for-service systems, managed care can offer Medicaid beneficiaries more coordinated forms of care and a greater likelihood of having a primary care provider. ²

In June 1994, 7.8 million Medicaid beneficiaries were enrolled in managed care plans. By 2007 that number had grown to more than 28 million beneficiaries.³

Medicaid managed care arrangements typically involve a primary care health care professional, known as a primary care provider who acts as gatekeeper and coordinates the delivery of care. State Medicaid programs include different professionals in their lists of primary care providers. Family physicians, general practitioners, pediatricians and internists are routinely included. Some states also define PAs, obstetricians/gynecologists and nurse practitioners as primary care providers. Some jurisdictions specify that PAs and NPs may serve in association with physicians, that physicians may be supported by PAs and advanced practice nurses, or that the managed care organization may determine the composition of the primary care network.⁴

When implementing Medicaid managed care programs, states are also responsible for developing and maintaining a sufficient network of health care professionals to ensure access to care.⁴ In addition to
determining which categories of health professionals are eligible to participate in the network, their geographic proximity, and patient access to specialty care, a decision is made on the maximum number of Medicaid beneficiaries enrolled per provider.

Medicaid managed care administrators in several states have struggled with the question of how many beneficiaries to enroll per PA. Their decisions have usually allotted to PAs a number equal to 20-100 percent of the Medicaid patients assigned to a physician.

**PAs as Medicaid Providers**

As states experiment with different methods of providing and holding down the cost of medical care, it is important to recognize the contributions that PAs can make in this process. In all 50 states and the District of Columbia, PAs provide Medicaid beneficiaries with quality health care services. Studies show that there is little difference in the level of patient satisfaction when care is provided by a PA as opposed to a physician.

Numerous independent studies have concluded that the quality of medical care provided by PAs is equivalent to that of physicians when PAs are practicing within the scope of their education and training. As far back as 1986, the Office of Technology Assessment found that “PAs provide care that is equivalent in quality to the care provided by physicians.”

Medicaid-eligible residents who are located in areas with limited access to primary care services often find it difficult, if not impossible, to obtain timely and appropriate health care services. This situation can lead to instances in which residents do not seek necessary primary care and enter the health care system when illnesses have progressed, resulting in higher medical costs. States have found that including PAs in the medical teams that care for Medicaid patients improve access to care and can help alleviate this costly problem.

A relatively high proportion of PAs practice in areas with large Medicaid populations. PAs in those practices have demonstrated a commitment to caring for this patient population. Moreover, it is important to promote continuity of care. When patients are satisfied with their current providers of care, they should be allowed, or even encouraged, to maintain those health care relationships under a Medicaid managed care program.

Difficulties in the ability to provide timely and appropriate access to care arise when federal and state Medicaid regulations contain provisions that do not allow PAs to function to the full extent of their education and training. Any practice limitation that is more restrictive than the existing PA Practice Act potentially limits the ability of physicians to delegate to PAs those medically necessary services that PAs are legally authorized to deliver. Regulations that limit the types of services PAs may deliver, deny coverage for first assisting at surgery, or require on-site physician supervision, serve to limit access to care for Medicaid beneficiaries.
Studies on PAs in managed care indicate that PAs are as productive as physicians. Using a random five percent sample of all patient visits in one year, researchers at one managed care entity determined that physicians and PAs saw similar types and numbers of patients.  

**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.

**References**

Professional Competence

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

- AAPA is committed to helping PAs to maintain the knowledge and skills necessary to achieve professional competence in order to deliver the highest quality health care.

Introduction

AAPA has had a long-standing interest in identifying the determinants of professional competence and in assisting PAs in maintaining their competence. AAPA has an important role in helping PAs acquire and maintain the knowledge, skills, and attributes needed to deliver high quality healthcare. A national focus on medical errors and patient safety, and an emphasis on cost-effective, quality care have sharpened the attention of the public, legislators, regulators, employers, educators and health professionals on the importance of maintaining and demonstrating professional competence.

Maintenance of professional competence is a lifelong process, and is motivated by a number of factors, including curiosity, self-identified gaps in knowledge, and the desire to provide the very best care to patients. Competence requires that the PA develops knowledge and skills through continuous professional development. This includes traditional continuing medical education (CME), self-study and application of knowledge from professional journals and publications, self-reflective and performance improvement CME (PI-CME), chart and peer review, and utilization of learning portfolios. Initial certification by the National Commission on Certification of Physician Assistants (NCCPA), required by all states in order to practice as a PA, is one part of demonstrating professional competence. Recertification, while not required in all states, is highly recommended as one way to demonstrate a commitment to maintaining professional competence.

Competence, Competencies and Competency-based Education

The concept of professional competence has evolved over the last 40 years from a one-dimensional construct representing “specialized knowledge” to a more global one which includes the application of specialized knowledge. Furthermore, competence implies a minimum level of proficiency or a threshold in performance. The most common definition of professional competence used today is Epstein and Hundert’s which defines it as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.”

The distinction between “competence” and “competency” should be made, as the terms are often used interchangeably. Webster’s dictionary defines a “competency” as an “ability or fitness.” A competency is a
single skill or function, yet it includes the underlying knowledge, abilities and attitudes necessary for optimal performance. It must be performed to a specific standard under specific conditions. A competency is usually written as a broad composite statement detailing an observable set of behaviors reflecting components of knowledge, skills and attitudes. Competence, on the other hand, is more expansive and all encompassing. It represents the **totality** of knowledge, skills, attributes, behaviors and attitudes (or competencies), as well as, the ability to orchestrate these competencies into the full range of activities necessary for professional practice. Competence also implies a minimum level of proficiency or threshold in performance.

To prepare for professional practice, PAs complete a competency-based educational program which is considered to be the “gold standard” for training PAs for clinical practice. Competency-based education provides the construct for curriculum development, accreditation standards, practice statutes, and certification. Entry-level programs consist of didactic and clinical experiences designed to provide a core of clinical knowledge, technical skills, and problem-solving abilities fundamental to competent clinical practice. Upon completion of an entry level program, it is assumed that a practitioner possesses the general characteristics and has acquired the requisite proficiencies during professional education. Initial certification, conferred by the NCCPA, verifies that an entry-level practitioner has demonstrated a minimum level of knowledge and skills, or competence.

The concept of competency-based education is not always well understood. Competency-based education was first introduced in the United States addressing teacher education in the early 1960’s. Health professions began looking at the framework in the 1970’s and generally stated competencies were created. For over 40 years the PA profession has been one of the few health professions to embrace competency-based education and created unique assessment tools to measure student competence. Interest in competency-based education in the health professions grew in the late 1990’s resulting in the transformation of other health professions education programs from traditional time-based education to competency-based education.

The Physician Assistant Education Association (PAEA), formerly known as the Association of Physician Assistant Programs, with funding from the Health Resources and Services Administration, published a document entitled, *Meeting the Objective: Physician Assistant Education, Curriculum Objectives Resource Guide* in 2005. This web-based document has assisted programs in focusing on outcome-based education, a primary principle of competency-based education. Integration of outcome-based education into PA education helps to ensure PAs are adequately prepared with the appropriate clinical competencies to enter a dynamic healthcare environment.

AAPA, PAEA, NCCPA and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) defined the competencies for the PA profession. These competencies were adapted from those developed by the Accreditation Council for Graduate Medical Education for physicians but identify areas specific to PA practice. The competencies were endorsed by all four organizations and disseminated to
PAs in 2005. The organizations identified six general areas of competency for competent PA practice including:

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

An overarching competency PAs must possess is the ability to practice interdependently in the physician/PA team: A skill that requires medical knowledge, professionalism, and interpersonal and communication skills, but is more than the sum of these parts. NCCPA, in conjunction with AAPA, ARC-PA, and PAEA, has developed the Physician Assistant Competencies: A Self-Evaluation Tool which is designed to assess strengths in each competency domain. This form of self-assessment can likewise reveal areas in need of improvement for a given competency, which then can be utilized to direct learning activities.

Assessment of Competence

Most aspects of professional competence, and certainly overall competence, are difficult and expensive to measure. All physician specialty boards require significant efforts from physicians to show ongoing professional competence. This includes the need to take written exams, which primarily measure one aspect of competence, namely medical knowledge. Additionally, evidence of peer-review and self-assessment are required by many physician boards for ongoing certification in a variety of medical specialties. Since competence is multidimensional, its assessment should also be multidimensional, preferably having a performance-based component. These assessment exercises sample behaviors performed in the artificial testing situation. In order to measure competence, one needs to be able to evaluate the knowledge, skills, and abilities represented by those behaviors in the actual practice setting. Entry-level PA programs like many physician residency programs have long used performance-based tests, such as patient management problems, objective structured clinical examinations, and standardized patients.

The physician profession under the leadership of the American Board of Medical Specialties has embraced a model of ongoing assessment called “maintenance of certification” (MOC). Maintenance of certification is an ongoing process of assessment and improvement in four components. The first component is evidence of professional standing, such as licensure. The second component is evidence of commitment to life-long learning and self-assessment, such as CME. The third component is evidence of cognitive expertise based on a valid and reliable examination. The final component is demonstration of evaluation of performance in practice including such skills as communication and professionalism.
Historically, certification maintenance for PAs, included obtaining 100 CME credits every two years and successful completion of a recertification examination every six years. In January 2014, NCCPA implemented changes to certification maintenance for PAs including additional requirements for self-assessment and performance improvement CME activities, and an extension of the recertification examination cycle from six to 10 years. Self-assessment and performance improvement activities are important activities and PAs should participate in them. The accreditation criteria for these new CME requirements ensure that approved activities are relevant, meaningful and validated, not overly burdensome to practicing PAs, and available to PAs who are not currently licensed or practicing clinically.

**Continuing Professional Development**

AAPA has endorsed continuing professional development (CPD) as a model to better integrate CME and other educational activities into a more comprehensive approach to maintaining professional competence. AAPA policy defines CPD as “a process that includes ongoing identification of learning needs, development of a learning plan, acquisition of new knowledge and skills, application to practice, and reassessment.” Traditional CME, which is a component of CPD, has focused primarily on the competency domains of medical knowledge and patient care. Delivery of quality patient care requires more than just proficiency of medical knowledge but proficiency in other competency areas as well. CPD provides a more expansive framework for the ongoing acquisition of knowledge, skills, and attitudes that define clinical competence. By using the CPD model and including activities such as quality improvement activities, peer review, patient surveys, chart audits, and the use of learning portfolios PAs have the means to not only increase clinical knowledge and skill levels, but to also enhance other competency domains such as system-based practice and professionalism, which will translate into improved patient care.

**Conclusions**

Professional competence is multidimensional. The dimensions of competence evolve as a PA’s career evolves. Achieving competence, as demonstrated in knowledge, skills, abilities, attitudes and behaviors, is a lifelong process, motivated by both self-interest and a commitment to providing the highest quality care. The entry-level PA educational program lays the foundation for application of the competencies in clinical practice. Upon entering clinical practice, it is the responsibility of the individual PA to continue their life-long learning. Safeguarding the public begins with national certification, but initial certification does not ensure continued competence, only a demonstrated minimum level of entry knowledge and skills. For life-long learning, PAs must engage in continuing professional development, using a variety of modalities to continuously assess and improve their knowledge, skills and attitudes with the goal of improving patient care outcomes.

Recertification represents part of a process that should encourage PAs to remain competent through periodic reassessment of strengths and deficiencies, as well as participation in professional development.
activities. Although a periodic written examination can only yield a useful measurement of cognitive ability, a multidimensional assessment process can truly reflect the competence that comes from the pursuit of lifelong learning. However, care should be taken to apply a model that is appropriate to the unique and valued role of PAs in health care.

The public is demanding more rigorous accountability from healthcare professionals. Whether it is a focus on competency-based education, certification or recertification, the PA profession has long been a leader in demonstrating its commitment to competence. Likewise, AAPA is committed to helping PAs to maintain the knowledge and skills necessary to achieve professional competence in order to deliver the highest quality health care.

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4. Board on Health Care Services. America’s Uninsured Crisis: Consequences for Health and Health Care. 2/23/09
Executive Summary of Policy Contained in this Paper

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

- AAPA believes PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts.
- AAPA supports educational activities that prepare the profession for participation in disaster medical planning, training and response.
- AAPA will work with all appropriate disaster response agencies to update their policies, in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.
- AAPA believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for all disasters that affect our communities, nation and the world.
- AAPA supports the concept of photo IDs to identify qualified medical personnel during a disaster response.
- AAPA recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response.
- AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state or local emergencies and public health crises.

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

**Preparation Through Education**

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

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

1. Basic knowledge of the National Incident Management System’s Incident Command System, along with local and state emergency services and management.
2. Recognize the importance of safety in disaster response situations, including protective equipment, decontamination and site security.
3. Have a working knowledge of the principles of triage in a disaster setting.
   a. Do the greatest good for the greatest number and maximize survival.
4. Learn how to develop the clinical competence to provide effective care with extremely limited resources.
   a. Maintain certifications in BLS, ACLS, and PALS, and, if possible, specialty training such as Advanced Disaster Life Support, Advanced Trauma Life Support, and Advanced Disaster Medical Response.
b. Stay up to date with ever-changing disaster medical information from various AAPA-approved web sites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.

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

6. Understand the ethical and legal issues in disaster response for PAs. These include:
   a. Their professional and moral responsibility to treat victims
   b. Their rights and responsibilities to protect themselves from harm
   c. Issues surrounding their responsibilities and rights as volunteers
   d. Associated liability issues.

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

**Credentials and Roles**

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

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

Response teams often include healthcare providers who have not trained together and are not familiar with one another’s background, skills and scope of practice. They also may find themselves in austere conditions with few medical resources available. Team members should explain their training and skills to one another and talk about how they will share responsibilities. PAs needs to be able to articulate the PA role and scope of practice educating other team members about PA capabilities while facilitating consensus regarding their respective disaster roles and who will supply what levels of emergency care. For example, who is best prepared to suture lacerations? Set a broken arm? Insert an emergency chest tube? Participants should discuss these kinds of issues as their team begins working together.²
There will be situations when PAs are the most qualified healthcare providers available to serve as medical officers for a disaster-stricken area. In these situations, PAs should recognize the need for their skills and abilities and be willing to assume the required responsibility for the benefit of the team. PAs who find themselves in such situations should seek out additional medical resources as needed.

**State Laws/Federal Exemptions**

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

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

The AAPA Guidelines for State Regulation of PAs and the AAPA Model State Legislation both include model language regarding PA licensure during disaster conditions. This language reads:

*PAs should be allowed to provide medical care in disaster and emergency situations. This may require the state to adopt language exempting PAs from supervision provisions when they respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees.*

*Physicians who supervise PAs in such disaster or emergency situations should be exempt from routine documentation or supervision requirements. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.*
Responding to International Crises

Outside of the United States, government programs and NGOs must ensure that U.S. providers have permission to offer medical care in the disaster area. Well-prepared response organizations should be able to prevent in advance any licensing problems that can thwart efforts to deploy to the disaster area. Even so, it remains incumbent upon PAs to ensure that they are properly authorized to practice medicine in the region where they have assumed patient care roles. The international arena presents a myriad of issues that may not exist on the domestic front. Cultural beliefs, governmental regulations, political instability, and lack of established standards of healthcare may all present complications. PAs need to investigate international disaster relief standards and response organizations before volunteering. PAs also need to consider the possibility that host countries may refuse foreign assistance, and should be respectful of that decision.

Beware the Ill-prepared Relief Worker

Research substantiates two categories of resource problems that typically arise during disaster response: needs that are a direct result of the disaster, and those resulting from the additional demands placed on resources by relief workers themselves.

Ill-prepared relief workers can compound disaster situations by increasing demands on potentially limited resources. They may need water, food and shelter; have incompatible radio systems that complicate communications; or be unwilling to accept unexpected assignments. These responder-generated demands can be somewhat alleviated through foresight, preparedness courses and individual preparation for the new roles often encountered found in complex situations. Responders may need to be fully self-sufficient so as to not drain precious, limited resources and further deplete supplies for survivors.

Each group that responds to a disaster brings its own logistical capabilities, priorities, goals and expectations. Coordinating this sudden ad hoc network of organizations can be a very big challenge. As a rule, in a multi-organizational response to a disaster, the more unfamiliar responders are with their tasks and with their co-workers, the less efficient and the more resource-intensive is the response. PA relief workers should be aware of the efforts and objectives of these other response operations, and ensure that efforts to provide medical care don’t hamper efforts to provide clean water, electrical power or other necessities.

Disaster Response Standards

In preparation for the multifaceted aspects of disaster response, clinicians should become familiar with generally accepted standards for re-establishing basic societal functions. The Sphere Project (www.sphereproject.org), an international coalition that includes the International Red Cross/Red Crescent and other experienced response organizations, has developed a comprehensive set of standards setting forth what they believe people affected by disasters have a right to expect from humanitarian assistance. The Sphere Project aims to improve the quality of assistance provided to people affected by disasters and to enhance the accountability of the humanitarian system in disaster response.
The standards outline the basic societal functions that should be addressed, the degree to which organizations should strive to restore them, and minimum goals that should be seen as interim steps to complete recovery. According to the Sphere Project, these basic functions are:

- Clothing, bedding and household items
- Water supply, water quality, latrines, and other sanitation facilities
- Supply and security of food stores, nutrition, and monitoring of vitamin deficiencies
- Healthcare, including preventive and surveillance measures.

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

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

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

**Standards for Crisis Care**

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

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

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

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

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

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

**Guidelines for PAs Responding to Disasters**

1. PAs should participate in disaster relief through established channels
   a. Consider joining non-governmental organizations, government agencies, State Medical Assistance Teams, Disaster Medical Assistance Teams, or other organized groups with a focus in providing disaster services. AAPA’s Disaster Medicine Association of PAs can help provide direction as well.
   b. Participate in work place disaster planning.
c. Stay current with information from reliable resources.
d. Make every effort not to become a victim of the event or to cause harm to others.

2. PAs should support comprehensive, team-based healthcare.
   a. Become proficient in the National Incident Management System’s Incident Command System.
   b. Learn to be flexible in working in unfamiliar places and circumstances – many times you have to become comfortable with “hurry up and wait” scenarios.

3. PAs should prepare for and expect the possibility of coping with scarce medical resources and nonmedical assignment in disaster situations.
   a. Participate in local disaster planning events.
   b. Participate in various webinars, table top drills, etc…
   c. Bookmark federal and state websites that have an abundance of current information for medical providers, which might include:
      i. Centers for Disease Control (CDC)
      ii. Federal Emergency Management Agency (FEMA)
      iii. Department of Homeland Security (DHS)
      iv. Health and Human Resources (HHS)
      v. State Medical Assistance Team (SMAT)

4. PAs should be prepared to provide documentation of their qualifications at any disaster site.
   a. Always have access to a portable file containing hard copies of your driver’s license, medical license, DEA license, and any specialty certifications.

5. PAs involved in medical relief efforts should be familiar with standards of disaster response and develop printed and electronic quick reference resources, including
   a. Disaster triage guides (i.e., Start, Jump Start, and others)
   b. Triage coding guides
   c. Decontamination principles
   d. Treatment guidelines for victims of biological, chemical, radiological, or natural disasters (e.g., hurricanes, tornadoes, floods, cold/heat emergencies, pandemics.)

6. PAs should maintain a high degree of cultural sensitivity when working with all populations.

**Principles of Disaster Triage:**

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

Summary

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

- AAPA believes PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts.
- AAPA supports educational activities that prepare the profession for participation in disaster medical planning, training and response.
- AAPA will work with all appropriate disaster response agencies to update their policies in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.
- AAPA believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals and practices in preparation for all disasters that affect our communities, nation and the world.
- AAPA supports the concept of photo IDs to identify qualified medical personnel during a disaster response.
- AAPA recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response.
- AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state, or local emergencies and public health crises.
References


Resources

ASS’N FOR PREVENTION TEACHING AND RESEARCH, CLINICIAN COMPETENCIES FOR EMERGENCY PREPAREDNESS BROCHURE


End-of-Life Decision Making

**Introduction**

“A dying man needs to die, as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless, to resist.”

*Stewart Alsop*

(1) Life is a continuum framed by the mysteries of birth and death. As medical science has advanced, it has succeeded in modifying events at both ends of the continuum, but death remains inevitable. Despite clinical interventions -- and sometimes because of them -- society and health care professionals face a tangle of dilemmas at the end of life.

(2) PAs are students and practitioners of the science of life. Death is an integral part of each life, making end-of-life problems an appropriate subject of serious study for PAs. The growth of medical technology and knowledge has increasingly blurred the line between life and death. Many advances are double-edged: techniques that rescue one person from premature and needless death can cause suffering, indignity, and financial ruin for another person whose death is inevitable.

(3) Every death takes place in a unique set of circumstances. These include the clinical aspects of disease; the ethical and religious beliefs of the patient and caregivers; physical and emotional tolerance of pain; and the availability and acceptability of measures to prolong life and/or reduce suffering.

(4) Although ethical and moral principles are often considered absolute and unchanging, they are actually dynamic and evolving, defined largely by society. From one generation to the next, changes in knowledge, values, and social structure have resulted in substantial shifts in the limits of what is morally and ethically acceptable regarding death and many other subjects.

**Historical Background**

(5) For thousands of years, many nomadic peoples practiced active euthanasia when elders could no longer function independently or keep up with the tribe. In ancient Greece, assisted suicide was officially sanctioned: "Whoever no longer wishes to live shall state his reasons to the Senate. If your existence is hateful to you...abandon life." (Libanius) Japanese culture long considered suicide an acceptable option to escape dishonor or advance military goals.

(6) During the Renaissance, scientific enlightenment merged with Christian philosophy and a more stable social structure to form the basis of many modern Western views on ethics and morality. In Thomas More's *Utopia*, "the Utopians treat the sick with great kindness and leave nothing undone to restore their health...but if a disease is not merely beyond treatment, but is also a constant source of pain and
agony, the priests and magistrates remind him that he is not up to all the tasks of life, is troublesome to others and a burden to himself, and is now outliving his own death."

(7) In modern times, end-of-life quandaries have been fueled by the explosion of clinical advances enabling the postponement of death, indefinitely in many cases. The use of mechanical ventilators to assist breathing began a mere four decades ago. Then came defibrillators, hemodialysis, cardiopulmonary resuscitation, pacemakers, heart-lung bypass, and ventricular assist devices, not to mention vast progress in pharmacologic life support and parenteral nutrition.

(8) As technology boomed, medical decision making shifted away from physicians, whose primacy had been unchallenged for centuries. A more informed, consumer-minded, and anti-authoritarian public began to demand a greater role in making decisions about their own medical care. 1 Here are some milestones in the evolution of this debate:

(9) Euthanasia, while still technically illegal, becomes socially and politically acceptable under certain circumstances in the Netherlands in the early 1970s. 2

(10) On Death and Dying, by Elizabeth Kubler-Ross, published in 1969, brings the process of death into the realm of popular discussion. 3

(11) In 1974, the first hospice in the US is founded by Hospice Inc., in New Haven, CT.

(12) The parents of Karen Ann Quinlan, a young woman in a "persistent vegetative state," petition to have their daughter removed from artificial life support. The request is granted on appeal in 1976. Quinlan lives for several years after life support is withdrawn. 4

(13) California passes its "Natural Death Act" in 1976, allowing competent adults to control decisions about withholding, refusing, or withdrawing life support.

(14) The Hemlock Society, which advocates assisted suicide and voluntary euthanasia in cases of terminal illness, is founded in 1980 by Derek Humphrey, who two years earlier had published an account of assisting in the suicide of his terminally ill wife.

(15) The Journal of the American Medical Association publishes “It's Over, Debbie", an anonymous account of active euthanasia written by a house officer, in 1988. 5

(16) In the case of Nancy Cruzan, who had been comatose since 1983, the US Supreme Court ruled in 1990 that a person whose wishes are clearly known has the right to refuse life-sustaining medical treatment. 6

(17) In 1990, Jack Kevorkian, MD, is charged with murder in the death of Janet Adkins, the first in a long and highly publicized series of assisted suicides linked to the Michigan pathologist. 7

(18) In 1991, Derek Humphrey publishes Final Exit, which contains suicide "how-to" advice for terminally ill persons and achieves widespread readership. 8
In 1991, a National Opinion Research Center poll reveals that legalized euthanasia by physicians at the request of terminally ill patients is supported by over 60% of Americans.  

Timothy Quill, MD, a New York internist, describes in The New England Journal of Medicine in 1991 how he assisted a leukemia patient's suicide by prescribing a lethal quantity of barbiturates. His soul-searching account is viewed by many as the antithesis of Dr. Kevorkian's techniques.

The emergence of Acquired Immunodeficiency Syndrome (AIDS) has had significant impact in turning society’s attention toward end-of-life decision making. This tragic illness that affects predominantly young adults and is very frequently fatal has dramatically increased an entire generation’s awareness of its own mortality. Among persons who have contracted AIDS, the questions shift away from “Will I die?” to “Where would I like to be when I die?” and “How would I like to die?” and “Who will be with me when I die?” The struggles of these individuals to face the philosophical and practical aspects of their mortality have brought a myriad of end-of-life issues out of the shadows and into the light.

**Legal Issues at the End of Life**

The following definitions may help to clarify discussions about end-of-life decisions.

**Suicide**: the intentional taking of one's own life.

**Assisted suicide**: providing information, medication (or other means) or direct assistance that enables a person to take his or her own life. The final action remains with the person who wishes to die.

**Euthanasia**: deliberately bringing about the death of another to spare the individual suffering. In this context, a painless and humane death delivered to a person who is terminally ill.

**Passive euthanasia**: the act of withdrawing support or intervention necessary to keep a patient alive, such as unplugging a ventilator or stopping parenteral feeding.

**Active euthanasia**: direct intervention by another person to cause death, for example, by injecting a lethal dose of a drug.

**Voluntary euthanasia**: performed on a patient who has made clear the wish to die, but is unable to act on it.

**Double effect euthanasia**: provision of palliative treatment that may have fatal side effects; i.e., steadily rising doses of morphine, intended to control pain and agitation, also "inadvertently" hasten death by depressing respiration.

**Terminal sedation**: after removal of life sustaining devices, a person is heavily sedated for comfort until death occurs.

**Advance directive**: explicit instructions and guidelines regarding an individual's desires for treatment, comfort, and resuscitative efforts in the event of terminal illness or incapacitation.
Suicide or attempted suicide, while not technically legal, is not prosecuted or punished in any state. All states, however, have prohibitions on intentionally causing the death of another or inducing an individual to commit suicide. At present, assisted suicide is explicitly banned in at least 30 states.\(^{13}\) On March 6, 1996, the first physician-assisted suicide case decided at the federal appellate level found a Washington state ban on physician-assisted suicide to be unconstitutional. The law in question had allowed "passive" withdrawal or withholding of life support, but prohibited "active" assisted suicide. The decision by the US Court of Appeals for the Ninth Circuit affirmed and clarified a 1994 judgment that had declared the state law unconstitutional. In an 8-3 decision, the appellate court stated, “We hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment (to the US Constitution).”\(^{14}\)

Less than a month after the Ninth Circuit Court decision, the US Court of Appeals for the Second Circuit struck down a New York law prohibiting assisted suicide. The court found the state had no rational basis for distinguishing between competent, terminally ill patients who may legally choose to refuse medical treatment or have care withdrawn, and patients who choose to end their lives by self-administration of drugs prescribed by their physicians. The court held that “physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness.”\(^{15}\)

The states of Washington and New York appealed the two circuit court decisions to the US Supreme Court, which heard the case on January 8, 1997. The Supreme Court ruled that terminally ill patients do not have a constitutionally protected right to assisted suicide. The ruling against a constitutional right refers the issue back into state legislatures and courts.\(^{16}\)

The risk of criminal liability in withdrawing or withholding life support at the request of a patient or surrogate is exceedingly small. Risk increases somewhat if a clinician directly causes a patient's death by administering a lethal dose of medicine. "Assisting" in a suicide by providing medical advice or means (e.g., a prescription) also carries significant risk of prosecution.\(^{18}\) In 1999, a Michigan court convicted Dr. Jack Kevorkian of second degree murder for administering a lethal injection to a patient suffering from Lou Gehrig’s Disease (People vs. Kevorkian). He was sentenced to 10-25 years’ imprisonment. Conviction in such cases is rare if the clinician has acted ethically and compassionately in accordance with the patient's wishes.

Several states have mounted efforts to legalize assisted suicide. A 1991 initiative -- also in the state of Washington -- was defeated in a general election by a 54 to 46% vote. Although the bill's underlying premise seemed to elicit substantial support, there was also strong concern about inadequate safeguards against potential abuse. A year later, a similar initiative in California with broader
safeguards was defeated by a similar margin. In 1994, Oregon voters passed a measure permitting a physician to supply a terminally ill patient with a prescription for a lethal amount of drugs, the Death with Dignity Act. The hotly contested bill, which passed by a narrow margin, was actively opposed by the American Medical Association, and its implementation blocked by litigation. In 2006, the United States Supreme Court upheld the Oregon Death with Dignity Act in a 6-3 opinion. The court rules that the controlled substances act does not prohibit the use of controlled substances for physician-assisted suicide (Gonzales vs. Oregon no. 04-623).

(37) In 2005, the United States Supreme Court upheld the right of the Florida State Court to order the removal of a feeding tube in the case of Terri Schiavo. It was the sixth time the Supreme Court refused to intervene in the prolonged litigation between the patient’s husband and parents.

(38) The debate over assisted suicide points up the distinction between legalizing an action and decriminalizing it. Legalization makes an action legal in a defined set of circumstances. Decriminalization maintains the prohibition against an action, but reduces the gravity of the charge and the severity of the penalty, usually to a misdemeanor. Absence of criminal liability by no means precludes the possibility of civil liability, such as suits for medical malpractice or wrongful death.

(39) After including safeguards against abuse, in 2008, initiative 1000, the Washington State Death with Dignity Act, was approved by 58% of votes. The law, which closely imitates the Oregon Death with Dignity Act, went into effect March 6, 2009. The act allows a competent adult with a terminal illness to make a written request for medication to be self-administered to end his or her life. The act includes civil, criminal, and professional disciplinary safeguards for providers who participate in the patient’s request.

(40) Another law that has exerted substantial impact on end-of-life decision making is the Patient Self-Determination Act (PL 101-508, 104 Stat 1388-321), enacted as an amendment to Medicare statutes in 1990. This act required states to develop or enact measures to inform patients of their decision making rights regarding treatment, life support, and resuscitation. Details vary from state to state, but the goal of alerting patients to their options regarding advance directives upon admission to a hospital or nursing home has been broadly realized.

Ethical Considerations

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

(42) Four generally accepted principles of bioethics are autonomy, beneficence, nonmaleficence, and justice.
(43) **Autonomy**, strictly speaking, is self-rule. To be truly autonomous, one must be capable of making decisions and choices.\(^{20}\)

(44) **Beneficence** is acting in what is (or is judged to be) the patient's best interest. It is often equated with paternalism.

(45) **Nonmaleficence** means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.

(46) **Justice** means that patients in similar circumstances should receive similar care. It also refers to norms for the fair distribution of resources, risks, and costs.

(47) For centuries, the healing professions, like the clergy, assumed a parental role. Physicians possessed a storehouse of scientific knowledge not accessible to the general public. Their healing endeavors were often cloaked in ritual and quasi-mysticism. Patients were considered incapable of choosing among complicated scientific theories, and physicians were expected to choose for them. Thus emerged the concept of the beneficent healer, and society came to accept medical paternalism and beneficence as one.

(48) Over the past three decades, a gradual but inexorable shift has taken place in the field of bioethics. Patients have become better educated and more capable of understanding scientific data. Medicine has become more accessible and somewhat de-mystified. From the mid-1960s on, authority figures -- physicians included -- have been subject to more challenge and scrutiny. As money has become more a focus of health care decisions and debate, physicians' aura of moral authority has eroded.

(49) In this milieu of change, patient autonomy has evolved as the primary precept of bioethics. In the last 20 years, substantial reforms have been undertaken in the fields of law, ethics, and medical education, all revolving around the patient's right to choose.\(^{1}\) Often, it is assumed that the principles of autonomy and beneficence are in conflict. This is true if one equates beneficence and paternalism, but the terms are not equivalent or interchangeable. In some circumstances, paternalism might be maleficent -- for example, if it violates a patient's right to choose. And beneficence may be far from paternal, since it may consist of educating the patient to enable his or her informed choice. Beneficence may complement autonomy.

(50) **Nonmaleficence** as an ethical principle requires that a provider "first, do no harm." This is a tangled issue in end-of-life decision making, since the same acts may be interpreted as harmful or beneficial depending on the circumstances and on participants' values and perspectives. For example, if a comatose patient with no advance directive is kept on life support in the ICU, is not harm inflicted through physical discomfort and financial hardship? On the other hand, if life support is withdrawn, is the patient not harmed by being deprived of even the remotest chance of recovery?
(51) The principle of justice is not a simplistic implication that all patients should receive the same treatments and resources. It does require that all patients be accorded respect for their individuality and autonomy. All should receive the same opportunity to be informed and choose their course of treatment. It also requires that scarce resources be allocated fairly (for example, on patients with a good chance of recovery rather than on those for whom treatment will be futile).21

Cooperative End-of-Life Decision Making

(52) A society's beliefs are reflected in its laws and ethical principles. The individual struggling with difficult decisions about death and dying can turn to those principles for guidance, but will rarely find that they provide all the answers. Ultimately, death is not societal but solitary and supremely personal. However, as medicine has succeeded in prolonging life, greater numbers of people have become enmeshed in the process of an individual's death. At the dying patient's bedside are family, loved ones, clergy, health care providers, technicians and, in absentia, lawyers, ethicists, and even third-party payers. Each brings a set of priorities, beliefs, and values, and achieving complete harmony among them is usually impossible. If the goal of end-of-life decision making is to make the process of dying as humane and compassionate as possible, it is essential to minimize conflict and maximize cooperation for the patient's benefit. One way to enhance cooperation is by understanding the internal and external influences that affect the patient, his or her family, and clinicians, especially physicians and PAs.

Patient and family concerns

(53) Often, the first question asked by patient or family in cases of serious illness or injury is, "Is this condition terminal?" If death seems imminent, the next question is almost always, "How much time is left?" The longing for certainty is natural, but these questions are usually impossible to answer satisfactorily. PAs and physicians have seen too many unexpected deaths and unforeseen recoveries to make firm predictions or speak in absolute terms. Patients and families may then become frustrated by what they perceive as a lack of competence, concern, or communication. They want answers, which the clinician often simply cannot provide -- sometimes giving rise to an adversarial relationship.

(54) The next big question often pertains to suffering. "Will I be in pain? Can you control it? Will I have to be sedated or unconscious in order to be comfortable?" Studies have shown that many patients fear pain less than the loss of control.22

(55) Finances are a third major concern for patients and families. "What will all this care cost? Is it covered by insurance? Will my family or loved ones be bankrupted to provide me with a few extra days or weeks of existence?"
Faced with the prospects of uncertainty, pain, loss of control, and financial ruin, some patients and families begin to consider options other than intensive medical intervention. They may choose no therapy other than pain control (palliative therapy). They may even consider suicide, assisted suicide, or some form of euthanasia.

PAs should be prepared and willing to discuss advance directives and living wills with their patients. Concerns with advance directives often center around several areas:

Families may believe their loved one is not competent or capable enough to formulate an informed advance directive. They may believe the patient is too upset to be rational or doesn't understand all the options.

Patients often worry that family members will contradict their advance directive.

Patients and families are concerned lest physicians override their wishes. In fact, some studies suggest that physicians may do just that in up to 25% of cases, even when the wishes of the patient were clear.

In situations where patients decline to draw up an advance directive or living will, they should at least be encouraged to enact a health-care power of attorney, designating a family member, loved one, or friend as a surrogate with the authority to make medical care decisions for an incapacitated individual. This may avoid the "majority rule" mode of decision making that often arises when no advance directive exists.

Patients and families should also learn about the availability of home care and hospice services. Hospice in particular can be an invaluable resource. Not only do the volunteers and nurses provide bedside care and family support, but they can also assist with education, planning, and accessing social services.

Questions of a moral or religious nature often arise in end-of-life decisions. In Western culture, matters of life and death have been traditionally presumed to be in God's hands. As technology has placed more moral weight onto human shoulders, many patients feel guilt over wishing for death or asking to die. They fear condemnation for choosing the time and manner of their own death, and may seek moral validation through the active or tacit approval and even the assistance of others, especially "authority" figures such as a clergy member, physician, or PA.

The major premises of American bioethics are based on values that are predominately western, white, and middle class. The values and beliefs of other races and cultures may differ significantly. For example, the perception and expression of pain is significantly influenced by cultural and racial factors. At the end of life, cultures that are more family oriented, such as Korean, Chinese, or Mexican, may place much less emphasis on patient autonomy and fully-informed individual consent. Others may be likely to insist on aggressive, life-sustaining treatment. Studies have shown that...
substantially fewer minority patients make use of advance directives, even when such directives are readily available.\textsuperscript{25}

(65) While it is wrong to ignore the effects of culture and ethnicity on end-of-life planning, it is equally wrong to assume that all members of a particular cultural or ethnic heritage share the same values and beliefs. Providers must individualize their care of dying patients and their families, while remaining sensitive to cultural variables such as language, family dynamics, religion, economics, pain behaviors, and alternative healing practices. In some situations, providers may need to seek assistance from religious leaders, traditional healers, translators, and cultural consultants.\textsuperscript{25}

**Evaluating requests for assistance in dying**

(66) End-of-life decisions are influenced by factors including uncertainty, fear, pain, ethical and moral concerns, financial factors, and family support (or lack of it). When patients express a desire for active involvement in their own death in any manner, family and providers should carefully evaluate their state of mind and intent. Such requests may actually represent:

(67) feelings of abandonment by family or the medical establishment.

(68) desire for more effective symptom control, or simply more control over treatment and surroundings.

(69) concern about becoming a financial burden.

(70) clinical depression. (Terminally ill patients often suffer from depression, and it is wrong to assume that it is a natural part of the disease process; treatment often improves quality of life.)

(71) reaction to real or perceived conflicts with family members, or a belief that others expect them to "pass away quietly."

(72) Determining true intent at this stressful juncture can be very difficult. A person may request death because no other reasonable options seem possible. Thus, some requests may be interpreted as an invitation to better and more open communication, rather than a genuine wish to die.\textsuperscript{26}

(73) As a final guideline in conflicts over end-of-life decision making, clinicians and family members should recall the first principle of bioethics: patient autonomy. The patient's right to choose is primary, provided that the choice is informed, uncoerced, and does not seriously conflict with the autonomy of others.

**Caregivers' concerns**

(74) For physicians, PAs, and other caregivers, the death of a patient is a complicated and trying event, provoking a host of ambivalent thoughts and feelings. Clinicians must meet the emotional, ethical, and legal challenges of caring for the dying while maintaining their own personal and professional integrity and values.
The relationship of patient to health care provider is a two-way interaction with mutual obligations, uncertainties, and rewards. Events affect both parties; beliefs and values of one may subtly or overtly affect the other. Those who care for the dying owe it to their patients and themselves to scrutinize their own attitudes, which may influence the kind of care they deliver.

Many studies have shown that the values, beliefs, and emotional health of the clinician are an integral part of the care and counseling given to the dying person. For example, patient choices depend not only on what information is given, but also how it is presented. Up to 20% of patients who have chosen a particular option will change their mind if the information is presented differently. A 1990 study showed that physician recommendations to withdraw life support in the ICU were rejected by patient or family only 2% of the time.

Diagnosis appears to affect physician attitudes about discussing resuscitation or do-not-resuscitate (DNR) orders. One study documented that up to 50% of AIDS and cancer patients had been involved in such decisions, but only 5 to 15% of patients with cirrhosis or congestive heart failure had such involvement, despite similar severity of illness and prognosis. Physicians have been documented as underestimating chronically ill patients' quality of life, and may incorrectly assume that such persons would wish to refuse life-sustaining interventions. And, unfortunately, undertreatment of the pain, agitation, and depression associated with terminal illnesses persists. Treatment decisions may be strongly influenced by the provider's own anxieties about the prospects of disability, aging, and death. Recent studies have shown that clinicians are reluctant to discuss advance directives with many patients who would welcome such a discussion. Their own opinions as to the appropriateness of resuscitating a patient were identified as strong determinants of whether or not such discussions were initiated.

The evidence is compelling: those who care for dying patients must examine and understand their own feelings, beliefs, and limitations regarding the process of dying. Caregivers often try, consciously or not, to validate their own beliefs by convincing others to share them. Religious and moral convictions are subject to infinite shadings and interpretations. Clinicians who are aware of, and comfortable with, their own beliefs are less likely to feel either conflicted or compromised.

PAs must recognize their own values with regard to pain and suffering and the physical process of dying. Many clinicians seem to value stoicism in themselves and others; they rarely ask for help and may look down on those who do. Others are so uncomfortable with human suffering that, if they cannot relieve it, they withdraw. Some value alertness and control over comfort in their own lives. By projecting their values and priorities onto the care of a dying patient, clinicians may make incorrect assumptions about the patient's wishes for sedation and symptom control.
Supporting patient autonomy may be easier said than done. Here is a short "examination of conscience" for clinicians:

Do I feel challenged or threatened if a patient questions my judgment or seeks another opinion?

Do I often disagree with patients over treatment plans?

Do I ever initiate tests or treatments without discussing them first, on the assumption that I know best?

Do I ever ignore a patient's specific directives, thinking that they just don't apply in this circumstance?

The clinician's comfort zone

The autonomy of the health care provider matters, too. Clinicians possess expert knowledge and should be free to use it in their best judgment. Respect for patient autonomy does not obligate the use of unproven or inappropriate treatment modalities. The clinician's morals and ethics must also be respected. If they conflict with those of the patient, the patient should be notified and allowed to seek another caregiver with more compatible attitudes and values.

Care for the terminally ill covers a range bounded by two extremes, from "do everything possible to sustain life" to "active euthanasia." In between lie all the subtle gradations of care: palliation, non-initiation of life support, withdrawal of mechanical support, withdrawal of nutritional support, terminal sedation, suicide, assisted suicide. No one can identify a single position on the continuum and apply it to every case. However, it is equally impossible for most clinicians to be comfortable from one end of the range to the other.

Rather, clinicians must establish a "comfort zone" wherein they can provide maximum benefit to the patient while adhering to their own moral convictions. The breadth and position of this comfort zone may change over time as skills and experience are gained.

Private Decisions, Public Demands

While end-of-life decisions are made in a very private setting, the framework upon which these decisions are based is shaped in the public arena. Some difficult questions cannot be addressed on the individual level, and society must make these broader decisions.

Strong arguments for and against liberalization of assisted suicide and euthanasia have raged over the past two decades. Legalization efforts have met with mixed results: voters reconfirmed Oregon’s Death with Dignity Act in 1997 and enacted Washington’s Death with Dignity Act in 2008, but a similar initiative failed by a wide margin (29% to 71%) in Michigan in 1999 and a narrow margin in Maine (49% to 51%) in 2000.

Opponents of liberalization often cite the so-called "slippery slope" argument: once restrictions are loosened, the process will be difficult to regulate and control. Those who fear the liberalized "slippery slope" express concerns that economically and socially vulnerable patients (for example, the poor, homeless, imprisoned, or disabled) may be inappropriately encouraged or "assisted" with...
suicide. They often point to the Dutch experience, which has found that in some cases of euthanasia, no request for assisted dying was documented. As Steven Miles, MD, has stated, "Law is too blunt an instrument and the psychology of 'rational' or 'irrational' suicides...is too murky to selectively empower only 'good' decisions by 'ideal' physicians. The legalization of assisted suicide would empower not only physicians with good relationships (with their patients), but also those with transient, inadequate, or troubled relationships."27

(91) However, there may be more than one slippery slope. Just as liberalization of assisted suicide could have unintended consequences, so too could absolute restriction on assisted suicide. For example, in many cases a patient’s request for assistance with suicide leads to a dialogue that results not in death, but in improved communication, better symptom control, and more appropriate use of available resources. Providers who fear criminal prosecution may be reluctant to enter into any discussion in which the patient mentions suicide or assistance with suicide. This could have a profoundly chilling effect on provider-patient communication.

(92) Judging from the public record, society wants change -- but they want it to be cautious and considered. Americans seem to want a legal framework that allows for compassion and flexibility but protects against abuse. One answer may be decriminalization within well-defined guidelines. For example, the recently passed Oregon initiative required that a patient's request be in writing and signed before two witnesses who agree that the patient is competent and acting voluntarily. Two physicians must agree that the patient is terminally ill and likely to die within six months, and counseling is required if depression is suspected.19 Timothy Quill, MD, has suggested additional guidelines that are admirable in intent but may be difficult to comply with. For example, "the physician must be sure that the patient's judgment is not distorted." Certainty in this regard may be elusive. Other guidelines suggested by Quill are more concrete, such as the need for clear documentation and mandatory consultation.22 Various criteria also exist for DNR orders and withdrawal of life support.37 While clinicians, legislators and ethicists may propose guidelines, it will remain society's responsibility to adopt and abide by them.

Cost and justice

(93) Inevitably, issues of cost will play a part in this debate. The financial burdens of a lingering death loom large in end-of-life decision making, but the costs of facilitating death are seldom considered. Legal advice, financial consultation, psychological testing and treatment, mandatory medical consultations, increased record keeping, and the activity of ethics committees all require money.

(94) Issues of access and justice also arise. In theory, all patients who need such services should be able to access them. In reality, will society extend end-of-life options to the uneducated, uninsured and
impoverished? Will those in special populations, including managed care organizations and programs such as Medicare and Medicaid, have equal opportunity for any benefits that arise from policy reform?

**Special Concerns for PAs**

(95) The patient is the central figure in end-of-life decision making, but PAs have an important role to play. In some cases, the PA will be the dying patient's primary 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.

(96) Within this context, it is easy to imagine scenarios that could place PAs in awkward or troublesome situations:

(97) Against a dying patient's wishes, a supervising physician intervenes in the patient's well-established relationship with a PA.

(98) A patient requests a PA's assistance in making or implementing end-of-life decisions, but a physician ethically opposed to the chosen course forbids the PA's participation.

(99) A physician is willing to grant a patient's request for withdrawal of life support, although the PA strongly recommends consideration of other issues such as depression or pain control.

(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.\(^{38}\)

**Conclusion**

(102) Life is a process with death as an integral part of the continuum. In the past, death has sometimes been relegated to a separate and distinct entity, isolated from human experience -- an interruption, an end, a form of oblivion. Science has given us the ability to prolong, sometimes indefinitely, the process of dying. With this ability comes the awesome responsibility of deciding when and how to use it. American society has been struggling with this responsibility. In recent years the contentious, sometimes heated, debate has spread from the bedside to legislative chambers and courtrooms.

(103) Even though many questions remain to be answered, the debate has helped focus attention on one undeniable fact. Our society and our profession have much room for improvement in the care of those who are near the end of their lives. The real issues and problems are much more complex and far-
reaching than the relatively narrow question of assisted suicide. Although this is a crucial and controversial question, perhaps its truest benefit has been to open and broaden the discussion of other issues surrounding end-of-life decision making.

(104) Not one of these issues exists in a vacuum, nor will most be resolved soon. That does not mean that improvements cannot take place as the debate continues. In light of the discussion presented in this paper, AAPA believes that:

(105) The ethical principles of patient autonomy and informed choice are of primary importance in end-of-life decision making. The autonomy of the health care provider must also be respected. Laws, policies, or unwritten rules that interfere with communication between provider and patient, or that inappropriately restrict patient autonomy, should be condemned.

(106) PAs and other providers who care for dying patients must be knowledgeable in managing that care. They should be able to recognize and treat physical and psychological conditions that adversely affect the patient’s comfort and emotional well-being. These providers should have specific and appropriate training in pain management and in the counseling of dying patients and their families.

(107) End-of-life decision making is far more inclusive than limited discussions of assisted suicide or euthanasia. “Assistance in dying” includes many interrelated aspects -- from planning, counseling, and advance directives to clinical care. Every point on the continuum of clinical care has unique moral, ethical, and legal implications for both patient and provider. A well-established therapeutic relationship with a clinician, based on mutual trust, respect, knowledge, and understanding, is essential to assisting a patient with any of these critical issues and decisions.

(108) Information about advance directives should be available in all health care settings, including outpatient clinics, home health agencies, pharmacies, and public health facilities. PAs should be prepared and willing to discuss advance directives with their patients.

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

(110) In some circumstances, certain terminally ill patients may find a dignified and painless death by suicide preferable to a continued life of pain and suffering. However, PAs and all providers must recognize that not all patients who request assistance with suicide really wish to die. They may suffer from depression, need better symptom control, or need more information to better understand their options.

(111) Any request for assistance and support from a terminally ill patient, whether or not it involves suicide, should be treated seriously and respectfully. PAs should be aware that their comments, demeanor, and attitudes can profoundly affect patients who are in a suggestible and vulnerable time of their lives.
AAPA does not advocate assisted suicide. However, AAPA feels that the ethical, compassionate, well-intentioned provider who discusses voluntary self-termination of life by competent informed terminally ill patients is not to be subject to prosecution.

PAs are front line caregivers for the dying. They should take a leadership role in educating the public, policymakers, other health professionals, and their patients regarding the need for enlightened and progressive policies in this area. AAPA believes that the most effective way to minimize the issue of assisted suicide is to optimize care and maximize quality of life for patients at the end of life.

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**Rural Health Clinics**

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

The Rural Health Clinic Services Act of 1977 increases primary care services in underserved areas by utilizing PAs and other non-physician providers. Certified rural health clinics receive cost-based compensation for treating Medicare and Medicaid patients. AAPA policies for effective administration of the RHC program are identified in this paper.

**Background**
To make quality health care available to millions of children and adults living in medically underserved rural areas, the federal government created the rural health clinics program in 1977. This program, authorized by Public Law 95-210, the Rural Health Clinic Services Act, assures Medicare and Medicaid reimbursement to certified clinics staffed by PAs and nurse practitioners (NPs) working with physician supervision. The purpose of the rural health clinic (RHC) program is to increase primary care medical services in rural, physician shortage areas by utilizing PAs and NPs and providing cost-based compensation for care of Medicare and Medicaid patients.

The concept of reimbursing clinics for services provided by PAs and NPs to poor and elderly rural Americans had widespread support. The 1977 legislation was endorsed by medical, PA, and nursing organizations, as well as insurers, unions, provider groups, senior citizens, educators, and public officials.¹ The program, however, failed to thrive until, more than a decade later, Congress made a series of changes that reduced burdensome paperwork, increased payment levels, and enhanced technical assistance and awareness. Modifications to state PA laws, such as relaxation of on-site supervision requirements and the delegation of prescriptive authority, have also contributed to the program’s success. As a result, the number of certified rural health clinics has grown from less than 600 in 1990 to approximately 3700 in 2008.²

The rural health clinic program is fulfilling its goal of increasing access to primary medical care in rural areas. The PAs, NPs, and physicians in these clinics provide access to primary and emergency services in many communities in which medical services would not otherwise exist.

In addition to increasing access to care, RHCs often stabilize the rural health care delivery system and the economy of rural communities. They help reduce the migration of patients and health care dollars to urban areas. They employ qualified local residents and support local businesses, such as pharmacies, office suppliers, printers, nursing homes, and other merchants. They provide rural residents and businesses with access to needed primary and emergency services and thus make living and working in a rural community possible for
many families. RHCs also play an important role in the education of future rural providers by serving as clinical training sites for PA students and others.

Rural health clinics care for large numbers of Medicare, Medicaid, and uninsured patients. A 2003 national survey revealed that approximately 56% of patient visits in rural health clinics are covered by Medicare or Medicaid and approximately 15% of patients are uninsured. Clinics continue to exist because of the reimbursement methodology that helps to provide financial stability. Approximately 50 percent of clinics are subject to a federal cap. Unlike a fee-for-service practice where Medicare payment is based on charges for all services provided, a rural health clinic is paid based on costs calculated into an all-inclusive rate that is reconciled and adjusted annually. The rate is subject to an inflationary adjustment each year based upon the Medicare economic index. The rate has not been adjusted to reflect changes since the inception of the resource based relative value scale methodology for fee-for-service payments.

In addition, Medicaid payments to rural health clinics in the majority of states are paid based upon a prospective payment system that was calculated using rates from 1999-2000. In many states this does not reflect the current costs of care.

The rural health clinics program is an essential component of rural health care delivery today. It has been successful in delivering health care to previously underserved areas. Steps should be taken to insure that this program continues so people in rural areas will have access to primary care and emergency services.

Recommendations

• AAPA supports continuation of the rural health clinic program to meet the goal of improving access to care in rural medically underserved areas.

• The Academy also supports retention of the original requirement that RHCs utilize PAs in order to extend access to primary care medical services in areas that have a shortage of physicians. The purpose of the RHC program is to increase access to health care in medically underserved rural areas through utilization of PAs and NPs.

• In light of the 2004 federal requirements that RHCS establish a comprehensive quality assessment and performance improvement program, the Academy recommends that the cost of developing and maintaining these programs be captured in the clinic’s per visit payment rate.

• Recognizing the economic difficulties of providing health care services in rural underserved areas, AAPA recommends the continuation of cost-based reimbursement for RHCs or the development of an alternative payment mechanism that would protect their financial viability and cover the costs of providing services to rural Medicare and Medicaid patients. RHCs should not be required to compute patient co-payments into any Medicare co-payment cap. In addition, the Medicaid rates in states using a prospective payment system methodology for rural health clinics should be updated to reflect actual costs of providing care.
• Rural health clinics that employ PAs at the minimum 50 percent staffing level or higher should be eligible for the Medicaid electronic health record incentives contained in the American Recovery and Reinvestment Act of 2009 and for future incentives authorized by Congress.
• Because of the important role that rural health clinics play in delivering care to rural communities, RHCs should be considered an integral part of the national safety net provider system along with community and migrant health centers, federally qualified health centers, and free clinics.
• AAPA encourages the federal government to make the following improvements to the Rural Health Clinic Services Act, its regulations, and implementation:
  • Allow PAs and NPs to contract to provide medical services at RHCs;
  • Add preventive primary health services to the list of covered services for which rural health clinics are reimbursed by Medicare and Medicaid;
  • Set per visit payment levels that cover the actual costs of providing care;
  • Adjust the per visit payment cap to the same level as rural federally qualified health centers that provide comparable or similar medical services;
  • Permit RHCs to participate in the federal government’s section 340b discount drug pricing program so as to increase patient access to needed medications;
  • Include RHCs in federal funding programs that enhance care for rural underserved populations, such as those programs available to community and migrant health centers and FQHCs;
  • Maintain the authority of a governor to designate areas as rural for the purposes of the RHC program;
  • Allow clinics that have obtained and comply with the shortage area facility designation requirements but who lose their traditional health professional shortage area, medically underserved area, or governor's designation to be considered essential providers for the purpose of retaining their RHC designation;
  • Allow clinics that are actively involved in the education and training of PA students to be eligible for designation as an essential community provider;
  • Allow clinics that are certified as medical homes to retain their RHC designation;
  • Allow sufficient time (at least 18 months) from the date a clinic is notified of the loss of its certification for its transition out of the program;
  • Require all clinics to demonstrate during a waiver period that they are making a good faith effort to recruit PAs and NPs;
  • Encourage RHCs to offer specialty services that can be billed under traditional Medicare part b without violating commingling provisions;
• Avoid the imposition of new regulatory requirements that add cost and administrative burden to RHCs;
• Include RHCs as recipients of electronic health record incentive payments;
• Maintain eligibility for Medicaid payments for any RHC that has lost its certification regardless of the clinic ownership.

References
2. Federal Register, Vol.73, No.125, June 27, 2008.
Complementary and Alternative Medicine (CAM)

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 encourages PAs to become knowledgeable about complementary and alternative medicine.
- AAPA encourages PAs to discuss the use of complementary and alternative medicine with their patients in a non-judgmental manner that is personally respectful and culturally sensitive.
- AAPA encourages the continued performance of well-designed, evidence-based research on the efficacy and safety of complementary and alternative medicine.

Introduction
The trend toward using complementary and alternative (CAM) therapies has remained steady from 2002 (36%) to 2007 (38%) according to the 2007 National Health Interview Survey (NHIS). (1) As more information about their efficacy and safety becomes available, the trends in different therapies will change but patients will continue to utilize them to for prevention and treatment of disease and assist with health promotion.

Definition of CAM
CAM includes diverse medical and health care systems, practices and products that are not usually considered part of conventional medicine. Complementary medicine is used together with conventional medicine, while alternative medicine is used in place of conventional medicine. Integrative medicine combines conventional medicine and CAM treatments which have been proven to be safe and effective. (1, 2)

Complementary and Alternative Medicine
Patients look to their primary care providers for guidance and information about the benefits and safety of CAM and the burden is on providers to assist patients with their choices especially as more information becomes available in books, magazines and the internet. The need for research regarding safety and effectiveness has become even more important. To that end, the National Center for Complementary and Alternative Medicine (NCCAM) is now the Federal Government’s lead agent for scientific research on CAM. (1, 2)

As the need for training in CAM therapies grows, AAPA believes there must be cooperative support from many different groups in the medical community: physicians, insurance providers, medical organizations, governmental agencies, and especially medical schools. Formal acceptance of CAM therapies from the entire medical community, as well as increased funding
for research, will help counter historical stigmas, and enable providers to obtain adequate training and assist patients in their preferred treatments. (1, 2)

**Conclusion**

Currently, CAM education is being incorporated into PA and medical curriculums. (3,4) While remedies are undergoing closer scrutiny in clinical trials, many consumers will continue to use alternative therapies that have not undergone rigorous testing. Therefore, in order to provide the best care possible to their patients, PAs need to be knowledgeable about what treatments, including CAM, their patients are currently using or anticipate using.

**References**

Guidelines for Ethical Conduct for the PA Profession

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Introduction

The PA profession has revised its code of ethics several times since the profession began. Although the fundamental principles underlying the ethical care of patients have not changed, the societal framework in which those principles are applied has. Economic pressures of the health care system, social pressures of church and state, technological advances, and changing patient demographics continually transform the landscape in which PAs practice.

Previous codes of the profession were brief lists of tenets for PAs to live by in their professional lives. This document departs from that format by attempting to describe ways in which those tenets apply. Each situation is unique. Individual PAs must use their best judgment in a given situation while considering the preferences of the patient and the supervising physician, clinical information, ethical concepts, and legal obligations.

Four main bioethical principles broadly guided the development of these guidelines: autonomy, beneficence, nonmaleficence, and justice.

Autonomy, strictly speaking, means self-rule. Patients have the right to make autonomous decisions and choices, and PAs should respect these decisions and choices.

Beneficence means that PAs should act in the patient’s best interest. In certain cases, respecting the patient’s autonomy and acting in their best interests may be difficult to balance.

Nonmaleficence means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.
Justice means that patients in similar circumstances should receive similar care. Justice also applies to norms for the fair distribution of resources, risks, and costs.

PAs are expected to behave both legally and morally. They should know and understand the laws governing their practice. Likewise, they should understand the ethical responsibilities of being a health care professional. Legal requirements and ethical expectations will not always be in agreement. Generally speaking, the law describes minimum standards of acceptable behavior, and ethical principles delineate the highest moral standards of behavior.

When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere – possibly from a supervising physician, a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies. PAs should seek legal counsel when they are concerned about the potential legal consequences of their decisions.

The following sections discuss ethical conduct of PAs in their professional interactions with patients, physicians, colleagues, other health professionals, and the public. The "Statement of Values" within this document defines the fundamental values that the PA profession strives to uphold. These values provide the foundation upon which the guidelines rest. The guidelines were written with the understanding that no document can encompass all actual and potential ethical responsibilities, and PAs should not regard them as comprehensive.

**Statement of Values of the PA Profession**

- PAs hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- PAs uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.
- PAs recognize and promote the value of diversity.
- PAs treat equally all persons who seek their care.
- PAs hold in confidence the information shared in the course of practicing medicine.
- PAs assess their personal capabilities and limitations, striving always to improve their medical practice.
- PAs actively seek to expand their knowledge and skills, keeping abreast of advances in medicine.
- PAs work with other members of the health care team to provide compassionate and effective care of patients.
- PAs use their knowledge and experience to contribute to an improved community.
- PAs respect their professional relationship with physicians.
- PAs share and expand knowledge within the profession.
The PA and Patient

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.

The principal value of the PA profession is to respect the health, safety, welfare, and dignity of all human beings. This concept is the foundation of the patient–PA relationship. PAs have an ethical obligation to see that each of their patients receives appropriate care. PAs should be sensitive to the beliefs and expectations of the patient. PAs should recognize that each patient is unique and has an ethical right to self-determination.

PAs are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their health 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.

PAs should always act in the best interests of their patients and as advocates when necessary. PAs should actively resist policies that restrict free exchange of medical information. For example, a PA should not withhold information about treatment options simply because the option is not covered by insurance. PAs should inform patients of financial incentives to limit care, use resources in a fair and efficient way, and avoid arrangements or financial incentives that conflict with the patient’s best interests.

The PA and Diversity

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

Nondiscrimination

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.
Initiation and Discontinuation of Care

In the absence of a preexisting patient–PA relationship, the PA is under no ethical obligation to care for a person unless no other provider is available. A PA is morally bound to provide care in emergency situations and to arrange proper follow-up. PAs should keep in mind that contracts with health insurance plans might define a legal obligation to provide care to certain patients.

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. Discontinuation of the professional relationship should be undertaken only after a serious attempt has been made to clarify and understand the expectations and concerns of all involved parties.

If the patient decides to terminate the relationship, they are entitled to access appropriate information contained within their medical record.

Informed Consent

PAs have a duty to protect and foster an individual patient’s free and informed choices. The doctrine of informed consent means that a PA provides adequate information that is comprehensible to a competent patient or patient surrogate. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved. PAs should be committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational, and personal factors.

In caring for adolescents, the PA should understand all of the laws and regulations in his or her jurisdiction that are related to the ability of minors to consent to or refuse health care. Adolescents should be encouraged to involve their families in health care decision making. The PA should also understand consent laws pertaining to emancipated or mature minors. (See the section on Confidentiality.)

When the person giving consent is a patient’s surrogate, a family member, or other legally authorized representative, the PA should take reasonable care to assure that the decisions made are consistent with the patient’s best interests and personal preferences, if known. If the PA believes the surrogate’s choices do not reflect the patient’s wishes or best interests, the PA should work to resolve the conflict. This may require the use of additional resources, such as an ethics committee.

Confidentiality

PAs should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly.

In cases of adolescent patients, family support is important but should be balanced with the patient’s need for confidentiality and the PA’s obligation to respect their emerging autonomy. Adolescents may not be
of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PAs be familiar with and understand the laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients. (See the section on Informed Consent.)

Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient. PAs should choose methods of storage and transmission of patient information that minimize the likelihood of data becoming available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. PAs should advocate for policies and procedures that secure the confidentiality of patient information.

The Patient and the Medical Record

PAs have an obligation to keep information in the patient’s medical record confidential. Information should be released only with the written permission of the patient or the patient’s legally authorized representative. Specific exceptions to this general rule may exist (e.g., workers compensation, communicable disease, HIV, knife/gunshot wounds, abuse, substance abuse). It is important that a PA be familiar with and understand the laws and regulations in his or her jurisdiction that relate to the release of information. For example, stringent legal restrictions on release of genetic test results and mental health records often exist.

Both ethically and legally, a patient has certain rights to know the information contained in his or her medical record. While the chart is legally the property of the practice or the institution, the information in the chart is the property of the patient. Most states have laws that provide patients access to their medical records. The PA should know the laws and facilitate patient access to the information.

Disclosure

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. Errors do not always constitute improper, negligent, or unethical behavior, but failure to disclose them may.

Care of Family Members and Co-workers

Treating oneself, co-workers, close friends, family members, or students whom the PA supervises or teaches may be unethical or create conflicts of interest. For example, it might be ethically acceptable to treat one’s own child for a case of otitis media but it probably is not acceptable to treat one’s spouse for depression. PAs should be aware that their judgment might be less than objective in cases involving friends, family
members, students, and colleagues and that providing “curbside” care might sway the individual from establishing an ongoing relationship with a provider. If it becomes necessary to treat a family member or close associate, a formal patient-provider relationship should be established, and the PA should consider transferring the patient’s care to another provider as soon as it is practical. If a close associate requests care, the PA may wish to assist by helping them find an appropriate provider.

There may be exceptions to this guideline, for example, when a PA runs an employee health center or works in occupational medicine. Even in those situations, the PA should be sure they do not provide informal treatment, but provide appropriate medical care in a formally established patient-provider relationship.

**Genetic Testing**

Evaluating the risk of disease and performing diagnostic genetic tests raise significant ethical concerns. PAs should be informed about the benefits and risks of genetic tests. Testing should be undertaken only after proper informed consent is obtained. If PAs order or conduct the tests, they should assure that appropriate pre- and post-test counseling is provided.

PAs should be sure that patients understand the potential consequences of undergoing genetic tests – from impact on patients themselves, possible implications for other family members, and potential use of the information by insurance companies or others who might have access to the information. Because of the potential for discrimination by insurers, employers, or others, PAs should be particularly aware of the need for confidentiality concerning genetic test results.

**Reproductive Decision Making**

Patients have a right to access the full range of reproductive health care services, including fertility treatments, contraception, sterilization, and abortion. PAs have an ethical obligation to provide balanced and unbiased clinical information about reproductive health care.

When the PA's personal values conflict with providing full disclosure or providing certain services such as sterilization or abortion, the PA need not become involved in that aspect of the patient's care. By referring the patient to a qualified provider who is willing to discuss and facilitate all treatment options, the PA fulfills their ethical obligation to ensure the patient’s access to all legal options.

**End of Life**

Among the ethical principles that are fundamental to providing compassionate care at the end of life, the most essential is recognizing that dying is a personal experience and part of the life cycle.

PAs should provide patients with the opportunity to plan for end of life care. Advance directives, living wills, durable power of attorney, and organ donation should be discussed during routine patient visits.

PAs should assure terminally-ill patients that their dignity is a priority and that relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental attitudes and should assure their terminally-ill patients that they will not be abandoned. To the extent possible, patient or surrogate preferences should be
honored, using the most appropriate measures consistent with their choices, including alternative and non-traditional treatments. PAs should explain palliative and hospice care and facilitate patient access to those services. End of life care should include assessment and management of psychological, social, and spiritual or religious needs.

While respecting patients’ 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.

**The PA and Individual Professionalism**

**Conflict of Interest**

PAs should place service to patients before personal material gain and should avoid undue influence on their clinical judgment. Trust can be undermined by even the appearance of improper influence. Examples of excessive or undue influence on clinical judgment can take several forms. These may include financial incentives, pharmaceutical or other industry gifts, and business arrangements involving referrals. PAs should disclose any actual or potential conflict of interest to their patients.

Acceptance of gifts, trips, hospitality, or other items is discouraged. Before accepting a gift or financial arrangement, PAs might consider the guidelines of the Royal College of Physicians, “Would I be willing to have this arrangement generally known?” or of the American College of Physicians, “What would the public or my patients think of this arrangement?”

**Professional Identity**

PAs should not misrepresent directly or indirectly, their skills, training, professional credentials, or identity. PAs should uphold the dignity of the PA profession and accept its ethical values.

**Competency**

PAs should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic health care providers. PAs should also strive to maintain and increase the quality of their health care knowledge, cultural sensitivity, and cultural competence through individual study and continuing education.

**Sexual Relationships**

It is unethical for PAs to become sexually involved with patients. It also may be unethical for PAs to become sexually involved with former patients or key third parties. Key third parties are individuals who have influence over the patient. These might include spouses or partners, parents, guardians, or surrogates.
Such relationships generally are unethical because of the PA’s position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

**Gender Discrimination and Sexual Harassment**

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.

It is unethical for PAs to engage in or condone any form of sexual harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work or academic environment, or
- Accepting or rejecting such conduct affects or may be perceived to affect professional decisions concerning an individual, or
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's training or professional position.

**The PA and Other Professionals**

**Team Practice**

PAs should be committed to working collegially with other members of the health care team to assure integrated, well-managed, and effective care of patients. PAs should strive to maintain a spirit of cooperation with other health care professionals, their organizations, and the general public.

**Illegal and Unethical Conduct**

PAs should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by health care professionals to the appropriate authorities.

**Impairment**

PAs have an ethical responsibility to protect patients and the public by identifying and assisting impaired colleagues. “Impaired” means being unable to practice medicine with reasonable skill and safety because of physical or mental illness, loss of motor skills, or excessive use or abuse of drugs and alcohol.

PAs should be able to recognize impairment in physician supervisors, PAs, and other health care providers and should seek assistance from appropriate resources to encourage these individuals to obtain treatment.
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.

Complementary and Alternative Medicine

When a patient asks about an alternative therapy, the PA has an ethical obligation to gain a basic understanding of the alternative therapy being considered or being used and how the treatment will affect the patient. If the treatment would harm the patient, the PA should work diligently to dissuade the patient from using it, advise other treatment, and perhaps consider transferring the patient to another provider.

The PA and the Health Care System

Workplace Actions

PAs may face difficult personal decisions to withhold medical services when workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to patients should be carefully weighed against the potential improvements to working conditions and, ultimately, patient care that could result. In general, PAs should individually and collectively work to find alternatives to such actions in addressing workplace concerns.

PAs as Educators

All PAs have a responsibility to share knowledge and information with patients, other health professionals, students, and the public. The ethical duty to teach includes effective communication with patients so that they will have the information necessary to participate in their health care and wellness.

PAs and Research

The most important ethical principle in research is honesty. This includes assuring subjects’ informed consent, following treatment protocols, and accurately reporting findings. Fraud and dishonesty in research should be reported so that the appropriate authorities can take action.

PAs involved in research must be aware of potential conflicts of interest. The patient's welfare takes precedence over the desired research outcome. Any conflict of interest should be disclosed.

In scientific writing, PAs should report information honestly and accurately. Sources of funding for the research must be included in the published reports.

Plagiarism is unethical. Incorporating the words of others, either verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. When submitting a document for publication, any previous publication of any portion of the document must be fully disclosed.
PAs as Expert Witnesses

The PA expert witness should testify to what he or she believes to be the truth. The PA’s review of medical facts should be thorough, fair, and impartial.

The PA expert witness should be fairly compensated for time spent preparing, appearing, and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given or derive personal, financial, or professional favor in addition to compensation.

The PA and Society

Lawfulness

PAs have the dual duty to respect the law and to work for positive change to laws that will enhance the health and well-being of the community.

Executions

PAs, as health care professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.

Access to Care / Resource Allocation

PAs have a responsibility to use health care resources in an appropriate and efficient manner so that all patients have access to needed health care. Resource allocation should be based on societal needs and policies, not the circumstances of an individual patient–PA encounter. PAs participating in policy decisions about resource allocation should consider medical need, cost-effectiveness, efficacy, and equitable distribution of benefits and burdens in society.

Community Well Being

PAs should work for the health, well-being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well-being of the community in general and the individual patient. Conflict between an individual patient’s best interest and the common good is not always easily resolved. In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.

Conclusion

AAPA recognizes its responsibility to aid the PA profession as it strives to provide high quality, accessible health care. PAs wrote these guidelines for themselves and other PAs. The ultimate goal is to honor patients and earn their trust while providing the best and most appropriate care possible. At the same time, PAs must understand their personal values and beliefs and recognize the ways in which those values and beliefs can impact the care they provide.
Specialty Certification, Clinical Flexibility, and Adaptability

[Adopted 2017]

Executive Summary of Policy Contained in this Paper

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

- AAPA 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. 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. This model has changed over time. In particular, the role of PA-physician collaboration has been redefined in a way that has tended toward increasing levels of PA autonomy. Regardless, the PA model has produced a remarkably flexible medical professional who can be trained fairly quickly and readily available to address unmet needs of patients and the healthcare system in general.

The flexibility of the PA to function in multiple venues is an attribute that is highly prized among physicians, the healthcare system, and PAs. PAs regularly take advantage of this flexibility. An analysis of PA cohorts between 1969 and 2008 found that 49% of PAs had changed specialties at least once in their careers, 24% made specialty switches to another specialty class (i.e., primary care to a surgical specialty), and 11% reported practicing in at least three specialties during their career. In a 2015 survey, 8.3% of PAs indicated that they had changed their specialty during 2014. 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.

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. 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.\(^7\) This has created an anomaly whereby a profession with a generalist training model and an assumed primary care trajectory is now dominated by specialty practice.

NCCPA introduced Certificates of Added Qualifications (CAQs) in 2011.\(^8\) In 2016, NCCPA proposed a change to the recertification process whereby at the time of recertification PAs would choose a specialty exam relevant to their practice and, if an exceptional level of performance was achieved, examinees would be eligible to be awarded a CAQ, in addition to the renewal of the PA-C credential should they desire to pursue CAQ and were willing to meet the additional requirements. After a spirited debate, this proposal was withdrawn. NCCPA 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.\(^9\) 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.\(^8\) 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.\(^10,11\)

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

To address these questions, 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 CAQ</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 2: Interprofessional PA-eligible Specialty Certifications*

<table>
<thead>
<tr>
<th>Credential</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Cardiac Life Support (ACLS)</td>
<td>Various</td>
</tr>
<tr>
<td>Advanced Trauma Life Support (ATLS)</td>
<td>Various</td>
</tr>
<tr>
<td>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 for PAs to be available in areas where there are workforce gaps. This could result in higher costs for the system and reduced access for patients.

**When Might Specialty Certification be Appropriate?**

The most compelling case for requiring specialty certification would be if a clear relationship between specialty certification and patient outcomes, including quality of care, could be demonstrated. Currently, there is a paucity of such evidence. This link has been difficult to demonstrate in physician literature. In a review of 33 findings by Sharp and colleagues, 16 demonstrated a positive relationship between certification status and desirable clinical outcomes. Fourteen showed no association, and an additional three showed a negative relationship, although the studies showing a negative relationship suffered from insufficient case mix.\(^1\)\(^2\) 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.


Use of Medical Interpreters for Patients with Limited English Proficiency

PAs provide vitally important services to patients. The effectiveness of the care delivered by PAs depends heavily on the establishment of a PA-patient relationship based on empathy, confidence, trust, and the free flow of communication. The exchange of information can be difficult when the two parties involved speak different languages.

Language difficulties have been identified as one of the leading barriers to obtaining effective health care in the United States. The number of people in the United States with limited English proficiency (LEP) is increasing. Recent census data show that 44 million Americans speak a language other than English at home.

Based on Title VI of the 1964 Civil Rights Act, which promises equal access to federally assisted programs and activities to everyone in the United States, the Office of Civil Rights (OCR) of the Department of Health and Human Services issued a policy guidance in August 2000 that affects PAs and other health care providers (see http://www.hhs.gov/ocr/lep/guide.html). The document clarifies a requirement that recipients of federal assistance provide translation services at no cost to people whose ability to read, speak, or understand English is limited. This means that health care providers who accept Medicare and Medicaid payment for their services to LEP patients should provide them with effective language assistance. The goal is to make sure that all patients receive quality medical care, even in circumstances where a health care professional and a patient speak different languages.

It is a challenge to determine how to overcome the communication barrier that could leave patients without adequate or appropriate medical attention. Because the diversity of health care providers does not match, either ethnically or geographically, the diversity of the patient population, the use of qualified medical interpreters is a critical part of the solution.

Competent medical interpretation requires a specialized set of skills that extends beyond the knowledge of two languages. The use of an interpreter who lacks the competency to accurately convey technical information can lead to misdiagnoses and inappropriate treatments. It also places health care providers at greatly increased legal risk. There are significant drawbacks to using a patient’s friends or family, especially children, as interpreters. These include the likelihood of inaccurate translations, omissions, additions, substitutions, volunteered answers, personal opinions, and other problems. The use of untrained interpreters also increases the risk of breaching patient privacy and confidentiality requirements.

Trained, professional medical interpreters are held to high standards by codes of ethics to which they must adhere. This helps preserve the confidentiality of patient information. In addition, professional interpreters should be able to provide not only accurate translations, but also culturally and socially informed explanations.
The Office of Civil Rights requires health care providers with publicly-assisted LEP patients to have reasonable policies and procedures in place. This may include hiring bilingual staff who are trained and competent interpreters, hiring staff interpreters, contracting with an outside interpreter service, arranging for the services of voluntary community interpreters, and using a telephone language interpreter service. Patients may be referred to nearby facilities that have translators, but providers are obligated to follow up to make sure that appropriate care is given. Written materials that are routinely provided to patients, such as consent forms and medication instructions, must be translated. LEP patients must also be notified of their right to free language assistance. OCR says that friends, family, and minor children may be used as interpreters only after patients have been informed of their right to free translation services and have declined their use.

OCR requires that covered providers ensure that they are using competent interpreters. Interpreters may hold formal certification. Alternatively, they may prove their competence through demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting, fundamental knowledge in both languages of any specialized terms or concepts, sensitivity to the LEP patient’s culture, and the ability to convey information in both languages accurately.

The requirements of assuring interpreter competency and underwriting the cost of providing interpreter services are two stumbling blocks to full and effective implementation of the OCR guidance. Nevertheless, compliance is required by all covered providers. OCR investigates all complaints, reports, or other information that allege or indicate noncompliance with Title VI of the Civil Rights Act. OCR will provide technical assistance, consultation, and reasonable timetables in such cases, but failure to resolve the problem could result in exclusion from the Medicare or Medicaid program, referral to the Department of Justice for enforcement proceedings, or other actions.

*The Guidelines for Ethical Conduct for the PA Profession* are clear in their emphasis on PA-patient relationships; respect for dignity, confidentiality, and diversity; non-discrimination; informed consent; and other principles that come into play when treating LEP patients. PAs thus have an ethical and legal obligation to use appropriately trained medical interpreters for their patients with limited ability to speak or understand English.
Antimicrobial Resistance  

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

- AAPA believes that antimicrobial resistance is a significant and continuing issue for medical practice.
- AAPA should work strategically with other organizations to educate medical providers, administrators and students about the issue of antimicrobial resistance and the need to limit the inappropriate use of antimicrobial use as a means of slowing evolution of antimicrobial resistance.
- PAs should understand the natural course of infectious diseases and the appropriate use of antimicrobial therapies.
- Whenever possible, cultures should be used to guide decision-making for antimicrobial use.
- A thorough knowledge would include antibiotic/food interactions and potential hidden sources of antibiotics.
- PAs should seek out the latest available data on local and/or regional resistance trends as part of their vigilance.

Introduction

At the turn of the century, infectious diseases were the leading cause of death in the United States. Tuberculosis, infectious diarrheal diseases, and pneumonia accounted for 30 percent of all deaths and kept life expectancy at about 47 years. Several factors helped reduce the mortality rate from these infectious diseases. Public policy and individual efforts placed a higher priority on hygiene and sanitation services which improved the quality of life. Government actions vastly improved food and water supplies. After World War II, the industrial production of penicillin was introduced. Within a few short years after the introduction of antibiotics to modern medicine, the first resistant bacteria to penicillin were discovered. Since then many different antimicrobial agents have been discovered and brought onto the market. Each new antibiotic creates a selective pressure that quickly leads to bacteria that survive the various mechanisms of microbial destruction. These pressures and the natural process of evolution combine to allow bacteria to adapt. As a result, some previously well controlled bacterial diseases (i.e. tuberculosis, staphylococcal infections, S. pneumoniae, enterococci, pseudomonal infections and Salmonella) have appeared in drug resistant forms in recent years. International travel also promotes the spread of drug-resistant strains. As we look to this coming century, the appropriate use of antimicrobials may be one of the most important challenges to the health of our patients.
**Misuse of Antimicrobial Agents**

Misuse and overuse of antimicrobial agents have exacerbated problems associated with resistant microbes.\(^5,7\) Inappropriate antibiotic prescription by clinicians treating patients is a major source of overuse. Patient and care-giver expectations result in inappropriate demand for antibiotic and antiviral medications. In some developing countries, antimicrobial agents are available without a prescription. All these and the ease of international travel further complicate emerging infectious diseases.\(^6,7\) Animal husbandry use have led directly to drug resistant pathogens.\(^9\) Antimicrobials are fed to animals in an effort to promote their growth and prevent infection which has contributed significantly to the emergence of drug-resistant organisms.\(^6,10,11,12\)

**Drug Resistant Organisms**

Drug resistance continues to be a serious public health problem.\(^3,13\) The list of drug resistant pathogens is growing much faster than our ability to identify agents effective in their treatment. Drug resistant pseudomonal infections, vancomycin-resistant enterococcus (VRE) and even vancomycin resistance *Staphylococcus aureus* are three common nosocomial infections.\(^7,13,14\) Drug resistant strains of tuberculosis, Methicillin-Resistant *Staphylococcus aureus*, *Neisseria gonorrhoeae* and *Streptococcus pneumoniae* are significant community acquired infections.\(^7,11,13\)

The problem of drug resistance is multifactorial. Solutions will require coordinated efforts of clinicians, microbiologists, researchers, the pharmaceutical industry, public health personnel, and our patients. Programs to improve antimicrobial use must be implemented to help preserve the effectiveness of current drugs since few new effective antimicrobial agents are being introduced.\(^5,9,11,13\)

**Conclusions**

The CDC has pooled strategies to try and decrease the pressures toward greater microbial resistance. There are four main components to the CDC plan that includes proper hygiene to prevent infections in the first place, diagnose the specific infectious agents before initiating appropriate antimicrobial therapy and then prevent the spread of infectious microbes by hand washing and isolating pathogens.\(^15\) These are the elements of antimicrobial strategy to decrease the burden of disease while lowering the selective pressures toward resistant pathogens. There are specific recommendations for most every clinical practice setting, but especially for hospitals and long term care facilities.

PAs should understand the natural course of infectious diseases and the appropriate use of antimicrobial therapies. Whenever possible, cultures should be used to guide decision-making. A thorough knowledge would include antibiotic/food interactions and potential hidden sources of antibiotics. PAs should seek out the latest available data on local and/or regional resistance trends as part of their vigilance.

**References**

Developing a Culture of Leadership Excellence in AAPA

ABSTRACT

Developing a Culture of Leadership Excellence in AAPA

The Leadership Advisory Commission (LAC) prepared this position paper to support a resolution to the House of Delegates. The resolution proposes a philosophy of leadership for the Academy, and explains the need for the resolution. The philosophy is based upon the following four principles:

- Leadership is defined by knowledge, skills, and abilities, rather than by position or title.
- The core competencies of leadership can be learned, and the learning is a life-long process.
- PA leaders value diversity and practice inclusion.
- PA leaders identify and mentor future PA leaders.

Section B of this paper provides a literature review for background reading, including qualities and characteristics of leaders, and the topics of vision, communication, and self-knowledge. Section C discusses the four principles in detail, including references to prior research conducted by the Academy and LAC. Each principle lays the foundation for the development of a culture of leadership excellence in AAPA. Section D, the conclusion, considers the LAC’s plans for future leadership training for the PA profession.

A. Introduction

The vision of AAPA is that PAs will be worldwide leaders vital to providing and improving the medical care of all people.

The mission of AAPA is to promote quality, cost-effective, and accessible health care and to promote the professional and personal development of PAs.

In order for AAPA to actualize its vision and mission, the development of PA leaders must become a focus of the Academy’s effort. While the Academy has researched its leadership needs and has developed a variety of excellent leadership training activities, AAPA has not yet developed an explicit philosophy of leadership.
The Leadership Advisory Commission (LAC) has prepared this position paper to support a resolution to the House of Delegates, proposing a philosophy of leadership for AAPA. The philosophy consists of shared values and beliefs that will provide the foundation for a culture of leadership excellence in AAPA, and is based on the following four principles:

1. **Leadership is defined by knowledge, skills, and abilities, rather than by position or title.**
2. **The core competencies of leadership can be learned, and the learning is a life-long process.**
3. **PA leaders value diversity and practice inclusion.**
4. **PA leaders identify and mentor future PA leaders.**

Section B of this paper provides a literature review for background reading, and Section C discusses the four principles of the philosophy. Section D, the conclusion, discusses the potential for actualizing the philosophy through comprehensive leadership training.

**B. Literature Review: Descriptions of Leaders and Leadership**

This section provides a brief overview of the leadership literature, identifying aspects of leadership related to the development of the proposed philosophy.

Philosophers, politicians, academicians, and business people have written about leadership for centuries, frequently touching themes that are as relevant today as in prior epochs. For example, Plato identified four virtues associated with philosopher-kings: (1)

- Wisdom
- Courage
- Moderation
- Justice

Plato’s list bears an interesting resemblance to Nanus and Dobbs’ recent formulation of the necessary leadership qualities for non-profit organizations: (2)

- Being competent
- Being forward looking
- Being inspiring
- Being honest

Listening is an essential leadership skill. In the early 1500s, Niccolo Machiavelli wrote his now-famous treatise on statesmanship and power, *The Prince*. Included in his advice to a ruler of that era was:

He ought to be a great asker, and a patient hearer of the truth about those things of which he has inquired; indeed, if he finds that anyone has scruples in telling him the truth he should be angry. (3)

Although he later became identified with manipulation and power politics, Machiavelli wrote with insight about the realities of leadership.

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Compare Machiavelli to John Kotter, who described four mental habits that enable leaders to become life-long learners. Among the habits Kotter identified were:

- Solicitation of opinions: Aggressive collection of information and ideas from others
- Careful listening: Propensity to listen to others (4)

**Vision**

The contemporary leadership literature emphasizes the importance of the leader’s vision, which is capable of providing focus and direction for the team or group. In their classic study of leaders, Bennis and Nanus described vision as “a target that beckons.” (5) In a later work, Bennis identified the first of four areas of leadership competence as management of attention – the ability of leaders to enroll people in their vision. (6) The SAAAPA Position Paper on Student Leadership referred to vision as:

Purpose. Leaders have a clear view of the group’s purpose. They develop mutually agreed-upon and challenging goals that clearly relate to this vision. (7)

The next step in the leadership process is applying knowledge to the vision. Kouzes and Posner list five practices of exemplary leadership (8)

- Challenge the process
- Inspire a shared vision
- Enable others to act
- Model the way
- Encourage the heart

The issue of vision in a non-profit organization takes on particular importance, since products and the bottom line do not provide the primary motivation. Like other non-profits, AAPA’s vision is directed at a set of values that transcend the profit motive. Nanus and Dobbs addressed this aspect of non-profit organizational vision by stating,

*The right direction* is the one that makes the greatest possible contribution over the long term to society or to the particular clients or community that the organization was created to serve. The right direction is *toward the greater good.* (2)

**Communication**

The ability to communicate a vision ranks among the key tasks of a leader. According to Bennis and Nanus, “All organizations depend on the existence of shared meaning and interpretations of reality, which facilitate coordinated action.” (5) While not all leaders are charismatic, leaders must be able to manage meaning in organizations. The combination of a compelling vision and effective communication skills inspires people to take action, a key issue for volunteer organizations.
Trust

According to Kouzes and Posner, credibility is a foundational element in the equation of effective leadership. Without honesty, credibility is negated, and they state:

Honesty is absolutely essential to leadership. If people are going to follow someone willingly, whether it be into battle or into the boardroom, they first want to assure themselves that the person is worthy of their trust. They want to know that the would-be leader is truthful and ethical. No matter where we have conducted our studies – regardless of country, geographical region, or type of organization – the most important leadership attribute since we began our research in 1981 has always been honesty. (9)

Constancy, reliability, and staying the course – all are ingredients of creating trust. (5, 6) People may be drawn to a vision, convinced by effective communication, but they must trust a leader to maintain their commitment to an organization or project. Leaders create trust with their honesty and demonstration of follow-through. This is particularly relevant to volunteers, who must prioritize their limited time.

Self-Knowledge

A final necessary component of leadership is self-knowledge, which includes:

- recognition of one’s own strengths and weaknesses
- ability to take risks
- recognition that mistakes are an opportunity for learning (5, 6)

In his classic, The Effective Executive, Peter Drucker stated,

Effective executives build on strengths – their own strengths, the strengths of their superiors, colleagues, and subordinates; and on the strengths in the situation, that is, on what they can do. (10)

Kotter described the mental habit that makes these insights possible as “humble self-reflection.” (4)

Covey and Goleman stated that “a leader possesses self-knowledge, accepts responsibility and exhibits emotional maturity.” (11) They further defined these characteristics as:

- Knowing oneself
- Being willing to engage in personal change
- Motivating oneself
- Taking responsibility for personal behaviors and actions
- Managing one’s emotions
- Recognizing others’ emotions
- Handling relationships
- Making corrections/adjustments as needed

The discussion above lays the foundation for the philosophy of leadership proposed by the LAC in the next section.
C. Proposed Philosophy of Leadership for AAPA

Tom Peters reminds us that for an organization to grow, to be a leader in its field, and to think outside the box, the organization needs to break the mold. (12) An innovative culture of leadership in AAPA would consider unconventional ideas and approaches to training, so that its leaders and members can

- embrace the organization and regard it as their own
- value its vision and mission
- lead the way into the next decade
- exhibit leadership at the local, regional, national, and international level

The LAC proposes the following four principles as the foundation of the philosophy of leadership of AAPA:

1. **Leadership is defined by knowledge, skills and abilities, rather than by position or title.**

   In order to broaden our shared understanding of PAs as leaders, we need a definition of leadership that is not limited to elected office. In their 1997 Leadership Audit report, Tecker Consultants recommended that the Academy should, “broaden the definition of leadership to encompass all leaders at all levels.” (13) In 1999, the Leadership Project Task Force Report asserted that, “leadership is not defined by or limited to the position or title one holds.” (14)

   This new definition, based on activities and traits rather than position, recognizes the many arenas in which PA exercise leadership including:

   - family
   - work settings (e.g. clinical, military, education, administration, research)
   - community organizations (e.g. religion-based, advocacy, social, sports, international)
   - formal and informal organizations in the workplace and community
   - political organizations (e.g. regional, state, national, international)
   - professional organizations (e.g. administrative, counseling, physician groups)
   - PA educator organizations (APAP consortia and national level)
   - AAPA (national level, constituent organizations, SAAAPA, local PA organizations, coalitions of PAs, and other health care professionals)

   The SAAAPA Position Paper on Student Leadership, published in 1999, aligned with this approach to leadership, as stated below:

   Leadership skills can be displayed in a variety of settings, not just while the student is fulfilling professional responsibilities. A student can be a leader in scholastics as well as a leader in multiple clinical settings. Fostering leadership skills in PA students only serves to create better PAs. (7)

   If not defined by position, what are the activities and traits that define leadership? Using the broad categories discussed in Section B above, LAC proposes that a set of knowledge, skills, and abilities can be
identified that define leadership in action. As trained clinicians, PAs learn the foundation of core competencies required for clinical practice in their PA educational programs and build upon that foundation in the workplace. Likewise, leadership requires a set of core competencies that can be taught, learned and reinforced over a lifetime.

From November 2001, until March 2002, the LAC conducted an on-line Leadership Needs Assessment survey. AAPA members were asked to rank their interest in and need for learning in selected leadership topics. The 900 respondents ranked the following two topics as both their highest interest area and their greatest need for development:

- Understanding the health care environment
- Developing credibility and integrity as a leader

The results highlight the core qualities of leadership and leaders discussed in the beginning of this paper – knowledge/competence and honesty/integrity/trust. (15)

In an earlier study, the 1999 LAC Survey Report summarized the responses of 155 AAPA leaders (44% return rate of 350 mailed surveys), who were asked to review a set of learning objectives related to leadership and rank their perceived importance. The top eight objectives chosen are listed below, from the highest rank in descending order:

1) Leadership theories, styles, and functions
2) Team building
3) Working with others
4) Strategic thinking
5) Strategic analysis and planning
6) Motivating and empowering
7) Conflict management
8) Conducting a meeting (16)

The results of both surveys can be used to build a blueprint of the core knowledge, skills, and abilities required for leadership. Core knowledge and abilities are explicitly identified in the 2002 survey. The skill sets identified in the 1999 survey imply other areas of knowledge and ability. For example, conflict management is a skill that requires knowledge: self-knowledge and knowledge of other people’s motivations and styles. Dealing successfully with conflict also requires abilities: flexibility, tolerance for conflict, and valuing differences of opinion.

By defining the core competencies of leadership and providing training to its members, the Academy can focus on leadership development at all levels. LAC will continue to define these core competencies and develop a corresponding agenda of leadership training.
2. The core competencies of leadership can be learned, and the learning is a life-long process.

As PAs, we have all had the experience of learning new competencies and developing our abilities through our education and in the workplace. Likewise, the core competencies of leadership can be learned, and like clinical skills, leadership takes time to develop. Staley provides an eloquent reminder about the necessity for patience with his statement, “Remember that leadership isn’t a moment of arrival, it is a lifelong process.” (17)

To actualize the vision and mission of the Academy, we must move beyond these common myths about leadership:

- Myth: Leadership is a rare skill.
- Myth: Leaders are born, not made.
- Myth: Leaders are charismatic.
- Myth: Leadership exists only at the top of an organization. (5)

As the 1999 AAPA Leadership Project Task Force Report states, “leadership skills can be learned through a variety of methods and media,” and, “becoming a good leader is a lifetime process, not a certification.” (18)

The Academy supports leadership learning by sponsoring a variety of training activities, including web based modules, workshops, presentations, mentoring, and peer facilitation. LAC provides training during the Leadership Summit and AAPA Annual Conference. With the identification of the core competencies of leadership, these activities can be expanded and organized to meet the needs of members at different stages of leadership development.

While recognizing the importance of Academy efforts in leadership development, it is necessary to reiterate the findings of the AAPA Leadership Project Task Force, “individuals are ultimately responsible for their own personal, career and leadership development.” (18) By adopting the proposed philosophy of leadership and by creating a culture of leadership, the Academy can empower its members to develop their own leadership potential at all levels.

3. PA leaders value diversity and practice inclusion

On the threshold of globalization of the PA profession, valuing diversity and practicing inclusion must become a high priority for the Academy and all PAs. The AAPA Strategic Management Directions for 2002-2003 include diversity as a cross-cutting concern, relevant to all other strategies:

Diversity – Promote an inclusive environment that maximizes individual and organizational opportunity, potential, and responsibility. Encourage an environment that promotes and educates PAs in the cultural competency of the patient care.
Diversity has many meanings in contemporary American life. Fundamental to most definitions of diversity, however, is the word “difference.” Among the learning objectives developed for the AAPA Leadership Skills Development Project, the following are related to appreciation of diversity:

- Recognize the unique characteristics that define oneself and others.
- Understand and appreciate the need for and advantages of working with individuals whose race, sex, religion, ethnic origin, culture, languages, skills, styles, and personalities are different from one’s own. (14)

The first objective requires self-knowledge, as mentioned earlier, as well as the ability to perceive similarities and differences with other people. While we celebrate our common ground as PAs, and realize that we have more in common than differences, we must recognize that,

People are different in fundamental ways. We often perceive these differences as “mistakes” that need correcting, rather than differences to be appreciated. (19)

Using a broad definition of diversity enables us to appreciate common ground and differences while recruiting volunteers, building teams, negotiating consensus, and managing conflict. Bennis described the value of diversity as follows,

Like portfolios, organizations benefit from diversity. Effective leaders resist the urge to people their staffs only with others who look or sound or think just like themselves….They look for good people from many molds, and then they encourage them to speak out, even to disagree. (6)

Appreciating diversity is not an abstract principle. Diversity in action means creating an environment which goes beyond tolerance to genuine appreciation of the differences among us. Practicing inclusion improves teams, organizations and communities. With regard to nonprofit organizations, Nanus and Dobbs stated,

Leaders have a special responsibility for seeking to develop multi-culturalism and diversity among staff. Diversity has proven valuable in all types of organizations in generating innovative ideas; broadening the appeal of the organization; expanding its network of donors and volunteers; and making it more open, flexible, and responsible.” (2)

An additional dimension of diversity needed for AAPA leadership is summarized in the frequently quoted phrase, “look beyond the front row.” (13)

4. **PA leaders identify and mentor future PA leaders**

Leaders inspire, motivate, and influence individuals to take action to achieve a common goal. Leadership develops from experience, training, and mentoring. (18) AAPA has the responsibility to identify and develop future PA leaders, who can adopt the philosophy and embody the culture of leadership excellence.
The responsibility for leadership development also rests with each leader. Opportunities to lead bring personal fulfillment and the satisfaction of making a difference. With these opportunities come responsibilities. PA leaders in their communities and organizations have a duty to identify potential successors, to pass along their knowledge, and to mentor the next generation of leaders. PA leaders who adopt the proposed culture of leadership excellence will help develop the next generation of leaders to be more capable and effective than themselves. Leaders should be willing to step up, step away, or step down in order to make way for new leaders, and this process should be planned thoughtfully. (20) The LAC advocates for initiatives that motivate leaders to identify and mentor future leaders.

**D. Conclusion: Toward a Culture of Leadership Excellence**

Building upon the foundation of Section B and the philosophy in Section C, the LAC proposes that AAPA formally adopt a philosophy of leadership, which will support the following Cross-cutting Concern in the 2002-2003 AAPA Strategic Management Directions:

Leadership – Promote the professional and personal development of PAs as leaders in their workplaces, their local and global communities, and the Academy.

Specifically, the proposed philosophy of leadership includes the following four principles:

1. **Leadership is defined by knowledge, skills and abilities, rather than by position or title.**
2. **The core competencies of leadership can be learned, and the learning is a life-long process.**
3. **PA leaders value diversity and practice inclusion.**
4. **PA leaders identify and mentor future PA leaders.**

Organizational culture requires a shared vision and action to support its vision. By adopting the proposed philosophy of leadership, current activities can be enhanced and new activities developed that will form a cohesive learning paradigm for every stage of leadership development in a PA’s career.

Following the adoption of the philosophy of leadership through the proposed HOD resolution, the LAC plans to develop a comprehensive plan for leadership training based on the following:

- Training and development activities should align with the principles of the proposed philosophy of leadership.
- The knowledge, skills, and abilities, which form the core competencies of leadership, should be identified and utilized to plan leadership training.
- Activities should be conducted at the national, regional, and local level, using a train-the-trainer model whenever possible.

Adopting a philosophy of leadership will lead to the development of a culture of leadership excellence, and will promote the actualization of the AAPA vision that: *PAs will be worldwide leaders vital to providing and improving the medical care of all people.*
Acknowledgement
The work of the AAPA Leadership Project Task Force was fundamental to the formulation of this paper, and we appreciate their efforts and vision.

References


**Resources**


Schwartz gives a strong argument of why organizations must adjust their business view outside of short-term time frames focused on profit, to one encompassing time frames far into the future. The organization is viewed as more of a flat entity rather than hierarchical one.


This book (also available on tape) is an excellent resource of forward leadership thinking. In particular, the book hones in on the ‘what if’ scenario when we suspend our current technological paradigms to dream of the possibilities.


A how to win book created by two well-known political strategists who point out that while having a 49% market share in business means overwhelming success; in politics, it means you lost. In their words, the purpose of the book is “to make you faster, smarter, and more aggressive.” Carville and Begala’s powerful and humorous insights from the world of politics are exactly what aspiring leaders need to get ahead and stay ahead.


Although this book was written for academic leaders, the concepts and lessons are appropriate for any aspiring leader, in particular, minorities. Eleven contributors are academic administrators representing people of color who share their experiences, challenges, and successes as leaders in predominately white institutions.


The Diversity Impact Checklist was created to address key issues of diversity within the Academy. The Checklist can be used in conjunction with the *Four Layers of Diversity.*

Encouraging the Heart is a book that reminds us that there is a leader in all of us, and that true leadership does not always take place in the boardroom, but often takes place at the level where people work, struggle, and tread their ways through their daily grinds. Encouraging the Heart is a constant reminder of what is truly important – the people.


The Four Layers of Diversity provide internal, external and organizational dimensions that create the diverse personality of each individual.


Staley puts to rest the notion that leaders are born, and advocates for leaders’ ability to inspire, influence and motivate.


This book provides an excellent viewpoint of the underlying flavor of another culture. It provides you with intangible information that travel books do not tell you (e.g., when to arrive for an appointment, what certain greetings mean, etc.). A must have for anyone traveling, or wanting to better understand other cultures and values.


Leaders is a classic exploration of the qualities and characteristics of leadership, based on the authors’ extensive interviews with the CEOs of a variety of business and non-profit organizations. Its examples don’t seem as dated as many business-related books, since it focuses on core leadership skills and abilities, rather than on success driven by the bottom-line.


Tichy combines the concepts of Ideas, Values, and Emotion/Energy/Edge to describe the teaching of leadership skills. Tichy’s handbook for leaders on developing leaders combines the fundamentals and real life organizational issues.


Leading with Soul is the parable of the journey of Steve, a high-powered executive who finds himself searching for more. The challenge of this book is to take one’s leadership gifts and lay them on the altar of one’s spiritual roots and rebirth them into wisdom, compassion and love. A must read if you are searching, or even if you think you aren’t.

Peters argues effectively for the importance of breaking the mold and thinking outside the box for organizational success.


This is a paper-back book every professional and leader needs for citing literature references. It’s small; it’s cheap; it’s great!


Based on the Tao Te Ching by Lao Tzu, this slim text successfully translates ageless insights into contemporary language. Not a traditional how-to manual, reading this book stimulates self-knowledge and self-reflection.
Improving Children’s Access to Health Care

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

AAPA supports co-parent or second parent adoption in order to protect the child’s right to maintain continuing legal relationships with both parents, thereby creating security and access to health care for the child.

AAPA believes that the following benefits result from co-parent or second parent adoption:

1. The child’s legal right of relationship with both parents is protected.
2. The second parent’s custody rights and responsibilities are also guaranteed if the legal parent were to die or become incapacitated, or the couple separates.
3. The requirement for child support for both parents is established in the event of the parents’ separation.
4. The child’s eligibility for health benefits from both parents
5. The legal grounds are provided for either parent to provide consent for medical care and to make education, health care and other important decisions on behalf of the child, and the basis for financial security for children is created in the event of the death of either parent by ensuring eligibility to all appropriate entitlements, such as social security survivors’ benefits.

Introduction

The increasing diversity of the American family has challenged society to recognize new definitions of family. Included in that diversity are families in which children are parented by unmarried couples, or couples whose marital status is not afforded the same legal protection from state to state. This changing demography of America has resulted in the visible emergence of non-traditional families and parenting structures. Despite these changes, the central core of the family has remained constant. Families are individuals who join together to meet each other’s basic needs and provide nurturing, security, and love. Families also exist to meet responsibilities, obligations and commitments to each other and the society in which they exist.

With increasing frequency, children are raised in families in which there is only one biological or adoptive legal parent. The second individual in a parental role is called the "co-parent" and/or "second parent." Under current laws, the security of a two parent family may be in jeopardy if the legally recognized parent should die, be declared incompetent, or if the couple separates. Children deserve to know that their relationships with both of their parents are stable and should be legally recognized.
Like other professional medical associations, AAPA has endorsed the goals of the Healthy People 2010 project, which is “firmly dedicated to the principle that “regardless of age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation-every person in every community across the nation deserves equal access to comprehensive, culturally competent, community-based health care systems…” (Healthy People 2010, 2000).

Providing all qualified adults with co-parent/second parent adoption rights promotes the health of children by giving them the legal and social benefits of two parents along with subsequent access to health care. co-parent and/or second parent adoption provides legal grounds for either parent to make decisions on behalf of the child, such as providing medical consent and ensuring the child’s eligibility to access the health care benefits of both parents.

**Conclusion**

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Licensure Eligibility for PAs Trained Abroad

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

- PAs, whether citizens of the U.S. or other countries, who are trained in programs not in the United States, should be required to graduate from ARC-PA accredited entry-level programs and take the NCCPA examination to be eligible to practice.

- PA programs that have the interest and capacity to offer PAs trained abroad an opportunity for advanced standing should consider doing so.

PAs in the U.S.

Physicians around the world have sought and received help from many types of health care workers. Until recently, however, PAs have been a uniquely American phenomenon. Now, educational programs for PAs exist in several countries. Some of these programs have been independently developed; others have been assisted by American PA educators. The early graduates of these programs will be the pioneers who seek recognition and acceptance of PA practice in their own countries. However, it is likely that some graduates will immigrate to the United States, where they will qualify for visas as PAs under the Immigration and Nationality Act if their education is comparable to that obtained by their U.S. counterparts. (See Appendix 1 for background on immigration requirements.) It also appears possible that PA programs may be established outside the U.S. Borders, similar to off-shore medical schools, for the purpose of training American citizens as PAs.

Currently, state PA licensure laws contain two standard requirements related to education and examination. The education requirement is graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessors. The examination requirement is passage of the Physician Assistant National Certification Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).

As things stand now, PAs trained abroad will not be able to meet either of these two state requirements for licensure. At this time, there are no ARC-PA accredited programs outside the United States. International accreditation is a very difficult and expensive proposition and the ARC-PA has no plans to extend the scope of its activities. Eligibility for the PANCE depends upon graduation from an ARC-PA accredited PA program.

Without changes to state laws, PAs trained abroad will be unable to qualify for licensure. Faced with this dilemma, these PAs and their advocates could put pressure on the NCCPA to change its eligibility criteria and on legislatures and state licensing boards to change laws and regulations.
To avoid the problems that could result from this situation, the PA profession must be prepared with recommendations for government policymakers. These recommendations should have as their goal, first and foremost, the protection of the public health and safety. However, they should also reflect the PA profession’s tradition of inclusiveness and its ethical principles of fairness and non-discrimination. Any policy proposed by the Academy should not seek to limit competition and should recognize the diversity of culture in the United States and the important role played by immigrants from all corners of the world in founding and shaping this nation. It should also recognize the workforce shortages in the U.S. and the need for additional health care providers.

**Licensure Requirements for PAs Trained Abroad**

AAPA believes that the following represents a framework for PAs trained abroad who wish to become licensed in the United States.

- A visa screening or credentialing organization, such as the Commission on Graduates of Foreign Nursing Schools or other recognized entity, should verify the PA education, PA licensure, experience, and English proficiency of non-U.S. citizen PAs trained abroad, as is currently required by federal law for international health care workers, entering the United States.
- PAs trained abroad should apply for acceptance at an ARC-PA accredited entry level PA program. They should present evidence of their prior education and experience and request credit for coursework completed.
- Entry level PA programs should consider applications from PAs trained abroad and offer advanced standing, if appropriate, to those who meet their admission criteria.
- The education for these individuals in U.S. PA programs is envisioned to include four components:
  - Credit for some of the coursework and/or rotations done in their own country and/or in the United States;
  - Didactic coursework in those areas for which they did not receive advanced standing;
  - Mandatory didactic coursework about physician-PA role and team practice and standards of care in the United States;
  - Clinical rotations.
- Only those programs with the interest and resources necessary to handle this complement of students should do so. Those that lack the faculty or clinical rotations or that would face state or institutional barriers would not have to offer this educational experience to PAs trained outside the United States.

In summary, non U.S. citizen PAs trained abroad who wish to enter the U.S. for the purposes of working as PAs should have their education, experience, license, and English proficiency verified by CGFNS or another approved visa screening organization. They would submit their certification with their visa applications. If granted visas, they would come to the U.S., where they would apply for admission to an
accredited PA program. Programs that choose to accept these individuals, including American citizens who have obtained PA training abroad, can apply their own admission criteria and may consider granting advanced standing to the limits established by the program’s sponsoring institution. After admission and graduation from an accredited PA program, these individuals would be eligible to sit for the PANCE. Passage of the PANCE would make them eligible for state licensure.

This system is similar to the one that exists for physicians (see Appendix 2) in that it requires additional supervised education in the U.S. Completion of this education would be followed by a requirement to take the same NCCPA examination that is given to U.S. graduates prior to licensure.

The proposal described above does not necessarily require every PA trained abroad to repeat his or her entire education after arriving in this country. AAPA believes it is appropriate to evaluate separately each individual who has received PA education outside the U.S. and to give credit for coursework and/or rotations completed in their own country or in the U.S.

AAPA acknowledges that there are cultural and educational differences among the countries of the world, and that the knowledge needed to practice according to the standards of care of each country can vary substantially. That is why the Academy recommends that PAs trained abroad seeking licensure be required to have additional supervised clinical education at an accredited entry-level PA program and be taught more about the PA role as part of physician-led teams in the U.S. health care system.

The Academy hopes, with the adoption of this document, that other countries will adopt similar practice requirements for American PAs who wish to work abroad. While American PAs may have much to contribute, it is essential to respect cultural differences and values and to be knowledgeable about health system norms, allocation of resources, and treatment of conditions common to the population before working in another country.

Appendix 1. Immigration Procedures for Foreign Health Care Workers

Immigration law requires that individuals wishing to enter the United States on either a temporary or permanent basis must apply to the U.S. State Department for a visa. There are two major categories of visas: non-immigrant and immigrant. Non-immigrant visas are given to individuals who wish to come to the U.S. on a temporary basis and for a specific purpose. There are approximately 60 different non-immigrant visa classifications, in areas such as business, education, pleasure, and temporary work. Immigrant visas are given to individuals who intend to live and work permanently in the U.S. These visas are either family- or employment-based.

The law specifies the documentation that must accompany visa applications. For example, individuals applying for H-1B visas (temporary work in a specialty occupation such as law or engineering) must submit evidence regarding education or experience and qualifications. In some cases, a permanent or temporary state license to practice must be obtained prior to approval of the visa application.
There are specific provisions in the law regarding foreign physicians and nurses. In 1996, Congress amended the Immigration and Nationality Act to add, among other things, provisions related to other foreign health care workers. The 1996 amendments require all immigrants and non-immigrants coming to the U.S. as health care workers to be screened and certified by the Commission on Graduates of Foreign Nursing Schools (CGFNS) or an equivalent independent credentialing organization approved by the U.S. Attorney General. Health care workers are defined as physical and occupational therapists, medical technicians and clinical laboratory scientists, speech language pathologists and audiologists, and PAs.

The screening organization must verify that the alien’s education, training, license, and experience are comparable to those required for an American health care worker of the same type; that they are authentic, and, in the case of a license, unencumbered. The foreign health care worker must also have an appropriate level of proficiency in written and spoken English. If the majority of states licensing the profession in which the alien intends to work recognize a test that predicts an applicant’s success on the profession’s licensing or certification examination, then the alien must have passed that test.

Anyone who meets these criteria is given a certificate that becomes part of his or her visa application.

**CGFNS**

Based on its capabilities and established track record, as well as the specific reference to the organization in the law, CGFNS has been authorized by the Department of Homeland Security (DHS) to review the qualifications of all the types of foreign health care workers mentioned above.

CGFNS uses committees composed of members of each particular profession to establish the standards against which they assess the comparability of foreign education. All the members of the CGFNS Physician Assistant Professional Standards Committee have expertise in PA education and accreditation and are familiar with the issues surrounding foreign medical graduates.

The PA Professional Standards Committee began its work in May 2001. Using the American accreditation standards for PA educational programs as a basis for its work, the group has developed a document that describes, in detail, the curriculum content that they consider essential, including education on the special relationship between physicians and PAs. The document is more specific than the ARC-PA accreditation standards, particularly in the areas of pharmacotherapeutics, clinical skills, and diagnostic testing and imaging as they are practiced in the United States. The committee is confident that the standards will prevent unqualified individuals from gaining visas as PAs.

**Other Visa Screening Agencies**

To gain recognition as a visa screening and certifying agency from the Department of Homeland Security, which now houses the agencies concerned with immigration issues, an organization must meet fairly stringent criteria. It must have the ability to evaluate credentials and English competency. It must maintain comprehensive and current information on foreign educational institutions and it must have no conflict of
interest regarding whether an alien receives a visa. The organization’s ability to conduct examinations outside
the United States is also considered before it is recognized by DHS.

The Department of Homeland Security has recognized, in addition to CGFNS, the Foreign
Credentialing Commission on Physical Therapy and the National Board on Certification of Occupational
Therapists as screening agencies for PTs and OTs, respectively. DHS does not limit the number of
organizations it will recognize to perform the visa screening function for any given health care profession, nor
does it review the educational equivalency standard used by each organization.

Appendix 2 - Requirements for Graduates of Foreign Medical Schools

Graduates of foreign medical schools who apply for visas to enter the United States as members of the
medical profession or to receive graduate medical education (GME) must be certified by the Educational
Commission for Foreign Medical Graduates (ECFMG).

ECFMG certification is necessary before foreign medical school graduates or foreign-trained
physicians can enter an accredited residency program, take Step 3 of the U.S. Medical Licensing Examination
(USMLE), or, in most states, obtain a license to practice medicine.

ECFMG certification is obtained by:

- passing Steps 1 and 2 of the USMLE. Step 1 has approximately 350 multiple-choice test items,
divided into seven 60-minute blocks, focused on the understanding and application of basic science
concepts. Step 2 includes test questions in clinical subjects and requires the development of a
diagnosis and prognosis, as well as identification of disease mechanisms and treatments. It has
approximately 400 multiple-choice questions divided into eight 60-minute blocks.

- passing the Test of English as a Foreign Language (TOEFL).

- successfully completing a day-long Clinical Skills Assessment that evaluates the ability to gather and
interpret clinical patient data by obtaining a relevant medical history, performing a focused physical
exam, and composing a written record of the patient encounter. Proficiency in spoken English and
appropriate interpersonal skills are also evaluated by standardized patients at 11 testing stations.

- verifying completion of four credit years at a medical school listed in the International Medical
Education Directory, maintained by the Foundation for Advancement of International Medical
Education and Research, a non-profit foundation of ECFMG. (Some diplomas, such as those for
Licensed Medical Practitioner or Assistant Medical Practitioner, and some licenses, such as those for
stomatology, ayurvedic or homeopathic medicine, are not acceptable.)

- ECFMG certification is necessary in order to take Step 3 of the USMLE, which has approximately 500
multiple-choice test items administered over two days. Step 3 content reflects a data-based model of
generalist medical practice in the United States and includes computer-based case simulations.
To obtain a license to practice, graduates of foreign medical schools are required to pass the USMLE (all three steps within a certain time period). There is frequently a limit on the number of attempts allowed to pass each step. Applicants must also complete at least one year of graduate medical education in an accredited residency program. More than half the states require foreign medical school graduates to complete three years of GME. Licensure requirements for foreign medical school graduates are more stringent than for graduates of accredited U.S. medical schools.
Direct to Consumer Advertising

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

- AAPA believes that Direct to Consumer Advertising (DTCA) presented in a responsible and ethical manner may be of some value to patients. Such information should be scientifically substantiated, accurately presented, and free of bias and false or misleading claims.

- AAPA urges that any DTCA by pharmaceutical companies be based on disease state only, without mention of a specific drug by name or category of drug, and that patients should always be urged to see their health care professional before taking prescription medications.

Introduction
Direct-to-consumer advertising (DTCA) is the promotion directly to potential patients of prescription drugs through newspaper, magazine, television and internet marketing. Drug companies also produce a range of other materials that are available in medical offices or designed to be given to patients by medical professionals or via patient groups.

The only two developed countries where DTCA is currently legal are the U.S. and New Zealand. While banned elsewhere, the drug industry has repeatedly mounted major lobbying campaigns to have DTCA allowed in Europe and Canada. While there is oversight of pharmaceutical marketing in the developed world, there are few provisions for monitoring DTCA in low and middle income countries, where it remains illegal. Furthermore, the use of social media platforms and advertising through the internet circumvents national boundaries and has resulted in largely unchecked global DTCA by both legitimate and illegitimate pharmaceutical companies.

The federal Food and Drug Administration (FDA) regulates the promotion and advertising of prescription drugs in the United States, including DTCA and materials directed to medical professionals, to ensure that they are not false or misleading and otherwise comply with applicable laws and regulations. [see 21 U.S.C. § 352(n), 21 C.F.R. § 202.1 (2013)]. FDA regulations require that drug companies submit final advertising materials to the FDA at the time they are first disseminated to the public. In addition, drug companies may voluntarily submit draft versions of DTC advertising materials to FDA prior to their release in order to obtain advisory comments from the agency. FDA’s authority does not extend to “help-seeking” advertisements – those that do not identify prescription drugs by name, but rather discuss a disease or condition and advise the audience to “see your doctor” for possible treatments.
In 1997 the FDA relaxed regulations on broadcast media advertising of prescription drugs by stating that adequate provision of risks and benefits could be communicated by simply referencing a toll free number or website. Annual spending on DTCA promptly tripled to $1.3 billion dollars and reached $4.3 billion by 2010. The fastest growing aspect of drug marketing, DTCA has outpaced marketing directly to providers, and drug research and development. The majority of spending is now on television advertising with viewers exposed to nine commercials per day for prescription drugs. As spending increased, so did the number of regulatory letters sent by the FDA to pharmaceutical companies concerning false or misleading DTCA.

**The Pros and Cons of DTCA**

The pharmaceutical industry argues that DTCA advertising helps educate consumers of potential conditions and encourages them to see their health care professional for diagnosis and treatment. While acknowledging that DTCA increases the amount spent on prescription drugs, they argue that in the long run early treatment and diagnosis reduces spending on other medical services, such as hospitalization.

Critics of DTCA argue that the industry's advertising is primarily emotional in style and understates the adverse side-effects and as such is misleading. The imagery of the ads is appealing while the potentially serious side effects are buried in the fine print. They also argue that the claimed health benefits are overstated. Surveys reveal that people who have seen DTCA ads will often request and be prescribed the drug. DTCA campaigns will usually aim to have pre-primed prescribers via a closely linked parallel promotional campaign. Critics argue that this results in over-diagnosis of conditions and inappropriate use of prescription drugs, even where non-drug treatments are as effective or more effective. As a result, they say, DTCA unnecessarily drives up the overall cost of healthcare without necessarily improving the health of those treated.

Problems with DTCA of pharmaceuticals may have significant unintended consequences. These include but are not limited to patients that seek medications from pharmacies on the Internet and outside the United States without a prescription or without prescriber monitoring or even awareness of medications. Patients may not be aware of the entire spectrum of other more appropriate and less expensive therapeutic options than the advertised drug. Side effects are often not communicated in a comprehensive manner in advertising or marketing communications. Furthermore, every drug has risks and benefits, and patients are often unaware of drug-drug, drug-herb, drug-supplement, or drug-food interactions. Health care professional monitoring ensures that pharmaceuticals are appropriate for a patient’s particular health condition and that the benefit outweighs any risk.

A November 2006 report by the U.S. Government Accountability Office report noted that "studies we reviewed found that increases in DTC advertising have contributed to overall increases in spending on both the advertised drug itself and on other drugs that treat the same conditions. For example, one study of 64 drugs found a median increase in sales of $2.20 for every $1 spent on DTC advertising. Consumer surveys suggest that DTC advertising increases utilization of drugs by prompting some consumers to request the advertised
drugs from their physicians, who studies find are generally responsive to these requests. The surveys we reviewed found that between 2 and 7 percent of consumers who saw DTC advertising requested and ultimately received a prescription for the advertised drug." [http://www.gao.gov/htext/d0754.html Accessed March 8, 2014]

**Conclusion**

AAPA believes Direct to Consumer Advertising (DTCA) that is presented in a responsible and ethical manner may be of some value to patients. Such information should be scientifically substantiated, accurately presented, and free of bias and false or misleading claims. DTCA and marketing of pharmaceuticals, devices, or surgical procedures may create significant patient safety concerns if it leads patients to seek health care solutions without consulting with a health care professional, increases costs of care, or inappropriately directs patients or providers away from best-practice solutions or evidence-based medicine. As such, AAPA urges that any DTCA by pharmaceutical companies be based on disease state only, without mention of a specific drug by name or category of drug, and that patients should always be urged to see their health care professional before taking prescription medications.

**References**

Introduction

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

The Court found diversity to be a compelling state interest and upheld the law school’s admissions program, but struck down the undergraduate admission. The court found that the undergraduate admissions policy, which awarded points to underrepresented minority applicants solely because of race was insufficiently “narrowly tailored to achieve the interest in educational diversity that respondents claim justifies their program.” Justice O’Connor explained that race can be considered a “plus” factor in admissions if that factor is considered in the context of a “highly individualized, holistic review of each applicant’s file, giving serious consideration to all the ways an applicant might contribute to a diverse educational environment.” What is considered to be tailored narrowly enough is still a matter of debate.

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

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

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

Affirmative Action in Medical Education

Supporters of affirmative action in medical education believe that such programs are necessary to meet the social mandate to address the future health care needs of the increasingly multicultural population by training physicians who reflect the diversity of that population. Until medical school applications from all backgrounds emerge from the educational pipeline with comparable academic credentials, affirmative action
programs are proposed as the solution to ensuring that an equally diverse population of providers enters the health care workforce.\textsuperscript{ii}

A more diverse health care force may also improve both access to health care as well as the health status of minority populations. Research has shown that minority physicians are more likely to practice in medically underserved areas. Patients also express strong preference for racial/ethnic concordance with their health care provider.\textsuperscript{iii} One study of the effect of race and gender on the physician-patient partnership showed that patients who saw physicians of their own race rated the decision making style of the provider as more participatory and involved.\textsuperscript{iii} As members of the health care team, PAs who are ethnically and culturally diverse are equally important to improving access and quality of care.

**Educational Benefits of Diversity**

The educational benefit of diversity among students for both minority and majority students is well established. In a meta-analysis of diversity research, Smith et al concluded that diversity initiatives positively impact institutional satisfaction, involvement, and academic growth for both minority and majority students. Students who interact with other students from varied backgrounds show greater growth in critical thinking skills and tend to be more engaged in learning. Student surveys reveal that those students who are educated in diversified environments rate their own academic, social and interpersonal skills higher than those from homogeneous programs. These students who interact with peers from diverse backgrounds are more likely to engage in community service and demonstrate greater awareness and acceptance of people from other cultures.\textsuperscript{iv}

Similar results were found by Whitla et al in a 2000 survey of medical students about the relevance of diversity among students in their medical education. A telephone survey was conducted of 639 medical students enrolled in all four years of the Harvard and University of California San Francisco medical schools. A majority of students reported that diversity enhanced discussion and was more likely to foster serious discussions of alternative viewpoints. Understanding of medical conditions and treatments was also reported to be enhanced by diversity in the classroom. Concerns about the equity of the health care system, access to medical care for the underserved, and concerns about cultural competence were also thought to be increased by interactions with diverse peers as well as faculty. The majority of students agreed with published reports of many investigators that the medical profession should represent the country’s racial and ethnic composition to a larger degree.\textsuperscript{v}

In January 2004, the Institute of Medicine released a report entitled *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce*. The report reinforces the importance of increasing racial and ethnic diversity among health professionals. Greater diversity among health care professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students while in
training. The report goes on to make recommendations to policy makers, accreditation agencies and health professions educators on strategies to increase the diversity of the health care workforce. vi

**Diversity and Competence**

Professional competence has been defined as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.” vii The therapeutic relationship and affective/moral dimensions of competence depend, in part, upon cultural rather than scientific competence. Cultural competence can be defined as a set of academic and personal skills that allow individuals to gain increased understanding and appreciation of cultural differences among groups. viii Cultural competence is not achieved solely from reading textbooks or attending lectures. Recruitment and retention of diverse student populations allows individuals to educate each other about cultural differences in health beliefs and experience of illness, to confront prejudice and prior assumptions, and to experience dealing with racial conflict in a sensitive manner. PAs must strive to develop cultural competence as one aspect of professional competence.

**Recommendations**

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

**References**


vi Reference the IOM report.


viii Archbold M. (in IOM report, p 279)
Global Epidemic HIV/AIDS

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

- AAPA supports proven/demonstrable/international efforts to curb the global HIV/AIDS epidemic.
- AAPA supports participation of all nations in a coordinated global effort to reduce the incidence of HIV/AIDS.
- AAPA recognizes the direct role of prevention programs in reducing the incidence of new HIV infection.
- AAPA supports national and international prevention strategies that include counseling and testing programs, programs with special focus on young adults, programs to prevent mother-to-child vertical transmission, provision of pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) in accordance with established recommendations and guidelines, and legislative efforts to promote women’s rights and sex workers’ rights.
- AAPA encourages providers to screen all individuals ages 13 to 64 for HIV at least once, with follow-up testing based on risk, in accordance with the CDC recommendation.
- AAPA believes that treatment programs should be sustainable and expanded to provide essential antiretroviral therapy.
- AAPA supports the creation of specially-trained HIV/AIDS medical providers to augment new and existing global prevention and treatment efforts.
- AAPA believes that international, national, and community leaders should be strong and vocal advocates for HIV/AIDS education, prevention and treatment efforts.
- AAPA believes that community leaders should promote equality and that people with HIV/AIDS should not experience discrimination or bias.
- AAPA supports the giving of unrestricted financial support to global AIDS efforts without ideological or political influence on the distribution of funding.

Introduction

According to the most recent World Health Organization (WHO) data, approximately 35 million people are living with HIV world-wide\(^1\) and there were 1.5 million deaths secondary to complications from AIDS in 2013. This represents a decrease in the number of deaths annually since 2008. Approximately 2.1 million people were newly infected with HIV in 2013; however, the overall number of new infections has decreased since 2001. This is attributed, in part, to global efforts in education and prevention. The overall
decline in deaths due to complications from AIDS can be attributed to advances in pharmacotherapeutics and improved access to antiretroviral therapy. Yet, the magnitude of the ongoing pandemic is vast.

**Global Impact of HIV**

Because of the pathogenesis of HIV infections, men who have sex with men (MSM), those who injected drugs and health care workers were all at immediate risk for contracting HIV. Multiple sexual partners and the presence of concomitant sexually transmitted infections facilitated HIV transmission. Similarly, needle sharing and/or high risk sexual activity led to HIV exposure in those that used injected drugs. Although HIV infections worldwide occur predominately through heterosexual contact, MSM and those using injected drugs continue to represent significant epidemiological categories.

Screening, diagnostic and treatment efforts have raised awareness, detection and management of HIV/AIDS globally over the past decade. Yet, HIV/AIDS remains a global disease. Of the 35 million people infected with HIV, an estimated 24.7 million live in Sub-Saharan Africa. In fact, Sub-Saharan Africa accounted for 1.1 million of the 1.5 million (73%) people that died from HIV-related complications in the world in 2013.

Certain geographic and demographic populations are affected disproportionally by the incidence of infection. For example, Sub-Saharan Africa accounts for 70% of HIV infections and this is due to economic, political and cultural phenomena. Despite a general decline in the number of new HIV infections globally, Eastern Europe, Central Asia, the Middle East, and Northern Africa continue to see increases in new HIV infections. While many areas of the world are experiencing a decline in high risk behavior, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports some countries are seeing an increase in the number of sexual partners one has and a decrease in condom use. In Latin America, North America and Europe, the number of new cases of HIV is most notable among MSM which is attributed to a rise in sexual risk behaviors.

The epidemic is exceptionally difficult for women due to an imbalance of physical, financial, and/or cultural power. Thus, women in much of the world are less able to avoid contracting HIV infections due to these power imbalances. Intimate partner violence raises one’s risk of acquiring HIV as women with an abusive partner have difficulty negotiating condom use, if they are able to at all. The morbidity and mortality among the female population secondary to HIV/AIDS is devastating to families and communities. Worldwide, women now account for more than half of all adults with HIV/AIDS. Women are more likely to lose jobs, lose income, raise children, and face stigma and discrimination. In addition to managing their own illness, the burden of caring for others often falls to women. Young girls frequently leave school to care for sick parents or younger siblings. The AIDS epidemic affects the entire family, and impacts children of HIV infected mothers in multiple dimensions (e.g., born to an HIV infected mother, orphaned by a parent who died secondary to
AIDS, or left to care for a parent or family member with AIDS). Sex workers and transgender women also experience increased risk of acquiring HIV, myriad socioeconomic consequences of infection and barriers to accessing medical care.

Ethnic minorities have a disproportionate burden of HIV infections and progression to AIDS. Even in developed countries, young people of color are at higher risk than their white counterparts. More than half of new HIV cases in the United States occur among ethnic minorities.

The distribution of available resources for prevention and treatment also reflects disparities. Antiretroviral therapy (ART) decreases HIV mortality by approximately 80% and over the past five years, the number of people receiving therapy has increased dramatically. People with HIV are living longer due to advances in ART. Globally, the number of persons living with HIV/AIDS (PLWHA) receiving ART has increased three fold since 2010. Although globally the number of PLWHA receiving ART has increased to 10.6 million, people in low income countries represent a disproportionately low number of those who are receiving treatment. This increase in PLWHA on ART has been attributed to coordinated educational and therapeutic efforts in certain populations. For example, the World Health Organization (WHO) called for increased use of ART among pregnant women to reduce mother-to-child transmission. Through these programs, the number of women receiving ART during pregnancy increased from 57% to 62% in just one year. A 52% reduction was seen in the number of new HIV infections among children from 2001 to 2012.

Despite global efforts to increase the number of PLWHA on ART, some high-prevalence populations - such as injection drug users (IDU) and transgender individuals - may not be receiving treatment due to socioeconomic barriers to care and fear of or actual discrimination.

The world’s poorest countries face shortages of healthcare providers. International health leaders report the shortage of health care workers as one of the largest constraints to antiretroviral drug programs and meeting people’s basic health care needs. Sub-Saharan Africa must add the equivalent of one million health workers through recruitment, retention, and training to achieve UN Millennium Goals for health. The solution will require a combination of leadership from within each country, financial support and donations of time and human resources. One proposed solution includes a medical service corps through which resource-rich countries would train medical providers and community health workers.

**PrEP and nPEP**

The U.S. Public Health Service recently released clinical practice guidelines for the administration of pre-exposure prophylaxis (PrEP) for HIV prevention in the United States. In high-risk individuals including MSM, heterosexual men and women with risk factors, serodiscordant couples, and IDU, daily oral PrEP has been shown to decrease the risk of HIV acquisition when existing HIV infection has been ruled out. In addition to oral antiretroviral medications, participants in PrEP studies also received access to condoms, risk
reduction education and counseling, and treatment for other sexually transmitted infections. Screening for HIV should be done no less than every 3 months while a patient is on PrEP.\textsuperscript{10}

For individuals who seek medical care less than 72 hours after a possible exposure to the infectious body fluids of a person known to have HIV, the U.S. Department of Health and Human Services states that non-occupational post-exposure prophylaxis (nPEP) may be beneficial to reducing transmission.\textsuperscript{11} In instances where the HIV status of an individual is unknown or a patient presents more than 72 hours after the exposure, providers should use clinical judgment to determine whether or not the use of nPEP is warranted. Data supporting the efficacy of nPEP come from several types of studies including animal models, perinatal clinical trials, studies of transmission following health care exposures and clinical observation.\textsuperscript{11} Implementation of a randomized control trial for nPEP is unlikely for ethical reasons.

**HIV Screening**

HIV screening has tremendous public health implications. Individuals who are unaware of their HIV status are more likely to transmit HIV than those who know their status and early treatment of HIV can reduce sexual transmission.\textsuperscript{12,13,14} For the individual, early linkage to care is associated with HIV viral load suppression and improved long term health outcomes.\textsuperscript{15} The CDC recommends HIV screening for everyone ages 13 to 64 at least once, with follow-up testing based on individual risk.\textsuperscript{16}

**Summary**

HIV/AIDS is a global emergency with long-term public health consequences. Clearly, the international community has identified HIV/AIDS as a prominent agenda item and demands significant contributions in order to effectively implement sustainable educational, preventive and therapeutic interventions. Readers should refer to the CDC, WHO and UNAIDS for up-to-date references and resources (below) as the list is extensive and in constant flux and outside the scope of this policy paper.

**Conclusions**

- AAPA supports proven/demonstrable/international efforts to curb the global HIV/AIDS epidemic.
- AAPA supports participation of all nations in a coordinated global effort to reduce the incidence of HIV/AIDS.
- AAPA recognizes the direct role of prevention programs in reducing the incidence of new HIV infection.
- AAPA supports national and international prevention strategies that include counseling and testing programs, programs with special focus on young adults, programs to prevent mother-to-child vertical transmission, provision of pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) in accordance with established recommendations and guidelines, and legislative efforts to promote women’s rights and sex workers’ rights.
- AAPA encourages providers to screen all individuals ages 13 to 64 for HIV at least once, with follow-up testing based on risk, in accordance with the CDC recommendation.
- AAPA believes that treatment programs should be sustainable and expanded to provide essential antiretroviral therapy.
- AAPA supports the creation of specially-trained HIV/AIDS medical providers to augment new and existing global prevention and treatment efforts.
- AAPA believes that international, national, and community leaders should be strong and vocal advocates for HIV/AIDS education, prevention and treatment efforts.
- AAPA believes that community leaders should promote equality among all populations, and that people with HIV/AIDS should not experience discrimination or bias.
- AAPA supports the giving of unrestricted financial support to global AIDS funding efforts, without ideological or political influence on the distribution of funding.

References


Resources

World Health Organization http://www.who.int/hiv/en/

Pan American Health Organization, PAHO Response to HIV

Centers for Disease Control and Prevention (CDC), Selected MMWR articles
http://www.cdc.gov/hiv/resources/reports/mmwr/
CDC HIV/AIDS Statistics and Surveillance

http://www.cdc.gov/hiv/topics/surveillance/resources/reports/
Scientific Integrity and Public Policy

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

- AAPA believes that government agencies should appoint members and other advisors based upon their expertise and qualifications.
- AAPA believes that the public policy development process must be open and transparent.
- AAPA believes scientific research and discussion should be free from undue political, religious, financial or other ideological influence.
- AAPA believes that in the arenas of public policy and scientific research, safeguards can ensure the integrity of the processes and the results.

Patient outcomes may be improved by implementation of evidence based medicine. Access to quality information for both medical providers and patients is essential for provision of evidence based care in all practice settings. In this same way, public health policy should be based on the best, most valid scientific evidence.

A wide variety of institutions and agencies determine policies that impact health care in this country. These policy-makers rely on committees, councils, task forces, and other groups to review information and provide ideas and opinions to assist them in formulating sound public policies. AAPA believes that all agencies should appoint members and other advisors based upon their expertise and qualifications. Diversity of backgrounds and perspectives are desirable. No one should be chosen or eliminated based solely on their religious or political beliefs. Advisors and committee members should disclose conflicts of interest. Those whose employer/interests have a financial stake in policy outcomes should not be in a position to directly affect those policy decisions. Further, AAPA believes that the public policy development process must be open and transparent.

AAPA believes scientific research and discussion should be free from undue political, religious, financial, or other ideological influence. Research must be held to high standards of objectivity and accuracy; methods must be disclosed and results be reproducible. Peer review of the research is essential to the process. Peer reviewers must be chosen based upon their qualifications, with diversity of backgrounds and perspectives again being optimal. Valid scientific conclusions should not be dismissed for ideological reasons.

AAPA believes safeguards should be in place to ensure the integrity of the processes and the results of scientific research and public policy. Uncompromised commitment to the scientific process and to balanced
representation based on qualifications will ensure the best possible public policy. Allowing scientific and medical research to move forward and advance public health policy benefits us all.

**Summary**

In summary, AAPA endorses the following statements:

- AAPA believes that government agencies should appoint members and other advisors based upon their expertise and qualifications.
- AAPA believes that the public policy development process must be open and transparent.
- AAPA believes scientific research and discussion should be free from undue political, religious, financial or other ideological influence.
- AAPA believes that in the arenas of public policy and scientific research, safeguards can ensure the integrity of the processes and the results.

**Resources**


Quality Incentive Programs

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

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

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

**Introduction**

The United States spends more than any other nation on health care—well over twice the per capita average among industrialized nations. Health expenditures have grown from $1.3 trillion in 2000 to $1.7 trillion in 2003, and the portion of gross domestic product consumed by the health sector over that period has increased from 13.3 percent to 15.3 percent. According to estimates by the Centers for Medicare and Medicaid Services (CMS) by 2014, total health spending will constitute 18.7 percent of gross domestic product.

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

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

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

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

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

**Growth of Quality Incentive Programs**

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

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

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

- Requirements for continuing medical education
- Development of clinical practice guidelines
- Use of benchmarking and sharing performance data with providers
- Integration of new information and decision support systems
- Certification and credentialing of providers

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

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

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

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

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

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

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

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

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

Evidence-based benchmarks

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

Patient satisfaction

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

Adoption of information technology

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

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

**Key Principles for Quality Incentive Programs**

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

1. **Focus on processes that lead to better patient outcomes**

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

2. **Foster the team approach to care**

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

3. **Offer voluntary practice participation**

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

4. **Use reliable and accurate patient data**

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Quality incentive programs should use reliable and accurate patient data. Informative and useful performance measurement requires standards for reliability and accuracy. Data will reflect the care and health of patient populations. The selection of patient information to be measured must be relevant to the clinical practice of medicine and patient care outcomes. Incentive programs are the most beneficial when they identify circumstances in which there is variation in optimal and current clinical practice, there is opportunity for significant improvement in patient outcomes, and a proven practice intervention exists to reduce the variation.

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

5. Provide feasible and practical reporting

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

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

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

**Impact on PAs**

Most PAs believe they are providing the highest quality care they possibly can. However, there are many pressures on all clinicians to do more during patient visits. The healthcare system itself has created disincentives to provide the highest quality care. Preventable medical errors persist, and there are unexplained differences in health outcomes among different healthcare institutions and clinicians. There is also significant delay in widespread adoption of many clinical advances proven to deliver superior patient outcomes.
PAs should be expected to share in the benefits that quality incentives give to the practice. Whether this results in more staff, more visit time, or more resources, PAs should be able to take advantage of these incentives to improve the quality of care they deliver. Quality incentive programs will most likely measure and reward performance of practices, not individuals. A portion of provider reimbursement could be placed “at risk” through performance measurement. PAs play an important role in the improvement of their practice’s patient care and quality performance. Quality incentive programs and PA employment agreements should reflect the PA’s contribution to any financial and non-financial incentives.

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

**Challenges of quality incentive programs**

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

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

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

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

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

References


PREAMBLE

Between 2003-2004, the National Commission on Certification of Physician Assistants (NCCPA) led an effort with three other national PA organizations (Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), AAPA, and Physician Assistant Education Association (PAEA) -- formerly Association of Physician Assistant Programs (APAP)) to define PA competencies in response to similar efforts being conducted within other health care professions and the growing demand for accountability and assessment in clinical practice.

The resultant document, Competencies for the Physician Assistant Profession, provided a foundation from which PA organizations, other PA organizations and individual PAs could chart a course for advancing the competencies of the PA profession.

In 2011, representatives from the same four national PA organizations convened to review and revise the document. The revised manuscript was then reviewed and approved by the leadership of the four organizations in 2012.

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. While some competencies will be acquired during formal PA education, others will be developed and mastered as PAs progress through their careers. The PA profession defines the specific knowledge, skills, attitudes, and educational experiences requisite for PAs to acquire and demonstrate these competencies.

The clinical role of PAs includes primary and specialty care in medical and surgical practice settings. Professional competencies for PAs include the effective and appropriate application of medical knowledge, interpersonal and communication skills, patient care, professionalism, practice-based learning and improvement and systems-based practice.

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.

PA COMPETENCIES

Medical knowledge

Medical knowledge includes the synthesis of pathophysiology, patient presentation, differential diagnosis, patient management, surgical principles, health promotion, and disease prevention. PAs must
demonstrate core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care in their area of practice. In addition, PAs are expected to demonstrate an investigative and analytic thinking approach to clinical situations. PAs are expected to understand, evaluate, and apply the following to clinical scenarios:

- evidence-based medicine
- scientific principles related to patient care
- etiologies, risk factors, underlying pathologic process, and epidemiology for medical conditions
- signs and symptoms of medical and surgical conditions
- appropriate diagnostic studies
- Management of general medical and surgical conditions to include pharmacologic and other treatment modalities
- interventions for prevention of disease and health promotion/maintenance
- screening methods to detect conditions in an asymptomatic individual
- history and physical findings and diagnostic studies to formulate differential diagnosis

**Interpersonal & Communication Skills**

Interpersonal and communication skills encompass verbal, nonverbal, written, and electronic exchange of information. PAs must demonstrate interpersonal and communication skills that result in effective information exchange with patients, patients’ families, physicians, professional associates, and other individuals within the health care system. PAs are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective communication skills to elicit and provide information
- adapt communication style and messages to the context of the interaction
- work effectively with physicians and other health care professionals as a member or leader of a health care team or other professional group
- demonstrate emotional resilience and stability, adaptability, flexibility, and tolerance of ambiguity and anxiety
- accurately and adequately document information regarding care for medical, legal, quality, and financial purposes

**Patient Care**

Patient care includes patient- and setting- specific assessment, evaluation, and management. PAs must demonstrate care that is effective, safe, high quality, and equitable. PAs are expected to:

- work effectively with physicians and other health care professionals to provide patient-centered care
- demonstrate compassionate and respectful behaviors when interacting with patients and their families
obtain essential and accurate information about their patients
make decisions about diagnostic and therapeutic interventions based on patient information and preferences, current scientific evidence, and informed clinical judgment
develop and implement patient management plans
counsel and educate patients and their families
perform medical and surgical procedures essential to their area of practice
provide health care services and education aimed at disease prevention and health maintenance
use information technology to support patient care decisions and patient education

Professionalism

Professionalism is the expression of positive values and ideals as care is delivered. Foremost, it involves prioritizing the interests of those being served above one’s own. PAs must acknowledge their professional and personal limitations. Professionalism also requires that PAs practice without impairment from substance abuse, cognitive deficiency or mental illness. PAs must demonstrate a high level of responsibility, ethical practice, sensitivity to a diverse patient population, and adherence to legal and regulatory requirements. 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
- respect, compassion, and integrity
- accountability to patients, society, and the profession
- commitment to excellence and on-going professional development
- commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- sensitivity and responsiveness to patients’ culture, age, gender, and abilities
- self-reflection, critical curiosity, and initiative
- healthy behaviors and life balance
- commitment to the education of students and other health care professionals

Practice-based Learning and Improvement

Practice-based learning and improvement includes the processes through which PAs engage in critical analysis of their own practice experience, the medical literature, and other information resources for the purposes of self- and practice-improvement. PAs must be able to assess, evaluate, and improve their patient care practices. PAs are expected to:

1. analyze practice experience and perform practice-based improvement activities using a systematic methodology in concert with other members of the health care delivery team
2. locate, appraise, and integrate evidence from scientific studies related to their patients’ health
3. apply knowledge of study designs and statistical methods to the appraisal of clinical literature and other information on diagnostic and therapeutic effectiveness
4. utilize information technology to manage information, access medical information, and support their own education
5. recognize and appropriately address personal biases, gaps in medical knowledge, and physical limitations in themselves and others

**Systems-based practice**

Systems-based practice encompasses the societal, organizational, and economic environments in which health care is delivered. PAs must demonstrate an awareness of and responsiveness to the larger system of health care to provide patient care that balances quality and cost, while maintaining the primacy of the individual patient. 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
- accept responsibility for promoting a safe environment for patient care and recognizing and correcting systems-based factors that negatively impact patient care
- apply medical information and clinical data systems to provide effective, efficient patient care
- recognize and appropriately address system biases that contribute to health care disparities
- apply the concepts of population health to patient care.
Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources
(Adopted 2006, amended 2011, 2016)

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

AAPA believes that the PA profession can participate in addressing the problems of health literacy by

- adopting expanded definitions of health literacy that include the individual and public health perspectives
- optimizing efforts to increase health knowledge, self-efficacy, self-management behaviors, and positive outcomes with patients
- participating in local community groups to provide social support and advocacy leading to sustainable behavior changes conducive to better health
- identifying and utilizing resources to increase opportunities for patient activation, access to care, and development of skills to increase physical mental well-being.

Call to Action

Recent efforts by AAPA and other organizations to focus on health literacy have resulted in a broadened health literacy definition, and increasing focus on the shared responsibility of providers and patients to create information and communication partnerships. Sophisticated and clinician-focused resources now exist to provide PAs and other clinicians with tools to improve patient health literacy. National efforts to form strategic organizational partnerships provide rich opportunity for AAPA to participate in efforts to address this problem impacting the health of millions of Americans.

Accordingly, AAPA believes that the PA profession can further address this critical social and medical problem by

- adopting expanded definitions of health literacy that include the individual and public health perspectives
- optimizing efforts to increase health knowledge, self-efficacy, self-management behaviors, and positive outcomes with patients
- participating in local community groups to provide social support and advocacy leading to sustainable behavior changes conducive to better health
- identifying and utilizing resources to increase opportunities for patient activation, access to care, and development of skills to increase physical and mental well-being.
AAPA believes that individual and organizational participation in these steps has the potential to
decrease and eliminate the negative health impact of inadequate communication between providers and
patients. By using available resources, PAs empower patients, increase provider awareness of the impact of
communication gaps, and improve the health of patients.

**Increased Estimates of Number of Patients Impacted**

In May 2004 the Institute of Medicine (IOM) released the comprehensive report, *Health Literacy: A
Prescription to End Confusion*, defining health literacy as “The degree to which individuals have the capacity
to obtain, process, and understand basic health information and service needed to make appropriate health
decisions.” [1] At that time it was estimated that half of the United States adult population, nearly 90 million
people, had difficulty understanding and acting on health information. According to the more recent May 2010
*National Action Plan to Improve Health Literacy* from the Department of Health and Human Services’ Office
of Disease Prevention and Health Promotion, new estimates indicate that inadequate health literacy now
affects the health of most adults, with almost 90% of Americans having “…difficulty using the everyday
health information that is routinely available in our health care facilities, retail outlets, media, and
communities”. [2]

The increasing problem of health literacy is not surprising given the variety of tools needed to navigate
the U.S. health care system and process the often complex information and treatment decisions patients’ face.
In order to accomplish these tasks, individuals need skills and abilities such as:

- cultural and conceptual knowledge
- numeracy skills
- listening, writing, and reading skills
- communication skills
- comprehension of healthcare information and decision making
- social skills to function as a healthcare consumer

An individual with adequate health literacy has the ability to take responsibility for their own health as
well as the health of their community.[3, 4] The focus of health literacy has broadened from the individual
perspective to a societal focus by linking health literacy to economic growth, socio-cultural, and political
change.[4, 5]

Public health literacy recognizes the multi-dimensional impact of health literacy on groups and
communities. According to Nutbeam [6] there are three dimensions of health literacy: functional health
literacy refers to having the basic skills of reading and writing necessary to function in everyday situations;
interactive health literacy refers to having advanced cognitive skills used to extract meaning and information
from different forms of communication; critical health literacy refers to more advanced cognitive skills
combined with the social skills needed to apply and analyze information to exert greater control over one’s life.

**“Universal Precautions” and Health Literacy**

In April 2010, the U.S. Department of Health and Human Services’ Agency for Health Care Research and Quality released a *Health Literacy Universal Precautions Toolkit*. offering primary care practices a way to assess and improve their health literacy efforts with patients.[7] The toolkit assumes that it is difficult to identify those patients who may not understand health information and instead recommends that each practice create an environment where patients of all literacy levels can thrive. [7] The resources provided in the toolkit are designed to help practices take a systematic approach to reducing the complexity of medical care and ensure that patients can succeed in the health care environment.

**The Role of PAs in Health Literacy**

AAPA created policy in 2010 that acknowledged the evolving view of health literacy, embracing more shared responsibility of the patient and the provider. HP-3300.1.7.2 reads:

AAPA encourages PAs to identify and utilize reliable and accurate consumer health information to encourage patient compliance and improve health education. Health education information should be evidence based and appropriate to the patient's culture and level of literacy. Provision of such resources is consistent with AAPA efforts to promote health literacy. [8]

The cultural component of this policy also reshapes the conventional belief that health literacy is simply about reading, missing the larger context of factors that impact patient-provider communication. PAs can play a role in improving health literacy by providing community and individual support promoting empowerment and autonomy. Research has shown that improving health literacy leads to lower healthcare costs, increased health knowledge, shorter hospitalization, increased self-efficacy, and positive health behaviors [9, 10]. Advancing health literacy in the community may lead to greater equality and sustainable changes in public health.[11]

A more partnered patient-provider approach to health care communication is emerging in national policy. This is underscored by Healthy People 2020 Health Communication and Health Information Technology objectives found in table 1.[12]
Table 1

**Healthy People 2020 Objectives for Health Communication and Health Information Technology**

- **HC/HIT–1.1** Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition.
- **HC/HIT–1.2** Increase the proportion of persons who report their health care provider always asked them to describe how they will follow the instructions.
- **HC/HIT–1.3** Increase the proportion of persons who report their health care providers’ office always offered help in filling out a form.
- **HC/HIT–2.1** Increase the proportion of persons who report that their health care provider always listened carefully to them.
- **HC/HIT–2.2** Increase the proportion of persons who report that their health care provider always explained things so they could understand them.
- **HC/HIT–2.3** Increase the proportion of persons who report that their health care provider always showed respect for what they had to say.
- **HC/HIT–2.4** Increase the proportion of persons who report that their health care provider always spent enough time with them.


**Emergence of the “Health Information Literacy” Concept**

While the medical community continues to expand its understanding of the complexity of health literacy, medical librarians have combined the American Library Association’s definition of “information literacy” with the traditional notion of “health literacy.” The result has been the concept of “health information literacy,” described by the Medical Library Association (MLA) as “the set of abilities needed to recognize a health information need, identify likely information sources and use them to retrieve relevant information, assess the quality of the information and its applicability to a specific situation, and analyze, understand, and use the information to make good health decisions.” [13] Resources available from the MLA may help to raise clinician awareness of their key role in assessing and addressing patient health literacy status, their obligation to partner with patients in this effort, and opportunities to engage with health information experts to improve the health of patients.
**Call to Develop Strategic Partnerships**

Many recent guidelines call for the development of partnerships to increase the effectiveness of efforts to address health literacy. As noted in the National Action Plan, “this…plan seeks to engage organizations, professionals, policymakers, communities, individuals, and families in a linked, multisector effort to improve health literacy.”[2] These partnerships may include other medical associations, state chapters, special interest groups, specialty organizations, patient-advocacy groups, medical librarians, health information technology organizations, and other information specialists.

**Resources for PAs**

Efforts by individual PAs and PA organizations can be enhanced by guidelines and projects that have been developed to assist the medical community in addressing health literacy. They include

- *Healthy People 2020* guideline that provides a structure focused on clinical activity. Its metrics to measure national success in addressing health literacy issues provide a valuable perspective that can be used to guide clinical efforts at the practice level.[12]
- The *Health Literacy Universal Precautions Toolkit* targets clinical activity with its proposed framework to support clinicians in understanding the scope and breadth of health literacy challenges and in proposing a specific shift in how clinicians view patient care.[7]
- The *National Action Plan* provides broader direction to organizations, professions, policymakers, and communities, highlighting strategies and actions that organizations and professions can take to set and achieve organizational goals.[2]
- The MLA’s “Resources for Health and Information Professionals” may support clinician efforts to improve their health communication with patients.
  The National Library of Medicine’s Consumer Health Portal for Patients and Health Professionals. This site links to the National Institute of Health and provides tutorials, graphs, audio instructions, and resources in different languages.
- NIH Senior Health - http://nihseniorhealth.gov/ - a site designed for older adults and caregivers. Site includes large texts and a feature for visually impaired. This site includes a senior health toolkit http://nihseniorhealth.gov/toolkit/toolkit.html for caregivers and providers to access.
- Understanding Medical Words http://www.nlm.nih.gov/medlineplus/medicalwords.html. An interactive site that helps patients understand how medical words are formed.

**Summary**

AAPA believes that the PA profession can participate in addressing the problems of health literacy by
• adopting expanded definitions of health literacy that include the individual and public health perspectives
• optimizing efforts to increase health knowledge, self-efficacy, self-management behaviors, and positive outcomes with patients
• participating in local community groups to provide social support and advocacy leading to sustainable behavior changes conducive to better health
• identifying and utilizing resources to increase opportunities for patient activation, access to care, and development of skills to increase physical and mental well-being.

References


The Role of In-Store or Retail Based Convenient Care Clinics  
(Adopted 2017)

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

AAPA 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.\textsuperscript{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 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


False or Deceptive Health Care Advertising

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

- AAPA believes that providers, including PAs, should not use deceptive practices such as photographs that do not represent benefits ordinarily obtained by patients. They should not make claims regarding painless or miraculous cures; promote unproven or scientifically unsound modalities not supported by evidence-based studies, such as chelation to reverse atherosclerosis, reparative therapy to change sexual orientation, or the use of over-the-counter human growth hormone pills to prevent aging; and they should not make inflated statements about their qualifications. In addition, they should not mislead patients about the scope of services offered, as in the case of pregnancy counseling centers that provide only anti-abortion information.

- AAPA also believes that ethical providers should make every effort to insure that their patients are exposed to accurate information so they can make informed choices about treatment.

False or deceptive advertising is an act of deliberately misleading people about products, services, or companies in general by reporting false or misleading information or data in advertising or other promotional materials. False advertising is a type of fraud and it is a crime.  

In an era when health providers have begun to market their services aggressively, deceptive health care advertising poses significant risks to the public. Fraudulent claims may entice consumers to undergo costly, ineffective, and even more importantly, dangerous medical procedures.

In the United States, the Federal Trade Commission (FTC) is empowered and directed by law to prevent unfair or deceptive acts or practices in or affecting commerce. The Federal Trade Commission Act also prohibits the false advertisement of “food, drugs, devices, services, or cosmetics.”

According to the FTC, advertisements should be accurate and not contain explicit false claims or misrepresentations of material fact. They must not by implication create false or unjustified expectations, and they must contain certain information if the absence of that information would make the ad misleading. Finally, the claims in advertisements must be substantiated.

Accurate information about health care choices is vital to consumers. Each year, consumers spend hundreds of billions of dollars on health care products and services. Advertising plays an important role in informing consumers about the availability, cost, and other features of these products and services.
Role of Providers

A successful provider-patient relationship is based on trust. The patient trusts that the health care provider has the appropriate training and skills, will listen to the patient’s complaints and symptoms, and will advise the patient accurately and objectively about the alternative courses of treatment. It is essential to this relationship that the patient has confidence that the provider is honest and is not manipulating the information presented for any purpose. Because the patient is often in a relatively uninformed position, patients usually assume that the provider is telling them all they need to know and that what they are told is accurate.

For this reason, false and deceptive advertising by providers destroys the trust relationship between the provider and patient that is essential to quality medical care. Misrepresentation may harm patients by making them less likely to seek out treatments they need or vulnerable to accepting treatments that are not useful or necessary.  

Conclusion

AAPA believes that providers, including PAs, should not use deceptive practices such as photographs that do not represent benefits ordinarily obtained by patients. They should not make claims regarding painless or miraculous cures; promote unproven or scientifically unsound modalities not supported by evidence-based studies, such as chelation to reverse atherosclerosis, reparative therapy to change sexual orientation, or the use of over-the-counter human growth hormone pills to prevent aging; and they should not make inflated statements about their qualifications. In addition, they should not mislead patients about the scope of services offered, as in the case of pregnancy counseling centers that provide only anti-abortion information.

AAPA also believes that ethical providers should make every effort to insure that their patients are exposed to accurate information so they can make informed choices about treatment.

References


Acknowledging and Apologizing for Adverse Outcomes  

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

Improving healthcare quality and reducing preventable adverse events in care delivery continue to be a  
top priority for the United States health care system. Since the Institute of Medicine (IOM) published its 1999  
report titled “To Err is Human: Building a Safer Health System,” emphasis and effort in reducing preventable  
injury and improving care delivery have taken place. Further, the discipline of disclosure of medical error has  
seen significant advancement.  

- AAPA believes that patients deserve complete and honest explanations of adverse outcomes  
  and apologies for medical mistakes.  
- AAPA also supports not only the current science around disclosure and apology during care  
  delivery, but also encourages PAs to be active participants in local disclosure programs.  
- AAPA commits to providing education to PAs and advancing the science of medical error  
  disclosure.  

**Disclosing Errors**  
The IOM has previously reported that as many as 98,000 people die each year as a result of medical  
error (1). Adverse outcomes can occur in any health care setting, including inpatient, outpatient, home and  
long-term care (2). Further, preventable harm from care delivery impacts not only patients, but families,  
caregivers, staff and communities (2).  

Healthcare organizations that establish a culture of quality and safety are more likely to proactively  
identify a crisis management plan. These plans include processes that enhance communication between and  
among all stakeholders (2). Thus, every health care organization should establish a plan to address adverse  
events. The response should be prioritized to include 1) the patient and family; 2) the frontline staff, and; 3)  
the organizational response (i.e. initiate root cause analysis and crisis management team) (2).  

**The Patient and Family**  
The patient and family must be the priority of the health care organization and the provider before,  
during and after an adverse event (2). Disclosing medical errors respects patient autonomy and truth-telling, is  
desired by patients, and has been endorsed by many ethicists and professional organizations. According to the  
“Guidelines for Ethical Conduct for the PA Profession,” PAs “should disclose errors to patients if such  
information is significant to the patient’s interests and well-being. As disclosure science in health care
continues to develop, much of the data generated highlights the fundamental importance of openly admitting error (4). A number of studies suggest that both the public and health care professionals generally agree that medical errors causing harm should be disclosed to the patient, an apology rendered, and fair compensation be negotiated. This process has demonstrated a reduction in litigation costs and has been widely adopted by health systems both academic and federal (5).

**The Frontline Staff**

Health care staff can become the “second victims’ of adverse events (2). This may occur secondary to blaming behaviors, damage to personal or professional reputation, and unresolved feelings of sorrow and loss (2). Organizations with an existing crisis management plan, a shared process of root cause analysis and culture of inclusion promote patient-centered quality and safety (2).

**The Organizational Response**

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

**Policy and Legislation**

To counter the perceived risk of increased liability, a number of states have adopted or are considering apology laws that exempt expressions of regret, sympathy, or compassion from being considered as admissions of liability in medical malpractice lawsuits. Federal legislation has also been drafted that promotes medical error reporting, disclosure to patients, apology, and, in cases when the standard of care is not met, offers of compensation. This legislation is based on the principles of The Sorry Works! Coalition, which believes that full disclosure addresses the root cause of the medical malpractice crisis better than any other approach currently under consideration. According to the coalition, Sorry Works! restores the provider-patient relationship and improves the communication and trust between all parties, thus reducing the filing of non-meritorious claims and saving on legal expenses. While the coalition believes that legislative action or mandates are not necessary preconditions for implementation of a full disclosure program, others prefer the security provided by legislation that reduces liability.

**Conclusion**

In the spirit of patient-centered care, AAPA believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes. AAPA also supports not only the
current science around disclosure and apology during care delivery, but also encourages PAs to be active participants in local disclosure programs.

References

Routine Vaccination for Human Papillomavirus

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

- AAPA supports routine HPV vaccination for the prevention of HPV-related diseases, which include cancer.
- AAPA supports coverage of HPV vaccination by all insurers as well as public funding for HPV vaccination for underinsured or uninsured patients.
- AAPA encourages all PAs to discuss and recommend HPV vaccination for their patients in the appropriate populations.
- PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States (U.S.). HPV is associated with oropharyngeal, anal, cervical, vaginal, vulvar, and penile cancers as well as condyloma, precancerous conditions of the cervix, and recurrent respiratory papillomatosis. Furthermore, appropriate condom usage does not completely confer protection from HPV-related disease as transmission can occur through contact with infected skin. An estimated 30,700 HPV-related cancers occur annually in the U.S., with approximately 62% of these cancers occurring in women and 38% of these cancers occurring in men. 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.

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.

Vaccines that are approved by the Food and Drug Administration (FDA) should be administered to all individuals as per the recommendations of the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practice (ACIP).
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.\(^6\) Vaccination is most effective prior to the onset of any type of sexual activity and the immune response is optimal in the target age group.

Some parents and clinicians are uncomfortable broaching the subject of sexuality with patients in the target age group and as a result may be reluctant to discuss the need for vaccination. PAs can play a key role in initiating an objective, patient-centered discussion on the benefits of vaccination against HPV in the same manner they recommend all routine immunizations. Strong communication with patients and caregivers about the safety and benefits of HPV vaccination is directly associated with vaccine uptake.\(^7,8\) PAs are well-positioned to provide such education as practitioners of evidence-based medicine. Messages which focus on HPV vaccination as a means of cancer prevention may be more efficacious than messages which focus on prevention of a sexually transmitted infection.

**Recommendations**

- AAPA supports routine HPV vaccination for the prevention of HPV-related diseases, which include cancer.
- AAPA supports coverage of HPV vaccination by all insurers as well as public funding for HPV vaccination for underinsured and uninsured patients.
- AAPA encourages all PAs to discuss and recommend HPV vaccination for their patients in the appropriate populations.
- PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

**Conclusion**

AAPA supports routine HPV vaccination for the prevention of HPV-related diseases, which include cancer. In addition AAPA supports coverage of HPV vaccination by all insurers as well as public funding for HPV vaccination for underinsured and uninsured patients. Furthermore AAPA encourages all PAs to discuss and recommend vaccination for their patients in the appropriate populations. PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

**References**


Health Disparities: Promoting the Equitable Treatment of All Patients
(Adopted 2011, amended 2016)

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

AAPA will strive to:

- Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, involving but not limited to education, employment, housing, geographic location and public accommodation.
- Eliminate health disparities in all areas including but not limited to: race, ethnicity, sex, gender identity, sexual orientation, disability status or special health care needs.
- Increase PA awareness of health disparities.
- Create and promote health equity tools and resources for PAs.
- Utilize the U.S. Department of Health and Human Services “Healthy People” collaborative as a template for increased organizational efforts to support health surveillance systems that track outcomes.
- Support legislation and policy that eliminates disparities.

Introduction

Health disparities are differences in health among groups of people that are closely tied to social or demographic factors such as race, sex, income, or geographic region. Decades ago, the issue of health disparities was seen primarily as one of race and ethnicity. As the focus on health disparities has sharpened, definitions have broadened to include gender, sexual orientation, gender identity, religion, socioeconomic status, mental health, geographic location, and other characteristics typically linked to discrimination or exclusion. [1]

Accompanying this more sophisticated understanding of health disparities has been a growing body of research demonstrating healthcare inequities. Data suggest that increasing provider awareness of health disparities, social determinants of health, and implicit bias can decrease the impact of health disparities.

Current public policy interest in health disparities offers unprecedented opportunities for AAPA and individual PAs to join in global efforts to promote health equity. Increased understanding of the social determinants of health and the role that clinician beliefs and behaviors may play in disparities has made the need for increasing provider awareness and action more urgent than ever.
Mounting Evidence of Health Disparities

The release of the Institute of Medicine’s (IOM) 2003 report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” provided sobering evidence of persistent, extensive health disparities. The report identified complex contributing factors including how health systems operate, bureaucratic processes, biases of health care professionals, and patients’ behaviors.[1]

The National Plan for Action, includes compelling data that substantiates the far-reaching and negative impact of health disparities on the health of minority populations. Striking examples include disparities in cardiovascular disease, diabetes, HIV/AIDS, infant mortality, oral health, mental health, and healthcare quality and access.[2]

The American Public Health Association’s brief, “Health Disparities: The Basics,” offers a snapshot of data related to health disparities for broader populations: high infant mortality rates among ethnic and racial minorities, risk for obesity among people with lower income and education, cervical cancer rate among Vietnamese-American women five times higher than among Caucasian American women, and the high incidence of chronic illnesses among rural residents.[3]

One example of the recent expansion of the definition of disparities is the inclusion of lesbian, bisexual, gay and transgender populations in the overall examination of health disparities. A study “How to Close the LGBT Health Disparities Gap,” from the Center for American Progress, reports on health disparities in the lesbian, gay, bisexual and transgender populations. The report states that the LGBT population faces higher rates of cancer, mental illnesses, substance abuse, and delaying care, and lower rates for mammograms (LB), and health insurance than the adult heterosexual population.[4] Additionally, Healthy People 2020 included LGBT disparities in its overview for the first time.[5]

Social Determinants of Health

Social determinants of health include social, economic and political forces under which people live, which are key to creating and maintaining health status gaps between specific populations. They include wealth/income, education, legislation, nutrition, physical environment, health care, housing, employment, stress and racism/discrimination.[5]

There is a growing body of research on racial inequity and its related stresses as a social determinant of health. When studies control for socioeconomic status, blacks have poorer health than white counterparts. Middle-class blacks have poorer health than middle-class whites, with middle-class whites living an average of 10 years longer than their middle-class black counterparts.[6]
Implicit Bias and Unconscious Stereotyping

Implicit bias and stereotyping by clinicians are seen increasingly as likely contributors to health inequities.[6,7] Stereotyping allows clinicians to make complex decisions in short periods of time. Researchers have extensively described how this mechanism operates, and have shown that stereotypes are often activated subliminally, with quick associations caused by a variety of triggers. For example, clinicians subliminally exposed to African American stereotype-laden words are more likely to evaluate the same hypothetical patient more negatively than when exposed to more neutral language.

While still a relatively new area of research, studies have demonstrated unequal care for patients presenting to the same facilities, and seeing the same providers.[8] Clinical stereotyping can be exacerbated by the uncertainty occurring when a cultural gap between the provider and the patient occurs, as well as by increased time pressures placed on provider-patient interactions. These triggers may lead to situations where well-intentioned PAs create a discriminatory pattern of care, causing “… powerful effects on thinking and actions at an implicit, unconscious level, even among well-meaning, well-educated persons who are not overtly biased.”[9]

Data from psychology research suggest that increasing provider awareness of implicit bias and stereotyping can decrease the activation of PAs’ own biases. Such research supports aggressive efforts by AAPA to increase provider awareness of bias and stereotyping, with the goal of promoting more equitable care of all patients.[11-14] The Harvard Implicit Association Test (https://implicit.harvard.edu/implicit/demo/) provides an opportunity to explore personal unconscious biases.[15]

Action Plan

Therefore, AAPA will strive to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, including but limited to education, employment, housing, geographic location and public accommodation.
2. Eliminate health disparities in all areas including but not limited to: race, ethnicity, sex, gender identity, sexual orientation, disability status or special health care needs.
3. Increase PA awareness of health disparities.
4. Create and promote health equity tools and resources for PAs.
5. Utilize the U.S. Department of Health and Human Services “Healthy People” collaborative as a template for increased organizational efforts to support health surveillance systems that track outcomes.

These actions are consistent with the AAPA values as explained in the strategic plan “We commit to the highest standards and seek to eliminate disparities and barriers to quality health care.”[16]

**Conclusion**

AAPA believes that enhancing strategic partnerships, supporting increased provider and organizational awareness of health disparities, creating and promoting clinically relevant resources, and supporting data collection related to health disparities will result in decreased health inequities and result in the improved health of all patients.

**References**


Proliferation and Dispersal of Anti-personnel Weapons
(Adopted 2012, reaffirmed 2017)

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

- AAPA believes in supporting national and international efforts to reach a permanent ban on the use and proliferation of landmines.
- AAPA advocates for expanded support by the United States for programs to clear landmines.
- AAPA advocates for continued support by the United States to provide long-term assistance to victims of land mines.
- PAs should understand the risk for injury and death (particularly among children) from other types of unexploded ordnance.
- AAPA supports programs currently aimed at clearance of landmines, and assistance to victims, and recognizes the contribution that our country has made to clear landmines and assist victims. The dangers from unexploded ordnance should not be overlooked as they pose a risk to 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. 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). Beside land mines, several other types of anti-personnel munitions can persist in an armed but undetonated state. These include grenades, mortar and artillery shells, expended rockets, and cluster munitions. Cluster munitions are compound bombs that contain hundreds of bomblets which are designed to remain active beyond the initial explosion, disperse and detonate secondarily. It is not uncommon for bomblets to remain undetonated and dangerous for years.
Data from limited published studies indicate that children account for approximately one half of injuries and deaths from all types of UXO. Adult males suffer the majority of civilian casualties from landmines, often when traveling or farming. Children under 18 years of age are more than two times more likely to be injured by other types of UXO, while playing or tending animals. 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. 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. 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.

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. However; it still retains 10.4 millions of stockpiled antipersonnel mines for potential future use.

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. 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.

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.

**Conclusion**

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

**References**

1. Wennerstrom M, Baaser S, Salams P, etal. Injuries Associated with Landmines and Unexploded


Telemedicine
(Adopted 2015)

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

PAs are essential members of the healthcare team. It is critical that PAs remain in the forefront of this emerging trend, and that AAPA be fully engaged in ensuring the ability of PAs to practice fully. The growth in the use of telemedicine represents both a significant opportunity for the advancement of the PA profession, but also holds an important risk. If the practice of telemedicine fails to: 1) allow for the efficient utilization of PAs, and/or 2) recognize PA contributions to the healthcare system; the profession will be at a distinct disadvantage as the healthcare system continues to evolve.

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

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

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

**Establishing a Provider-Patient Relationship**

A provider-patient relationship is fundamental to the provision of quality medical care. A PA using telemedicine technologies in the provision of medical services must take appropriate steps to establish a provider-patient relationship and conduct all evaluations and history of the patient consistent with prevailing standards of care specific to the individual patient presentation. Establishing a provider-patient relationship includes, but is not limited to, obtaining a medical history, describing treatment risks, benefits, and alternatives, arranging appropriate follow up care, and maintaining complete and accurate health records. The provider-patient relationship may be formed via telemedicine or via an initial in-person consultation according to the individual PA’s professional judgment and as appropriate to the case-specific patient presentation. Understanding that the appropriateness of the use of telemedicine technologies can be specialty specific, and to a greater extent case-specific, the appropriateness of the use of telemedicine technologies and the method for establishing the provider-patient relationship should be left to the individual PA’s professional judgment.

**Patient Disclosures and Consent to Treatment**

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

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

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- Express patient consent for forwarding patient-identifiable information to third parties

**Evaluation and Treatment of the Patient**

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

**Continuity of Care**

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

**Referrals for Emergency Services**

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

**Medical Records and Patient Confidentiality**

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

**Liability Coverage**

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

**Reimbursement**

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

**Continuing Medical Education (CME)**

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

**Conclusion**

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

A number of approaches have been put forward regarding licensure including interstate compacts, mutual state recognition and even national licensure. Regardless of the approach used, AAPA must remain vigilant in ensuring that PAs are adequately represented and protected in any such discussions to ensure we may continue to serve the nation’s patients through both traditional and evolving methods of delivering healthcare services. All laws, policies or programs involving telemedicine practice should include PAs, either by specifically naming PAs, including PAs in the definition of provider or other similar term, or by implication. Additionally, PAs who provide medical care, electronically or otherwise, must maintain the highest degree of professionalism and ethics. PAs must always place the welfare of the patient first, with the highest value placed on quality of care, maintenance of appropriate standards of practice, and adhering to the ethical standards of the profession.
Nicotine Dependence
(Adopted 2016)

Executive Summary of Policy Contained in this Paper

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

- AAPA shall support the position of the Surgeon General and the U.S Preventive Service Task Force and encourage PAs to increase patient awareness as to the dangers in the use of nicotine products.
- AAPA recognizes the public health hazards of nicotine products as a leading cause of preventable disease and encourages efforts to eliminate nicotine use in this country and around the world.
- AAPA encourages PAs to work to support legislation which will eliminate the public’s exposure to secondhand smoke, eliminate minors’ access to nicotine products including electronic nicotine delivery systems and prohibit advertising of nicotine products.
- AAPA supports state utilization of tobacco settlement money for prevention and treatment of nicotine use. The Academy urges its constituent organizations to work with state governments and other health care and advocacy organizations to assure tobacco settlement funds are used for the prevention and treatment of nicotine use.
- AAPA encourages all PAs to be actively involved in community outreach that is directed toward providing nicotine product education based upon current evidence based guidelines to people of all ages about the dangers of nicotine with the goal of eliminating nicotine use.
- AAPA supports (a) development and promotion of nicotine cessation materials and programs to advance consumer health-awareness among all segments of society, but especially for youth; (b) dissemination of evidence-based clinical practice guidelines concerning the treatment of patients with nicotine dependence; (c) effective use of both nicotine cessation materials and evidence-based clinical practice guidelines by PAs, for the treatment of patients with nicotine dependence.
- AAPA encourages PAs to model nicotine cessation activities in their practices, including (a) quitting nicotine products and assisting their colleagues to quit; (b) inquiring of all patients at every visit about their use of nicotine in any form; (c) at every visit, counseling those who smoke to quit smoking and eliminate use of nicotine to eliminate use in all forms; (d) working to prohibit the use of nicotine products by all individuals in healthcare settings; (e) providing
nicotine information; (f) becoming aware of nicotine cessation programs in the community and of their success rates and, where possible, referring patients to those programs.

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

- AAPA supports third-party coverage for the treatment of nicotine addiction and the management of behavioral dependence associated with nicotine use.

- AAPA supports regulation of electronic nicotine delivery systems (E-cigarettes) by the U.S. Food and Drug Administration (FDA) Center for Tobacco Products.

**Introduction**

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

**Tobacco Exposure and Nicotine Use**

Not only are cigarettes manufactured to increase the addictive properties, but combustion produces thousands of toxic chemicals which lead to disease and early death. [2] After half a century of research on tobacco use, new research continues to emerge demonstrating the detrimental effects of smoking. Adverse effects of tobacco smoke have been documented in all organ systems of the body. In the 2014 report from the U.S. Surgeon General the following new research findings are provided: 1) liver cancer and colorectal cancer are caused by smoking; 2) secondhand smoke exposure is a cause of
cerebral vascular accident; 3) smoking increases the risk of death among cancer survivors; 4) smoking causes diabetes mellitus; and 5) smoking impairs immune function and causes rheumatoid arthritis. [2] As a result, productivity suffers from tobacco use. From 2009-2012 economic costs were estimated at over $289 billion. Losses from early death between 2005 and 2009 totaled roughly $150 billion [2]

The negative impact of tobacco smoke is not limited to the person who smokes. The U.S. Surgeon General reported no safe level of exposure to secondhand smoke. [2] Secondhand has been identified as a cause of cerebrovascular accident, ENT disease, coronary heart disease, sudden infant death syndrome, and low-birth weight [2]. The economic impact of secondhand smoke exposure in 2006 was estimated at $5.6 billion in lost productivity. Although use of chewing tobacco has declined since the 1980s, use of snuff has increased [2]. In 2006, tobacco companies began selling snuff under cigarette brand names and produced advertisements indicating these products may be a “socially acceptable” alternative to cigarette use [2]. Use of smokeless tobacco products including chewing tobacco, snuff, and dissolvable tobacco products carry their own set of harmful consequences. Similar to tobacco cigarettes, smokeless tobacco products are highly addictive. Young adults who use smokeless tobacco are more likely to become traditional cigarette smokers [3]. Periodontal disease, tooth loss, leukoplakia, and increased risk of heart diseases have been identified as consequences of smokeless tobacco use. Smokeless tobacco use has been identified as a cause of oropharyngeal, esophageal, and pancreatic cancers [3]. Women who use smokeless tobacco during pregnancy are at increased risk for stillbirth, perinatal death, and can impact the brain development of the fetus [2].

The rise in popularity of “e-cigarettes” and other electronic nicotine delivery devices particularly among adolescents, is concerning. Public perception of e-cigarette safety seems to be favorable to tobacco cigarettes despite a lack of evidence [4]. The American Lung Association identified 500 brands and over 7,000 flavors of e-cigarettes available to the public, none of which are regulated by the Food and Drug Administration (FDA) [5]. Without FDA oversight, it is unknown what chemicals are present in e-cigarettes. Data from the 2014 National Youth Tobacco Survey showed 13.4% of high school students reported past month e-cigarette use [6]. Use of e-cigarettes now exceeds the use of other tobacco products, including cigarettes. This is troubling given most adult cigarette smokers began using during adolescence. Although restrictions on tobacco advertising have been in place since the Master Settlement Agreement, similar restrictions do not exist for e-cigarettes. Data from the 2014 National Youth Tobacco Survey showed 68.9% of middle and high school students were exposed to advertisements for e-cigarettes [7]. Little is known about secondhand exposure to e-cigarette vapors. According to the American Lung Association, carcinogens have been
identified in the vapor exhaled by e-cigarette users. To date, no evidence has found that secondhand inhalation of e-cigarette vapors are safe [8].

**Nicotine Cessation**

Overall, tobacco smoking rates have declined since the first Surgeon General’s report in 1964 however, racial, ethnic, and socioeconomic disparities persist. Major gains including warning labels on tobacco product packaging, tobacco education, smoking bans, advertising restrictions, and increased pricing have contributed to lower levels of tobacco use and the available evidence supports the use of these techniques [2]. Most individuals who smoke report attempting to quit at some point in the past and have often attempted to quit multiple times, however, providers often do not address smoking cessation during office visits. [1] Often smoking cessation requires repeated interventions however, effective treatments including prescription medication and nicotine replacement products are available and should be made available to individuals who are ready to quit. Smoking cessation improves health outcomes for the individual who smokes, those exposed to secondhand smoke, and is also cost effective. [1]

With a rise in the use of nicotine replacement products and e-cigarettes, concern has been raised regarding whether or not nicotine has a carcinogenic effect. Although in vitro studies suggest nicotine may play a role in carcinogenesis, most animal studies do not demonstrate this. Use of smokeless tobacco products have been linked to several cancers however, to date, only one study has addressed this concern among individuals who use nicotine replacement products. The results of the study showed no association between use of nicotine replacement products and malignancy [2]. Many e-cigarette users begin using the devices as tool to help quit traditional cigarettes despite lack of research to support their use in smoking cessation programs. Polosa, Caponnetto, Morjaria, Papale, Campagna & Russo (2011) conducted a pilot study of e-cigarette use for smoking cessation among 40 tobacco cigarette smokers. The authors concluded that e-cigarette use decreased tobacco cigarette use with few side effects [9]. Bullen, McRobbie, Thornley, Glover, Lin, & Laugesen (2010) found similar results in their study the effects of e-cigarettes on desire to smoke [10] Although promising, it should be noted that the e-cigarettes used in these studies contained solutions with known concentrations of nicotine and other ingredients, unlike what is currently available to the public. The authors of both papers discuss the need for further research into long-term safety and use. Additionally, there is concern regarding advertising strategies that may be targeting younger individuals and that use of e-cigarettes may increase the risk of future tobacco use.

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

**Master Settlement Agreement**

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

**Conclusions**

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

- AAPA shall support the position of the Surgeon General and the U.S Preventive Service Task Force and encourage PAs to increase patient awareness as to the dangers in the use of nicotine products.
AAPA recognizes the public health hazards of nicotine products as a leading cause of preventable disease and encourages efforts to eliminate tobacco use in this country and around the world.

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The Importance of PAs in Executive Leadership  
*(Adopted 2017)*

**Executive Summary of Policy Contained in this Paper**

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

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.\(^2\) 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
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%).

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.

The PA workforce is expected to grow over 30% by 2024. 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. 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. 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.

Today, over 40% of PAs work in hospitals and healthcare systems which are mandatorily and traditionally lead by physician and nurse executives. 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 is 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


PA Student Supervised Clinical Practice Experiences -
Recommendations to Address Barriers
(Adopted 2017)

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

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

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

PA programs, like allopathic and osteopathic medical schools and nurse practitioner (NP) programs, are faced with a shortage of preceptors and SCPE for their students. For several years, PAEA has addressed this issue by developing innovative clinical training opportunities and encouraging an atmosphere of collaboration rather than competition among PA programs. AAPA, along with PAEA, ARC-PA, and NCCPA, is uniquely positioned to work with PAs, PA employers, and PA programs to help expand the availability of preceptors and SCPE for PA students.

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

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

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

As the PA profession continues to grow rapidly, with new programs developing and the number of PA students increasing, the demand for preceptors and SCPE will only continue to increase in the coming years. From 2015 to 2016 alone, the number of accredited PA programs grew from 196 to 218 (6). Currently, ARC-PA reports that there are approximately 52 additional programs seeking accreditation. The continued growth of the profession depends on the growth of PA programs, and one of the essential rate-limiting factors in the growth of these programs is SCPE barriers.
The availability of preceptors and SCPE was first formally addressed by clinical coordinators at the 1998 Association of Physician Assistant Programs (APAP, now PAEA) Education Forum. Since that time, PAEA has prioritized the issue, making the development of “a broad range of innovative clinical training opportunities” part of its strategic plan and encouraging an environment of collaboration rather than competition among PA programs (7). PAEA also works independently as the main source of research and data regarding the state of PA education. The continued efforts of the PAEA in identifying and addressing the preceptor shortage are crucial to improving the clinical education environment in the coming years. However, due to the extent of the problem and the continued growth of the PA profession, the issue will be best handled if approached by the entire PA community.

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

Each of the four national PA organizations (AAPA, PAEA, ARC-PA, and NCCPA) has collectively contributed to the growth of the profession and quality of healthcare that PAs provide each day. For this growth and practice quality to continue, these four organizations are encouraged to work together in an unprecedented manner to provide input and address the issue of clinical preceptor and SCPE shortage. The long-term solutions will require actions from each of these organizations, each acting within its already established mission and philosophy. Because the current model of clinical education is not sustainable and cannot support the projected demand for PAs in the coming decades, now is the time for action. In order to shape the future of the PA profession and American 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 negative impacts of teaching for some providers (4, 9). While many preceptors stress that patient care responsibilities are too time consuming to allow them to be good teachers, studies have found a correlation between productivity and highly-rated teachers, with positive impacts including enhanced enjoyment of practice and keeping one’s knowledge up-to-date (10, 11).

Competition from a steady increase in the numbers of allopathic (MD), osteopathic (DO), offshore allopathic medical students, NP, and PA students over the past several decades without a corresponding increase in the number of preceptors and SCPE is a second barrier to SCPE. This interprofessional competition leaves existing SCPE overwhelmed with students causing interprofessional competition for such sites. According to the Association of American Medical Colleges (AAMC), there were 86,746 medical students enrolled in United States osteopathic and allopathic medical programs during the 2015-2016 school year (Association of American Medical Colleges, 2015). There has also been a steady increase in U.S. medical student enrollment for the past decade. Since 2006-2007, there has been a 16 percent increase in the total number of matriculated medical students (12). These figures do not include medical students at offshore allopathic medical schools (i.e., those in the Caribbean and other countries) who send many of their students to the U.S. to complete clinical training. There are two accrediting bodies for offshore medical schools, the Accreditation Commission on Colleges of Medicine (ACCM) and the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP). These governing bodies currently accredit 15 medical schools with over 15,000 students annually enrolled. Additionally, there were an estimated 17,000 new nurse practitioners (NPs) completing their academic programs in 2013-2014 (13).

PA schools have experienced a similar growth rate over the past decade. At the time that this report was submitted, ARC-PA reported 218 accredited programs with additional programs expected to be accredited at its March 2017 meeting. This includes 154 with full accreditation, 55 with provisional status, and 9 programs on probation, up from 134 programs in November 2005 (14). Cohort sizes in PA programs range from approximately 15 to 100 students. Lack of availability and sufficient quality and quantity of SCPE is limiting the ability of some programs to increase their cohort sizes or even maintain their current cohort size. With an estimated growth to 270 programs by 2020, the consistent increase in students has the potential to further exacerbate the preceptor and SCPE shortage (6).
An often overlooked issue that may create an additional barrier to SCPE placement for PA students is the requirement of some PA programs that their pre-PA applicants obtain shadowing hours. According to the PAEA Program Directory, there are 139 programs in various stages of accreditation that require some form of healthcare experience in order to apply (15). Of those 139 programs, 67 consider ‘shadowing a physician or PA’ to be an acceptable form of experience, and the number of hours required ranges from 50 to 1000, with 500 hours being the most common. Two programs specifically request 20 hours of shadowing as their only required form of healthcare experience prior to applying (15). The concern, then, is that these requests for shadowing experiences are in direct competition with PA student SCPE placement, and it is often less stressful for providers to simply have an individual shadowing them for a few days as opposed to having a student to precept which requires a great deal more supervision, clinical education, and paperwork. Thus, while the concept of pre-PA shadowing may be valuable, it also has the potential to complicate an already challenging climate for current PA student placement.

Furthermore, there are legislative barriers to SCPE, particularly those between states. One example involves the emergence of State Authorization requirements since approximately 2010. Each state regulates education provided within their state, with most determining that provision of clinical education for students from training programs outside their state require “authorization”. These requirements vary widely, from simple paperwork in some states to lengthy procedures and thousands of dollars in others, resulting in many programs curtailing out of state rotations. In response to this arrangement, several health professions’ education associations sent an April 2015 letter to Congress recommending a nationwide exemption for SCPE from future Department of Education (DOE) regulations pertaining to state authorization (16). In spite of DOE setting aside national requirements for authorization, states considered clinical training across state lines as providing education in their state, requiring authorization. A solution for most states developed independently from the DOE. The National Council for State Authorization Reciprocity Agreements (NC-SARA) establishes reciprocity for educational requirements across state lines. States are members, and then each institution joins their state organization. So, PA programs that meet their state requirements and whose institutions are approved essentially meet requirements for state authorization in 47 states. Currently, three states (California, Florida, and Massachusetts) do not belong to NC-SARA, which means that clinical placements across state lines in those states may trigger an additional requirement for state authorization (17).

**AAPA-PAEA Joint Task Force Survey**

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

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

**Obligation to Precept**

Overwhelmingly, respondents felt that precepting PA students is an excellent way to contribute to the growth of the PA profession and to give back to the profession. However, many disagreed with the use of the word ‘obligation.’ Those that agreed commented that it was a meaningful way to pass on knowledge gained through years of practice to incoming PAs, as well as an excellent means to keep one’s medical knowledge current. Medicine is a profession of lifelong learning, and precepting students engages this critical function daily. These respondents indicated that students can bring a fresh attitude to the profession and remind preceptors of why they chose to become PAs.

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

Top Barriers to Precepting and How to Minimize These Barriers

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

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

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

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

One of the most commonly cited concerns among survey participants was the lack of clear understanding about the expectations of precepting a student. While some of these expectations are specific to each program, many aspects of precepting are universal. Respondents repeatedly suggested that a standard precepting toolkit or workshops that guide preceptors in the basic requirements of teaching PA students would
be beneficial. This could be achieved through the development of a standardized “PA student passport” or educational checklist that would be common to all PA students and that might include a summary of a student’s didactic education and the skills that 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 Loheny 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.
  - Maximum of 10 Category 1 CME credits per calendar year.
  - 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. This is consistent with current AAPA policy HP-3200.3.2.

- 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**


Attempts to Change a Minor’s Sexual Orientation, Gender Identity or Gender Expression
[Adopted 2017]

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

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

Review of the Evidence

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

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


The purpose of this 76-page report is to provide “accurate information about effective and ineffective therapeutic practices related to children’s and adolescent’s sexual orientation and gender identity”.

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

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

**Recommendation**

AAPA endorses the consensus statements of the 2015 SAMHSA publication\(^1\) noted below, resulting from the convening of subject matter experts in the fields of psychology, social work and psychiatry as part of the collaboration between the American Psychological Association and the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, and as follows:

**PROFESSIONAL CONSENSUS ON CONVERSION THERAPY WITH MINORS**

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

**PROFESSIONAL CONSENSUS ON SEXUAL ORIENTATION IN YOUTH**

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

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

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

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

**PROFESSIONAL CONSENSUS ON GENDER IDENTITY AND GENDER EXPRESSION IN YOUTH**

**Consensus on the Overall Phenomenon of Gender Identity and Gender Expression**

- AAPA believes that variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.

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

**Consensus on Efforts to Change Gender Identity**

- AAPA believes that there is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.

- AAPA believes that it is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child’s or adolescent’s gender identity or gender expression.
• AAPA believes that mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

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

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

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

Pre-Pubertal Children

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

Peri-Pubertal Adolescents

• For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics, and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent’s gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peripubertal adolescent, parents or guardians, and other 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.

**Reference**