**A Report to the AAPA Board of Directors by the Ad Hoc Committee on PAs in Telemedicine**

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**Introduction:**

The AAPA Board of Directors, under the guidance of AAPA Board President, David Mittman, commissioned several ad hoc committees during the 2019-2020 board term. Among them was a committee intended to investigate the PA position as it relates to the practice of telemedicine - both a current state assessment, as well as a forward thinking one with a focus on barriers and approaches to resolving them, as well as opportunities for the profession in this rapidly growing healthcare space. At its inception, the charges presented to the committee were thoughtful, wide-ranging and comprehensive with respect to a current state assessment and future-thinking guidance for the profession.

During the committee term, as for all committees, the COVID-19 pandemic hit the United States healthcare system directly in early 2020. While other committees likely rescoped or reframed their work to a certain extent, the ad hoc committee for PA practice in telemedicine and the associated charges were impacted in a unique and significant way. What was a forward thinking and timely ad hoc committee in the summer of 2019 was transformed. That is - telemedicine had been an aspirational area of healthcare practice for years, if not decades, but a global pandemic had suddenly and urgently thrust telemedicine into the spotlight. The PA path forward in this space has been exposed to significant and sudden pressures that were not anticipated at the outset of the committee. This has led to new learnings that warrant further investigation and expanding upon so that we might appropriately assess the current and future states for PAs in telemedicine. Further, the work of the committee with respect to this rapidly shifting landscape remains, admittedly, unfinished. In part, this is the nature of our current experience in the healthcare system and for healthcare providers - multiple competing priorities for our time and attention, including the essential need to balance work and life in the context of a pandemic, economic hardships and changing job responsibilities or realities. In part, the landscape in the telemedicine space is shifting so quickly in the current reality that work by any committee speaking to this area of care is unlikely to have the enduring longevity for which one might hope.

To that end, the AAPA is encouraged to remain intently engaged in this area, and be ready to rapidly adjust course as appropriate in response to Federal and state legislative realities, as well as the broader healthcare system response to expansion of telemedicine services. While an ad hoc committee was an appropriate consideration for PA practice in 2019, the current reality in the healthcare system demands ongoing attention to this area of care so that the PA profession may remain up to date and abreast of changes, as well as work to remain competitive with respect to other clinician types as services scale, new care models are deployed, and legislative realities rapidly evolve. As a summary of our work, the committee was presented with an array of charges, which will be explored here.

**The committee will identify current and/or emerging barriers to PAs entering or wanting to incorporate virtual/telemedicine into their practice and discuss options to eliminate these barriers.**

Barriers to PA practice exist in telemedicine in a variety of capacities. Of these barriers, some come in familiar forms - those experienced in traditional healthcare practice settings and that PAs are already intimately familiar. Some barriers are somewhat non-traditional - exposed by the nature of care delivery via telemedicine modalities that disconnect providers from patients both by geography and time. As telemedicine scales dramatically, it is clear that some of the most urgent barriers to PA access to telemedicine are in the area of direct-to-consumer (DTC) telemedicine.

DTC telemedicine is the fastest growing area of telemedicine, and occupies an increasing segment of the broader telemedicine pie, which makes it a relative bellwether for telemedicine trends broadly. Larger DTC organizations are at the leading edge of legislative change and lobbying as it relates to change in this space, as well. As such, they play a significant role in the trajectory of telemedicine rules related to practice regulations, reimbursement, and care models. In our conversations, as they have occurred, DTC organizations cite one of several barriers to PA hiring: legislative or administrative burdens encountered are greater than those of other clinicians (physicians and NPs), a lack of awareness of best practices in working with PAs, or contracts with enterprise partnerships that stipulate a specific clinician type in providing care (typically physicians).

DTC organizations typically operate without a physical, brick-and-mortar practice apparatus and prioritize flexibility and ease of hiring with respect to legislative and administrative burdens in the execution of clinical practice. To that end, physicians and nurse practitioners have rapidly gained a robust foothold in this care space owing to their relatively fewer legislative practice restrictions and administrative hurdles, while PAs have faced significant challenges in finding similar opportunities. As many DTC organizations function with a similar scope of practice to a lower complexity urgent care, the ability to hire clinicians with few legislative or administrative restrictions on their practice enables the flexibility in staffing to meet dynamic patient care demands essential in this realm of telemedicine practice where care occurs largely on a 24/7, on demand basis. Observing many DTC organizations' responses to hiring during the COVID-19 pandemic has clarified this hard truth - many organizations simultaneously claimed difficulty hiring enough providers to meet patient demands, while also excluding PAs from their hiring practices due to legislative and administrative challenges. Further, many DTC organizations hire clinicians as independent contractors. The traditional supervisory or collaborative arrangements required for PA practice are inconvenient in this setting, and many DTC organizations have indicated difficulty effectively navigating the legislative and administrative barriers typical of PA practice as compared to physicians or nurse practitioners.

With respect to legislative and administrative burdens, AAPA should continue to advance OTP policy and assist states in pursuing these legislative changes. That said, while state

timelines towards OTP are individualized, there must be an engagement with the urgency of now. That is - telemedicine is rapidly scaling and PAs do not enjoy legislative parity with comparable clinician types (primarily NPs). The longer this area of care scales rapidly without a reliable and significant PA footprint, the more difficult our eventual broader entry to this area of care becomes. Certainly, there will be opportunities, though the trade off with not having more immediate access and parity is presumably significant - limited opportunity to move into leadership or administrative roles that may help dictate organizational planning, hiring decisions, and strategy that could be complementary to PA practice - or not. To that end, the AAPA should encourage states to define more aggressive and explicit timelines in seeking full OTP, where possible, especially in states where NP full practice authority is already in effect, or anticipated within a matter of years. Further, as AAPA has already done, financial support should continue to be allocated to states who may have a favorable path towards full OTP, as well as identify opportunities in more legislatively restricted states for PAs, at least as it relates to maintaining parity in comparison to NPs.

With respect to lack of awareness of best practices in working with PAs, AAPA is encouraged to develop and maintain current resources that can be rapidly deployed when encountering telemedicine organizations that are unfamiliar with PA practice and how to most effectively work with PAs in a remote/telemedicine practice setting. Specifically, these resources should outline PA training, scope of practice, and state-by-state practice regulations with a focus on any rules that may encumber a PA in a remote/telemedicine setting, as well as propose solutions to navigating around or through these challenges. Additionally, resources related to PA cost effectiveness and efficacy in providing direct patient care will help further justify PAs from both economic and care quality perspectives. While these resources may already exist to an extent, AAPA is encouraged to help clarify explicitly how PAs can be most readily and effectively utilized in a telemedicine environment as PA practice quickly runs up against state-based rules and regulations that are complex, unfamiliar, or simply inconvenient for DTC organizations to navigate when other clinician types may be more familiar, and readily available to hire and deploy. In developing or refining these resources, AAPA is encouraged to collaborate with various specialty interest groups and specialty organizations with insight into either telemedicine delivery, such as PAs in Virtual Medicine and Telemedicine, or PA practice specific to a given telemedicine specialty area, for example Society of Dermatology PAs with teledermatology.

As it relates to established enterprise contracts and client expectations for DTC organizations with regards to types of clinicians involved in care delivery - this is ultimately more challenging to navigate as both organizational and client perspectives must be taken into account. This area has not been explored intently by the committee, but considerations here may include those referenced above, in particular resources and research demonstrating both PA effectiveness and quality in care delivery, as well as economic advantages in utilizing PAs. While this item is a barrier to PA practice in telemedicine, the committee believes the other items outlined above are more significant and warrant greater focus and action.

With respect to DTC telemedicine, specifically, the committee believes there is value in seeking conversations and engagement with large DTC organizations to help better identify and clarify barriers to PA practice in these settings despite the content outlined here. In doing so,

AAPA can better understand and confirm the strategic path forward towards seeking parity in this setting, as well as identify ourselves as interested and relevant parties in the delivery of telemedicine services in DTC settings. This dialogue will offer key insights for the PA profession in this space, perhaps enabling additional PA access to DTC telemedicine roles, and clarifying a more explicit roadmap forward in this space. Additionally, AAPA is encouraged to engage with DTC organizations regarding OTP and its specific policy principles so that we might clarify whether realization of full OTP at the state level will offer PAs the practice parity they seek, especially in states where NP full practice is already in effect.

Within the DTC vein, telemedicine practice enables a clinician to readily launch their own independent practice. Telemedicine overhead costs are generally less than traditional brick-and-mortar practices, and we are already seeing a rapid expansion into this space on an individual level. Numerous barriers exist for PAs in this area, however. Among them, supervisory or collaborating physician requirements are commonly a barrier in this realm of telemedicine practice. A PA must first identify a physician who is agreeable to the practice arrangement, and if so, must compensate them fairly for the role of supervisor, whether or not they are directly involved in day-to-day patient care. Many physicians cannot consider such opportunities if they are employed, as they may represent relevant employer conflicts of interest and would otherwise be prohibited. The financial burden of this arrangement may alone be prohibitive of a PA practicing in this entrepreneurial space. Additionally, the logistics of setting up the PA/physician supervisory arrangement is challenging, as many physicians may not be seeking these type of opportunities, and even when identified, state law may prohibit the arrangement based on PA business ownership laws, patient/provider proximity rules, or specific rules that limit a PAs practice with respect to the location of the physician. Finally, should a physician be identified, and all necessary steps are taken to establish the business, a PA remains at the discretion of the physician to continue their daily practice. Should the physician determine they no longer wish to function as supervisor for whatever reason, the PAs business is inevitably threatened should an alternative supervisor not be readily available. Of course, contracts serve to protect both the PA and the physician in this context, but the scenario is not unfamiliar, and is a reality for many PAs who have sought such arrangements.

While large DTC organizations will likely represent a significant segment of DTC telemedicine in the coming years, the promise of opportunity found in the small, independent business settings is one that must be given significant attention. The business potential for PAs in this area is quite robust, yet the barriers are similarly steep as discussed above. Again, advancing OTP is critical, as this will enable PAs to practice more freely in this space. However, current state provisions may not allow a PA to function as a majority business owner or sole proprietor, or there may be regulations that significantly restrict their ability to do so. Specific attention must be paid to state-by-state business rules and regulations allowing a PA to function as a majority business owner or sole proprietor. In states where this is not allowed, or where this arrangement is significantly encumbered, AAPA is encouraged to outline the necessary legislative changes at the state level to enable this type of practice in a more ideal setting. Further, there should be a resource that helps to explicitly clarify the current status of these rules at the individual state level, and identify gaps in existing state legislation prohibiting more free and unencumbered PA practice as an independent business owner.

**The committee will provide advice on future congressional and state (if any) legislative priorities that could strengthen us in this area.**

Optimal Team Practice (OTP) remains a central focus of legislative priorities that will allow PAs to achieve greater parity in the practice of telemedicine. Full OTP enables practice level decisions related to scope of practice, PA autonomy, and provision of care. That said, there must be serious attention paid to the progress made by our NP colleagues as it relates to full practice authority, or graduated full practice. While OTP largely accomplishes this, there are relevant questions to be raised regarding PA practice with respect to NPs when comparing OTP to full practice authority. States such as North Dakota will provide greater clarity in addressing this unresolved question more directly, and PAs must pay close attention to professional progress in North Dakota, as it is a relative road test for the efficacy of OTP as a policy when compared to full practice authority. As it relates to telemedicine, we must remain critically attentive to PA practice opportunities and parity, especially in those environments where we have achieved what is considered to be our more ideal practice status, and whether these legislative rules offer the practice parity we seek.

At both the state and Federal level, it is critical that PAs remain on the radar of legislative leaders. That is - any legislation related to telemedicine and telehealth must include PAs, or at least not unfairly restrict PA practice in this space. State constituent organizations, specialty organizations, and AAPA are intently encouraged to remain abreast of any legislative developments in the area of telemedicine to ensure PA scope of practice is effectively sustained or advanced. To that end, existing barriers such as requirements for PA proximity to either the physician or the patient must be eliminated. Additionally, out of state practice - where a PA provides care with a relevant state license from outside the state jurisdiction - must be fully enabled. The committee believes that OTP will largely attend to these issues, but it is important that AAPA and PAs broadly remain aware of unique restrictions on our practice that may not necessarily be resolved by full adoption of OTP.

An interstate medical license compact, or license portability, must be achieved quickly. Telemedicine is inherently a cross-state or multistate endeavor. To continue in this environment without the ability to easily achieve licensure in multiple jurisdictions is a tremendous disadvantage to the profession. While private services to enable this exist, they are very costly, and often still time consuming. A physician compact already exists and is active in 27 states and DC. A nurse practitioner compact exists, though it is only active in 3 states and is not in effect until it has been adopted by at least 10. The Federation of State Medical Boards (FSMB) has current grant funding to explore a PA interstate compact, and remains in the exploratory stage attempting to better define what this may look like and how it may be executed upon. After OTP, PA license portability is a top legislative priority and demands continued attention and effort to ensure forward movement and timely adoption. AAPA is encouraged to clarify a reasonable timeline for a final interstate licensing solution with FSMB, as well as expedite it if possible. The current grant funding for this project covers a 5 year window, of which we are currently in year 1. The current state with respect to telemedicine growth and utilization is significant. Any license

portability or multi-state compact solution will require a significant legislative effort to enact and deploy on a state-by-state basis. With this timing in mind, it is critical that PAs seek a robust solution, but one that can be realized on an expedited timeline if possible. Similarly, national telehealth licensure conversations are not a new concept. However, the COVID-19 pandemic has clarified the extent to which existing clinical capacity must be able to readily shift across state lines where and when appropriate, with telemedicine being a primary means for deploying this capacity. Where conversations regarding national telehealth licensure may be occurring, AAPA must ensure PAs are involved in the dialogue, and included in any legislation that might lead to a national licensing status.

At the Federal level, AAPA should be encouraged to engage more directly and consistently with congressional leaders focused on telehealth expansion. A congressional telehealth caucus already exists, and frequently spearheads legislative efforts related to telemedicine. AAPA should seek to engage with these congressional leaders, and develop relationships that will yield favorable outcomes for PAs as it relates to Federal legislative efforts in telemedicine. This is a very active area of legislation, as COVID-19 related legislative changes have had major impacts on telehealth delivery models and reimbursement. It is significantly likely that many of these changes will be made permanent - either in part or in full. Congressional leaders focusing in the area of telehealth will be key stakeholders in driving the language and rules related to any bills to extend or make permanent changes in telehealth delivery and reimbursement. Medicare/Medicaid direct payment authorization remains a critical piece of this near term and long term legislative roadmap, and AAPA is encouraged to continue their efforts in moving this legislation from inception to final signature.

**The committee will advise staff regarding the impact of new healthcare models that might utilize PAs in virtual/telemedicine.**

Direct-to-consumer (DTC) telemedicine has been given significant attention in some of the exploration above. While this concept is not reasonably considered “new”, the delivery and care models are unique and different enough from traditional urgent or transactional care as to warrant significant attention. We will not reiterate the content discussed above here, but must emphasize the importance of fully investigating this model of care delivery in a telemedicine setting as it will have enormous implications on the current state and future direction of telemedicine nationally.

While healthcare models are rapidly evolving across the system, substance use disorder (SUD) and medication assisted treatment (MAT) are areas that warrant significant attention as it relates to telemedicine. Already, providers who provide MAT for SUD patients have sought opportunity to move components of their practice into a virtual/remote space, allowing for various aspects of routine care and follow up to happen via remote means. Looking forward, the legislative roadmap and national political will is one that guarantees an inevitable future for this area of care through telemedicine. The SUPPORT Act, passed in 2018, contained provisions to expand Federal rules for controlled substance prescribing by telemedicine, with a particular focus on MAT in addressing the ongoing national opioid crisis. While the rules for a “special

registration for telemedicine" are overdue and not yet available, they are highly anticipated once the DEA has completed the necessary work to render them. COVID-19 has begun to offer a glimpse into a healthcare system functioning more liberally with respect to controlled substance prescribing via remote means. During the Federal emergency declaration, Ryan Haight Act provisions, which dictate prescribing rules for controlled substances via telemedicine, have been lifted or eased in many capacities. In doing so, the Federal government believes patients will be able to continue to access essential care, including controlled substance prescriptions, without posing unnecessary public health risks or exposure that can be reasonably avoided. While the committee cannot speculate reliably on the percentage of MAT care that will occur in a telemedicine environment in the future, we anticipate the amount of routine MAT care that will shift into telemedicine to be substantial. To that end, AAPA is encouraged to focus on this area of care with respect to PA education and training, and any necessary resources to support effective PA involvement in MAT-related care, including training for X-waivers and other necessary content to support competent PA care in this space. There is very clearly a roadmap here that presumes significant involvement in telemedicine. PAs would be wise to ensure they are prepared to support MAT/SUD related care via telemedicine, and should do so through effective education and training in this area specifically, as well as consider a relative toolkit for this care in a telemedicine space to allow for rapid deployment and scaling as appropriate. AAPA may consider collaborating with organizations such as Society of PAs in Addiction Medicine to further plan necessary actions in this area of care.

**The committee shall look at both undergraduate education and postgraduate education to practice or become familiar with virtual/telemedicine and how one would obtain this education.**

Effective education in telemedicine - both for trainees and practicing clinicians - is an area of ongoing work for the healthcare system at large. It has been talked about for years, and has been spoken to directly through various curricula on an ad hoc basis, but has largely not received appropriate attention until more recently. As a byproduct of the COVID-19 response, many organizations are suddenly and urgently investing in telemedicine curriculum, as well as seeking best practices in ongoing training. To an extent, an ideal curriculum has not yet been developed, nor have absolute best practices yet been developed. Further, the organizations overseeing PA education and accreditation have not yet rendered explicit recommendations related to telemedicine training, or relevant competencies to be attended to through curriculum. These are important steps to be taken for our profession. PAEA, ARC-PA, NCCPA and any organization with a footprint or impact on PA training curriculum, program accreditation, or PA certification must begin to integrate tenets of telemedicine into training requirements and associated assessments. Integration of telemedicine content into training curricula should aim to be seamless. That is, telemedicine as a care delivery tool is essentially inevitable for all PAs. As such, curriculum should seek to elegantly incorporate telemedicine content into training such that it does not feel intentionally different or set apart from other routine aspects of PA student training. Increasingly, we must look to telemedicine as a tool to enable care, and reiterate that

standard of care in telemedicine must be the same as other areas of care. Training related to the use of telemedicine should be designed to flow naturally with the broader curriculum for the developing PA. Specifically, after foundational concepts in telemedicine related to history, terminology, and delivery tools have been explored, telemedicine principles should be instilled throughout all aspects of PA training. Content and exercises may seek to add a telemedicine "element" to help engage PA students and broaden their thinking as it relates to these care delivery strategies such that it becomes a natural and routine part of a PA student's awareness, and broader PA training.

Work is already underway across the PA educational spectrum. PA programs across the country have begun to develop telemedicine curriculum - either comprehensively, or in part - to support their student's very sudden and urgent needs to develop in these areas of clinical competency. Some PA programs had already begun to invest, and were farther along in their journey when COVID-19 hit, while others had not yet started. Regardless of their status or progress along this timeline, PA programs should be invited to engage in developing these resources for their students, or resources should be developed and made available for PA programs to utilize. Some of this work has already been done. Recently, a cohort of PA faculty completed a project through the University of Maryland Physician Assistant Leadership and Learning Academy which proposed and developed a model telemedicine curriculum to be integrated throughout the standard PA student curriculum. Other projects exist as well, though this may be the most comprehensive curriculum focusing specifically on PA training in telemedicine to date. As a next step, there is opportunity to explore this curriculum proposal, utilize it within existing PA programs to test its efficacy, as well as identify any potential gaps or opportunities that remain despite this curriculum, in particular related to the clinical rotations period of PA student training. While PA students should anticipate encountering telemedicine more commonly through an array of standard clinical rotations, some attention must be paid to developing model telemedicine training through clinical exposure, and seeking to create and maintain a robust roster of more dedicated telemedicine training sites to the benefit of PA students. As a profession, we must ensure that PA students are adequately prepared for a clinical environment that presumes the use of telemedicine in care delivery.

For practicing clinicians, similarly, resources to support PA acquisition of knowledge and expertise in telemedicine warrants consideration. An array of content already exists - both with respect to the utilization of telemedicine in routine clinical practice, generally - as well as in more content specific areas such as teledermatology. The fundamental concepts that underpin telemedicine delivery are broad-based. That is - regardless of your area of clinical practice, these concepts largely apply. Ranging from legal and ethical considerations, to webside manner, effectively engaging patients in this setting, and reimbursement, the opportunity to more directly support PAs in their development of telemedicine knowledge is robust. Additionally, several organizations already offer accreditation for organizations seeking specific status with respect to their telemedicine delivery services. This accreditation, and the care quality it suggests, naturally impacts clinicians providing care in these settings. While a specific accreditation status for individual PAs is not likely practical, nor essential, consideration should be paid to the opportunity to provide PAs advanced and targeted training in telemedicine delivery services - either generally or specific to their area of practice. Further, as the use of

telemedicine continues to evolve and expand, AAPA is encouraged to remain aware of and engaged with an evolving concept of a healthcare “virtualist”. While this is not a recognized clinical specialty, there is significant movement in the healthcare space to begin to define relevant and specific expertise in telehealth delivery, and the title of virtualist is one we may anticipate seeing in the coming years. As with all areas of clinical delivery, if PAs are not involved, then we will not be considered. Attention should be paid towards any progress towards defining this role more explicitly, as well as attempts to engage with relevant parties to help ensure this is an area for future PA practice without unfair restrictions.

**The committee will provide advice to update the Guidelines for State Regulation of PA Practice if any regarding virtual/telemedicine.**

With respect to the section regarding Optimal Team Practice, the committee encourages consideration of language that specifies practice level agreements include arrangements where a PA practices via remote means in the provision of patient care, as well as provides care to patients in multiple states simultaneously. While OTP language is crafted to remain broad and inclusive, there may be rationale for speaking directly to the unique arrangements with respect to geography, proximity, and multi-state status that may be more typical in a telehealth environment. If existing language is deemed to be appropriately inclusive of these practice arrangements, then no further action is warranted.

With respect to the section regarding Disasters, Emergency Field Response and Volunteering, the committee encourages modification of existing language stating “[t]his may require the state to adopt language that permits PAs to respond to medical emergencies that occur outside the place of employment” to “states should adopt language that permits PAs to respond to medical emergencies that occur outside the place of employment”. The COVID-19 pandemic has been an excellent opportunity to demonstrate the strength or weakness of existing state language to enable PA practice in light of emergencies. Some states have required executive orders specifically regarding PA practice in order for PAs to provide relevant care in the context of an ongoing emergency. States who have enshrined PA-specific language regarding status under an emergency declaration may have more effectively enabled both in-state and out-of-state PA clinicians in providing patient care. This is particularly relevant to out-of-state license provisions and the use of telemedicine. Where a state already includes this provision in state regulations under an emergency declaration, PAs are more readily able to provide services to patients, even from outside of the state. While there is a counter-argument that emergency provision language enshrined in state PA practice law may lack the nuance and flexibility necessary to meet the needs of a specific emergency, those states who do not have this language proactively in place have had to reissue or clarify emergency orders at times to ensure PAs are included, leading to unnecessary delays in PAs obtaining the ability to provide care, or delays in patient care and subsequent outcomes. By including this language proactively, the existence of an emergency declaration alone is enough to enable appropriate

PA practice under these circumstances without special attention to emergency order language to ensure PAs are included.

**The committee shall look at credentialing and reimbursement barriers and solutions.**

The committee did not extensively assess this charge. However, as it relates to credentialing in telemedicine, the AAPA is encouraged to consider opportunities to coordinate with relevant state entities and other stakeholders to both streamline credentialing timelines, as well as associated costs. Specifically, with respect to comparable clinicians such as NPs. Healthcare, and telemedicine, is acutely exposed to the laws of economics. Where a less costly or more expedient solution exists, and quality is not significantly impacted, an organization is likely to seek this path. As discrepancies are identified in either the comparable costs or timelines in achieving relevant credentialing for PAs or NPs, AAPA is encouraged to support processes and actions that will yield parity. While the committee was not specifically charged with investigating licensing, the same can be stated here. On a state-by-state basis, where either costs are more significant, or timelines more prolonged when comparing PAs to similar clinical professions such as NPs, AAPA is encouraged to support efforts to achieve parity. Given telemedicine is often a multi-state endeavor, these cost and timeline discrepancies become quickly significant for an organization that may be seeking to license and credential tens or even hundreds of providers. Where discrepancies exist, the PA profession will likely suffer from the perspective of competitiveness.

For reimbursement, the landscape in telemedicine is one where a rising tide lifts all boats. That is, as reimbursement improves for telemedicine services, so too will those for PAs. While reimbursement challenges in telemedicine are relatively equivalent for all clinicians, the fact that PAs continue to have an “invisible provider” status with respect to CMS is increasingly relevant. CMS is the leading edge of telemedicine reimbursement provisions, and PAs must achieve the critical direct payment provisions sought for years. This is a top legislative item for PAs, and the impacts of this legislation - or lack thereof - is equivalently felt in the area of telemedicine as in other areas of care. Perhaps even more so in a clinical space where dollars and cents are more intently scrutinized and pennies pinched. The PA status within CMS related to reimbursement creates yet another barrier to effective PA practice in telemedicine, broad organizational engagement in PA hiring, and cost effectiveness of PA practice in routine patient care delivery.

**The committee will provide suggestions for position papers related to the future of PAs in virtual/telemedicine and virtual healthcare.**

A number of possibilities exist in this area that warrant investigation and consideration. Position papers related to telemedicine may seek to highlight the PA role in care, specifically, or our generalist nature in our standard training. Additionally, position papers may seek to identify

unique elements of telemedicine care relevant to both PA practice and novel concepts intersecting with healthcare.

To be specific, the following areas may be considered for future positions papers relevant to PA practice:

- Healthcare access, equity, and healthcare disparities and PA practice in telemedicine
- PA rural healthcare delivery through telemedicine
- Pain management care via telemedicine
- Telemedicine and climate change
- National telehealth licensure or multi-state PA licensure
- The PA role in serving as a leading clinician in effective transitions within the healthcare system, i.e. from primary care to specialty care to reduce patient loss to follow up
- The PA role in telemental healthcare delivery and addressing mental healthcare shortages
- Telemedicine and the healthcare quadruple aim

**The committee shall identify one liaison group for the AAPA to consider interaction with. The American Telemedicine Association should be considered.**

The AAPA is encouraged to interact with organizations who have a direct influence on policy level decisions at the state and Federal level. Further, organizations who have effectively engaged stakeholders across the telehealth spectrum that represent thoughtful and cross-functional integration - clinical, IT, administrative, reimbursement, etc. Several organizations are doing this effectively to various degrees. The American Telemedicine Association (ATA) is among those, and has been effective in their ongoing standard bearing for the broader telehealth space for several decades. That said, as this is a competitive and dynamic environment, the AAPA must be cautious in over-committing to a single organization while others may warrant attention. From a policy perspective, both Alliance for Connected Care and The Center for Telehealth and E-Health Law (CTeL) have been effective in engaging policymakers at the state and Federal levels. Recently, the Alliance for Connected Care has helped spearhead a task force on advancing Federal telehealth policy. In doing so, they have effectively engaged an array of expert telehealth organizations and individuals, including the ATA, and others, in executing on this work.

Suffice it to say, the organization(s) with whom the AAPA liaises must have PAs demonstrably on their roadmaps for telehealth expansion and improvements. This commitment should be explicit, and AAPA should seek active involvement in conversations with these organizations inclusive of “seats at the table” such that we may ensure PAs are adequately represented. While there are likely “wrong” decisions that can be made as it relates to selecting a liaison organization, ATA, Alliance for Connected Care, and CTeL are all figureheads within the telehealth policy system. To that end, AAPA may be encouraged to consider more than one organization with whom to engage, with a focus on a definitive roadmap that is inclusive of PAs, a welcome entry point to relevant conversation, and effective collaboration with stakeholders across the telehealth spectrum.

**Conclusion:**

The charges laid before this committee in the summer of 2019 were exciting and engaging, but at the time also felt aspirational or somewhere off in the distance. That is - the work felt as though it was still out in front of us. As COVID-19 has demonstrated, this view was mostly an optical illusion. Quite suddenly, the telemedicine revolution is upon us. A roadmap that might have been forward thinking over 3 to 5 to 10 years has been rapidly truncated to "now". The needs for the PA profession in the telemedicine space are quite broad as have been outlined here - legislation, administrative and operational needs, reimbursement, education, employment, competitive clinical parity. We should not let this long list, or the associated sense of urgency, deter our work, however. What has always been true of the PA profession still is - our exceptional clinical training and versatility are assets to our current and future growth and sustainability. We have rapidly shifting grounds beneath our feet, and it is incumbent upon PA professional organizations such as AAPA to ensure we respond quickly to these changes, as well as anticipate those ahead of us.

The coming months and years are likely to serve as a significant test to our profession. We face notable headwinds, both with respect to telemedicine, and more broadly across the healthcare system. As a profession, we will be faced with very difficult decisions, including some that may challenge our identity and history. As individuals, we will be forced to reckon with the realities that stand in front of us, whether they have impacted us personally or not.

Looking ahead, we can be sure that telemedicine is here to stay. As a profession that has established itself as an essential clinical provider within the broader healthcare milieu, we must pay attention to any area where PAs have opportunity to expand their position, or those where PAs may be unfairly limited. Telemedicine as an entity offers insights into both sides of that equation - robust and significant opportunity as clinical niches and services remain unoccupied, but very real limitations on PA practice that seem to have little to do with our actual clinical capacities and training. If necessity is the mother of invention, the current climate guarantees that we must find unique and creative solutions as a profession to ensure we flourish in this space on an ongoing basis. Fortunately, while we must engage external collaborative partners in this endeavor, the decision on the path forward is largely our own. Should we elect to clarify that path with the clear resolve of the almost 140,000 practicing PAs nationally, continued and expanded success surely lies ahead of us.