Reference Committee Hearings will occur in the following order: A, B, and then C

Reference Committee A Resolutions

Resolution Name	Resolution Type	Title/Description
2022-A-01-GOVCOM *	Bylaws	Article X, XI -- Governance Commission & Oversight of Nominating Work Group
2022-A-02-GOVCOM *	Bylaws	Article III, Section 4, Article V, Section 4a, Article XIII, Section 5a -- Credentialed Student Members Voting in General Elections
2022-A-03-GOVCOM *	Bylaws	Article I -- Corporate Name Change
2022-A-04-GOVCOM	Policy	Spanish Translation for Professional Title
2022-A-05-PALH	Policy	Branding Asociado Medico
2022-A-06-PR	Policy	Diversity, Equity, and Inclusion through Language Access
2022-A-07-SPAAM	Policy	Reducing Barriers to Board of Directors Candidacy & Other AAPA Opportunities
2022-A-08-DEI	Policy	Access to Care
2022-A-09-DEI	Policy	Health Disparities
2022-A-10-DEI	Policy	Providing Culturally Effective Care and Eliminating Health Disparity Gaps
2022-A-11-DEI	Policy	Educational Experiences Targeting Diversity and Inclusion in Strategic Partnerships to Eliminate Health Disparities
2022-A-12-DEI	Policy	Legislation and Policies to Eliminate Discrimination
2022-A-13-NY	Policy	Usage of Advanced Practice Provider (APP) and Advanced Care Provider (ACP) during PA Events
2022-A-14-GRPA	Policy Paper	Guidelines for State Regulation of PAs

* Needs ratification by the Board of Directors if amendments are passed by the HOD

Reference Committee Hearings will occur in the following order: A, B, and then C

Reference Committee B Resolutions

Resolution Name	Resolution Type	Title/Description
2022-B-01-CCPDE	Policy	Initial Education
2022-B-02-CCPDE	Policy Paper	Specialty Certification, Clinical Flexibility, and Adaptability
2022-B-03-MI	Policy	Increased CME Credit for Precepting
2022-B-04-MI	Policy Paper	PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers
2022-B-05-OH	Policy	Identifying and Cultivating CORE Leadership Skills for PAs
2022-B-06-GRPA	Policy	Replacement Policy for the Importance of PAs in Executive Leadership Policy Paper
2022-B-07-OH	Policy	Development of Transition to Practice Programs/Onboarding Templates
2022-B-08-HOTP	Policy	Reproductive Healthcare Restrictions
2022-B-09-HOTP	Policy	Breastfeeding
2022-B-10-HOTP	Policy	Button Battery Safety
2022-B-11-HOTP	Policy	Cannabinoids
2022-B-12-HOTP	Policy Paper	False or Deceptive Healthcare Advertising
2022-B-13-HOTP	Policy	Hepatitis
2022-B-14-NY	Policy	Interprofessional Medical Education to Incorporate the PAs Role
2022-B-15-SA	Policy	Health Equity for Students Pursuing PA Education
2022-B-16-SA	Policy	Recruitment and Retention - Amendment to Include Disabilities and Application Barriers

Reference Committee Hearings will occur in the following order: A, B, and then C

Reference Committee C Resolutions

Resolution Name	Resolution Type	Title/Description
2022-C-01-CO	Policy	Support for Hemorrhage Control/Stop the Bleed Campaign
2022-C-02-TX	Policy Paper	Immunizations in Children and Adults
2022-C-03-NY	Policy Paper	Global Epidemic HIV-AIDS
2022-C-04-SPAAM	Policy	Reduced Restrictions on Methadone
2022-C-05-PAHPM	Policy	Advancing Progress of Palliative Care Education and Practice
2022-C-06-PAHPM	Policy	Patient Hospice Benefits and PA Barriers
2022-C-07-SA	Policy	Role of EMS PAs in Pre-Hospital Care
2022-C-08-GRPA	Policy	Reimbursement or Regulation of PAs Based on Academic Credentials
2022-C-09-GRPA	Policy	AAPA's Promotion of PA Utilization
2022-C-10-GRPA	Policy	Team-Based Care
2022-C-11-GRPA	Policy	PA Practice Act Language
2022-C-12-GRPA	Policy	Unrestricted Shared Decision-Making Between Patient and Provider
2022-C-13-GRPA	Policy	Electronic Prescribing Compliance
2022-C-14-GRPA	Policy Paper	The PA in Disaster Repose: Core Guidelines
2022-C-15-GRPA	Policy Paper	The Role of In-Store or Retail-Based Convenient Care Clinics
2022-C-16-GRPA	Policy	AAPA Encourages Use of Telemedicine Services by PAs
2022-C-17-GRPA	Policy	Advocacy for Telemedicine Implementation and Removal of Barriers
2022-C-18-GRPA	Policy	Pharmaceutical Samples Access
2022-C-19-GRPA	Policy	NCCPA Lobby Activity

2022-A-01-GovCom Governance Commission & Oversight of Nominating Work Group

2022-A-01 Resolved

Amend the AAPA Bylaws as follows:

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

INSERT NEW SECTION 3:

SECTION 3: GOVERNANCE COMMISSION. THE GOVERNANCE COMMISSION SHALL BE RESPONSIBLE FOR REVIEWING AND ANALYZING AAPA'S BYLAWS, POLICIES AND OTHER GOVERNING DOCUMENTS, STRUCTURES AND PROCESSES TO ENSURE THEY CONTINUALLY SUPPORT THE GOVERNANCE OF AAPA.

A. COMPOSITION. THE GOVERNANCE COMMISSION SHALL BE APPOINTED BY THE AAPA BOARD OF DIRECTORS IN ACCORDANCE WITH POLICIES AND PROCEDURES ESTABLISHED BY THE BOARD.
B. DUTIES & RESPONSIBILITIES. THE DUTIES AND RESPONSIBILITIES OF THE GOVERNANCE COMMISSION SHALL INCLUDE:
   I. REVIEW AAPA GOVERNING DOCUMENTS AND MAKE RECOMMENDATIONS TO IMPROVE THE EFFECTIVENESS OF AAPA'S GOVERNANCE.
   II. ESTABLISH POLICIES AND PROCEDURES GOVERNING ALL AAPA ELECTIONS AND APPROVE COMPETENCIES FOR CANDIDATES SEEKING ELECTED OFFICE.
   III. OVERSEE THE CHARGES AND ACTIVITIES OF THE NOMINATING WORK GROUP.
   IV. CARRY OUT SUCH PROCESSES AS ARE SET FORTH IN THESE BYLAWS.
   V. CARRY OUT OTHER DUTIES AND RESPONSIBILITIES ASSIGNED BY THE AAPA BOARD OF DIRECTORS.

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~~ THE GOVERNANCE COMMISSION. Such duties and responsibilities shall include:

a. Annually evaluate the environment and recommend to the Governance Commission any skills, capabilities or other characteristics that will support a diverse and high-performing Board of Directors.

b. Support communication and education efforts to inform all members of elected leadership opportunities and how to qualify for those positions.

c. Identify and recruit qualified members and encourage a broad slate of candidates to run for elected positions within AAPA.

d. Evaluating 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~~ GOVERNANCE COMMISSION.

e. Endorsing a single or multiple slate of candidates for each ~~nominated~~ OPEN BOARD POSITION.

Rationale/Justification

In recent years there has been an ongoing dialogue among leaders regarding the role and efficacy of the Nominating Work Group (NWG) and efforts are under way within the work group to strengthen its endorsement process. Unfortunately, confusion regarding oversight responsibility over the NWG has made it difficult to ensure the group is working within an appropriate scope of authority when developing and recommending changes to key processes.

The NWG is commonly understood to be a work group of the Governance Commission, however the NWG's charges as currently reflected in the AAPA Bylaws (Article XI Section 1) include inconsistencies that make it difficult to interpret to which body the NWG is ultimately accountable (i.e., the AAPA Board of Directors or the Governance Commission). Proposed amendments to Article XI, Section 1 make the NWG clearly accountable to the Governance Commission, which is the body currently designated by the Bylaws as responsible for establishing timelines and procedures for all elections.

However, the current AAPA Bylaws include several references to the Governance Commission without formally establishing it as a commission. This can lead to confusion when attempting to interpret the Commission's scope of authority, including its oversight of the Nominating Work Group (NWG). While this oversight is implied in the Bylaws, as well by the Commission's Board-approved charges, formally establishing the Commission under Article X of the Bylaws helps to clarify the extent to which the Commission is subject to the charges of the AAPA Board of Directors and the extent to which it has independent duties and authority as assigned in the Bylaws.

Related AAPA Policy

BA-2400.3.1.0 Commission

A commission is a group that carries out the volunteer work of AAPA. Each commission is given unique annual charges rooted in AAPA's policy and business priorities and initiatives. Each commission has a chair and an even number of members, allowing for an overall odd number of members to facilitate majority voting.

Each commission should include at least three (3) AAPA members with expertise and experience in the subject matter, as well as at least one BOD member and an AAPA staff member. Outside experts may be appointed as members if additional expertise is required. All commission members who are PAs must be members of AAPA and members of a constituent organization.

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 their respective commissions.

[Reaffirmed 2015, 2016, amended 1989, 1994, 1997, 1998, 2002, 2003, 2007, 2010, 2021]

BA-2400.3.2.0 Work Group of a Commission

A work group is a leadership body existing beneath a commission, that has a technical role related to achieving the charges of that commission.

Each work group has a chair and an even number of members, allowing for an overall odd number of members to facilitate majority voting. A work group has a designated staff advisor to support the group's work.

A work group chair reports to the chair of the respective commission under which it was established. All work group members who are PAs shall be members of AAPA and a constituent organization.

[Adopted 2010, reaffirmed 2015, 2016, amended 2021]

BA-2400.4.6 Governance Commission

The commission will:

- Review all Bylaws amendments to be considered at the House of Delegates for the purpose of ensuring proposed changes and amendments conform with existing policies.
- As an impartial body, establish consistent processes and procedures to bring parity to all AAPA elections with dual goals of increasing member transparency and election engagement (candidate and voter).
- Serve in an advisory capacity to the Nominating Work Group and Constituent Relations Work Group.
- Carry out the duties assigned in section 9.3 of the AAPA Judicial Affairs Manual.

- As needed, review AAPA governance documents to identify and eliminate conflicting and inconsistent language.
- Review AAPA policies assigned by the House Officers, to include but not limited to five-year policy review, and develop recommendations for consideration by the appropriate body.
- Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning.
- The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates.
- The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.

[Adopted 2010, amended 2015, 2016, 2018, 2019, 2020, 2021]

Possible Negative Implications

None

Financial Impact

None

Signature

William Hoser, PA-C
Chair, Governance Commission

Contact for the Resolution

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2022-A-02-GovCom **Credentialed Student Members Voting in General Elections (Referred 2021-A-08)**

2022-A-02 Resolved

Reject referred resolution 2021-A-08 which proposed the amendments below.

Amend AAPA Bylaws Article III, Section 4 as follows:

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

Further Resolved

Amend Article V, Section 4a. as follows:

Section 4: Student Academy Board of Directors. The Student Academy Board of Directors directs the activities of the Student Academy.

a. The Student Academy President serves on AAPA's Board of Directors as the Student Director. THIS STUDENT DIRECTOR SHALL HAVE ALL RIGHTS AND PRIVILEGES OF ANY OTHER MEMBER OF SUCH BOARD.

Further Resolved

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

Section 5: Eligible Voters.

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

Rationale/Justification

This bylaws resolution was assigned to the Governance Commission by the House Officers after it was referred by the 2021 House of Delegates. The Governance Commission reviewed this resolution alongside the AAPA Articles of Incorporation, the existing AAPA Bylaws, North Carolina non-profit corporate statute as well as AAPA's stated mission and vision. The Governance Commission met with Student Academy leaders and consulted the opinion of AAPA's legal counsel. Legal counsel advised the Commission to consider the question of member voting rights through the lens of understanding what qualifies someone to vote in the AAPA BOD/General election?

The Governance Commission determined that the answer to this question can be derived from AAPA's mission statement: AAPA leads the profession and empowers our members to advance their careers and enhance patient health.

Emphasis added above is placed on the word profession. AAPA's organizational mission is centered on leading and empowering members of the PA profession. Based on this, the Governance Commission believes that granting full rights of membership, including the right to vote in the General Election should, at a minimum, be rooted in whether someone is a PA.

The AAPA Bylaws defines a Fellow Member, as "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… 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."

While student members are a valued part of the AAPA community and make up a significant portion of AAPA's total membership, they are not yet members of the profession, according to the above criteria. The Governance Commission believes that extending voting rights to any portion of student members would step outside the bounds of appropriate governance for an association that is organized around the profession, as opposed to broader goals and ideals related to health care or medical science.

The Governance Commission took several other factors into consideration, including input shared by Student Academy leaders. The Student Academy's argument in favor of extending voting rights to student members is based on two assertions:

1. Student members feel silenced and disenfranchised by being unable to participate in the General Election; and

2. Student members will be more likely to convert to and engage as Fellow Members if given the opportunity to vote in the General Election.

Unlike every other non-Fellow member class, the AAPA Bylaws (Article V) grants the Student Academy the right to operate as a subsidiary unit representing all AAPA student members. The Student Academy has its own Board of Directors, an Assembly of Representatives, a voting

delegation in the AAPA House of Delegates, Student Board Committees, and seats on several AAPA volunteer commissions. The Student Academy President sits on the AAPA Board of Directors with full voting privileges as the Student Director. The PA Foundation Board of Trustees also includes a Student Trustee with full voting rights.

By far, members of the Student Academy have a great deal of representation in AAPA's governance, more than any other non-Fellow member class. Hence, the Governance Commission struggled to see how extending a small group of students the right to vote in the General Election would increase or improve the inclusion and representation of students beyond what is already afforded the Student Academy. The Governance Commission also did not see any evidence supporting the argument that allowing students to vote in the General Election would necessarily lead to increased engagement as Fellows.

The Governance Commission would like to stress that students and the Student Academy are a valued part of the AAPA community. It must also be acknowledged, though, that until they graduate and become professional PAs, student members' roles and rights within the Academy will be different from Fellows.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature
William Hoser, PA-C
Chair, Governance Commission

Contact for the Resolution
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2022-A-03-GovCom **Corporate Name Change**

2022-A-03 Resolved

Amend the AAPA Bylaws as follows:

ARTICLE I Name.

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

Rationale/Justification

This amendment will conform the AAPA Bylaws with AAPA's recent title change for the profession. Following the 2021 House of Delegate's (HOD's) adoption of "physician associate" as the official title of the PA profession, the HOD adopted a resolution requesting the Board of Directors change AAPA's corporate name to correspond with the new title. In August 2021, new Articles of Incorporation were filed to officially change AAPA's name. Amendments to the Bylaws and other policies are required to align all governing documents with the corporate name change.

Related AAPA Policy

HP-3100.1.1
AAPA affirms "physician associate" as the official title for the PA profession.
[Adopted 2000, reaffirmed 2005, 2010, 2015, amended 2021]

Possible Negative Implications

None except that some confusion may result from the fact that other PA organizations [COs, ARC-PA, NCCPA and PAEA] have not yet changed their names to reflect PA title change. It should be noted then that this is the only bylaws provision where "physician assistant" needs to be replaced with "physician associate" at this time. All other references to "physician assistant" are attached to other PA organizations' corporate title, over which AAPA has no jurisdiction.

Financial Impact

None

Signature

William Hoser, MS, PA-C
Chair, Governance Commission

Contact for the Resolution

Rachel Miller-Bleich

Director, Board of Directors & Governance
rmiller-bleich@aapa.org

2022-A-04-GovCom **Spanish Translation for Professional Title**

2022-A-04 Resolved

Amend policy HP-3100.1.2 as follows:

AAPA shall adopt “asociado médico” as the official Spanish translation for physician ~~assistant~~ ASSOCIATE.

Rationale/Justification

The purpose of this amendment is to conform with the title change for the profession. Associate is the literal translation of “asociado.”

Related AAPA Policy

HP-3100.1.0 Professional Title

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

[Adopted 2000, reaffirmed 2005, 2010, 2015, amended 2021]

Possible Negative Implications

None

Financial Impact

None

Signature

William Hoser, MS, PA-C

Chair, Governance Commission

Contact for the Resolution

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2022-A-05-PALH **Branding of the title Asociado Médico and other adopted titles**

2022-A-05 Resolved

The HOD recommends AAPA brand "Asociado Médico" in a similar manner as "Physician Associate". Furthermore, any other official title translation adopted by AAPA should be branded in a similar fashion.

Rationale/Justification

Currently there are two official titles for our profession. Physician Associate as amended in 2021 and "Asociado Médico" adopted as our official title translated in Spanish in 1998 and reaffirmed in 2003, 2008, 2013, 2018 in our current policy for "Physician Assistant / Physician Associate"

As our representative organization AAPA has never truly, embraced our Spanish title, nor has AAPA ever marketed this title the way it should have been. The U.S. is one of largest Spanish speaking countries in the world with more that 45 million people fluent in Spanish and growing. In 1998 the HOD, recognized the importance of having a title in Spanish as presented by PAs for Latino Health (PALH). Those present stated that the translation truly represented our name and profession, and in fact 23 years later the title Physician Assistant would be amended to Physician Associate, which is more accurately translated to Asociado Médico (versus just in ideology). Over the years there have been minimal attempts; T-shirts, buttons, a Spanish brochure to accomplish this task, all sold in the AAPA store, all were very short lived. Today, if one were to do a search on the AAPA website, they would yield no information or even find the name Asociado Médico noted anywhere except in our AAPA Policy Manuel - Policy HP-3100.1.2. and in – Guidelines for State Regulation of PAs (Adopted in 1988, amended 1993,1998, 2001, 2005, 2006, 2011, 2013, 2017) under **Title and Practice Protection,** and only if you searched for it in **AAPA Governance – Documents and Policies**

Rectifying the delay in marketing our title Asociado Médico is now **imperative** given that there is an ARC-PA Credentialed PA Program in Puerto Rico (PR), at San Juan Bautista's School of Medicine, in PR primarily a Spanish speaking country. It is also **urgent** that the AAPA markets this title as much as possible to **protect our title** both in English and Spanish as set forth in AAPA policy **Non-Physician Licensure for Medical School Graduates**.

Current legislation Ley-71-17, in Puerto Rico designates non-PAs as Médicos Asistentes. These providers are "Generalist Physicians" who cannot pass their medical board exams but by law have been given authority in PR to call themselves PAs when they sign their names. These non-PAs do not meet the standards of NCCPA Certification for a PAs / Asociados Médicos and they cannot practice medicine or be licensed to practice medicine anywhere else as a Certified - PA. Unfortunately, this law limits the ability of a NCCPA Certified - Asociado Medico / PA to work in PR as a medical provider. An issue that Academia de Asociados Médicos de Puerto Rico (AAMPR) our newest AAPA Constituent Organization in Puerto Rico and PALH are currently addressing to create a new law that is specifically empowers Asociados Médicos / Physician Associates to practice and in particular because there will be a graduating cohort of students that will be unable to work in PR, thus perpetuating the brain drain that the PA Program is hoping to abate.

Marketing **our title**, would significantly increase AAMPRs / PALHs success in meeting this present challenge in PR. Additionally effectively marketing our professional name to our Spanish speaking patients and the Spanish speaking medical community would help to educate them about our profession. Taking this action will catapult our title into the Spanish speaking community at large, and into the Latinx world as well.

This was the expectation and hope when the HOD adopted the title in 1998 - 24 years ago that the names would be **synonymous.**

Related AAPA Policy

HP-3100.1.1
AAPA affirms "physician associate" as the official title for the PA profession.
[Adopted 2000, reaffirmed 2005, 2010, 2015, amended 2021]

HP-3100.1.2
AAPA shall adopt “asociado médico” as the official Spanish translation for physician assistant.
[Adopted 1998, reaffirmed 2003, 2008, 2013, 2018]

HP-3500.3.4
Guidelines for State Regulation of PAs (paper on page 120)
[Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 2017]

- 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.

HP-3500.1.4
Non-Physician Licensure for Medical School Graduates (paper on page 329)
[Adopted 2019]

- AAPA opposes the creation of new categories of licensure for medical school graduates who have not completed the requirements of physician licensure.
- AAPA opposes legislation which would categorize such licensees as PAs in any circumstances.
- AAPA supports efforts to increase access to healthcare in underserved areas by improving outdated state laws and regulations which place non-evidence-based limits on PA practice.
- Several states have either considered or enacted legislation to allow medical school graduates who have not completed the requirements of physician licensure to become licensed as “assistant physicians,” “graduate registered physicians,” “associate physicians,’ or other, similarly named practitioners. Proposed AAPA policies regarding this new category of licensure are identified in this paper

Possible Negative Implications

None

Financial Impact

There will be an additional increase to the cost associated in branding "Physician Associate / Asociado Médico" in all of the mediums planned.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted.

Signature & Contact for the Resolution

Robert S. Smith, MS, DHSc, PA-C, DFAAPA,
PALH, Treasurer, Chief Delegate, AAPA HOD
rsspac1958@gmail.com or rsspac@aol.com

2022-A-06-PR **Diversity, Equity, and Inclusion through Language Access**

2022-A-06 Resolved

The HOD requests that the AAPA promote inclusion of all individuals with Limited English Proficiency (LEP) by providing multilingual marketing and educational materials in the language in which patients communicate. Furthermore, the HOD suggests to begin providing materials in Spanish.

Rationale/Justification

Whereas the AAPA works to ensure recognition of PAs and advancing the PA identity.[1]

Whereas the PA profession is at an exciting juncture of implementing the Physician Associate title change[2].

Whereas AAPA is committed to fostering Diversity, Equity, and Inclusion (DEI), part of which includes empowering PAs and patients with "information, tools, and resources to address…inequity."[3]

It is the proposal of the Academia de Asociados Médicos de Puerto Rico (AAMPR), with support from PAs for Latino Health (PALH) that AAPA express these values by first, providing all "vital documents in the non-English language of each regularly encountered group[4]." The first language translation to be in Spanish; second, using "Asociado Médico" alongside all Title Change Implementation planning. Doing so supports patients, PA students, PA legislative efforts, and the PA profession.

~

Among the most vulnerable populations are patients who cannot communicate in the same language as their healthcare provider, leading to more adverse outcomes, less patient autonomy, and poorer health literacy[5]. Referencing Title VI of the Civil Rights Act of 1964 and Title III of the Americans with Disabilities Act (ADA) we propose AAPA demonstrate "meaningful access…that is accurate, timely, and effective at no cost to the Limited English Proficient (LEP) individual" for all AAPA media documents– in Spanish first, as it is the most spoken non-English language in the US and the required language of instruction in Puerto Rico[6]. In the U.S. 13 percent of the population speaks Spanish at home (over 41 million people) and projections estimate by 2050, one in three people in the U.S. will speak Spanish.[7]

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[1] https://www.aapa.org/wp-content/uploads/2019/02/About_AAPA_Fact_Sheet_February2019.pdf

[2] Title Change, resolution affirming "physician associate" May 24, 2021

[3] AAPA's Diversity, Equity, and Inclusion Statement, https://www.aapa.org/about/dei-resource-center/

[4] https://www.lep.gov/sites/lep/files/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf

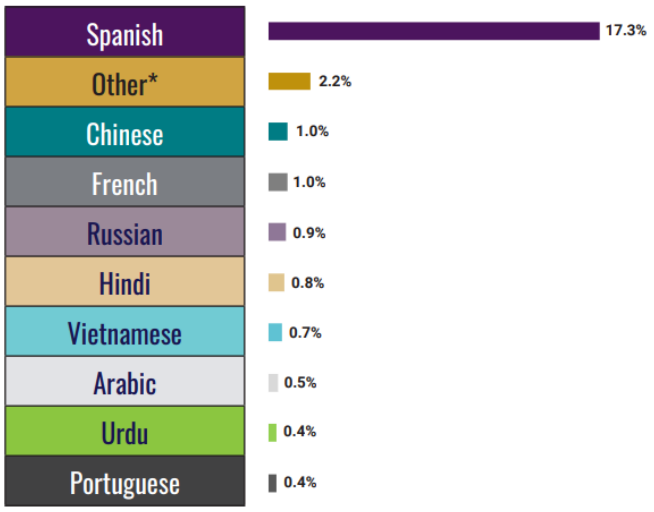
[5] https://link.springer.com/article/10.1111/j.1525-1497.2005.0174.x

[6] https://guides.loc.gov/language-in-puerto-rico

[7] https://www.forbes.com/sites/soniathompson/2021/05/27/the-us-has-the-second-largest-population-of-spanish-speakers-how-to-equip-your-brand-to-serve-them/?sh=20bc5382793a

[8] https://www.nccoa.net/wp-content/uploads/2021/07/Statistical-Profile-of-Certified-Pas-2020.pdf

[9] AAPA Policy Manual HP-3100..1.2



Percentage of Certified PAs who communicate with patients in languages other than English by the top 10 most frequently identified languages.

Per NCCPA 2021:[8]
Percentage of Certified PAs who communicate with patients in languages other than English by the top 10 most frequently identified languages.

For Certified PAs who responded "other" to language, the most frequently selected include: American Sign Language, Hebrew, Punjabi, and Malayalam.

The year 2021 saw the establishment and incorporation of the first constituent organization (state/territory chapter) in Puerto Rico: Academia de Asociados Médicos de Puerto Rico (AAMPR), and the matriculation of a pioneering cohort of PA students to the first bilingual PA Program at San Juan Bautista School of Medicine. At this time the first cohort of students has begun their clinical rotations in Puerto Rico (PR) in almost exclusively Spanish-only speaking settings, with Spanish-only patients and Spanish-only preceptors that urgently need these types of materials. While it is the responsibility of each institution to provide materials for students/preceptors, there are no foundational materials or reference materials from our national professional society.

The legislative hurdles we face in PR stem from the creation of Law 71 (Ley Setenta y uno), in which PAs were included in the law with foreign medical graduates and medical students that have not passed their board exams and/or did not match for a residency. The law intended to name PAs along with the medical students as "asistente médicos" but unfortunately the authors purposefully chose to use "medicos asistentes" in the title of the law. This law has created significant confusion about our profession as these other non-licensed MDs included in the law are allowed to call themselves PAs.
AAPA adopted "Asociado Médico"[9] as the official Spanish translation for PA in 1998 and reaffirmed several times thereafter. Notwithstanding this triumphant step, there is currently no policy that allows for the provision of all AAPA endorsed materials in both English and Spanish, the second most spoken language in the US and the primary language in Puerto Rico where, as of 2021, there is a PA program.

To address this issue, AAMPR and PALH are working hard to create a PA Practice Act that will establish our name as Asociado Médicos and fulfill the tenants of OTP. AAPA's firm

commitment to provide key information in Spanish would be monumental in assisting AAMPR in its legislative efforts and helping our patients understand our role in the delivery of their health care.

As our profession continues to grow, the commitment AAPA has made to addressing health disparities and diversity issues make it necessary to have sustaining policy in place.
The time is now in our rebranding efforts for AAPA to embrace and market "Asociado Médico", for our colleagues, our students in Puerto Rico, our legislative efforts, as well as the health literacy of our patients.

Related AAPA Policy

Enacting this policy meets the tenets of the DEI overarching strategy. The following policies are examples that also support this resolution:

BA-2500.4.3
AAPA leadership and national office staff will incorporate diversity and equity 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.
[Adopted 1995, reaffirmed 2000, 2005, 2010, 2015, amended 2016, 2021]

HP-3100.1.0 Professional Title
HP-3100.1.1
AAPA affirms "physician associate" as the official title for the PA profession.
[Adopted 2000, reaffirmed 2005, 2010, 2015, amended 2021]

HP-3100.1.2
AAPA shall adopt **"asociado médico"** as the official Spanish translation for physician assistant.
[Adopted 1998, reaffirmed 2003, 2008, 2013, 2018]

HP-3200.2.2
AAPA reviews and approves 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).

[Adopted 1979, amended 1985, 1993, 1996, 1997, 2006, 2011, 2016, reaffirmed 1990, 1998, 2003, 2021]

HP-3200.6.0 Recruitment and Retention
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, reaffirmed 2020]

HP-3200.5.5
AAPA supports initiatives for increased funding for development and operation of PA programs at Historically Black Colleges and Universities, predominantly black institutions, Hispanic-Serving Institutions, and rural serving institutions.
[Adopted 2018]

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.
[Adopted 2004, reaffirmed 2009, 2014, 2019]

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 healthcare. 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.
[Adopted 1996, reaffirmed 2001, 2007, 2012, amended 1997, 2017]

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.
[Adopted 1996, amended 2006, reaffirmed 2001, 2012, 2017]

HP-3400.2.2.1 AAPA supports the full scope of practice for PAs operating in the surgical and procedural subspecialties by the promotion of state, federal and institutional policy focused on the advancement of technical skills for PAs.
[Adopted 2019]

HP-3700.3.0 International
HP-3700.3.1

Guidelines for PAs Working Internationally 1. PAs should establish and maintain appropriate healthcare team relationships. 2. PAs should accurately represent their skills, training, professional credentials, identity, or service. 3. PAs should provide only those services for which they are qualified via their education and/or experiences, and in accordance with all pertinent legal and regulatory processes. 4. PAs should respect the culture, values, beliefs, and expectations of the patients, local healthcare providers, and the local healthcare systems. 5. PAs should be aware of the role of the traditional healer and support a patient's decision to utilize such care. 6. PAs should take responsibility for being familiar with, and adhering to the customs, laws, and regulations of the country where they will be providing services. 7. When applicable, PAs should identify and train local personnel who can assume the role of providing care and continuing the education process. 8. PA students require the same supervision abroad as they do domestically. 9. PAs should provide the best standards of care and strive to maintain quality abroad. 10. Sustainable programs that integrate local providers and supplies should be the goal. 11. PAs should assign medical tasks, as appropriate, to nonmedical volunteers only when they have the competency and supervision needed for the tasks for which they are assigned.
[Adopted 2001, reaffirmed 2006, 2016, amended 2011, 2021]

HX-4100.00 HUMAN RIGHTS

HX-4100.1.0 General

HX-4100.1.10

AAPA is committed to respecting the values and diversity of all individuals irrespective of race, ethnicity, culture, faith, sex, gender identity or expression and sexual orientation. 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.
[Adopted 1995, reaffirmed 2003, 2008, amended 1997, 2013, 2018]

HX-4100.1.10.1

AAPA leadership and national office staff is committed to fostering a culture that embraces the value of justice, diversity, equity, and inclusion within the Academy, and within our profession. AAPA recognizes that embracing the principles of diversity, equity, and inclusion (DEI) in the workplace is essential to improved collaboration and morale as well as greater innovation, productivity, tolerance, and representation in the work we do both internally and externally within our communities.

AAPA is committed to promoting partnerships and programs that allow us to innovate and implement the changes required to meet our DEI goals.

AAPA is committed to empowering PAs with information, tools, and resources to address inequities in their daily practice and by using AAPA resources (staffing, finances, and strategic planning) to allow PAs to be the change agents for DEI in their practices and in their communities.

AAPA will incorporate change management techniques that demand accountability, measurement, and ongoing monitoring for the effectiveness of DEI initiatives.

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

1. DEI is placed as an ongoing overarching goal as part of AAPA's Strategic Plan outlining measurable steps necessary to achieve DEI within AAPA.

2. DEI initiatives are included in annual budgets, timelines for actions are in place and there are mechanisms to audit the Plan, Do, Study, Act (PDSA) Cycles.

3. AAPA implements partnerships and programs that attract more underrepresented minorities to the profession through collaboration to develop opportunities for innovative changes to DEI inequities in healthcare.

4. AAPA promotes or creates initiatives with all our partners to collectively voice and support policy and legislative solutions to address DEI, health and social issues, justice, tolerance, and address changes to eliminate health disparities (local, state, national and international).

5. AAPA will continue to support constituent organizations and make extraordinary efforts to have representation of all human beings at the decision table.

6. The CEO will report on DEI annually to AAPA's HOD.
[Adopted 2021]

HX-4600.00 ACCESS TO CARE
HX-4600.1.0 General

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. 90 [Adopted 1992, reaffirmed 1997, 2002, 2007, 2012, 2017]

Policy Paper

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 healthcare 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.

Possible Negative Implications

None known

Financial Impact

Total financial impact is unknown, but there would be an initial expense estimated at $5K-$10K, to properly translate and publish the current materials. It is believed that this would be included in title change publication and media activities. There would be ongoing expenses in new production and new language materials as they are needed in the future. This would need to be a line item in budget to ensure ongoing application of this priority.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board of Directors and approved as submitted.

Signature & Contact for the Resolution

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Co-sponsors

PAs for Latino Health (PALH)
African Heritage PA Caucus
New Jersey State Society of PAs (NJSSPA)
New York State Society of PAs (NYSSPA)
Texas Academy of PAs

2022-A-07-SPAAM **Reducing Barriers to Board of Directors Candidacy and Other Minority Population AAPA Opportunities**

2022-A-07 Resolved

Amend policy HP-3200.6.4 as follows:

AAPA affirms its commitment to non-discrimination in membership, scholarship and leadership opportunities and encourages constituent organizations to offer equitable and inclusive treatment of all student members, regardless of their educational setting. FURTHERMORE, AAPA SUPPORTS CONTINUOUS REVIEW OF CURRENT BYLAWS AND OTHER POLICIES WHICH MAY CREATE BARRIERS TO BIPOC (BLACK, INDIGENOUS, AND PEOPLE OF COLOR) AND OTHER MINORITY POPULATION'S PARTICIPATION IN AAPA BOARD OF DIRECTORS ELECTIONS AND ADDRESSING/REDUCING/ELIMINATING ANY IDENTIFIED BARRIERS IN SUPPORT OF DIVERSIFYING THE BOARD OF DIRECTORS AND OTHER PA LEADERSHIP OPPORTUNITIES WITHIN THE AAPA LEADERSHIP STRUCTURE.

Rationale/Justification

The current AAPA criteria for who may run for the AAPA Board of Directors poses a barrier to members who are BIPOC/LBGTQ, and other minority populations who may wish to serve on the BOD, but who are unable to meet the restrictive criteria allowing them to run for the BOD.

It is demonstrative that there are fewer restrictions to running for the United States House of Representatives than there are for declaring candidacy for the AAPA Board of Directors. The AAPA Board should reflect the diversity of our profession, as well as of our patients. This is not the case with our current BOD membership.

The current AAPA qualifications to apply for BOD positions are as follows:

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 AAPA's House of Delegates or a representative to the Student Academy of AAPA's Assembly of Representatives.
iii. A board member, trustee, or committee chair of the Student Academy of AAPA, PA

Foundation, Physician Assistant History Society, AAPA's Political Action Committee, Physician Assistant Education Association or National Commission on Certification of Physician Assistants.

iv. AAPA Board appointee.

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

Compare this to the current qualifications for running as a candidate for the US House of Representatives:

Constitutional Qualifications:
No Person shall be a Representative who shall not have attained to the age of twenty five Years, and been seven Years a Citizen of the United States, and who shall not, when elected, be an Inhabitant of that State in which he shall be chosen."
— U.S. Constitution, Article I, section 2, clause 2

The current BIPOC, LBGTQ, and other minority populations of the AAPA Board is not consistent with our membership, and the current restrictions are unreasonable barriers to participations for BIPOC, LBGTQ, and other minority populations.

Related AAPA Policy

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 14 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 acted 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

Possible Negative Implications

None

Financial Impact

None

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature & Contact for the Resolution

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Co-sponsor

Camille J. Dyer, MS, PA-C, AACC DFAAPA
President, African Heritage PA Caucus

2022-A-08-DEI **Access to Care**

2022-A-08 Resolved

AAPA recognizes the unique healthcare needs of at-risk and under resourced communities, including immigrant status, adversely affecting their physical, mental health, and overall wellbeing. Social, political, economic, educational, environmental, and systemic barriers widen the gap of health disparities resulting in detrimental negative outcomes. PAs are uniquely qualified to continue promoting and delivering innovative community-oriented, high quality healthcare services to all, eliminating barriers, advancing access, and improving outcomes.

Rationale/Justification

Currently there are four policies in place that are recommended to be expired. This one policy can be an overarching policy that would include all of these policies and remove redundancy that is currently in place, throughout the policy manual. This policy clearly addresses all of these current policies and potentially reaffirms others, potentially replacing other policies as well.

Related AAPA Policy

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 healthcare practitioners.
[Adopted 2002, amended 2012, reaffirmed 2007, 2017]

HX-4600.1.10
AAPA believes that all patients deserve access to healthcare and opposes the establishment of local, federal, or state initiatives that require healthcare providers to refuse care to undocumented persons or to report suspected undocumented persons to authorities.
[Adopted 2007, reaffirmed 2012, 2017]

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]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

Robert Wooten PA-C
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2022-A-09-DEI **Health Disparities**

2022-A-09 Resolved

Amend policy HP-3300.2.7 as follows:

AAPA encourages PAs to provide care for medically underserved populations and/or practice in medically ~~underserved~~ UNDER RESOURCED areas TO ADDRESS HEALTH DISPARITIES.

Rationale/Justification

The commission wanted the policy to reflect that populations are underserved as well as under resourced. This allows for the policy to have more inclusive verbiage as it pertains to health disparities.

Related AAPA Policy

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, 2021]

HX-4600.1.6

AAPA recognizes that discrimination contributes to health disparities. AAPA supports legislation and policies that will eliminate discrimination.
[Adopted 2001, amended 2006, 2011, 2016, reaffirmed 2021]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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2022-A-10-DEI **Providing Culturally Effective Care and Eliminating Health Disparity Gaps**

2022-A-10 Resolved

Amend by substitution policies HP-3300.2.9 and HX-4100.1.11 as follows:

~~HP-3300.2.9~~
~~AAPA believes PAs should continually work towards acquiring the knowledge, skills and attitudes needed to provide culturally competent care for patients.~~

~~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.~~

AAPA SUPPORTS PA ACTIVITIES TO ACQUIRE THE KNOWLEDGE, SKILLS, AND ATTITUDES NECESSARY TO PROVIDE CULTURALLY EFFECTIVE CARE WITH THE GOAL OF ELIMINATING HEALTH DISPARITY GAPS.

Rationale/Justification
To reduce redundancy, the commission recommends expiring the current versions of these policies and combining the concepts into a single policy.

Related AAPA Policy
HP-3300.2.7
AAPA encourages PAs to provide care for medically underserved populations and/or practice in medically underserved areas.
[Adopted 1991, amended 1996, 2011, reaffirmed 2001, 2006, 2016, 2021]

HP-3300.2.9
AAPA believes PAs should continually work towards acquiring the knowledge, skills and attitudes needed to provide culturally competent care for patients.
[Adopted 2006, reaffirmed 2016, amended 2011, 2021]

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, 2021]

Possible Negative Implications
None

Financial Impact

None

Signature & Contact for the Resolution

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2022-A-11-DEI **Educational Experiences Targeting Diversity and Inclusion in Strategic Partnerships to Eliminate Health Disparities**

2022-A-11 Resolved

Amend by substitution policies HA-2100.1.1 and HX-4600.1.5 as follows:

~~HA-2100.1.1~~
~~AAPA should provide and support ongoing educational experiences that are focused on diversity, healthcare disparity issues, and social determinants of health.~~

~~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.~~

AAPA SHALL PROMOTE EDUCATIONAL POLICIES AND PROGRAMS THAT TARGET DIVERSITY AND INCLUSION ELIMINATING HEALTH DISPARITIES. FURTHERMORE, AAPA SHALL SUPPORT THE FORMATION OF "STRATEGIC PARTNERSHIPS" WITH OTHER ORGANIZATIONS THAT SEEK TO ADDRESS AND ELIMINATE HEALTH DISPARITY GAPS.

Rationale/Justification
To reduce redundancy, the commission recommends expiring the current versions of these policies and combining the concepts into a single policy. This would provide strength and clarity to our policy.

Related AAPA Policy
HP-3300.2.7
AAPA encourages PAs to provide care for medically underserved populations and/or practice in medically underserved areas.
[Adopted 1991, amended 1996, 2011, reaffirmed 2001, 2006, 2016, 2021]

HP-3300.2.9
AAPA believes PAs should continually work towards acquiring the knowledge, skills and attitudes needed to provide culturally competent care for patients.
[Adopted 2006, reaffirmed 2016, amended 2011, 2021]

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for the Resolution

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2022-A-12-DEI **Legislation and Policies to Eliminate Discrimination**

2022-A-12 Resolved

Amend policy HX-4600.1.6 as follows:

~~AAPA recognizes that discrimination contributes to health disparities.~~ AAPA SHALL SUPPORT ~~supports~~ legislation and policies TO ~~that will~~ eliminate discrimination THAT CONTRIBUTES TO HEALTH DISPARITIES.

Rationale/Justification

The commission wanted the policy to compliment the policies listed below.

Related AAPA Policy

HP-3300.2.7

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

[Adopted 1991, amended 1996, 2011, reaffirmed 2001, 2006, 2016, 2021]

HP-3300.2.9

AAPA believes PAs should continually work towards acquiring the knowledge, skills and attitudes needed to provide culturally competent care for patients.

[Adopted 2006, reaffirmed 2016, amended 2011, 2021]

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, 2021]

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.

[Adopted 2001, reaffirmed 2006, 2011, 2016, 2021]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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2022-A-13-NY **Usage of Advanced Practice Provider (APP) and Advanced Care Provider (ACP) during PA Events**

2022-A-13 Resolved

Amend policy HP-3100.1.3.1 as follows:

AAPA believes whenever possible, PAs should be referred to as PAs. AAPA recognizes entities may use the terms "advanced practice providers" or "advanced practice clinicians" which should only be used when referring to PAs and APRNs COMBINED. APP/ACP USE SHOULD BE LIMITED TO ADMINISTRATIVE CONTEXT AND SHOULD BE AVOIDED AT PA SPECIFIC EVENTS AND DURING PERIODS OF RECOGNITION MEANT FOR PAS.

Rationale/Justification

The AAPA acknowledges the importance of interprofessional decorum and medical collegiality. The use of APP and ACP is recognized as descriptors for other medical team members (i.e., advanced practice nurses, respiratory therapists, radiology technologists) including PAs. Hospital administrators also utilize the terms APP and ACP to describe other health care providers who are not physicians. The AAPA will avoid using APP and ACP during events, publications, social media postings, or other announcements intended to specifically recognize PAs and their contributions to the healthcare system.

Related AAPA Policy

None

Possible Negative Implications

None foreseen at this time.

Financial Impact

No foreseen financial impact anticipated at this time.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature and Contact for the Resolution

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Co-sponsor

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2022-A-14-GRPA **Guidelines for State Regulation of PAs**

2022-A-14 Resolved

Amend the policy paper entitled *Guidelines for State Regulation of PAs.* See policy paper.

Rationale/Justification

Policy has been updated to reflect the current legislative and regulatory efforts of states and territories to achieve OTP. Language has been updated to remove redundant paragraphs and ensure alignment with key messages that are important for OTP's success.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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Guidelines for State Regulation of PAs

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

Executive Summary of Policy Contained in this Paper

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

- AAPA believes inclusion of PAs in state law and delegation of authority to regulate their practice to a state agency serves to both protect the public from incompetent performance by unqualified medical providers and to define the role of PAs in the healthcare system.

- AAPA, while recognizing the differences in political and healthcare climates in each state, endorses standardization of PA regulation as a way to enhance appropriate and flexible professional practice.

Introduction

Recognition of PAs as medical providers led to the development of state AND TERRITORY laws and regulations to govern ~~their~~ PA 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. 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 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~~ PA PRACTICE SHOULD BE CONSIDERED the practice OF 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 STREAMLINE THE LICENSURE PROCESS AND not require UNNECESSARY STEPS INCLUDING, BUT NOT LIMITED TO, employment or identification of a supervising, collaborating, or other specific relationship with a physician(s), JURISPRUDENCE EXAMS, OR BOARD APPROVAL OF PRACTICE ELEMENTS 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. REGULATORY AGENCY STAFF SHOULD BE EMPOWERED TO APPROVE AN UNCOMPLICATED PA LICENSE APPLICATION WITHOUT DIRECT BOARD ACTION. IF ISSUANCE OF A FULL LICENSE REQUIRES APPROVAL OR RATIFICATION 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~~ WHEN A PA returnS 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 ISSUE A LICENSE AND ALLOW APPLICANTS TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE. EACH PA REENTERING CLINICAL PRACTICE WILL HAVE UNIQUE CIRCUMSTANCES; THEREFORE, THE BOARD SHOULD BE AUTHORIZED TO customize requirements imposed on PA~~a~~s reentering clinical practice. Acceptable options could include UNRESTRICTED LICENSURE OR requiring ~~current certification~~ CERTIFIED MEDICAL EDUCATION, development of a personalized re-entry plan, or temporary authorization to practice for a specified period of time**.** ~~Although i~~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~~. THEREFORE, R~~R~~e-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 AND/OR FINGERPRINTING FOR PA LICENSE APPLICANTS ~~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, ~~patient-centered~~ PA~~/~~AND~~/~~p~~/~~physician ~~teams are~~ COLLABORATION IS ~~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.~~

OPTIMAL TEAM PRACTICE ADDRESSES THE NEEDS IN AN ~~The~~ evolving medical practice; TODAY'S HEALTHCARE 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~~ OTHER HEALTHCARE PROVIDERS work together should be determined at the practice level.

WITHIN STATE LAWS AND REGULATIONS, OPTIMAL TEAM PRACTICE OCCURS WHEN PAS ARE NOT REQUIRED TO HAVE A SPECIFIC RELATIONSHIP WITH ANY OTHER HEALTHCARE PROVIDER TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE. PAS WILL CONTINUE TO CONSULT, COLLABORATE, OR REFER WHEN NECESSARY, AS INDICATED BY THE PATIENT'S CONDITION AND THE STANDARD OF CARE, AND IN ACCORDANCE WITH THE PA'S COMPTENCIES. ALTERNATIVE REQUIREMENTS DIMINISH TEAM FLEXIBILITY AND THEREFORE LIMIT PATIENT ACCESS TO CARE, WITHOUT IMPROVING PATIENT SAFETY. BY REMOVING ADMINISTRATIVE RESTRICTION,

PAS AND THEIR TEAMS WILL HAVE GREATER FLEXIBILITY TO MORE EFFECTIVELY CARE FOR PATIENTS.

~~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 experienced. Such requirements diminish team flexibility and therefore limit patient access to care, without improving patient safety.~~ In addition, THE ADMINISTRATIVE RELATIONSHIP ~~such~~ requirement~~s~~ putS 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~~ STATE 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. STATE LAW SHOULD RECOGNIZE PAS AS RESPONSIBLE FOR THE CARE THEY PROVIDE TO THEIR PATIENTS.

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

~~Nothwithstanding 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 PAYMENT, 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~~ HEALTHCARE team 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 OR OTHER HEALTHCARE PROVIDER who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

IN ACCORDANCE WITH AAPA POLICY HP-3600.1.4, PAS SHOULD BE ELIGIBLE FOR DIRECT REIMBURSEMENT FOR THE CARE THEY PROVIDE TO FACILITATE TRANSPARENCY AND PRACTICE BUSINESS.

Disasters, Emergency Field Response and Volunteering

PAs should be allowed to provide medical care in disaster and emergency situations WITHOUT ~~concern for state laws~~ REQUIRING A SPECIFIC RELATIONSHIP WITH A PHYSICIAN OR OTHER HEALTHCARE PROVIDER. This may require the state to adopt language that permits PAs to respond to EMERGING PUBLIC HEALTH THREATS, SUDDEN emergencies, OR OTHER EVENTS NECESSITATING EMERGENCY MEDICAL CARE, REGARDLESS OF SETTING, PROVIDED THE CARE IS WITHIN THE PA'S EDUCATION, TRAINING, AND EXPERIENCE.

This exemption should extend to PAs who are licensed in STATES OTHER THAN WHERE THE CARE IS PROVIDED or who are federal employees. PAs should be granted "Good Samaritan" immunity to the same extent that it is available to other health professionals UNDER THE LAWS OF THE STATE IN WHICH THE CARE IS RENDERED.

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~~ HEALTHCARE PROVIDER ~~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 AUTONOMOUSLY provide any legal medical service that is within the PA's education, training and experience. PA SCOPE SHOULD NOT BE LIMITED TO PHYSICIAN-DELEGATED TASKS AND PA SCOPE OF PRACTICE SHOULD NOT BE LINKED TO ANY OTHER HEALTHCARE PROVIDER'S SCOPE OF PRACTICE.

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, CERTIFICATES OF ADDED QUALIFICATIONS (CAQS), 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~~ UNITED STATES Drug Enforcement Administration AND RELEVANT STATE AGENCIES.

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," "PHYSICIAN ASSOCIATE" (OR ITS PREDECESSOR "PHYSICIAN ASSISTANT," 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 RESPONSIBLE FOR THE LICENSURE, DISCIPLINE, AND REGULATION OF PAS AND 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~~ OTHER HEALTHCARE PROFESSIONALS IN THE STATE LICENSED TO PRACTICE MEDICINE. 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. AAPA 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 AND REGULATIONS THAT SPECIFICALLY ENUMERATE PHYSICIANS AND NURSE PRACTITIONERS, INCLUDING PROVISIONS 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.

2022-B-01-CCPDE **Initial Education**

2022-B-01 Resolved

Amend policy HP-3200.1.3 as follows:

AAPA recognizes that PA education is conducted at the graduate level and supports awarding the master's degree AS THE TERMINAL DEGREE. ~~for new PA graduates.~~

Rationale/Justification

This amendment brings the policy into line with existing policy which opens the possibility of initial doctoral programs and recommends study of post professional doctoral programs while opposing making a doctoral degree mandatory for initial education. Affirming that a master's degree is the current terminal degree standard is important to ensuring that PA programs can recruit and retain faculty members.

Related AAPA Policy

HP-3200.1.4
AAPA opposes a mandatory entry-level doctorate for PAs.
[Adopted 2010, reaffirmed 2015, amended 2021]

HP-3200.1.4.1
AAPA supports PA-specific post-professional doctoral degrees as one option for PAs to engage in lifelong learning.

The House of Delegates recommends AAPA support additional research on the outcomes associated with PA-specific post-professional doctoral degrees as well as emerging trends related to these programs to inform future policy deliberations on this topic.
[Adopted 2021]

Possible Negative Implications

None

Financial Impact

None

Signature and Contact for the Resolution

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2022-B-02-CCPDE **Specialty Certification, Clinical Flexibility, and Adaptability**

2022-B-02 Resolved

Amend the policy paper entitled *Specialty Certification, Clinical Flexibility, and Adaptability*. See policy paper.

Rationale/Justification

This policy was assigned to the Commission on Continuing Professional Development and Education as part of AAPA's routine 5-year policy review process. The Commission consulted stakeholders to determine current sentiment related to the topics addressed in this policy paper and updated other underlying data.

Related AAPA Policy

HP-3200.4.3
AAPA opposes any NCCPA requirement that PAs must practice for an identified time in a given specialty practice as a precondition for specialty certification.
[Adopted 2010, reaffirmed 2015, 2020]

Possible Negative Implications

The threat that specialty certification poses to the clinical flexibility that is valued by PAs and by the healthcare system must be carefully balanced against the opportunities to compete against other professions for employment and for recognition and promotion within health systems.

Financial Impact

None

Signature & Contact for the Resolution

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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 health-care 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) OR SIMILAR COMPETENCY-BASED ASSESSMENTS as a more comprehensive and textured approach for evaluating the qualifications of a PA.
- Research should be conducted to determine if there is a link between specialty certification and improved quality of care, and whether or not any such improvement would offset the potential losses to the system of the flexibility and adaptability inherent in the current model.

Background

The PA profession was created in the late 1960s as a response to a shortage of primary care physicians and a need to extend the availability of medical services for patients beyond what physicians alone were able to provide. The initial idea was that physicians would be able to delegate many routine tasks to this new medical professional. The training pattern that emerged and was eventually formalized through accreditation of PA programs was a curriculum averaging 26 months that combined a didactic grounding in the basic sciences with a clinical apprenticeship model emphasizing general medical knowledge and its application in a primary care setting. (1) The profession was originally designed to be physician-dependent. Once in practice, PAs would form dyadic collaborative relationships with physicians, who would take moral and legal responsibility for the PA's work and extend the PA's scope of practice as the PA demonstrated competency related to specific tasks. (2) This model has changed over time. In particular, the role of PA-physician collaboration has been redefined in a way that has tended toward increasing levels of PA autonomy. Regardless, the PA model has produced a remarkably flexible medical professional who can be trained fairly quickly and 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. (3) ~~In a 2015 survey, 8.3% of PAs indicated that they had changed their specialty during 2014.~~ IN SURVEYS CONDUCTED BY AAPA BETWEEN 2015 AND 2018 PAS REPORT CHANGING SPECIALITES AT RATES RANGING FROM 5.5% AND 6.5% EACH YEAR (4) The generalist training, coupled with a culture that emphasizes lifelong learning, has been seen as the keys to this adaptability and, as a result, specialty certification has been viewed by many members of the profession as a specific threat to flexibility and adaptability. AAPA has had policy opposing specialty certification since 2002. (5)

At its founding, the PA model rested on two assumptions. The first assumption was that most PAs would enter the primary care workforce, and the second was that physicians would be the primary employers of PAs. (1) Both of these assumptions are challenged by the realities of contemporary PA practice. Health systems have emerged as direct employers of PAs, altering the paradigm of the PA working with their supervising physician in a mentor role that was initially designed for the profession. (6) 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. (1) According to ~~2015~~ 2020 NCCPA data, ~~just over 70% of PAs report that they practice in a medical specialty~~ 24,4% OF CERTIFIED PAS REPORT PRACTICING IN PRIMARY CARE SPECIALIES (FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, PEDIATRICS) INDICATING THAT THREE OUT OF FOUR PAS ARE INVOLVED IN SPECIALTY PRACTICE. (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~~ REDESIGNED PANRE ~~on~~ AROUND WHAT IT HAS IDENTIFIED AS "core knowledge~~,~~" ~~and efforts are underway to define more specifically what "core knowledge" represents for PA practice~~ IN AN EFFORT TO ENSURE THAT IT IS FOCUSED ON KNOWLDEGE RELEVANT TO PRACTICING PAS IN ALL SPECIALTIES. (9) Participation in the CAQ has SHOWN MODEST GROWTH BUT REMAINS ~~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. ARC-PA ACCREDITATION OF POSTGRADUATE PROGRAMS HAS RESUMED IN JANUARY OF 2020 WITH NINE ORGANIZATIONS ACHIEVING ACCREDITATION AS OF MARCH OF 2021. THE NUMBER OF NON-ACCREDITED POSTGRADUATE PROGRAMS HAS CONTINUED TO GROW. AS OF 2022 THE ASSOCIATION OF POSTGRADUATE PA PROGRAMS LISTS 143 PROGRAMS IN 35 SPECIALTIES. IT IS REASONABLE TO ASSUME THAT THE NUMBER OF PROGRAMS THAT SEEK ARC-PA ACCREDITATION WILL ALSO INCREASE NOW THAT ACCREDITATION HAS RESUMED. 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, AAPA's 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~~ BUILT UPON THE WORK OF A TASKFORCE IT HAD CONVENED IN 2017, REVIEWED NEW DEVELOPMENTS, UPDATED DATA, AND CONDUCTED SURVEYS WITH STAKEHOLDERS TO UNDERSTAND CURRENT PERSPECTIVES ON SPECIALTY CERTIFICATION.

Stakeholder Input

A member of the 2017 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~~ COMMISSION 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~~ 6 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.~~ THAT CURRENTLY HAVE A CAQ ASSOCIATED WITH THEIR SPECIALTY AND 2 ADDITIONAL ORGANIZATIONS FOR WHICH A NEW CAQ RELEVANT TO THEIR SPECIALTY HAS BEEN ANNOUNCED. RESPONSES WERE RECEIVED FROM 7 ORGANIZATIONS. PAS IN CARDIOTHORACIC AND VASCULAR SURGERY DECLINED TO PARTICIPATE STATING THAT THEY WERE DEBATING THEIR POSITION INTERNALLY AND PLANNED TO PUBLISH AN OFFICIAL STATEMENT IN THE NEAR FUTURE. 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 "Huddle." ~~Twenty~~ SEVENTEEN 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.~~ 6 REPORTED HOLDING A DIRECTOR TITLE, 5 HELD A "LEAD" TITLE, 1 REPORTED A TITLE OF "CHIEF PA," OTHER TITLES INCLUDED "SUPERVISOR" AND "TRANSITION TO PRACTICE MANAGER" OR SIMPLY "PA." ALL BUT 3 RESPONDENTS HAD TITLES INDICATING THAT THEY HAD RESPONSIBILITY FOR MANAGING PAS AND NPS.

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 AND THE TWO SPECIALTIES FOR WHICH A CAQ HAS BEEN ANNOUNCED BUT NOT YET AVAILABLE were determined to be the most relevant to this discussion (Table 1). However, the ~~task force~~ COMMISSION 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 1

Specialty CAQs	Number Held*	Number of PAs in Specialty**	Estimated Percent of PAs in Specialty with CAQ ***

Cardiovascular and thoracic surgery	~~41~~ 67	~~2738~~ 2,729	~~1.5~~ 2.4
Emergency medicine	~~519~~ 1124	~~10,876~~ 13,219	~~4.8~~ 8.5
Hospital medicine	~~84~~ 199	~~2,654~~ 3,859	~~3.2~~ 5.1
Nephrology	~~19~~ 36	~~Not reported~~ 397	
Orthopaedic surgery	~~122~~ 258	~~9,071~~ 11,597	~~1.3~~ 2.2
Pediatrics	~~46~~ 78	~~1,631~~ 2,000	~~2.8~~ 3.9
Psychiatry	~~205~~ 588	~~1,033~~ 1,887	~~19.8~~ 31.2
DERMATOLOGY	N/A	4,350	N/A
HOSPICE & PALLIATIVE	N/A	3,859	N/A

*NCCPA as of ~~December 2016~~ NOVEMBER 2021 from a data set with a reported denominator of ~~~115,500~~ 148,560.

~~Specialty-specific data not yet published~~

** NCCPA ~~2015~~ 2021 Statistical Report with an overall denominator of ~~108,717~~ 148,560

*** Calculated using different data sets so valid only as a rough estimate

Table 2: Interprofessional PA-eligible Specialty Certifications*

Credential	Sponsor
Advanced Cardiac Life Support (ACLS)	Various
Advanced Trauma Life Support (ATLS)	Various
~~Basic Life Support (BLS)~~	~~Various~~
Pediatric Advanced Life Support (PALS)	Various
Approved Clinical Supervisor (ACS)	Center for Credentialing & Education
Registered Diagnostic Medical Sonographer (RDMS)	American Registry for Medical Diagnostic Sonography
Board Certified Advanced Diabetes Management (BC-ADM)	American Association of Diabetes Educators
Certified Clinical Densitometrist (CCD)	International Society for Clinical Densitometry
Certified Diabetes ~~Educator~~ CARE AND EDUCATION SPECIALIST ~~(CDE)~~ (CDCES)	~~National~~ Certification Board ~~of~~ FOR Diabetes ~~Educators~~ CARE AND EDUCATION
Certified Menopause Practitioner (NCMP)	North American Menopause Society
HIV Specialist™ (AAHIVS)	American Academy of HIV Medicine

Fellow of the American College of Critical Care Medicine (FCCM)	American College of Critical Care Medicine
Master of the American College of Critical Care Medicine (MCCM)	American College of Critical Care Medicine
Multiple Sclerosis Clinical Specialist (MSCS)	The Consortium of Multiple Sclerosis Centers
Board Certified Specialist in Obesity and Weight Management	Commission on Dietetic Registration

*These certifications were uncovered during our environmental scan, but the list is not intended to be exhaustive

Results

Of the ~~24~~ 6 specialty organizations ~~and special interest groups~~ responding to the questionnaire, ~~only 10~~ 2 organizations had official positions ~~on specialty certification, and of these organizations, eight were officially opposed~~ ENDORSING THE CAQ IN THEIR SPECIALTY. ~~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~~, AND THE SOCIETY OF DERMATOLOGY PAS are the only AAPA-affiliated specialty organizations with a position endorsing the CAQ in their specialty. THE ASSOCIATION OF PAS IN PSYCHIATRY HAD PREVIOUSLY INDICATED THAT THEY ENDORSED THE CAQ. HOWEVER, CURRENT LEADERSHIP IS UNAWARE OF A PREVIOUS ENDORSEMENT AND FEELS THAT THE TOPIC MERITS PERIODIC REASSESSMENT. 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.~~ USING THE CREDENTIAL AS A MARKER FOR PATIENT SAFETY AND QUALITY, THREE ORGANIZATIONS INDICATED THAT THEY FELT THAT THIS USE OF THE CAQ WAS INAPPROPRIATE,TWO FELT IT WAS APPROPRIATE AND ANOTHER ORGANIZATION WAS UNSURE. WHILE THERE WAS A GREATER RANGE OF OPINIONS THAN IN 2017, 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 Model

~~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~~ PROFESSIONALS, 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~~ CONFERS CME/CE CREDITS ANDAWARDS 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 ~~3000~~ 2,000 TO 4,000 hours of experience in the field DEPENDING ON THE SPECIALTY, 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. (12) 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 IN A SPECIALTY POSITION, 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 PROMOTION FOR PAS WITHOUT THE CREDENTIAL WHO ARE OTHERWISE DESERVING OF PROMOTION, 5) 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. (13)(14)(15)(16) They are in current use among U.S. medical students, residents, and fellows, and their potential for the PA profession is being explored. (17) Unlike current specialty certifications that document that an individual has passed a knowledge test, a portfolio SUCH AS AAPA'S "PA 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. (18) 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. (19) 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. MICROCREDENTIALLING AND DIGITAL BADGING ARE AN EMERGING TECHNOLOGY THAT ALLOWS THE HOLDER OF THE CREDENTIAL TO SHARE IT IN ELECTRONIC FORMATS IN A WAY THAT ALLOWS AN ASSESSOR TO AUDIT IT BACK TO THE ISSUER AND MAY ENHANCE THE CREDIBILITY

OF FORMALLY ASSESSED COMPETENCIES COMMUNICATED IN AN ELECTRONIC PORTFOLIO.

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.

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2022-B-03-MI **Increased CME Credit for Precepting**

2022-B-03 Resolved

Amend policy HP-3200.3.3.1 as follows:

The preceptors of entry-level accredited PA programs may earn two Category 1 credits per week for each PA student they precept. The preceptor may earn a maximum of ~~20~~ 30 Category 1 credits during any single calendar year.

Rationale/Justification

High quality clinical preceptorships are a mainstay in the PA educational process. Preceptorships protect the future of the PA profession by providing opportunities for patient engagement through clinical mentorship and ensuring competency upon graduation. The issue of clinical preceptor shortage has been an ongoing issue for many years and is constantly compounded by the increased number of PA programs opening annually across the nation. Due to this and the crowding of medical educational settings by non-PA students, such as medical students and nurse practitioner students, the shortage has become even more visible. Currently, there are 282 accredited PA programs with more in various stages of formation. The ever-growing number of programs have greatly increased the need for high quality preceptors.

A variety of techniques are utilized to recruit and retain preceptors including compensating them and programs offering titles such as adjunct or affiliated professor. While these incentives can be useful not all programs are able to offer financial compensation to incentivize preceptorships. Due to this, increased CME credit might be a useful tool to somewhat even the playing field between programs.

Some examples of continuing education credit offered by other professions include:

- In four weeks, an NP can earn 25% of the total credits required for an entire five-year cycle
- Osteopathic physicians earn CME for precepting on an hour-for-hour basis. After only 24 clinical hours of precepting, osteopathic physicians achieve the maximum allowable hours for precepting and satisfy 20 percent of required CME for an entire three-year CME cycle.

In contrast, it takes PAs months in order to accrue a substantial amount of CME hours through precepting despite the many sacrifices that are required to be an effective preceptor. Additionally, even with the improvements to the allotment of CME hours available for preceptor in 2019, PA preceptors are still unable to attain the required amount of Category 1 CME for their two-year cycle even if the PA preceptors continuously precept multiple students.

In order to preserve the quality of clinical rotations available for our future colleagues, it is crucial that we put more weight into the importance of precepting and educating the future of our profession.

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Related AAPA Policy:

HP-3200.3.2
AAPA believes that it is vital for graduate PAs to be involved in the education of student PAs. This involvement may include but is not limited to 1) recruitment of new students 2) participation in the selection of new students 3) classroom instruction and 4) clinical preceptorship. AAPA will, through its publications, programs and services, encourage its members to actively participate in these educational opportunities.
[Adopted 1994, amended 2004, reaffirmed 1999, 2009, 2014, 2019]

HP-3200.3.3
AAPA supports approved PA programs in awarding category 1 CME to graduate PAs whose precept PA students.
[*Adopted 2014*]

HP-3200.1.6
PA Student Supervised Clinical Practice Experiences - Recommendations to Address Barriers
[*Adopted 2017, amended 2018*]

Possible Negative Implications

None

Financial Implications

AAPA is already providing CME credit for precepting and no additional cost is anticipated.

Attestation

I attest that this resolution was reviewed by the submitting organization/s Board and/or officers and approved as submitted (commissions, work groups and task forces are except).

Signature

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2022-B-04-MI **PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers**

2022-B-04 Resolved

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

Rationale/Justification

The existing policy paper was updated to reflect continued issues of competition and Supervised Clinical Practice Experiences (SCPEs) shortage. The goal of amending HP-3200.1.6 is to make it an evergreen piece of AAPA Policy since it appears that SCPE shortage will not be a short-term issue.

Related AAPA Policy:

HP-3200.3.2

AAPA believes that it is vital for graduate PAs to be involved in the education of student PAs. This involvement may include but is not limited to 1) recruitment of new students 2) participation in the selection of new students 3) classroom instruction and 4) clinical preceptorship. AAPA will, through its publications, programs and services, encourage its members to actively participate in these educational opportunities.
[Adopted 1994, amended 2004, reaffirmed 1999, 2009, 2014, 2019]

HP-3200.3.3.1

The preceptors of entry-level accredited PA programs may earn two Category 1 credits per week for each PA student they precept. The preceptor may earn a maximum of 20 Category 1 credits during any single calendar year.
[Adopted 2019]

HP-3200.3.3

AAPA supports approved PA programs in awarding category 1 CME to graduate PAs whose precept PA students.
[*Adopted 2014*]

HP-3200.1.6

PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers (paper on page 303)
[Adopted 2017, amended 2018, 2021]

Possible Negative Implications

None

Financial Implications

AAPA is already providing CME credit for precepting and no additional cost is anticipated.

Attestation

I attest that this resolution was reviewed by the submitting organization/s Board and/or officers and approved as submitted (commissions, work groups and task forces are except).

Signature & Contact for the Resolution

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PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers

(Adopted 2017, amended 2018, 2021)

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 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 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). 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 AAPA and its members to carefully review the ARC-PA standards when they come up for review and to provide feedback and suggestions regarding expansion of programs and maintenance of adequate, qualified SCPE sites.

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

Barriers to Supervised Clinical Practice Experiences

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

Competition from a steady increase in the numbers of allopathic (MD), osteopathic (DO), offshore allopathic medical students, NP, and PA students over the past several decades without a corresponding increase in the number of preceptors and SCPE is a second barrier to SCPE. This interprofessional competition leaves existing SCPE overwhelmed with students causing interprofessional competition for such sites. According to the Association of American Medical Colleges (AAMC), there were 86,746 medical students enrolled in United States osteopathic and allopathic medical programs during the 2015-2016 school year (Association of American Medical Colleges, 2015). There has also been a steady increase in U.S. medical student enrollment for the past decade. Since 2006-2007, there has been a 16 percent increase in the total

number of matriculated medical students (12). These figures do not include medical students at offshore allopathic medical schools (i.e., those in the Caribbean and other countries) who send many of their students to the U.S. to complete clinical training. There are two accrediting bodies for offshore medical schools, the Accreditation Commission on Colleges of Medicine (ACCM) and the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP). These governing bodies currently accredit 15 medical schools with more than 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 programs have experienced EXPONENTIAL GROWTH OVER THE LAST FEW DECADES. ~~a similar growth rate over the past decade. At the time that this report was submitted, ARC-PA reported 282 218 accredited programs with additional programs expected to be accredited at its March 2017 meeting. This includes 154 with full accreditation, 64 55 with provisional status, and 18 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, t~~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~~ MOST OF THESE PROGRAMS REQUIRE HEALTHCARE EXPERIENCE INCLUDING "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, AAPA's Board of Directors (BOD) established a Joint Task Force (JTF) between AAPA and PAEA "to investigate factors that affect practicing PAs' ability to serve as preceptors for PA students, identify opportunities to improve policy to support preceptorship, and collaborate with PAEA efforts to develop innovative and practical long-term approaches to increase availability and accessibility of sustainable clinical education models for PA students." The AAPA-PAEA Joint Task Force (JTF) is made up of students, early career PAs, experienced PAs, PAs in hospital administration, and PA educators. The JTF held monthly meetings beginning in October 2016 to discuss barriers and possible solutions to shortages regarding SCPE. Additionally, they conducted an informal survey of external stakeholders to gather a wide

range of input and ideas regarding the matter, the results of which are reviewed below. The JTF used this survey and direct inquiry to investigate current incentives for precepting students in a clinical setting, and they also reviewed publicly available policy from other PA organizations such as the Accreditation Review Commission on Education for the PA (ARC-PA) and National Commission on Certification of PAs (NCCPA). The JTF utilized the research and information gathered to revise and present this policy paper for consideration in the 2017 HOD.

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

Obligation to Precept

Overwhelmingly, respondents felt that precepting PA students is an excellent way to contribute to the growth of the PA profession and to give back to the profession. However, many disagreed with the use of the word 'obligation.' Those that agreed commented that it was a meaningful way to pass on knowledge gained through years of practice to incoming PAs, as well as an excellent means to keep one's medical knowledge current. Medicine is a profession of lifelong learning, and precepting students engages this critical function daily. These respondents indicated that students can bring a fresh attitude to the profession and remind preceptors of why they chose to become PAs.

Several individuals, however, argued that some PAs are not strong in teaching or are not motivated to teach, thus a precepting mandate would not necessarily ensure quality SCPE. Additionally, some students commented that they would rather learn from a preceptor who is

genuinely engaged in teaching and possesses a desire to precept. Some indicated that PAs' true professional obligation is to the care of their patients; if they perceive that precepting detracts from that, then they should not precept. Additionally, these respondents cited time constraints and difficulty honoring the high volume of precepting and shadowing requests as additional reasons that PAs should not be obligated to precept.

Top Barriers to Precepting and How to Minimize These Barriers

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

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

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

Respondents offered some suggestions for how to minimize each of these barriers. As to time and space, they recommended sharing students among providers, not requiring students to see every patient an individual preceptor treats, having students perform necessary chart and results review, and utilization of scribes by the provider if available. Although peer-reviewed research is limited, utilization of trained medical scribes has shown the potential to decrease the amount of time spent on required patient documentation, therefore potentially enabling the practitioner to focus more on the SCPE educational process (18). In support of the concept of student sharing among providers, The Liaison Committee on Medical Education (LCME) requires that MD students receive some interprofessional training. This could be used to leverage inclusion of PAs on MD training teams (19). Many of the ideas concerning remedies for loss of productivity or financial cost echo the suggestions for creating an efficient, time effective workspace. In addition, it is critical for organizations like AAPA and PAEA to work with healthcare systems and providers to help them understand how to incorporate student education and training into their systems. It is important to provide support for the numerous motivated and

productive PAs who are willing to precept PA students without risk of financial penalty (i.e., loss of time and RVUS).

One of the most commonly cited concerns among survey participants was the lack of clear understanding about the expectations of precepting a student. While some of these expectations are specific to each program, many aspects of precepting are universal. Respondents repeatedly suggested that a standard precepting toolkit or workshops that guide preceptors in the basic requirements of teaching PA students would be beneficial. This could be achieved through the development of a standardized "PA student passport" or educational checklist that would be common to all PA students and that might include a summary of a student's didactic education and the skills that PA students are reasonably expected to perform. This could also be achieved by the implementation of Entrustable Professional Activities (EPAs) into PA education, which will be further discussed in the section on Long-Term Solutions. Survey participants also reported wanting more resources regarding best practices and teaching in a clinical setting.

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

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

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

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

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

Increasing the amount of AAPA Category 1 CME credit offered to PA preceptors was one of the most common suggestions. Currently, ~~two~~ AAPA Category 1 CME credits can be earned ~~weekly~~ for every PA student precepted. ~~A limit of 20 Category 1 CME credits can be earned per calendar year, contributing to the minimum requirement of 50 Category 1 CME credits every two years.~~ This increase in CME value might incentivize more PAs to take PA students for SCPE. 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 the potential to distribute student placement nationwide recognizing that there may be issues relating to contractual agreements between PA programs and clinical sites as well as federal legislation to be considered. In turn, this program could be utilized as a workforce pipeline for PAs by training PA students in communities with underserved patient populations, enabling new PAs to effectively address healthcare shortages. In order to ensure proper implementation of such a system inter-organization cooperation is paramount.

The value of precepting PA students can also be emphasized through a paradigm shift in the way precepting is marketed to the healthcare community, focusing on emphasizing the value of precepting students. In the long term, precepting PA students offers the potential for added value for health systems rather than a burden. In the stakeholder interviews, it was noted that

early exposure of PA students to future employers (i.e., health systems, private practices, etc.) can improve patient flow, provide patient education, address patient safety issues, and help with charting and medical documentation.

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

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

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

An additional innovation receiving increased attention in PA education is Entrustable Professional Activities (EPAs). EPAs describe ‘units of work’ that a student or graduate should be able to perform at a certain level of education, distinct from competencies which describe abilities. According to Lohenry et al., EPAs “answer the question, ‘What can a PA, medical graduate, or medical resident be entrusted to do?” (23) This concept has been used in medicine in order to bridge the gap between skill level and preparation of medical graduates and expectations of residency programs. Likewise, it may serve the same purpose in PA education to bridge a gap between didactic and clinical education and between graduation and employment. It would allow competency-based training, with the possibility that some students would meet program educational goals more quickly. This might result, in some cases, with students progressing to graduation with a requirement for less time in clinical settings while still meeting program goals. It could result in the need for fewer preceptors. The potential of this concept will become clearer as programs adopt EPAs and explore the impact they will have on PA education.

The Unique Position of AAPA in Working Toward a Solution

AAPA is the only national organization that represents PAs~~. With approximately 40,000 fellow members, AAPA is~~ MAKING THE ORGANIZATION ~~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):
- Preceptor of the Year Award:
- Category 1 CME Credit

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.

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2022-B-05-OH **Identifying and Cultivating CORE Leadership Skills for PAs**

2022-B-05 Resolved

AAPA strongly encourages PAs to become active leaders in administrative roles of their practice. To enhance the preparation of future PA Administrators, AAPA shall create a task force to identify CORE leadership skills and competencies required for entering an administrative role and develop learning modules containing such skills to be available as part of PA's continual leadership development.

Rationale/Justification

For over 15 years, AAPA has partnered with healthcare systems to offer conferences for PAs interested or participating in administrative management. (ELC, CCHS Executive Management meetings, Wake Forest, ASU, etc.).

AAPA strongly believes that PAs should be in management and administrative positions. And to this belief, AAPA has offered great executive leadership conferences.

Yet, each of these conferences had a wide level of experiences among the attendees. Some had no experience and were just beginning to be interested in management and others had years' experience and found some of the topics to be basic.

And although we have offered great topics, the actual CORE skills required to be comfortable within an administrative position still eludes most PAs.

CORE skills such as "how to facilitate a meeting", "presenting at the Executive Board", "business plans for beginners", "budgets for beginners", "succession planning"," understanding and using dashboards" are usually not topics in an executive conference. The task force will: first, need to identify all skills required and then cultivated each skill into a module for learning and for cultivating competency. This task force will also identify resources for enhancing skills in administration: such as Toast Masters and TED talks.

By creating modules with step-by-step learning on these topics, PAs who are interested in advancing into administration can access these and begin their management journey while also taking more formal educational activities: MBA, MHA, Doctorates, and ELC conferences.

Related AAPA Policy

HP-3400.2.4

AAPA shall promote the PA profession to hospital administrators, senior executives, and other healthcare leaders as critical to delivering high quality, safe, team based patient-centered care that improves patient access, patient experience and quality outcomes across the healthcare continuum.

[Adopted 2000, reaffirmed 2005, amended 2010, 2015, 2020]

HP-3400.3

AAPA encourages all healthcare accreditation organizations to recognize, support and endorse

the role of PAs in every healthcare facility they accredit and strongly encourages those organizations to include PAs in their accreditation language.
[Adopted 2019]

Possible Negative Implications
None

Financial Impact
Module creation may incur expense. Volunteers will create content. Creating the task force will incur expenses.

Attestation
I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature
Michell McDiffett
President, OAPA

Contact for the Resolution
Josanne K. Pagel
Delegate, OAPA
pagelrosa@aol.com

2022-B-06-GRPA **Replacement Policy for the Importance of PAs in Executive Leadership Policy Paper**

2022-B-06 Resolved

AAPA supports life-long learning and professional development for PAs that will enhance advancement opportunities in senior and executive leadership roles. The profession encourages all PAs that are interested in executive leadership to seek educational opportunities that will augment the strong PA clinical foundation and provide future opportunities to advance the profession and improve patient-care systems.

Rationale/Justification

With GRPA and PAAMS consensus, the policy paper titled *The Importance of PAs in Executive Leadership* (paper on page 299) is being recommended for expiration. PAs now serve in leadership roles at many levels and a specific policy paper is no longer felt necessary. The above language is recommended as a replacement policy to simplify the AAPA position on the support, role and contributions of PAs serving in Executive Leadership in healthcare.

Related AAPA Policy

HP-3300.2.0 Non-Clinical

HP-3300.2.1

AAPA values the involvement of PAs in AAPA who, although not practicing clinically, remain involved in positions related to healthcare delivery, including, but not limited to, health professional education, healthcare administration, healthcare policy or regulation, or serving in an elected capacity in government.

[Adopted 2000, reaffirmed 2005, 2010, 2015, 2021]

HP-3300.2.2

AAPA encourages PAs to-seek election to federal, state, and local office.

[Adopted 2012, amended 2017]

HP-3300.2.3

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

[Adopted 2000, reaffirmed 2005, 2010, 2015, 2020]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

Nichole Bateman, MPAS, PA-C
Chair, Government Relations and Practice Advancement Commission
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2022-B-07-OH **Development of Transition to Practice Programs/Onboarding Templates**

2022-B-07 Resolved

AAPA should create a task force to develop a model Transition to Practice program template to assist healthcare systems and practices to successfully onboard their newly hired graduate PAs and to assist with existing PA staff who want to change specialties and may require some additional onboarding and training.

Rationale/Justification

TTP is NOT a residency program.

Usually, residencies are open to any and all providers throughout the US. A health system may offer a residency in a specific service in which they shine. Attendees to the residency program do not tend to stay within that specific health system unless there are offers to do so. A TTP program is provided by the health system who is hiring the provider into their system as permanent employment. They usually are given a full salary and benefits and encouraged to be involved in all employment activities to enhance their onboarding.

Definitions and differences:

ONBOARDING
The act or process of orienting and training a new employee.

TRANSITION TO PRACTICE
A standardized system wide onboarding for all new graduate PA who have been hired as fully credentialed and privileged employees. Runs for about a year and is designed to ease a PA provider from academia to patient care. Designed to increase retention of the new employee, acclimating them to the health system while ramping up their skill levels. Integrates them into every aspect of the health system.

ORIENTATION:
To acquaint with existing situation or environment
To direct towards the interests of a particular group

RESIDENCY:
A program of training in a specific specialty/service, offered to licensed providers. Usually lasts a year and does not guarantee continued employment at the facility of training. Facility may hire them permanently if have open positions, most return to their home systems.

Many health systems just orient newly hired PA graduates in a 90 day probation period. Most times, expecting the new hire to carry a full patient load at the end of that 90 days. This can set the newly hired graduate up for failure and often times leads to the PA leaving the system. This exodus from the system is costly at times up to $250,000 in investing the time to onboard.

With a transition to practice program, the new graduate is mentored for an extended period of time, usually up to a year. This mentoring includes hands on trainings, lectures and case studies all while becoming more and more comfortable and competent in patient care.

The new Graduate is not given a full schedule of patients during this time, but instead it scaled up throughout the first year according to their skill level.

The TTP program is specifically designed to assist newly hired employees' success in their first year of employment.

A successful TTP program has been shown to increase retention of newly hired PAs, enhancement of quickly obtained competencies and increased engagement of the PA employee.

With AAPA strategic vision involving OTP for all PAs, each health system and constituent chapter will be tasked with explaining how a new graduate can be competent to see patients with full autonomy. A transition to practice program answers this concern.

Related AAPA Policy

HP-3400.2.4

AAPA shall promote the PA profession to hospital administrators, senior executives, and other healthcare leaders as critical to delivering high quality, safe, team based patient-centered care that improves patient access, patient experience and quality outcomes across the healthcare continuum.

[Adopted 2000, reaffirmed 2005, amended 2010, 2015, 2020]

HP-3400.3

AAPA encourages all healthcare accreditation organizations to recognize, support and endorse the role of PAs in every healthcare facility they accredit and strongly encourages those organizations to include PAs in their accreditation language.

[Adopted 2019]

Possible Negative Implications

None

Financial Impact

Template creation may incur expense. Volunteers will create content. Creating the task force incurs expenses.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature

Michell McDiffett
President, OAPA

Contact for the Resolution

Josanne K. Pagel
Delegate, OAPA
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2022-B-08-HOTP **Reproductive Healthcare Restrictions**

2022-B-08 Resolved

Amend policy HX-4600.6.1 as follows:

AAPA opposes RESTRICTIONS OR attempts to restrict the availability of reproductive healthcare.

Rationale/Justification

Since this policy was originally adopted, there have been restrictions placed on the availability of reproductive healthcare, for example, in 2021 in Texas with SB 8. This law both ban abortions after 6 weeks of pregnancy as well as allows individuals to sue others participating in obtaining or providing abortions. Abortions are a safe and essential part of reproductive healthcare.

Aligning with the statement from The American College of Obstetricians and Gynecologists,

> SB8 will dissuade clinicians in the state of Texas from providing patients with the medical care that they need and will clearly violate the patient-physician relationship. Clinicians should be able to provide patient-centered, evidence-based care and counsel, and patients should be able to access the care and information they need without fear of retribution. Such legislative interference will ultimately discourage compassionate, skilled clinicians from practicing in the state of Texas, further compromising patient access to care.

This will impair individual's access to safe healthcare, and thus, endangering patients. The previous statement is outdated due to these restrictions that are being sustained by the courts. Whether or not this law continues to be upheld by the court system, the policy needs to be expanded for future protection from successful restrictions.

"ACLU News & Commentary." *American Civil Liberties Union*, https://www.aclu.org/news/reproductive-freedom/heres-what-to-know-about-texas-radical-new-abortion-ban/

"Statement on Texas SB8." *ACOG*, https://www.acog.org/news/news-releases/2021/09/statement-on-texas-sb8.

"Texas SB8: 2021-2022: 87th Legislature." *LegiScan*, https://legiscan.com/TX/text/SB8/2021.

Related AAPA Policy

HX-4600.6.4
AAPA supports equitable and confidential access to comprehensive sexual and reproductive health information and services, to include family planning and birth control options, that are evidence-based, developmentally appropriate, culturally sensitive, and available in a telehealth capacity when face to face
care is not optimal.
[Adopted 1983, reaffirmed 1990, 1995, 1999, 2005, 2010, 2015, amended 2020]

HX-4600.6.5
AAPA believes all PAs should advocate for and promote evidence-based reproductive and sexual health interventions in order to prevent unintended pregnancies and sexually transmitted infections. AAPA should advocate to ensure that reproductive and sexual health promotion and preventive interventions are available via telehealth technology.
[Adopted 2005, reaffirmed 2010, amended 2015, 2021]

HP-3700.1.2
Guidelines for Ethical Conduct for the PA Profession (paper on page 191)
[Adopted 2000, reaffirmed 2013, amended 2004, 2006, 2007, 2008, 2018]

> p.197 Reproductive Decision Making
> "Patients have a right to access the full range of reproductive healthcare services, including fertility treatments, contraception, sterilization, and abortion. PAs have an ethical obligation to provide balanced and unbiased clinical information about reproductive healthcare. 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."

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for the Resolution
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2022-B-09-HOTP **Breastfeeding**
(Referred 2021-C-14)

2022-B-09 Resolved

Amend policy HX-4200.1.5 as follows:

AAPA endorses exclusive breast OR CHEST feeding ~~when possible,~~ for about the first 6 months of life. CONTINUED BREAST/CHEST FEEDING (ALONG WITH COMPLEMENTARY FOOD INTRODUCTION) UNLESS MEDICALLY CONTRAINDICATED, IS RECOMMENDED FOR AT LEAST THE FIRST YEAR OF THE INFANT'S LIFE AND THEN AS MUTUALLY DESIRED BY THE PARENT AND INFANT. ~~followed by breastfeeding with complementary food introduction until at least 12 months of age.~~

Rationale/Justification

The proposed amendment aligns with American Academy of Pediatrics (AAP) and American Academy of Family Physician (AAFP) and the Academy of Breastfeeding Medicine (ABM) policy statements addressing breastfeeding and the use human milk 1, 2,3. In addition, the recommendation includes omission of the language "when possible" as this expression is not defined nor is it clear who determines what is possible. This resolution has language similar to AAP and other professional medical organizations, is more patient-centered and supportive of mother-infant preferences.

The recommendation to support breastfeeding is data driven, and the previously submitted wording enforces the current statement from AAP on breastfeeding which reads: "The AAP reaffirms its recommendation of exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant."

In making these changes, consideration of families who are unable to provide human milk because of a medical contraindication is respected.

We aim to address gender neutrality by adding in chest feeding, which is acceptable language and referenced by the La Leche League in support of a term used by many transmasculine and non-binary parents to describe how they feed and nurture their children from their bodies. We also removed the term mother and replaced with "parent".

The World Health Organization advocates for exclusive breastfeeding for 6 months has many benefits for the infant and mother. Longer durations of breastfeeding also contribute to the health and well-being of mothers: it reduces the risk of ovarian and breast cancer and helps space pregnancies–exclusive breastfeeding of babies under 6 months has a hormonal effect which often induces a lack of menstruation. Another important benefit of breastfeeding is protection against gastrointestinal infections which is observed not only in developing but also industrialized countries 4.

The resolution was reviewed by the Association of PAs in Obstetrics & Gynecology, Society for PAs in Pediatrics and LGBT PA Caucus.

Related AAPA Policy

HX-4200.1.1
AAPA endorses the use of the U.S. Department of Health and Human Services' report Healthy People and its subsequent initiatives which serve as a guide to improve the health of the nation. All PAs should become familiar with the goals and objectives of Healthy People initiatives to improve health promotion, health equity, and disease prevention in their communities.
[Adopted 2002, amended 2007, 2012, reaffirmed 2017]

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.
[Adopted 1991, reaffirmed 1996, 2001, 2004, 2009, 2014, 2019]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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References

1. Eidelman, A. et al Breastfeeding and the Use of Human Milk Pediatrics (2012) 129 (3): e827–e841https://publications.aap.org/pediatrics/article/129/3/e827/31785/Breastfeeding-and-the-Use-of-Human-Milk

2. American Academy of Family Physicians. Breastfeeding, Family Physicians Supporting (Position Paper). Am Fam Physician. 2015 Jan 1;91(1):56-57 https://www.aafp.org/afp/2015/0101/afp20150101p56.pdf

3. Chantry, CJ, Eglash A, Labbock, M. ABM Position on Breastfeeding—Revised 2015 Breastfeeding Medicine, Volume 10, Number 9, 2015 https://www.bfmed.org/assets/DOCUMENTS/abm-position-breastfeeding.pdf

4. World Health Organization. Infant and young child feeding (Fact sheet N°342, Updated February 2014). https://www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding

2022-B-10-HOTP **Button Battery Safety**

2022-B-10 Resolved

AAPA supports the legislation and the use of safety-related labeling for button/coin batteries and more secure closure of compartments of products containing a button/coin battery.

Furthermore, AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines to current didactic curriculum of PA programs and continuing medical education for practicing PAs.

Rationale/Justification

Each year in the United States, more than 2800 children are treated in the ER after ingesting button battery (safekids.org). According to a recent report from the U.S. Consumer Product Safety Commission, ER-treated injuries related to button batteries rose by 93% among young children (ages 5 to 9) in 2020. Button battery ingestions result in significant morbidity and mortality in children before, during, and even after removal[1]. Serious and fatal complications include but are not limited to esophageal injuries, pneumothorax, aspiration pneumonia, vocal cord paralysis, and esophago-tracheal fistula[2]. Unfortunately, diagnosis and management can become delayed due to clinical presentation of vague symptoms and often unknown history of ingestion[3]. This calls for support of legislations such as Reese's Law to direct the Consumer Product Safety Commission to create safety standards that prevent accidental ingestion of button batteries in children ages six and younger.

These safety standards call for the Consumer Product Safety Commission to:

- Create performance standards requiring the compartments of a consumer product containing button cell or coin batteries to be secured in order to prevent access by children who are six years of age or younger.
- Require warning labels in literature accompanying the product, on the packaging, and directly on the product when practical so it is visible.
- Require warning labels to clearly identify the hazard of ingestion.
- Require warning labels that instruct consumers to keep new and used batteries out of the reach of children, and to seek immediate medical attention is a battery is ingested.

As PAs, we need to quickly recognize and appropriately manage button/coin battery ingestions and aspirations to prevent severe complications that may arise from prolonged exposure. Therefore, AAPA encourages incorporating education on recognition of symptoms and treatment guidelines.

With more awareness of the issue, education on prevention, mitigation of complication, and legislations on the labeling of the product, we expect to increase recognition of the injury patterns associated with button/coin battery ingestion, increase provider competency in management and treatment, and reduce morbidity and mortality from button/coin battery ingestion.

Related AAPA Policy

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 and adverse reactions, indications for usage, and contraindications. For those products not regulated by the FDA, AAPA strongly encourages manufacturers to provide consumers with information on the quality of a product and to be in compliance with the United States Pharmacopeia Standards
[Adopted 1982, reaffirmed 1990, 1995, 2009, 2014, amended 2000, 2004, 2019]

HX-4600.7.6
AAPA supports labeling and child-proof packaging of cannabinoids and cannabinoid related products and that limits advertising to adolescents
[Adopted 2016, amended 2021]

Possible Negative Implications

Button/coin battery manufacturers may argue against this policy because of the increased costs associated with additional labeling and product management. However, the benefit outweighs the cost associated with lawsuits from accidental button/coin battery ingestion.

Financial Impact

None

Signature & Contact for the Resolution.

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Co-sponsors

PAs for Women Empowerment
Texas Academy of PAs

References

1. Hoagland MA, Ing RJ, Jatana KR, Jacobs IN, Chatterjee D. Anesthetic Implications of the New Guidelines for Button Battery Ingestion in Children. *Anesth Analg.* 2020 Mar;130(3):665-672. doi: 10.1213/ANE.0000000000004029. PMID: 30829672.

2. Krom H, Visser M, Hulst JM, Wolters VM, Van den Neucker AM, de Meij T, van der Doef HPJ, Norbruis OF, Benninga MA, Smit MJM, Kindermann A. Serious complications after button battery ingestion in children. *Eur J Pediatr.* 2018 Jul;177(7):1063-1070. doi: 10.1007/s00431-018-3154-6. Epub 2018 May 2. PMID: 29717359; PMCID: PMC5997112.

3. Sethia R, Gibbs H, Jacobs IN, Reilly JS, Rhoades K, Jatana KR. Current management of button battery injuries. *Laryngoscope Investig Otolaryngol*. 2021 Apr 15;6(3):549-563. doi: 10.1002/lio2.535. PMID: 34195377; PMCID: PMC8223456.

4. United States Consumer Product Safety Commission, Hospital Emergency Room Treatment for Some Product-Related Injuries Rose During the Pandemic, Even as Overall ER Visits Dropped Press Release, March 2021, https://www.cpsc.gov/Newsroom/News-Releases/2021/Hospital-Emergency-Room-Treatment-for-Some-Product-Related-Injuries-Rose-During-the-Pandemic-Even-as-Overall-ER-Visits-Dropped

5. SafeKids battery safety tips https://www.safekids.org/safetytips/field_risks/batteries

2022-B-11-HOTP **Cannabinoids**
(Referred 2021-C-24)

2022-B-11 Resolved

Amend policy HX-4600.7.3 as follows:

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

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

Rationale/Justification

Choosing to replace the term “marijuana” with cannabinoids for two reasons primarily:
1) The Mexican term 'marijuana' is frequently used in referring to cannabis leaves or other crude plant material in many countries.
2) Cannabinoids are a group of substances found in the cannabis plant. Including THC and CBD.

Thirty-one states and the District of Columbia have decriminalized the possession of small amounts of marijuana for personal consumption. In these states, possession is treated as a civil or local infraction (or a minor misdemeanor with no jail time), instead of a crime. Eighteen states have legalized medical marijuana along with D.C., Guam, Puerto Rico and US Virgin Islands. Medical marijuana is not FDA approved but can be sold in dispensaries. In addition, several states are trying to balance regulating a legal marijuana market for adults while preventing access by children. This includes requiring identification checks at dispensaries, prohibiting anyone under age 21 inside dispensaries, requiring child-resistant packaging of cannabis products and prohibiting the use of marijuana in public.

Policy words and phrasing discussed with and agreed upon by the Society of PAs in Addiction Medicine.

Resources

https://www.ncsl.org/bookstore/state-legislatures-magazine/marijuana-deep-dive.aspx
https://www.britannica.com/plant/cannabis-plant
https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd#whatare
https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/drugs-psychoactive/cannabis
https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids-what-you-need-to-know
UpToDate: Cannabis (marijuana: Acute Intoxication, Accessed 1/3/2021

Related AAPA Policy

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 the status of cannabinoids as a federal Schedule I controlled substance be reviewed to facilitate and allow the conducting of clinical research.
[Adopted 2009, reaffirmed 2014, amended 2016, 2021]

HX-4600.7.2
AAPA recommends that in any state where medical cannabinoids laws exist, PAs are included as healthcare providers that can authorize or recommend the use of cannabinoids for patients.
AAPA believes effective patient care requires the free and unfettered exchange of information on treatment options and that discussion of cannabinoids as an option between PAs and patients should not subject either party to criminal sanctions.
[Adopted 2016, amended 2021]

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 cannabinoids by persons who are planning to become pregnant, are pregnant, or breastfeeding and shall treat and counsel on cessation of cannabinoids.
[Adopted 2016, amended 2021]

HX-4600.7.5
AAPA discourages the non-medical use of cannabinoids by those persons under the age of 21 and discourages the non-medical use of cannabinoids by adults who are in the presence of persons under the age of 21.
[Adopted 2016, amended 2021]

HX-4600.7.6
AAPA supports labeling and child-proof packaging of cannabinoids and cannabinoid related products and that limits advertising to adolescents.
[Adopted 2016, amended 2021]

Possible Negative Implications
As accessibility increases, so does the potential for overuse and abuse by pediatric, adolescent and expectant parents.

Financial Impact
None

Signature & Contact for the Resolution

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2022-B-12- HOTP **False or Deceptive Healthcare Advertising**

2022-B-12 Resolved

Amend the policy paper entitled *False or Deceptive Healthcare Advertising.* See policy paper.

Rationale/Justification

Overall, this paper exists to condemn false counseling of healthcare information as well as the promotion of improper qualifications and unsupported medical treatments. Some of the examples originally included in the paper are outdated; this is something that will continue to occur with time depending on current practices and continued advancements. Rather than having to update it with relevant examples every five years for review, removing the examples can keep the paper pertinent continuously.

Related AAPA Policy

HP-3300.2.8.1

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, medical devices, surgical procedures, and consumer-ordered diagnostic testing may create significant patient safety concerns if it leads patients to seek healthcare solutions without consulting with a qualified healthcare professional.

PAs should:

- maintain objectivity regarding advertised pharmaceuticals, medical devices, treatments, and diagnostic testing;
- evaluate the patient's understanding of the requested entity;
- provide appropriate counseling related to the patient's request;
- maintain commitment to providing value-based and evidence-based care and only prescribe or recommend a pharmaceutical, medical device, treatment, or diagnostic test that will benefit the patient.

[Adopted 2019]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution.

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False or Deceptive Healthcare Advertising

(Adopted 2007, reaffirmed 2012, 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 that providers, including PAs, should not use deceptive practices OR ADVERTISEMENTS ~~such as photographs~~ that do not represent benefits ordinarily obtained by patients. ~~They~~ CLINICIANS 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,~~ NOR 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 ensure that their patients are exposed to accurate information so they can make informed choices about treatment.

FALSE ADVERTISING IN HEALTHCARE

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. (1)

In an era when health providers have begun to market their services aggressively, deceptive healthcare advertising poses significant risks to the public. Fraudulent claims may entice consumers to undergo costly, ineffective, and even more importantly, dangerous medical procedures. (2)

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." (3)

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. (4)

Accurate information about healthcare choices is vital to consumers. Each year, consumers spend hundreds of billions of dollars on healthcare products and services. Advertising plays an important role in informing consumers about the availability, cost, and other features of these products and services. (3)

Role of Providers

A successful provider-patient relationship is based on trust. The patient trusts that the healthcare 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. (4)

Conclusion

AAPA believes that providers, including PAs, should not use deceptive practices OR ADVERTISEMENTS ~~such as photographs~~ that do not represent benefits ordinarily obtained by patients. ~~They~~ CLINICIANS 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~~ , NOR 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 ensure that their patients are exposed to accurate information so they can make informed choices about treatment.

References

1 Federal Trade Commission Act, 15 U.S.C. §41 et seq

2 Daynard M. "Physicians and Deceptive Advertising: How Should Federal and State Regulators Respond?" Brief based on speech presented at Administrators in Medicine meeting, April 22, 1992, Cambridge, MA. https://www.clearhq.org/resources/97-4.htm Accessed February 2022

3 Bernstein J. Federal Trade Commission testimony presented before Committee on Government Reform, U.S. House of Representatives, March 1999 Agency Lockout on the Off-Label Use of EDTA Chelation Therapy". https://www.ftc.gov/sites/default/files/documents/public_statements/prepared-statement-federal-trade-commission-chelation-therapy/acamtestimony.pdf Accessed February 2022

4 American Academy of Orthopaedic Surgeons. Opinions on Ethics and Professionalism. Advertising by Orthopaedic Surgeons https://www.aaos.org/contentassets/6507ec63e5ac4ea48375ad96d154daac/1205-advertisingopiniononethicsbodapprovedjune2016.pdf Accessed February 2022

~~5 Green S. "Chelation Therapy: Unproven Claims and Unsound Theories." Quackwatch. www.quackwatch.org/01QuackeryRelatedTopics/Chelation.htm. Accessed August 2006.~~

~~6 American Psychiatric Association. Position Statement. COPP Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies). www.psych.org/psych_pract/coopptherapyaddendum83100.cfm. Accessed January 2007.~~

~~7 Federal Trade Commission. FTC Consumer Alert. "HGH Pills and Sprays: Human Growth Hype?" Washington DC. June 2006. www.ftc.gov/bcp/conline/pubs/alerts/hghalrt.pdf. Accessed August 2006.~~

~~8 U.S. House of Representatives Committee on Government Reform. Special Investigations Division. "False and Misleading Information Provided by Federally Funded Pregnancy Resource Centers." July 2006.~~

2022-B-13-HOTP **Hepatitis**

2022-B-13 Resolved

Amend policy HX-4200.2.3 as follows:

AAPA supports increased focus on addressing the Hepatitis C epidemic. This will include: alignment with Centers for Disease Control and Prevention (CDC) recommendations FOR ALL ADULTS AGED 18 YEARS AND OLDER TO BE SCREENED FOR HEPATITIS C AT LEAST ONCE IN A LIFETIME and supports the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts.

Rationale/Justification

There continue to be an ongoing epidemic of hepatitis C in the United States. The CDC reports a four-fold increase in acute hepatitis C rates from 2005–2017 with 2.4 million adults living with hepatitis C during 2013–2016 (1% of all adults). Hepatis C is the leading cause of death from liver disease and historically, highest prevalence of chronic hepatitis C among the baby boomers (those born between the period of 1945–1965. With the opioid crisis, injection drug use, new cases are occurring among young adults.

In March 2020, the U.S. Preventive Services Task Force (USPSTF) released their recommendation to screen for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.

Resources

Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. CDC Recommendations for Hepatitis C Screening Among Adults — United States, 2020. *MMWR Recomm Rep* 2020;69(No. RR-2):1–17. DOI: http://dx.doi.org/10.15585/mmwr.rr6902a1

Final Recommendation Statement Hepatitis C Virus Infection in Adolescents and Adults: Screening March 02, 2020
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening

Vital Signs April 2020 https://www.cdc.gov/hepatitis/hcv/vitalsigns/pdf/hepatitisc-vitalsigns-april2020-H.pdf

Related AAPA Policy

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 individual risk profile. Preventive services offered to patients should be evidence-based, patient-centered, and demonstrate clinical efficacy. PAs should be familiar with the most current authoritative clinical preventive service guidelines and recommendations.
[Adopted 1978, reaffirmed 1990, 1995, 2005, 2010, amended 2000, 2015, 2020]

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.
[Adopted 1991, reaffirmed 1996, 2001, 2004, 2009, 2014, 2019]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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2022-B-14-NY Interprofessional Medical Education to Incorporate the PA's Role

2022-B-14 Resolved

Amend policy HP-3200.1.7 as follows:

AAPA acknowledges the importance of interprofessional curricula that includes PA practice and the PA's role in the seamless delivery of high-quality patient care. AAPA SUPPORTS COMMUNICATION WITH RESIDENCY AND FELLOWSHIP ORGANIZATIONS (ALLOPATHIC AND OSTEOPATHIC, PHARMACY PROGRAMS) TO SUPPORT EDUCATION REGARDING THE PA'S ROLE ON THE HEALTHCARE TEAM.

Rationale/Justification

Numerous policies affecting the practice, certification maintenance, or stakeholders affected by HOD policy implementation have seen unnecessary delays and confusion after passing the HOD. To promote and assist members and stakeholders to adhere to AAPA policy, AAPA Staff will be tasked with notifying, advising, and providing resources to the members and groups affected by adopted policy.

Related AAPA Policy

None

Possible Negative Implications

None foreseen at this time.

Financial Impact

No foreseen financial impact anticipated at this time, as this policy being proposed is incorporated into AAPA Staff daily routines.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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2022-B-15-SA **Health Equity for Students Pursuing PA Education**

2022-B-15 Resolved

AAPA believes that PA students should have access to cost-free or low-cost healthcare services or coverage while pursuing PA education.

Rationale/Justification

The benefits of having access to cost-free or low-cost healthcare services or coverage are important for all students pursuing PA education. Consideration should be given to the many barriers and challenges students encounter in accessing affordable healthcare services or coverage while pursuing PA education.

In 2021, AAPA amended the Diversity and Inclusion in PA Education Resolution which emphasized AAPA's support for "affirmative action programs and other diversity enhancement initiatives in PA education" (1). Historically, PA education attracts applicants that are adult learners from a variety of backgrounds, races, ethnicities, and income levels (8). PAEA's 2020 PA Program Report 35 included data from participating PA programs across the country and showed the average age of first-year PA students to range from 25 to 39 (2). While some students may participate in health plans, having insurance coverage does not mean that coverage is adequate or is not associated with burdensome cost-sharing through premium payments, copayments, and deductibles (3). The Kaiser Commission on Medicaid and the Uninsured notes that "people who lack insurance coverage have worse access than people who are insured, and 20% of uninsured adults in 2015 went without needed medical care because of cost" (6). A 2019 study by the CDC surveying more than 33 million Americans reported 14.7% of adults aged 18–64 were uninsured (4). Furthermore, the CDC's National Center on Health Statistics (NCHS) 2020 report stated, "among adults aged 18–64, Hispanic adults (29.7%) were more likely than non-Hispanic black (14.7%), non-Hispanic white (10.5%), and non-Hispanic Asian (7.5%) adults to be uninsured" (7). In another report, the CDC's data shows, "Among uninsured adults aged 18–64, the most common reason for being uninsured, affecting approximately 7 in 10 (73.7%), was because they perceived that coverage was not affordable" (5). To date, the many healthcare-associated burdens, along with the insured, underinsured, and uninsured status of students pursuing PA education have not been adequately researched. Furthermore, for PA students, the total expenses and medical debt related to healthcare premiums and costs of medical services rendered are also not published. This is especially important as it pertains to PA students from minority groups.

PA programs across the country become enriched, diverse, and fully representational of the communities PAs serve when students from minority groups in PA education are included. AAPA's resolution to increase diversity and inclusion is important as it aims to create a well-rounded, patient-centered, culturally compassionate PA workforce. However, the noble pursuit of diversity and inclusion recognized by the AAPA does not come without challenges. PA programs likely encounter difficulties matriculating minority students and people from marginalized and disadvantaged backgrounds as these groups traditionally encounter barriers to social, financial, educational, and healthcare-related resources traditionally made available to other non-minority

groups. In 2014, PA programs reported that 7.6% of their students identify as Hispanic, Latino, or Spanish (2). In 2015, PA programs reported information as it pertains to race with an estimated (and combined) 30.6% of PA students representing non-Hispanic minority groups to include: American Indian or Alaskan Native, Native Hawaiian or Pacific Islander, Multiracial, Black or African American, Asian, Unknown, or Other (2). With these student population groups in mind, an appreciation of minority health status is key to supporting and promoting a diverse learning space and workforce for PAs.

In a 2018 study on healthcare utilization and determination of disability, it was found that a 'lack of insurance, more than any other demographic or economic barrier, adversely affects the quality of health care received by minority populations. The study adds that "Nonelderly Hispanic, black, American Indian, and Alaska Native adults remain much more likely than whites to be uninsured despite coverage gains under the ACA"….while "Black and Latino adults are more likely to live in disadvantaged neighborhoods and to have inadequately resourced schools, which yield lower educational attainment and quality…Those factors can result in some racial and ethnic minorities experiencing higher rates of chronic and disabling illnesses, infectious diseases, and higher mortality than white Americans" (6). These data reflect the inequitable access to healthcare coverage that minority members of the general population encounter and raise curiosity regarding shared experiences among minority PA students and pre-PA applicants.

In 2022, an AAPA News Central article was published on the diversity and backgrounds of PA students and found 1.7% of student respondents reported, "having a diagnosed physical or mental impairment that substantially limits my participation in educational experiences and opportunities offered by a college", and further showed, "13.9% [of respondents] came from a family that received public assistance or are currently receiving public assistance (8).

The high prices associated with marketplace insurance options make it difficult for minority, disadvantaged, low-income, and under-resourced groups to access quality healthcare services and coverage options. A 2017 article discussing inequality in the healthcare system in America supports this claim while noting, "Unequal access to medical services is likely to contribute to disparities in health status, while rising costs (for both the insured and uninsured) reduce disposable incomes, particularly burdening low-income households" (12). The article further states, "Many patients cannot afford the care they need, and often forgo medical care altogether. For example, 19% of non-elderly adults in the USA who received prescriptions in 2014 (after full implementation of the Affordable Care Act [ACA]) could not afford to fill them. Millions of middle-class families have been bankrupted by illness and medical bills" (12). The high prices associated with marketplace insurance options make healthcare coverage difficult to obtain for certain populations, with state Medicaid often being looked upon as an affordable alternative. However, strict mandatory and optional state Medicaid eligibility guidelines present their own set of unique challenges for those who wish to obtain coverage. Individual income level and individuals electing COBRA continuation are just several of the optional, not mandatory, Medicaid groups that states may elect to participate in. These, and other optional Medicaid groups may preclude PA students, especially those from low-income minority backgrounds, from qualifying (13).

The CDC's reports and myriad other data sources shed light on the need for affordable healthcare services and coverage options for minority groups in America. With AAPA's goal of diversity, inclusion, and access for minority groups in PA education who traditionally face healthcare challenges, a reasonable strategy to achieve this goal should include realistic means for students to access cost-free or low-cost affordable healthcare services and coverage options while pursuing PA education. The benefits of having cost-free or low-cost affordable access to healthcare services or coverage are important for all students pursuing PA education, with special consideration given to minority students, and in light of the price tag on PA education that continues to rise.

The cost of attendance has been on a steady rise for nearly a decade. The PAEA's Program Report 35 reflects a consistent increase in the cost of attendance among PA programs between 2013 and 2019 (2). The total cost of PA education is program-dependent and varies when consideration is given to additional expenses and fees required for attendance at each program, respectively. In 2019, health services fees comprised 28% of the total fees collected by PA Programs which marks a substantial portion of required student fees and is in addition to the costly and continuously increasing PA education tuition (2). It is important to note that PA programs may require students to furnish proof of health insurance coverage or mandate students to participate in their respective school's health insurance coverage option(s). As a result of the inconsistent coverage requirements among PA programs, a varying degree of healthcare services fees exist.

The rising cost of attendance for PA education along with the considerable healthcare service fees required by PA programs coupled with expenses related to satisfying the ongoing healthcare needs of students is worsened by interest-accruing loan disbursement funds used to afford PA education. These expenses increase the total student debt for PA students across America. While not all students utilize loans to afford PA education, outside employment may not be a realistic means of income as a result of the rigors of full-time, graduate-level PA education or PA program contracts that discourage or actively prohibit students' gainful employment while attending a PA program. As a result of income restrictions, PA students may utilize qualifying federal or private loans to afford PA education. The utilization of student loans increases the total amount borrowed per student when interest percentages are added to principal loan balances over the life of the loan(s). Furthermore, the utilization of loan disbursement funds for healthcare-related costs (e.g. monthly insurance premiums, costs for acute or chronic illness, unexpected injuries, or annual wellness visits, etc.) increases the total debt amount, per student, with healthcare costs being financed throughout the duration of a student's PA education.

An article published in 2020 looking at an eleven-year range of medical debt found, "the amount of medical debt in collections in the US based on consumer credit reports from January 2009 to June 2020, reflecting care delivered prior to the COVID-19 pandemic, and suggests that the amount of medical debt was highest among individuals living in the South and in lower-income communities" (9). This information is important and relevant to the future of the PA profession as well as current and future PA students. According to the geographic distribution data made available by the PAEA Program Report 35 in 2020, the South Region is comprised of 83 PA programs which is 35.3% of all PA programs nationwide at the time of publishing. The Lancet

further notes healthcare disparity between states and regions within the U.S. stating, "Inequality in access to care is particularly stark in Southern states. For example, in Texas, Mississippi, and Florida, adults on a low income are more than twice as likely to face cost-related barriers to care as their counterparts in Maine (a relatively poor New England state) and Massachusetts (12). This data reflects individuals who live in the Southern U.S., or those who come from lower-income households such as those from the aforementioned minority groups that will accrue more medical debt and encounter cost-related barriers for their healthcare needs.

While the AAPA has yet to take action or generate a formal statement on the topic of cost-free, low-cost, or affordable healthcare services and coverage for students entering the PA profession, other professional health-related organizations have already acknowledged the healthcare needs of students in their respective professions. The American Medical Association (AMA) created a policy titled, "Insurance Coverage for Medical Students and Resident Physicians H-295.942" which, "urges all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students" (10). Additional support for students was put forth by the American Dental Association (ADA) which, "offers no-cost disability insurance for illness/injury and Term Life Insurance for all ADA student members and resident dentists" (11). Similar to students in other healthcare professions, PA students experience the rising cost of attendance, individual healthcare costs/fees for their needs, and program fees and income restrictions enacted by PA programs amid myriad other healthcare-related expenses.

PA students are a valuable population within the greater medical community, and similar to students in other healthcare professions, they are equally deserving of their healthcare needs and associated expenses being addressed. The contributions of PA students qualify them as an integral component to the future of the PA profession and the communities PAs serve. To ensure the future of the PA profession, leaders within the PA community should acknowledge the healthcare needs of PA students by supporting cost-free, or low-cost, affordable comprehensive healthcare services or coverage for students during their initial PA education.

Related AAPA Policy

HX-4600.1.8

Promoting the Access, Coverage and Delivery of Healthcare Services (paper on page 97)

[Adopted 2018]

Possible Negative Implications

None

Financial Impact

Potential for financial impact on PA programs, should they decide to offer health coverage. No financial impact seen for AAPA.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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2022-B-16-SA **Recruitment and Retention - Amendment to Include Disabilities and Application Barriers**

2022-B-16 Resolved

Amend policy HP-3200.6.1 as follows:

In order to ensure ~~the~~ DIVERSITY OF age, gender, racial, cultural, ~~and~~ economic AND DISABILITY STATUS WITHIN ~~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, AAPA supports ongoing, systematic and focused efforts to REDUCE UNDUE BARRIERS TO ENTRY FOR APPLICANTS AND attract and retain students, faculty, staff and others from demographically diverse backgrounds.

Rationale/Justification

While these two amendments and their respective rationales are largely separate, they are being presented as a single amendment, as recommended by the House Officers, to ensure HOD proceedings can occur without sequential discrepancies in the policy statement.

In its current form, HP-3200.6.1, Recruitment and Retention, is not inclusive of healthcare providers with disabilities as a focus of diversification efforts within the PA profession. The diversification of provider experiences is critical to the delivery of high-quality, competent care, particularly to patients affected by health disparities. (1)

According to the Americans with Disabilities Act (ADA), "the term 'disability' means, with respect to an individual - (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." (2)

The specific incorporation of disability status within this policy statement is intended to reduce presumptive stereotypes that impose an undue burden on PAs with a disability status. The goal of incorporating disability status into the policy is to specifically increase the recruitment and retention of students with disabilities which, in turn, leads to better patient care outcomes. (1) Similar to how patient-provider racial concordance can improve patient outcomes in racial minority populations, patient-provider concordance in disability status can lead to greater patient satisfaction and better utilization of health services. (3)

Disability status as a demographic category underrepresented in medicine has been recognized by other peer organizations. The American Medical Association (AMA) specifically includes disability status in the policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce: "Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality..." (4) A survey distributed by the Association of American Medical Colleges revealed that 4.6% of students in MD (doctor of medicine) programs and 4.3% of students in DO (doctor of osteopathic medicine) programs disclose their disability

status to the school. (5) For PA programs, only 1.0% of students disclose their disabilities according to data collected by AAPA in 2022. (6) Considering that 26% of the adults in the United States have some type of disability, it is expected that there would be comparable representation across different medical professions. (7) These comparative statistics highlight that PA students are less likely to disclose their disability status out of fear that this metric will negatively affect their application status or impose undue bias.

Patient safety is often cited as a core concern related to the inclusion of disabled healthcare providers in diversification efforts. It should be noted, however, that the inclusion of disability status in diversity statements does not alter the expectation that such individuals are highly qualified applicants despite entitlement to legal protections and to reasonable accommodations, as dictated by the ADA. (5) Currently, the AAPA has issued a statement of support for the integration of persons with disabilities as an external house policy, but does not provide support for the specific recruitment and retention of aspiring or practicing PAs with a disability status. Including disability status as a metric in HP-3200.6.1 can dispel presumptions as to the expectations, restrictions, and qualifications of providers with a disability status so that they can be seen as peers in the medical profession.

Additionally, the student delegation feels AAPA should recognize the current barriers that PA program applicants face, and the impact this has on the profession.

In 2021, AAPA reaffirmed that "...the quality and accessibility of healthcare improves when PAs reflect the race, ethnicity and culture of the patient populations they serve" and stood in support of affirmative action programs and other diversity enhancement initiatives in PA education (15). While this current policy admirably supports the role of affirmative action in PA program recruitment and retention, there is room to further recognize the many existing barriers to PA program application and the necessity of removing these barriers in order to increase diversity and equity within PA program recruitment, retention, and the profession overall. Applicants to PA programs face many barriers during the application process including expenses and non-standard requirements related to pre-requisite courses; standardized testing; Centralized Application Service for Physician Assistants (CASPA) and supplemental application fees; access to paid application services; travel and time off of work for interviews; varied access to shadowing opportunities; lack of standardization between PA program requirements; and concerns of bias during the application process.

Perhaps the most notable barrier to PA program application and enrollment is cost. When surveyed, 43.6% of underrepresented minorities (URM) in medicine reported financing PA school as the most important barrier to admission. Furthermore, 16% specifically cited high application fees as a deterrent, and 18% stated a lack of interview travel assistance as a significant cost limitation (16). Application costs to PA school in 2022 have been estimated to range from $2,500-$5,000 when considering CASPA application fees, interviewing, and travel expenses (17). In the 2020 annual AAPA Student Survey, 30.3% of PA students reported using paid application services including personal statement editing, interview coaching, and Graduate Record Examination (GRE) preparation courses which can cost hundreds to thousands of dollars (18). In addition to the upfront cost of program application, prospective applicants must consider the increasing cost of PA education itself, with debt burdens upon graduation rising to an

estimated $131,913 (18). Acknowledgement of undue barriers to application, such as prohibitive cost, will strengthen AAPA's recruitment and retention policy and encourage innovative solutions that fit the needs of programs and communities. Examples of this can be expansion of the CASPA Fee Assistance Program; increasing scholarship opportunities at program, regional, and state levels; and equitable improvements in the application and interview processes (e.g. retaining a virtual interview option for applicants who cannot afford travel or time off of work).

Navigating non-standardized prerequisite requirements creates additional barriers for applicants. Most PA programs require similar prerequisite coursework for consideration of program acceptance; however, a smaller percentage of programs require courses that are not standardized across programs. This lack of coursework standardization requires prospective students to complete additional coursework needed at only a select number of programs which increases the total cost of pre-PA expenses and lengthens the time for prospective candidates to matriculate. For example, while 91% of PA programs will require Physiology as a prerequisite course, only 19% require Genetics (19). This is an additional financial barrier for students, especially as prerequisite course requirements continue to evolve and change. In gaining patient care experience, prospective PA students often work relatively low-paying entry-level healthcare jobs such as medical assistant, phlebotomist, scribe, emergency medical technician (EMT), and certified nursing assistant (CNA). It may be difficult for students applying to PA school to balance the acquisition of clinical experience hours while also being able to afford cost of living, prerequisite course fees, standardized tests, and saving for school. Additionally, research shows unfavorable admission bias against applicants who attended community college before attending a four-year university. A 2020 study found that while 3 of 4 students that gain admission to PA school had taken some coursework from a community college, students that attended community college *before* a four-year university were 17% less likely to gain admission to PA school (13). These students were also significantly more likely to be Black, Hispanic, and come from a disadvantaged background than their peers who never attended community college (13). Coordinated efforts to standardize pre-requisite requirements across programs represent a potential strategy for reducing related barriers and their associated costs while improving equitable outcomes within the admissions process.

Barriers to PA program application disproportionately impact URM applicants and those of lower socioeconomic status, sexual and gender minorities, applicants with disabilities, and other non-traditional applicant groups. The fear of bias during PA school admissions impacts a large percentage of the applicant pool. The 2020 AAPA Student Survey found that about 40% of students agreed or strongly agreed with feeling "concerned about bias in the application process" (18). This effect was more pronounced in students who identified as URM, sexual/gender minority, low socioeconomic status, or having a disability (14). Additionally, applicants from historically marginalized identities may lack access to support and resources during the application process. PA students who were in the low socioeconomic group were less likely to receive support from family members, friends, or academic mentors during the application process (14). Another study found that URM applicants were overall 44.6% less likely to matriculate into a PA program than their non-URM counterparts (15). The authors found evidence that requirements to take standardized testing such as the GRE are likely to be a specific barrier for URM and older applicants.

Standardized testing requirements also contribute to program requirement variability and application barriers. The GRE poses additional financial barriers including the cost of the exam itself, as well as preparatory materials and possibly time away from work to study or sit for the exam. Many PA programs have limitations on how long a standardized test result remains valid (often 5 years from the date of the exam), creating another logistical hoop for nontraditional students that may already be in the workforce. The use of the GRE to predict success in PA school is likely inadequate and unreliable; research has consistently found the GRE to be a poor predictor of PANCE success (16, 17, 18). Many PA programs already recognize standardized testing as a barrier to application. GRE requirements are decreasing in popularity with now only around half of programs requiring the GRE compared to two thirds requiring the GRE in 2015. Some schools have begun transitioning to using the Physician Assistant College Admission Test (PA-CAT) instead, which means applicants for upcoming admissions cycles could potentially sit for both standardized tests at more cost to themselves in order to have a competitive application for multiple schools. While the PA-CAT could be an improvement from the GRE in the long term, it must be validated to ensure it is a reliable predictive metric for success in PA school and the PANCE. Due to the PA-CAT still being in its infancy, little data exists in this area. Of note, there are currently no fee waivers available to help students register for the PA-CAT. Careful consideration of the value of standardized testing as an admission tool for PA school must be weighed against the barriers standardized testing poses for prospective applicants.

In its current form, HP-3200.6.1 advocates the use of targeted strategies to attract and retain students from demographically diverse backgrounds. However, this language may be narrowly interpreted as outreach initiatives specifically focused on recruitment of diverse applicants (e.g., outreach initiatives and partnerships, education to healthcare pipelines, etc.). Evidence suggests a dual approach of eliminating barriers to application (such as removing standardized testing requirements) *in addition to* targeted recruitment strategies to increase the diversity of PA program application and matriculation (19). Efforts to remove barriers to application such as providing financial, academic, and social support for underrepresented and minority applicants, working to standardize prerequisite coursework, increasing access to CASPA fee waivers, optional standardized testing, and utilization of remote interviews are tangible steps in lessening the financial and social burdens prospective students face during application to PA school.

Related AAPA Policy

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.
[*Adopted 1983, amended 2000, 2010, reaffirmed 1990, 1995, 2005, 2015, 2020*]

HP-3200.6.3

Diversity and Inclusion in PA Education (paper on page 230)
[Adopted 2004, reaffirmed 2009, 2014, amended 2021]

Possible Negative Implications

None

Financial Impact

None

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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2022-C-01-CO Support for Hemorrhage Control/Stop the Bleed Campaign

2022-C-01 Resolved

AAPA believes that PAs should (1) advocate the appropriate placement of tourniquets in public spaces; (2) support increasing government and industry funding for the purchase of tourniquets; (3) encourage the American public become trained in recognizing and stopping life-threatening hemorrhage; 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 hemorrhage control in emergency situations.

Rationale/Justification

The Stop the Bleed campaign through the American College of Surgeons was started in October of 2015 following the Sandy Hook massacre. Upon review of the injuries from this mass casualty event, it was found that the lay public did not know how to recognize or control life-threatening hemorrhage. If that knowledge had been present, lives could have been saved. [4] Hemorrhage control has the possibility to save thousands of lives every year. According to the CDC, traumatic injuries remain a leading cause of death in the US, mainly impacting the population under 45 years of age. Hemorrhage is the leading cause of death following trauma.[1] Worldwide, the WHO estimates that trauma causes millions of deaths every year with hemorrhage accounting for approximately 35% of those deaths.[2,3] Teaching the public how to effectively control hemorrhage is imperative because nearly half of traumatic deaths occur prior to the victim reaching definitive care. [5]

Since its inception, the Stop the Bleed course has trained over 1.5 million people to identify and control life-threatening hemorrhage.[4] Increased support through national organizations like the AAPA will lead to further dissemination of knowledge about hemorrhage control, increased support for the placement of tourniquets in public spaces, and decreased deaths due to traumatic hemorrhage.

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Related AAPA Policy

HX-4500.7 sets the precedent for similar policy by advocating for the training and use of CPR and AEDs.

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, 2018]

Possible Negative Implications

None

Financial Impact

None

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature

Rachel Weinzimmer, PA-C
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2022-C-02-TX **Immunizations in Children and Adults**

2022-C-02 Resolved

Amend the policy paper entitled *Immunizations in Children and Adults*.
See policy paper.

Rationale/Justification

The current policy paper provides detailed information on the influenza virus, its prevention, and other general recommendations regarding other preventable communicable illnesses and their respective vaccine schedules. Due to the ongoing severe acute respiratory syndrome coronavirus (SARS-COV-2) pandemic and recent FDA approval of SARS-COV-2 vaccines Moderna (Spikevax 1/31/2022 approved by FDA for 18 and up) and Pfizer (Comirnaty, approved 8/23/2021 for 16 and up), it is recommended to update the policy paper to include SARS-COV-2 prevention recommendations. The inclusion of language validating the need for PAs to serve as trusted health care providers who promote vaccine efficacy and combat misinformation is vital.

Related AAPA Policy

HX-4500.2
Telemedicine (paper on page 283)
[Adopted 2015, amended 2021]

HX-4200.1.10
Disparities in Maternal Morbidity and Mortality (paper on page 343)
[Adopted 2021]

HP-3400.4
Supporting PA Practice in Settings External to Clinics and Hospitals: Adoption of Home-centered Care (paper on page 355)
[Adopted 2021]

Possible Negative Implications

Some SARS-COV-2 vaccines are still under Emergency Authorization Use, including some mentioned above for the pediatric population. However, with recent FDA approval of Spikewax/Comirnaty and the important role of PAs to be trusted health care providers for our patients there needed to be an update to AAPA policy to reflect that.

Financial Impact

None

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature & Contact for the Resolution

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Immunizations in Children and Adults

(Adopted 1994, amended 2004, 2006, 2011, 2016, 2018)

Executive Summary of Policy Contained in this Paper

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

AAPA 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 ALL PATIENT POPULATIONS AND CERTAIN HIGH-RISK INDIVIDUALS, ~~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. HIGH-RISK POPULATIONS 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 AND THE SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS (SARS-COV-2) vaccination SERIES UNLESS THERE IS A CLINICAL CONTRAINDICATION DUE TO THE PA'S MEDICAL HISTORY. This not only protects PAs, but also ~~protects patients by preventing~~ DECREASES THE RISK OF 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~~ TO PROTECT against vaccine-preventable diseases.
- PA students, LIKE PRACTICING PAs, should have all appropriate immunizations prior to STARTING 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 AND EASILY ACCESSIBLE DOCUMENTATION OF THE ~~to carry with them and a way to easily locate each~~ patient's immunization record in the patient's medical chart. High-risk patients should be identified, and ~~special~~ TARGETED programs implemented to ENSURE COMPLIANCE, SUCH AS AUTOMATED REMINDERS. ~~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. COLLABORATION ~~They should coordinate efforts~~ with the patients' primary care providers WILL ~~to~~ ensure COMPLIANCE WITH IMMUNIZATION SCHEDULES. ~~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 COVER ~~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 healthcare 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~~1) Recent economic analyses found that routine vaccination of children born from 1994 to 2018 will prevent about 419 million cases of disease and more than 936,000 early deaths, for

a societal cost savings of more than 1.9 trillion dollars. (~~3~~2) Given their proven benefit in reducing morbidity, mortality and healthcare 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 202~~0~~30 initiative has set vaccination coverage goals of 90-95 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)~~ IN ADDITION, THERE IS A PUSH TO REDUCE THE PROPORTION OF CHILDREN WHO GET NO RECOMMENDED VACCINES BY AGE TWO YEARS. Recent national coverage estimates showed that HP- 2020 targets of 90-95% were met for THE ABOVE-MENTIONED VACCINATIONS. (3) ~~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. (5)

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, HEALTHY PEOPLE 2030 GOALS were lagging for complete coverage for the ~~3-dose~~ HPV vaccine among ~~females~~ ADOLESCENTS (TARGET – 80%; 2018 DATA – 48%**)**. ~~(1)~~(3)(6)**(7)** This disparity in vaccination coverage indicates many missed opportunities to administer HPV vaccination in addition to TDaP and meningococcal conjugate vaccine during the same clinical visit.

Adult Immunization Programs

Adult immunization programs do not receive the same priority as efforts to immunize children, ~~despite the fact that~~ EVEN THOUGH most deaths from vaccine-preventable disease occur in adults. Between 5,000 AND 56,000 ~~50,000 and 90,000~~ adults die each year from vaccine-preventable diseases such as pneumococcal infection, influenza and hepatitis B. ~~(6)~~ (8)

Despite availability and effectiveness of vaccines current immunization rates fall below those recommended in Healthy People 20~~20~~30. 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 U.S. 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. ~~(7)~~(8)(9)

Unfortunately, adult vaccination coverage estimates for the four vaccines included in Healthy People 20~~20~~30 (influenza, pneumococcal, herpes zoster, and among healthcare providers, hepatitis B) remain below target levels. (10) 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. ~~(7)~~(9)(11)

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~~ vaccineS 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)[8] continues to promote a national immunization registry as a national goal in~~ Healthy People 20~~20~~30 IS ALSO DEVELOPING AN OBJECTIVE TO PROMOTE~~, 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. ~~(10) 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~~ YET 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:~~ CHALLENGES FOR ASSURING ACCESS AND AVAILABILITY OF VACCINES INCLUDE (12):

• UNPRECEDENTED VACCINE DELAYS

• DIMINISHED NUMBER OF VACCINE SUPPLIERS

• DISPARITIES OF GEOGRAPHIC AND SOCIOECONOMIC POPULATIONS

• EROSION OF INSURANCE COVERAGE FOR IMMUNIZATIONS

• 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.

COVID-19 PANDEMIC

CORONAVIRUS DISEASE 2019 (COVID-19) IS A RESPIRATORY ILLNESS CAUSED BY SARS-COV-2; A CORONAVIRUS FIRST DISCOVERED IN 2019. IT IS TRANSMITTED FROM PERSON-TO-PERSON VIA RESPIRATORY DROPLETS PRODUCED BY AN INFECTED PERSON. PATIENTS MAY BE ASYMPTOMATIC OR DEVELOP SEVERE ACUTE SYMPTOMS SUCH AS PULMONARY EMBOLISM, STROKE, HEART ATTACK, DEEP VEIN THROMBOSIS, AND EVEN DEATH. PATIENTS CAN ALSO DEVELOP COVID-19-LIKE SYMPTOMS FOR SEVERAL MONTHS OR EVEN SPONTANEOUSLY PRESENT WITH SYMPTOMS SEVERAL MONTHS AFTER INITIAL RECOVERY. MANY PATIENTS DEVELOP CHRONIC BRONCHITIS AND/OR BACTERIAL PNEUMONIA. DUE TO ITS HIGH PREVALENCE IN THE COMMUNITY, THE COVID-19 PANDEMIC WAS DECLARED A US NATIONAL EMERGENCY ON MARCH 13, 2020 AND HAS BECOME A GLOBAL PANDEMIC. ADULTS AGED 65 YEARS AND OLDER AND INDIVIDUALS OF ANY AGE WHO ARE IMMUNOCOMPROMISED ARE AT INCREASED RISK OF DEVELOPING SEVERE COVID-19 SYMPTOMS. COVID-19 TRANSMISSION AMONG HEALTHCARE PROVIDERS TO AND FROM THEIR PATIENTS HAS BEEN HIGHLY DOCUMENTED. DUE TO THE MORE HIGHLY VIRULENT COVID-19 MUTATIONS, MULTIPLE LOCAL AND WORLD HEALTH ORGANIZATIONS ADVOCATE FOR COMPLETE VACCINATION OF ALL CITIZENS WHO QUALIFY. MANY COVID-19 VACCINES ARE 1- OR 2- SHOT SERIES WITH SOME REQUIRING A BOOSTER VACCINE MONTHS

AFTER INITIAL INOCULATION. SOME VACCINES HAVE BEEN GIVEN FULL APPROVAL BY THE FOOD AND DRUG ADMINISTRATION (FDA) WHILE OTHERS HAVE BEEN ONLY GIVEN EMERGENCY USE AUTHORIZATION FOR CERTAIN POPULATIONS. DUE TO INITIAL VACCINE SKEPTICISM AND/OR MISINFORMATION, MANY PEOPLE ARE VACCINE HESITANT OR REFUSE TO FOLLOW PRIVATE BUSINESS, LOCAL COMMUNITY, STATE OR FEDERAL VACCINE MANDATES. THIS IN TURN HAS PROVIDED AN ENVIRONMENT THAT PROMOTES VIRUS MUTATION WHICH ALSO HAS THE POTENTIAL TO CREATE A VIRUS THAT IS RESISTANT TO EXISTING VACCINES. (13) ON NOVEMBER 3, 2021, THE CDC RECOMMENDED THAT ALL PEOPLE AGES 5 AND OLDER GET A COVID-19 VACCINE TO HELP PROTECT AGAINST THE VIRUS. FOR THIS REASON, IT IS IMPERATIVE THAT ALL PAS SERVE AS TRUSTED HEALTHCARE PROVIDERS THAT CAN PROMOTE VACCINE EFFICACY AND INCREASE VACCINE USE AMONG THEIR PATIENTS. TO DATE (OCTOBER 2021), APPROXIMATELY 719,000 AMERICANS AND 4.55 MILLION INDIVIDUALS WORLDWIDE HAVE DIED OF COVID-19 THOUGH THE FINAL NUMBER IS LIKELY TO BE MUCH HIGHER.

Influenza AND COVID-19 Vaccination of Healthcare Personnel

Influenza AND COVID-19 transmission and outbreaks in healthcare facilities are well documented. Healthcare workers (HCW) acquire influenza AND COVID-19 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 AND COVID-19, HCW should be considered a high priority group when expanding influenza AND COVID-19 vaccine use. In 2010 the Infectious Disease Society of America (IDSA) supported universal immunization of healthcare workers against ~~influenza~~ VIRAL ILLNESSES by healthcare 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~~ VIRAL ILLNESSES by healthcare workers. ~~(9)~~ (14)

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 healthcare 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 the patient's 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 ensure 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.

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2022-C-03-NY **Global Epidemic HIV/AIDS**

2022-C-03 Resolved

Amend the policy paper entitled *Global Epidemic HIV/AIDS*. See policy paper

Rationale/Justification

The existing policy paper was updated to reflect significant changes in HIV screening, prevention, and treatment consistent with the literature and updated CDC guidelines. The language was changed to be less stigmatizing to people who inject drugs and people accessing HIV services (preventive and treatment). The current policy addresses the international HIV/AIDS epidemic, and additional information about the US response to HIV was included reflecting the role in the global community. Citation and typographical errors in the existing policy were corrected. References to ARV vs ART were reframed to separate preventive and treatment HIV services (i.e., ARVs used for PrEP as compared to ART which is specifically to treat an~~d~~ existing HIV infection).

The addition of these concepts to medical education curricula would enhance these programs as they apply for reaccreditation and provide appropriate competencies regarding interprofessional care.

Related AAPA Policy

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.

[Adopted 1992, amended 2012, reaffirmed 1997, 2002, 2007, 2017]

HX-4100.1.10

AAPA is committed to respecting the values and diversity of all individuals irrespective of race, ethnicity, culture, faith, sex, gender identity or expression and sexual orientation. 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.

[Adopted 1995, reaffirmed 2003, 2008, amended 1997, 2013, 2018]

Possible Negative Implications

None foreseen at this time.

Financial Impact

No foreseen financial impact anticipated at this time.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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Global Epidemic HIV/AIDS

(Adopted 2005, amended 2010, 2015, 2020)

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 through a coordinated effort.

- AAPA supports national and international prevention strategies that include ~~counseling and testing~~ SCREENING, programs with particular focus on young adults, programs to prevent mother-to-child vertical transmission, PROGRAMS FOCUSED ON AT-RISK POPULATIONS INCLUDING SGM AND RACIAL/ETHNIC MINORITIES, routine EDUCATION ON AND provision of pre-~~-~~exposure prophylaxis (PrEP) and post-~~-~~exposure prophylaxis (PEP) ~~in accordance with established recommendations and guidelines~~ FOLLOWING EVIDENCE-BASED MEDICINE, and legislative efforts to promote women's rights and sex workers' rights.

- AAPA SUPPORTS THE DESTIGMATIZATION OF HIV INFECTION AND STRUCTURAL CHANGE TO ELIMINATE DISPARITIES AMONG MINORITIES.

- AAPA SUPPORTS THE REPRESENTATION OF WOMEN (CIS- AND TRANSGENDER) AT ALL LOCAL, STATE, FEDERAL, AND INTERNATIONAL LEVELS OF HIV RESEARCH, EDUCATION, AND PLANNING; ADDRESSING SEXUAL TRANSMISSION, PERINATAL TRANSMISSION, PARENTERAL TRANSMISSION, CHILDCARE, AND FAMILY CARE ISSUES AS THEY RELATE TO WOMEN AT EVERY LEVEL.

- AAPA SUPPORTS THE IDENTIFICATION OF INTERSECTIONAL IDENTITIES (SGM, RACIAL/ETHNIC MINORITIES, MENTAL HEALTH, AND SUBSTANCE USE) ASSOCIATED WITH HIV TRANSMISSION TO ENSURE ALL SOCIAL DETERMINANTS OF HEALTH ARE ADDRESSED IN ORDER TO OPTIMIZE OVERALL HEALTH, INCLUDING PROGRAMMING AND RESEARCH.

- AAPA encourages routine OPT-OUT-BASED HIV screening, FREE OF STIGMA, TO DIAGNOSE ALL PEOPLE WITH HIV AS EARLY AS POSSIBLE. ~~in accordance with the CDC recommendations.~~

- AAPA supports ~~the creation of~~ specially-trained HIV/AIDS medical providers to augment new and existing global prevention and treatment efforts~~.~~ AND INCREASE HIV WORKFORCE CAPACITY THROUGH SCHOLARSHIPS AND STUDENT LOAN REPAYMENT.

- AAPA SUPPORTS ACCESS TO HIV SERVICES, INCLUDING PREVENTION AND TREATMENT OF HIV, WHICH IS AFFIRMING AND FREE OF STIGMA FOR ALL

PEOPLE REGARDLESS OF IMMIGRATION STATUS AND INCLUSIVE OF BLACK, INDIGENOUS, AND PEOPLE OF COLOR.

- AAPA SUPPORTS ROUTINE PERINATAL HIV TESTING AND INCREASED FUNDING, RESEARCH, AND EDUCATION FOR PERINATAL HIV PREVENTION.

- AAPA believes that international, national, and community leaders should be firm and vocal advocates for HIV/AIDS education, prevention, and treatment efforts THAT PROMOTE EQUALITY AND THAT PEOPLE LIVING WITH HIV/AIDS SHOULD NOT EXPERIENCE DISCRIMINATION OR BIAS.

- ~~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 HIV/AIDS efforts, INCLUDING BUT NOT LIMITED TO HIV SERVICES, CARE, HOUSING, AND RESEARCH, without ideological or political influence on the distribution of funding.

- AAPA ~~recognizes~~ SUPPORTS INCREASING AWARENESS that individuals living with HIV who are virally suppressed on antiretroviral medication cannot sexually transmit HIV. Healthcare providers should be aware and educate patients that "undetectable = untransmittable~~.~~" WHILE ENSURING THAT THE DECISION TO INITIATE ANTIRETROVIRALS IS INFORMED AND AUTONOMOUS.

- AAPA SUPPORTS RAPID AND PATIENT-CENTERED INITIATION OF EFFECTIVE ART DIRECTLY AFTER HIV DIAGNOSIS TO ACHIEVE SUSTAINED VIRAL SUPPRESSION AND MINIMIZE TRANSMISSION.

- AAPA SUPPORTS INCREASING ACCESS TO PATIENT-CENTERED, EVIDENCE-BASED, PREVENTION OF NEW HIV TRANSMISSIONS, INCLUDING PREP, PEP, AND SYRINGE SERVICES PROGRAMS.

- AAPA SUPPORTS SURVEILLANCE, REPORTING, AND RESPONSE TO HIV OUTBREAKS.

Global Impact of HIV

Because of the pathogenesis and epidemiology of HIV infections, certain populations are at increased risk for contracting HIV, including sexual and gender minorities (SGM), men who have sex with men (MSM), ~~those~~ PERSONS who inject~~ed~~ drugs (PWID), and healthcare workers ~~are all at immediate risk for contracting HIV~~. Multiple sexual partners and concomitant sexually transmitted infections facilitate HIV transmission. Similarly, needle/DEVICE sharing and/or high-risk sexual activity leads to HIV exposure in ~~those that use injected drugs~~ PWID. (14) Although HIV infections worldwide occur predominately through heterosexual contact, SGM, including MSM and ~~those using injected drugs~~ PWID, continue to represent significant epidemiological categories IN THE UNITED STATES (US) AND INTERNATIONALLY. (~~4~~1)(~~5~~2)

THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) 2019 PLAN TARGETS GEOGRAPHIC AREAS DISPROPORTIONATELY AFFECTED BY HUMAN IMMUNODEFICIENCY VIRUS (HIV), WITH A GOAL TO REDUCE NEW HIV INFECTIONS BY 75% IN 5 YEARS AND AT LEAST 90% IN 10 YEARS. ACHIEVING SUCCESS IN THIS INITIATIVE WILL REQUIRE AN IMMEDIATE, SUBSTANTIAL, AND PERSISTENT RESPONSE. (3)(4) 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 public health crisis. Sub-Saharan Africa remains the most severely impacted, with 1 in every 25 adults living with HIV (LWH), which accounts for more than two-thirds of the people living with HIV (PLWH) worldwide (~~2~~5). The disparity in the disease burden of HIV is evident in the fact that 61% of HIV-related deaths occurred in Sub-Saharan Africa. (~~3~~6) 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. (~~1~~7) 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. (~~1~~7) 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~~, ANATOMIC SUSCEPTIBILITY, AND HIGH COMMUNITY PREVALENCE. (14) 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 can. (~~1~~7) The morbidity and mortality among the female population ~~secondary~~ DUE to HIV/AIDS are devastating to families and communities. Worldwide, women account for more than half of all adults with HIV/AIDS. (~~5~~2) Women are more likely to lose jobs, lose income, raise children, and face stigma and discrimination. In addition to managing their 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 HIV/AIDS epidemic affects the entire family. It impacts children of ~~HIV infected~~ mothers ~~living with HIV~~ LWH in multiple dimensions (e.g., born to a mother LWH, orphaned by a parent who died ~~secondary to~~ OF HIV-RELATED complications, or left to care for a parent or family member). (~~5~~2) Commercial sex workers (CSW) and transgender women (TGW) also experience an increased risk of acquiring HIV, A myriad socioeconomic consequences of infection, and barriers to accessing medical care. (~~5~~2) (8)

RACIAL AND ethnic minorities have a disproportionate burden of HIV ~~infections~~ and AN INCREASED RISK OF progression to AIDS. ~~Even in developed countries, y~~Young people of color are at higher risk than their white counterparts. More than half of new HIV cases in the ~~United States~~ US occur among RACIAL AND ethnic minorities. (~~5~~2)(8)

The distribution of available resources for prevention and treatment also reflects disparities. Antiretroviral~~s~~ THERAPY (~~ARVs~~ ART) decreases HIV mortality by approximately 80% ~~and over the past decade, the number of people receiving has increased dramatically~~. Globally, the number of ~~persons living with HIV/AIDS (~~PLWH~~A)~~ receiving ~~ARVs~~ ART has increased threefold since 2010. ~~(5)~~ Although globally, the number of PLWH~~A~~ receiving ~~ARVs~~ ART has increased to 23.3 million, people in low-income countries represent a disproportionally

low number of those receiving ART ~~treatment~~. ~~(5)~~ This increase in PLWH~~A~~ 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 44% globally in 2012 to 82% in 2018. ~~(5)~~ Between 2010 and 2018, there was also a 41% reduction in mother-to-child transmission of HIV. ~~(5)~~ Despite global efforts to increase the number of PLWH~~A~~ on ART, some high-prevalence populations, INCLUDING PWID ~~– such as injection drug users (IDU)~~ and transgender individuals~~–~~, may not be receiving treatment due to socioeconomic barriers to care and fear of actual discrimination. (~~5~~2)

The world's poorest countries face DISPROPORTIONATE shortages of healthcare ~~providers~~ WORKERS (HCW). International health leaders report the shortage of ~~healthcare workers~~ HCW as one of the largest constraints to ~~antiretroviral~~ ART ~~drug~~ programs and meeting people's basic healthcare needs. As of 2013, the global workforce fell short of the number of ~~healthcare workers~~ HCW needed for essential health services by 17.3 million. (~~6~~9) 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 train medical providers and community health workers. ~~(5)(6)(7)~~(2)(9)(10)

Healthcare Providers' Responsibility

With increased utilization of ~~antiretrovirals~~ ARVs to reduce the burden and transmission of HIV, healthcare providers with prescriptive authority, INCLUDING PAS, are in a unique and responsible position. HIV epidemiologic data and clinical research on PrEP fails to address sexual and gender diversity. The literature notably lacks robust data on gender-diverse individuals who were assigned female at birth and identify as male (including transgender men) and individuals who don't identify exclusively with either a male or female gender (including gender non-binary, gender fluid, and two-spirit identities). Regardless of sexual or gender identity, the following risk factors for sexual transmission of HIV should be considered in all patients: (11~~8~~)~~(9)~~

- Residing in areas of high HIV incidence ~~(CDC & JAMA)~~ (8)(12)(13)
- Not use barrier protection consistently (unwilling, unable, or have barriers to negotiating use with partners) ~~(CDC & JAMA)~~ (8)(12)(13)
- Recent diagnosis of a bacterial STI ~~(CDC & JAMA & NYC DOH)~~ (8)(12)(13)(14)
- Engaging in anal intercourse ~~(CDC & JAMA)~~ (8)(12)(13)(15)
- Engaging in transactional sex (i.e., sex for money, drugs, or housing) ~~(CDC & JAMA)~~ (8)(12)(13)
- Having sexual partners who are at high risk for unsuppressed HIV (i.e., partners with social and institutional barriers to HIV testing and treatment) ~~(CDC & JAMA)~~ (8)(12)(13)
- Having more than one sexual partner ~~(CDC & JAMA)~~ (8)(12)(13)
- Individuals with partners with more than one sexual partner ~~(CDC & JAMA)~~ (8)(12)(13)

STIGMA FUELS THE DISPROPORTIONATE EFFECTS OF HIV ON MARGINALIZED COMMUNITIES, INCLUDING SEXUAL, GENDER, RACIAL, ETHNIC, AND OTHER MINORITIES, ESPECIALLY THOSE WITH INTERSECTING SOCIOECONOMIC STATUS, MENTAL HEALTH, AND SUBSTANCE USE CONCERNS. STIGMA DRIVES BARRIERS TO UTILIZE PREVENTION, SCREENING/TESTING, DIAGNOSIS, LINKAGE TO CARE, TREATMENT, AND MAINTENANCE IN TREATMENT. (8) MENTAL HEALTH DISPARITIES AND SUBSTANCE USE AFFECT INDIVIDUALS' ABILITY TO ENGAGE IN HIV SERVICES, INCLUDING BOTH TREATMENT AND PREVENTION. INTERSECTING MINORITY STATUS AMONG SGMS, ETHNIC/RACIAL MINORITIES, SUBSTANCE USE, AND MENTAL HEALTH DISPARITIES MUST BE CONCURRENTLY ADDRESSED. (16)(17) HIV SERVICES CAN ONLY BE COMPREHENSIVELY ADDRESSED THROUGH DESTIGMATIZATION AND STRUCTURAL CHANGE.

PrEP

Preexposure prophylaxis (PrEP) is essential to reducing the incidence of HIV infection. PrEP is indicated for individuals at ongoing~~, significant~~ risk of HIV acquisition ~~including but not limited to SGMs~~ AMONG ADULTS and adolescents >35kg~~, IDUS~~. (13)(18) PrEP prescription is the responsibility of HEALTHCARE PROVIDERS ACROSS SPECIALTIES, INCLUDING primary care providers and ~~should not be limited to~~ ID specialists. HEALTHCARE PROVIDERS, INCLUDING PRIMARY CARE PROVIDERS, MUST BECOME AS PROFICIENT WITH MEDICAL MANAGEMENT OF HIV PREP AS THEY ARE WITH OTHER COMMON DIAGNOSES SUCH AS HYPERTENSION, HYPERLIPIDEMIA, AND DIABETES. PrEP use is supported by US PREVENTIVE SERVICES TASK FORCE (USPSTF), and CDC guidelines for prescribing and monitoring PrEP should be followed. Screening for HIV should be performed prior to PrEP initiation and no less than every three months while a patient ~~is on~~ USES PrEP. When PrEP is prescribed, clinicians should provide access to proven effective risk-reduction services. Patients should be encouraged and empowered to use PrEP in combination with other effective prevention methods as desired and appropriate for each individual patient. (8)(18)(12)(13)~~(9)(10)(11)~~

THE FOOD AND DRUG ADMINISTRATION (FDA) APPROVED THE FIRST INDICATION OF AN ORAL MEDICATION TO REDUCE THE RISK OF HIV INFECTION IN 2012. YEARS LATER, AWARENESS, ACCESS, AND UPTAKE OF HIV PREP ARE INADEQUATE. (13) FURTHER, USE DISPARITIES HAVE EMERGED ALONG RACIAL AND ETHNIC LINES, GEOGRAPHIC REGIONS, AND SGMS, WIDENING THE SOCIAL DETERMINANT GAP AMONG PEOPLE WITH NEW HIV INFECTIONS. IN THE US, ONLY 7% OF THE ESTIMATED 1.1 MILLION PEOPLE WITH INDICATIONS WERE PRESCRIBED PREP IN 2016;(19) BLACK AND HISPANIC PEOPLE HAVE THE LOWEST RATES OF PREP PRESCRIPTION, AND ONLY 27% OF THE PREP PRESCRIPTIONS WERE IN THE SOUTHERN STATES IN 2016. (19) PREP USE DEPENDS ON AN INDIVIDUAL'S ABILITY TO ACCESS AND AFFORD MEDICATION AND PREP RELATED SERVICES SUCH AS REGULAR MEDICAL VISITS AND LABORATORY COSTS. THE USPSTF GRADE A RECOMMENDATION OR PREP SUGGESTS IMPLEMENTATION IN CLINICAL PRACTICE AND ROUTINE COVERAGE BY PAYORS (I.E., PRIVATE AND PUBLIC MEDICAL INSURANCE) IN THE US. (20) FURTHER

DEVELOPMENT OF PATIENT-CENTERED OPTIONS, INCLUDING LONGER-ACTING INJECTABLE, IMPLANTABLE, AND OTHER ALTERNATE DOSING STRATEGIES, WILL INCREASE PREP ACCESS.

For individuals NOT ON PREP who seek medical care within 72 hours after a possible exposure to infectious body fluids of a person known to ~~have~~ BE LWH ~~HIV~~, the ~~U.S. Department of Health and Human Services~~ US DEPARTMENT OF HHS ~~states~~ RECOMMENDS CONSIDERING ~~that~~ non-occupational post-exposure prophylaxis (nPEP) ~~may be beneficial~~ to reduc~~e~~ing transmission. (~~10~~15) PEP should be initiated as soon as possible, and providers and institutions should work to eliminate barriers to expeditious PEP initiation. EXPERT CONSULTATION IS RECOMMENDED BUT SHOULD NOT DELAY PEP INITIATION. PEP USERS SHOULD COMPLETE A 28-DAY COURSE OF MEDICATION AND UNDERGO REGULAR LABORATORY TESTING, INCLUDING HIV TESTING AT THE TIME OF INITIATION AND THROUGH AT LEAST SIX MONTHS OF COMPLETION. (12)(20) In instances where the HIV status of an individual is unknown, providers should use clinical judgment to determine whether ~~or not~~ the use of nPEP is warranted. Data supporting the efficacy of nPEP come~~s~~ from several types of studies, including animal models, perinatal clinical trials, studies of transmission following healthcare exposures, and clinical observation. ~~(12)~~ ~~Implementation of~~ IMPLEMENTING a randomized, control~~led~~ trial for nPEP is unlikely for ethical reasons. All persons who ~~report behaviors or situations that place them at risk for frequently recurring HIV exposure (e.g., injection drug use, or sex without condoms) or who~~ report receipt of ~~>~~1 OR MORE course~~s~~ of nPEP ~~in the past year~~ should be provided risk education counseling and intervention services, including consideration of preexposure prophylaxis. (~~10~~15)(18)

~~ROUTINE~~ HIV Screening

HIV screening has tremendous public health implications FOR PLWH AND THEIR SEXUAL PARTNERS. ~~Individuals~~ PLWH who are unaware of their ~~HIV~~ status are 3.5 TIMES more likely to transmit HIV~~, than those who know their status~~ and early ~~treatment of HIV~~ INITIATION OF ARVS FOR PLWH ~~can~~ COULD reduce sexual transmission BY 40%. (1)(21)(22)~~(13)(14)~~ ~~For the individual, e~~Early linkage to care is associated with HIV viral load suppression and improved long-term health outcomes. (1)(21)(22)~~(13)(14)~~ ~~The CDC recommends HIV screening for everyone~~ IN ADDITION TO INDIVIDUALS WITH RISK FACTORS, ALL PEOPLE, ages 13 to 64 ~~at least once, with follow-up testing based on individual risk.~~ (23~~15~~) YEARS IN ALL CLINICAL SETTINGS MUST BE PROVIDED ROUTINE HIV SCREENINGS (ANTIGEN/ANTIBODY COMBINATION TESTING PREFERRED), WITH ANNUAL OR MORE FREQUENT RESCREENING OFFERED TO GAY/SAME-GENDER-LOVING, BISEXUAL, AND OTHER MSM. (24)(25) ROUTINE SCREENING SHOULD BE OFFERED IN AN OPT-OUT MODEL (I.E., NOTIFYING THE INDIVIDUAL THAT THE TEST WILL BE PERFORMED, GIVEN THE OPTION TO DECLINE, AND INFERRED ASSENT UNLESS THE INDIVIDUAL DECLINES TESTING). STRONG CONSIDERATION SHOULD BE GIVEN FOR MORE FREQUENT HIV SCREENING (FOR EXAMPLE, EVERY 3 TO 6 MONTHS) OF PEOPLE WITH ONGOING RISK. (1)(24) IN 2017, HIV INCIDENCE RATES WERE HIGHEST IN THE SOUTH, ACCOUNTING FOR 51% OF INCIDENT INFECTIONS IN THE US IN 2018. (1) BLACK AMERICANS, WHO ACCOUNT FOR 13% OF THE US POPULATION, WERE

DISPROPORTIONATELY BURDENED WITH 43% OF HIV DIAGNOSES, DESPITE A LOWER INCIDENCE OF REPORTED RISK BEHAVIORS. ALTHOUGH HIV DIAGNOSES AMONG WOMEN HAVE DECREASED IN RECENT YEARS, AROUND 7,000 WOMEN ARE DIAGNOSED WITH HIV IN THE US EACH YEAR. ONE IN NINE WOMEN LIVING WITH HIV ARE UNAWARE OF THEIR STATUS, AND WOMEN OF COLOR CONTINUE TO BE DISPROPORTIONATELY AFFECTED. IN 2018 BLACK WOMEN ACCOUNTED FOR 58% OF HIV INFECTIONS BUT ONLY 13% OF THE FEMALE POPULATION OF THE US. (1) ROUTINE, OPT-OUT SCREENING FOR HIV IS RECOMMENDED FOR ALL PREGNANT INDIVIDUALS, CONSISTENT WITH THE CENTERS FOR DISEASE CONTROL (CDC) GUIDANCE. ALTHOUGH FEW PERINATAL TRANSMISSIONS OCCUR IN THE US EACH YEAR (39 CHILDREN IN 2017), THE OCCURRENCE IS ASSOCIATED WITH A LACK OF TESTING IN THE PRENATAL PERIOD AND AT THE TIME OF BIRTH. (1)(8)

~~Undetectable = Untransmittable~~ INITIATE ANTIRETROVIRALS (ARVS) RAPIDLY AND EFFECTIVELY TO ACHIEVE SUSTAINED VIRAL SUPPRESSION

~~The use of antiretroviral therapy among PLWH to suppress the viral load to levels below the threshold of detection eliminates the risk of transmission (called undetectable = untransmittable, or U=U).(16)(17)~~

HIV CANNOT BE SEXUALLY TRANSMITTED FROM AN INDIVIDUAL WHO MAINTAINS AN UNDETECTABLE VIRAL LOAD - A CONCEPT KNOWN AS TREATMENT AS PREVENTION (TASP) OR UNDETECTABLE=UNTRANSMITTABLE (U=U). The ~~partner~~ PARTNER and ~~partner~~ PARTNER2 ~~study~~ TRIALS evaluated serodiscordant couples where the partner ~~living with HIV~~ LWH is virally suppressed on ~~ARVs~~ ART and the partner without HIV is not on ARV prevention (i.e., ~~pep~~ PEP or ~~prep~~ PrEP). The ~~partner~~ PARTNER ~~study~~ TRIAL showed no genetically linked HIV transmission among 1,166 couples with >58,000 condomless sexual acts. The ~~partner~~ PARTNER2 study showed no genetically linked HIV transmission among 782 MSM couples engaging in >76,000 condomless acts. ~~(16)(17)~~(26)(27)(28)

ALTHOUGH ARV INITIATION CARRIES A SIGNIFICANT PUBLIC HEALTH BENEFIT, ARV INITIATION SHOULD BE PATIENT-CENTERED FOCUSED ON THE INDIVIDUAL'S HEALTH. CLINICIANS MUST EMPOWER PEOPLE WITH THE INFORMATION THEY NEED TO MAKE AN INFORMED AND AUTONOMOUS DECISION TO INITIATE ARV. ACCESS TO ARV INCLUDES REGIMENS AS DETERMINED BY THE INDIVIDUAL AND THEIR PROVIDER, WHICH SHOULD BE COVERED BY ALL PAYORS (I.E., PRIVATE AND PUBLIC MEDICAL INSURANCE AS WELL AS LOCAL, STATE, NATIONAL, AND INTERNATIONAL PROGRAMS) WITHOUT BARRIERS SUCH AS PRIOR AUTHORIZATION. MAINTENANCE OF ART AND ONGOING CARE WITH A PROVIDER TRAINED IN HIV MANAGEMENT IS ESSENTIAL FOR THE HEALTH AND QUALITY OF LIFE OF PLWH.

WIDESPREAD IMPLEMENTATION OF TEST AND TREAT MODELS PROVIDING ACCESS TO ART WITHIN 72 HOURS OF HIV DIAGNOSIS WOULD REDUCE THE TIMELINE TO ACHIEVING VIRAL SUPPRESSION AND MINIMIZE THE WINDOW OF POTENTIAL TRANSMISSION. NEW YORK CITY'S SEXUAL HEALTH CLINICS HAVE

SHOWN THAT IMMEDIATE INITIATION OF ART AT THE TIME OF DIAGNOSIS RESULTED IN HIGH RATES OF LINKAGE TO CARE (84%) AND RAPID VIRAL LOAD SUPPRESSION (87% AMONG THOSE WITH FOLLOW-UP VIRAL LOAD TESTING). (29) A SHORTAGE OF TREATMENT PROVIDERS AND RESOURCES PREVENT NEWLY DIAGNOSED PERSONS FROM ACCESSING CARE PROMPTLY, WITH SOME WAITING MONTHS FOR AN APPOINTMENT WITH AN HIV SPECIALIST. THE US HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) COULD INCREASE THE CAPACITY OF THE HIV WORKFORCE BY DESIGNATING FUNDED JURISDICTIONS AS HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA), THEREBY ALLOWING MEDICAL PROVIDERS IN PROGRAMS FUNDED BY THE RYAN WHITE HIV/AIDS PROGRAM TO QUALIFY FOR SCHOLARSHIPS AND STUDENT LOAN REPAYMENT THROUGH THE NATIONAL HEALTH SERVICE CORPS (NHSC). (4)

RAPID RESPONSE TO POTENTIAL HIV OUTBREAKS

IDENTIFYING PATTERNS OF RAPID SPREAD OF HIV WHICH MIGHT OTHERWISE GO UNRECOGNIZED ALLOWS FOR SWIFT PUBLIC HEALTH ACTION. STATES WITH A SUBSTANTIALLY RURAL HIV BURDEN ARE MOST VULNERABLE TO AN HIV OUTBREAK AND NEED FOCUSED ATTENTION TO ENHANCE EPIDEMIOLOGIC INVESTIGATIONS. NEW HIV DIAGNOSES AND ASSOCIATED LABORATORY RESULTS MUST BE PROMPTLY REPORTED TO LOCAL AND STATE HEALTH DEPARTMENTS TO CURB PUBLIC HEALTH EMERGENCIES. IN AREAS WHERE HIV AND OPIOID EPIDEMICS INTERSECT, MODERNIZING LEGISLATION SURROUNDING BUPRENORPHINE PRESCRIBING FOR MEDICATION-ASSISTED TREATMENT (MAT) AND ESTABLISHING NEEDLE/DEVICE EXCHANGE OR SYRINGE SERVICE PROGRAMS WOULD ENRICH LONG-TERM RISK REDUCTION OPPORTUNITIES. (4)

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 to effectively implementing 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.

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2022-C-04-SPAAM **Support for Reduced Restrictions on Methadone in the Treatment of Opioid Use Disorder**

2022-C-04 Resolved

AAPA encourages federal, state, and local regulatory bodies to consider reducing restrictions on the use of methadone in the treatment of Opioid Use Disorder.

Rationale/Justification

Current federal, state, and local regulatory restrictions require patients to present daily to clinics that are federally approved and designated as Opioid Treatment Programs. These restrictions pose a barrier to treatment in the time of an ongoing opioid epidemic, make it difficult for patients to earn medication take-home privileges, and requiring patients to attend a variety of clinical treatment sessions in order to continue to receive methadone treatment. Patients are routinely treated in punitive manners when missing doses or appointments in ways that are not consistent with generally accepted medical practice.

Recent evidence and expert opinion about this issue indicates a shift in thinking about the tight and counter-productive methadone restrictions. This evidence is a result in large part to the impact of Covid-19 on the temporary loosening of take-home restrictions by federal agencies, allowing many patients advanced take-home medication status who would not normally have been eligible for such take-home privileges in order to reduce risk of spread of Covid-19. Subsequent study of the impact of this reduction in restrictions has provided evidence that it did not result in increased harm to patients or their communities.

Reduction of these restrictions would also likely promote the increased ability of PAs to treat patients with Opioid Use Disorder. This is currently a challenge, with regulations that not only result in non-medical methods of the treatment of Opioid Use Disorder, but that also severely limit the ability of PAs to provider urgently needed services for patients with addiction.

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Related AAPA Policy

HX-4200.7.4
AAPA supports the expansion of hospital-to-community care of patients with Opioid Use Disorder (OUD), including the initiation of medication assisted treatment (MAT) in hospitals and emergency rooms. This includes accessing community-based follow-up upon discharge from hospitals or emergency rooms where OUD medications have been initiated.
[Adopted 2019]

HX-4200.7.5
AAPA supports ongoing efforts to remove obstacles to PAs being fully utilized in the treatment of Opioid Use Disorder (OUD). This includes supporting PA-physician parity regarding training

requirements to prescribe buprenorphine, as well as optimizing resources for PAs to navigate the separate buprenorphine and methadone exemption processes.
[Adopted 2019]

HP-3300.1.12
AAPA encourages PAs to identify patients with substance use disorders and initiate treatment which may include medication assisted treatment as well as referral to qualified behavioral health providers.
[Adopted 2002, reaffirmed 2007, 2012, 2017, amended 2019]

Possible Negative Implications
None

Financial Impact
This resolution will have no financial impact on the AAPA. AAPA staff are already advocating for the modernization of regulations related to Medication Assisted Treatment, and such staff activity could include advocacy for such restriction reduction without the need for more staff.

Attestation
I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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2022-C-05-PAHPM **Advancing Progress of Palliative Care Education and Practice**

2022-C-05 Resolved

Amend policy HP-3300.1.19.3 as follows:

AAPA believes in partnering with other relevant associations including the PAEA, Patient Quality of Life Coalition (PQLC), American Academy of Hospice and Palliative Medicine (AAHPM), NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION (NHPCO), and ARC-PA to advance the progress of palliative care education AND PRACTICE.

Rationale/Justification

This policy was first enacted in 2018 and the influence of PAs in hospice and palliative medicine has grown substantially since then. PAHPM is now an affiliate member of the NHPCO and its members serve on NHPCO committees and are active in their projects.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None other than relevant staff time.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

Signature & Contact for the Resolution

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2022-C-06-PAHPM **Patient Hospice Benefits and PA Barriers**

2022-C-06 Resolved

AAPA believes that federal and state regulations should remove existing barriers for PA management of seriously ill and patients who elect to use their hospice benefit at state and national levels, allowing for parity with our advanced practice nursing colleagues.

Rationale/Justification

Ongoing and increasing shortage of providers, we have requisite training, the coming CAQ from NCCPA.

Related AAPA Policy

None

Possible Negative Implications

May be opposed by organized medicine since other providers are moving forward with similar proposals, which may cause them to be misinformed about our intentions.

Financial Impact

None other than relevant staff time.

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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2022-C-07-SA **The Role of EMS PAs in Pre-Hospital Care**

2022-C-07 Resolved

AAPA acknowledges the goals of EMS Agenda 2050 and the role that PAs can have, in collaboration with EMS providers, to provide care in the pre-hospital setting and expand ability for EMS agencies to support preventative health and community-centered programs.

Rationale/Justification

At the inception of emergency medical services (EMS), the focus of the service was centered on transporting a critically ill or injured patient to receive definitive treatment at a hospital. As the profession has evolved over the past 50 years, modern EMS in the United States progressed to include the rendering of advanced, life-saving care enroute by professional EMS providers which vastly improved patient outcomes. Despite advancements in healthcare since the start of the new millennium, the focus for EMS has largely remained on acute illness and injury. This general limitation of scope, in conjunction with the gaps in the overall healthcare continuum, has led to many within our society not receiving the care they need and deserve.

EMS agencies and associations are fully aware of the issue and have been leading the discussion on it, including with the landmark 1996 publication *EMS Agenda for the Future,* and the recent update of it, *EMS Agenda 2050*. *EMS Agenda 2050* was published in January 2019 by a technical expert panel comprised of physicians, paramedics, and EMS educators with the support of the National Highway Traffic Safety Administration (NHTSA) which regulates EMS within the United States. It features liaisons from a comprehensive list of organizations that work within or alongside EMS and was created in order to take an active role in shaping a vision for what EMS can potentially become. The vision of *EMS Agenda 2050* describes the EMS system of the future as people-centered, versatile, and serves as a mobile community healthcare resource that has an equal focus on preventing injury and illness and responding to emergencies. (7) The description of the EMS clinician of the future highlights the evolving nature of such individuals, and the more advanced and proactive role they will have to take in patient care. The Agenda's guiding principle of 'Integrated & Seamless' includes a provision that EMS and its partners will coordinate to provide the most appropriate care to the patient and recognize that transport to a healthcare facility is only one of many options. (7) Initiatives such as Mobile Integrated Healthcare–Community Paramedicine (MIH-CP) represent an existing effort to fulfill some of these goals. It increases access to care in underserved areas, expands the spectrum of services that patients can be transported or referred to, and compassionately reduces high system utilization. (1) However, there is an incredible burden on current EMS providers to fulfill this preventative role, while simultaneously being first-line providers in acute illness and trauma.

As EMS advances from a service that solely cares for acute illness and injury to one that also addresses the debilitating impact of chronic disease, it is important to consider that PAs are well-suited to support this change. Emergency Medical Services Physician Assistants (EMS PA) have an expanded scope of practice when compared to existing EMS providers and can provide

support in the form of advanced, non-algorithmic patient care, medical clearance on scene, and liaison between EMS systems and the larger healthcare continuum. (5) Stakeholder organizations such as the Society of Emergency Physician Assistants (SEMPA) and the National Association of EMS Physicians (NAEMSP) share this perspective and have authored documents detailing their recommendations for what the role of an EMS PA should be. In July 2021, SEMPA published the Guidelines for the Emergency Medical Services Physician Assistant. Within this document, roles and initiatives for EMS PAs to participate in are detailed, such as Field Advanced Practice, Field Response Alternative Dispositions, and Mobile Integrated Healthcare (MIH). (5) MIH, as aforementioned, is a service that is ideally oriented with an interprofessional approach that would also include vital care such as behavioral health and social support in addition to medical care. No matter the team, the EMS PA will be able to consistently provide a measure of interdisciplinary cohesion and unity. In November 2021, NAEMSP published a position statement, approved by the NAEMSP Board of Directors, on the role of EMS PAs and Nurse Practitioners (NP) in EMS systems. (3) The statement largely mirrors SEMPA's guidelines and signifies support by physicians for the utilization of PAs within EMS systems. Physician endorsement is invaluable given their central role in providing medical direction for EMS systems.

Issues with overextension of personnel and ineffective use of resources in the overall emergency services framework have been previously recognized by AAPA. Policy HX-4700.2.1 states that "AAPA believes overcrowded emergency departments (ED) threaten access to emergency care for all patients". This policy was adopted in 2007 and reaffirmed in 2012 and 2017, identifying it as an issue of importance. Policies HX-4700.2.2 and HX-4700.2.5 detail opposition to boarding of admitted patients in the ED and advocate for proper staffing in the name of patient safety. These policies recognize the issues brought upon hospitals when the only option for EMS is to transport patients to the ED, while alternatives exist and serve as an option to address overutilization of EMS.

Overutilization of EMS leads to a vicious cycle that focuses on temporary fixes and treatments and is a prime focus for EMS PAs and programs such as the Emergency Triage, Treat, and Transport (ET3) Model. In 2019, the Centers for Medicare and Medicaid Services (CMS) created ET3 which allows participating ambulance service providers to reimbursement for transporting patients to alternative destinations, like primary or urgent care, or provide medical treatment in place without transport. (6) This model signifies government support for EMS agencies' efforts to address chronic illness. The Los Angeles Fire Department also launched a pilot program known as the Advanced Provider Response Unit which initially featured an NP in the field with a paramedic partner to provide direct care as well as medical clearance, treatment in place, and referral to alternative destinations. During the first 18 months, the unit treated over 800 patients and 50% were treated on scene or medically cleared and transported to an alternative destination. 12 of 18 super-users encountered were connected with social services and decreased their EMS utilization in the following 90 days. (4) In Austin, Texas, a PA practices as a "paramedic practitioner" to similarly address these gaps and provide care to vulnerable populations. Currently, he treats between 80-120 patients a month, supporting mostly individuals

experiencing homelessness, but also individuals of lower socioeconomic status with limited health care access. (2)

The current emergency care framework in the U.S. falls short in caring for patients, especially those with high barriers to care. This multifactorial problem does not have a simple solution and deserves a concerted effort to address the foundational issues through reimagining how healthcare is delivered, and the providers involved in doing so. AAPA is able to support the implementation of a meaningful solution through recognizing the potential EMS PAs have to improve patient health and access by bringing a higher level of care to the most vulnerable within our society. EMS has a central role within the future of management of community health and chronic disease and PAs will be a key to its success.

Related AAPA Policy

HX-4700.2.1
AAPA believes overcrowded emergency departments (ED) threaten access to emergency care for all patients.
[*Adopted 2007, reaffirmed 2012, 2017*]

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.
[*Adopted 2007, reaffirmed 2012, 2017*]

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.
[*Adopted 2007, reaffirmed 2012, 2017*]

Possible Negative Implications

None

Financial Impact

None

Attestation

I attest that this resolution was reviewed by the submitting organization's Board and/or officers and approved as submitted (commissions, work groups and task forces are exempt).

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2022-C-08-GRPA **Reimbursement or Regulation of PAs Based on Academic Credentials**

2022-C-08 Resolved

Amend policy HP-3100.2.3 as follows:

AAPA opposes PRACTICE STATUTES AND REGULATIONS, OR PAYMENT POLICIES ~~any regulations, guidelines or payment policies~~ that TREAT ~~differentiate between~~ PAs DIFFERENTLY on the basis of length of, OR THE SPECIFIC ACADEMIC CREDENTIALS GRANTED UPON GRADUATION FROM THEIR PA EDUCATIONAL PROGRAM. ~~educational program or academic credentials granted if those PAs otherwise meet all criteria for fellow membership in the Academy.~~

Rationale/Justification

Combining HP-3100.2.3 and HP-3200.1.2 streamlines and clarifies policy language. It also eliminates redundant policies.

Related AAPA Policy

HP-3200.1.2 (recommended for expiration)

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.

[Adopted 2007, reaffirmed 2012, 2017]

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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2022-C-09-GRPA **AAPA's Promotion of PA Utilization**

2022-C-09 Resolved

Amend policy HP-3400.2.2 as follows:

AAPA shall promote THE optimal utilization of PAs TO EMPLOYERS, LEGISLATORS, POLICY MAKERS, PATIENTS AND OTHER HEALTHCARE STAKEHOLDERS. This includes providing information ~~on~~ AND DATA ON PA SCOPE OF PRACTICE, QUALITY OF CARE, ~~credentialing,~~ cost-effectiveness, ~~scope of practice,~~ reimbursement, and other relevant ~~data~~ TOPICS.

Rationale/Justification

The proposed language changes provide more context to a targeted audience. They also reflect the evolution of data driven metrics to guide healthcare decisions.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

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2022-C-10-GRPA **Team-Based Care**

2022-C-10 Resolved

Amend policy HP-3400.1.2 as follows:

AAPA believes THAT TEAM-BASED CARE LEADS TO BETTER PATIENT OUTCOMES. ~~the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high-quality healthcare~~. ~~As the structure of the healthcare system changes, it is critical that this essential relationship be preserved and strengthened.~~ PAs, PHYSICIANS AND OTHER HEALTH PROFESSIONALS CONTINUE TO BE ESSENTIAL AND TRUSTED MEMBERS OF THE HEALTHCARE TEAM.

Rationale/Justification

Since the adoption and implementation of OTP, transition to team-based language throughout HOD policies is a natural evolution to reflect the implementation of the tenets of OTP. It also represents an organizational commitment to a team concept central to Optimal Team Practice. AAPA language should reflect that team concept.

Related AAPA Policy

HP-3100.2.1
PAs practice patient-centered, team-based medicine with physicians and other healthcare professionals.
[Adopted 1980, reaffirmed 1990, 1993, 2000, 2005, 2010, amended 1991, 1996, 2015, 2021]

HP-3400.1.2.1
AAPA opposes any mandatory policy, regulation or restriction in state or federal law that limits the number of PAs and physicians that can form collaborative relationships. AAPA believes that the number of PA and physician collaborative relationships should be determined at the practice level.
[Adopted 2018]

HP-3400.2.1 (recommended for expiration)
AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality healthcare. 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.
[Adopted 1996, reaffirmed 2001, 2007, 2012, amended 1997, 2017]

Possible Negative Implications

None

Financial Impact

None

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2022-C-11-GRPA **PA Practice Act Language**

2022-C-11 Resolved

Amend policy HP-3500.3.4.4 as follows:

AAPA opposes the inclusion OF NON-PA HEALTHCARE PROFESSIONALS IN ~~or sharing of~~ PA state practice acts ~~with any non-PA healthcare professions~~.

Rationale/Justification

Clarify the language and context of the policy.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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2022-C-12-GRPA **Unrestricted Shared Decision-Making Between Patient and Provider**

2022-C-12 Resolved

Amend policy HX-4600.1.2 as follows:

AAPA supports the free AND TRANSPARENT exchange of information between the patient and provider NECESSARY TO MAKE INFORMED HEALTHCARE DECISIONS. AAPA ~~and~~ opposes any intrusion into the provider-patient relationship THAT INHIBITS THE PROVIDER'S ABILITY TO DELIVER NECESSARY MEDICAL SERVICES. ~~through restrictive informed consent laws, biased patient education or information, or restrictive government requirements of medical facilities.~~ AAPA SUPPORTS CREATION OF VIRTUAL METHODS AND PATIENT DECISION AIDS DESIGNED TO FACILITATE SHARED DECISION-MAKING AND INFORMED CONSENT IN AN EFFICIENT, LAWFUL, AND ETHICAL MANNER BETWEEN PATIENT AND PROVIDER.

Rationale/Justification

Update policy language and address the effect of virtual healthcare environments as well as the effects of isolated care environments such as Covid on patient-provider exchanges. Allow for emerging standardization of shared decision making and how informed consent is best obtained in these evolving and challenging environments.

Related AAPA Policy

HX-4600.1.1

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

[Adopted 1997, amended 2007, reaffirmed 2002, 2012, 2017]

Possible Negative Implications

None

Financial Impact

None

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2022-C-13-GRPA **Electronic Prescribing Compliance**

2022-C-13 Resolved

Amend policy HX-4600.5.4 as follows:

AAPA believes ~~that~~ information technology ~~software~~ should enable PAs to write ~~appropriate, legal~~ electronic prescriptions ~~that comply~~ IN COMPLIANCE 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.

Rationale/Justification

Updated language reflecting evolving technologic advancements in electronic prescribing programs that interface with electronic medical record systems.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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2022-C-14-GRPA **The PA in Disaster Response: Core Guidelines (Referred 2021-D-10)**

2022-C-14 Resolved

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

Rationale/Justification

The PA in Disaster Response: Core Guidelines paper has been updated to better reflect the needs of both patients and PAs in an everchanging environment that involves the need to plan and execute disaster relief efforts.

Changes in the paper highlight the need to understand how to provide services to patients under the challenges of surge capacity under resource-constrained conditions and the implementation of crisis standards of care including the utilization of alternate care facilities.

The paper also updates language encouraging PAs, to the extent possible, to be mindful and respectful of the cultural norms, customs and healthcare beliefs of the patient populations they are serving during a disaster.

Added to the paper is a section regarding disaster medicine training programs and the need to develop standardized training, competency-based and inter-professional education and training, and risk-reduction interventions as part of the overall approach to disaster medicine relief efforts.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

Signature & Contact for the Resolution

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The PA in Disaster Response: Core Guidelines

[Adopted 2006, amended 2010, 2015]

Executive Summary of Policy Contained in this Paper

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

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

Introduction

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

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

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

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

1. Reverse adverse health effects caused by the event
2. Modify the hazard responsible for the event (reducing the risk of the occurrence of another event)
3. Decrease the vulnerability of 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~~ TECHNOLOGICAL advances, environmental changes and economic uncertainty. In addition, all facets of the emergency management community can face increasing complexity and decreasing predictability in their

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

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

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

AAPA recommends that all PAs become more familiar with the tenets and challenges of disaster medicine and working in austere environments and encourages PA education programs to introduce this specialty area as part of their curriculum.

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

Preparation Through Education

In addition to understanding the principles of critical event management, effective disaster response requires training and preparation for austere practice conditions and unanticipated assignments. Unless absolutely necessary, disaster medicine should not be practiced by PAs who do not possess the knowledge and skills needed to function effectively AND SAFELY in the specialized environment with ALTERNATIVE

STANDARDS OF PATIENT CARE of the disaster scene. THEREFORE, PAs should ~~therefore~~ prepare in advance for 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 PERSONAL safety in disaster response situations, including having the proper protective equipment (PPE), TRAINING AND ABILITY TO PROVIDE DECONTAMINATION TO BOTH SELF AND PATIENTS.
3. RECOGNIZE THAT PPE IS TYPICALLY NOT PROVIDED OR MAY NOT BE ADEQUATE AT A DISASTER SITE, ESPECIALLY THOSE SPONSORED BY NON-GOVERNMENTAL ORGANIZATIONS (NGOs). PAs SHOULD BE PREPARED TO BRING THEIR OWN PPE APPROPRIATE BASED ON SPECIFIC HAZARD VULNERABILITY ANALYSIS.
4. 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.~~
5. UNDERSTAND HOW TO PROVIDE SERVICES TO PATIENTS UNDER THE CHALLENGES OF SURGE CAPACITY IN RESOURCE CONSTRAINED SETTINGS.
6. UNDERSTAND IMPLEMENTATION OF CRISIS STANDARDS OF CARE AND UTILIZATION OF ALTERNATIVE CARE FACILITIES.
7. UNDERSTAND HOSPITAL PREPAREDNESS AND HAZARD VULNERABILTIY.
8. UNDERSTAND THE BASIC TENETS OF FATALITY MANAGEMENT.

9. DEVELOP COPING MECHANISMS TO DEAL WITH EMOTIONAL AND PSYCHOLOGICAL STRESS THAT FREQUENTLY OCCUR DURING AND AFTER DISASTERS.
10. Learn how to develop clinical competence to provide effective care with extremely limited resources.
    a. Maintain certifications in: BLS, ACLS, and PALS
    b. RECOGNIZING THE NEED FOR PROFICIENCY IN TRAUMA, MAINTENANCE OF ADVANCE TRAUMA LIFE SUPPORT (ATLS) CERTIFICATION WOULD BE RECOMMENDED EVERY 4 YEARS.
    c. Additional ~~recommended~~ specialty training THAT IS HIGHLY RECOMMENDED INCLUDE: ~~in:~~ Advanced Disaster Life Support, ~~Advanced Trauma Life Support~~, Advanced Disaster Medical Response AND ADVANCED HAZARD LIFE SUPPORT. Prepare and take the National healthcare Disaster Certification (NHDP-BC) offered by the American Nurses Credentialing center (ANCC) or equivalent certification examination. NOTE THAT THE ANCC CERTIFICATION WILL BE RETIRED DECEMBER 31, 2022.
    d. Stay up to date with ever-changing disaster medical information from various AAPA-approved web sites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.
11. 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.
12. 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.

13. 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) OR FEDERAL TEAMS SUCH AS: DISASTER MEDICAL ASSISTANCE TEAMS (THROUGH THE NATIONAL DISASTER MEDICAL SYSTEM), FEDERAL CITIZENS RESPONSE TEAMS (CERT), MEDICAL RESERVE CORP. THERE ARE ALSO VARIOUS STATE TEAMS INCLUDING: STATE MEDICAL ASSISTANCE TEAMS (SMAT) OR THROUGH OTHER TEAMS ORGANIZED BY CHARITIES OR STATE/LOCAL GOVERNMENTS. VOLUNTEERING THROUGH ESTABLISHED EMERGENCY RESPONSE ORGANIZATIONS HELPS TO ENSURE VERIFICATION OF ALL RESPONDER'S CREDENTIALS IN ADVANCE OF A DISASTER EVENT. IN ADDITION, ALL WORKERS SHOULD CARRY COPIES OF THEIR LICENSE AND RELEVANT CERTIFICATIONS TO PRESENT WHEN REQUESTED.

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 need 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, 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 authorizations 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 of 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 alleviated through foresight, preparedness courses and individual preparation for the new roles often encountered found in complex situations. (3)(4) Responders may need to be fully self-

sufficient so as to not drain precious, limited resources and further deplete supplies for survivors.

Each group that responds to a disaster brings its own logistical capabilities, priorities, goals and expectations. Coordinating this sudden ad hoc network of organizations can be a very big challenge. As a rule, in a multi-organizational response to a disaster, the more unfamiliar responders are with their tasks and with their co-workers, the less efficient and the more resource-intensive the response is. (3)(5) PA relief workers should be aware of the efforts and objectives of these other response operations and ensure that efforts to provide medical care do not 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 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 handwashing, 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~~ MINDFULNESS and for individual workers to be sensitive to the population they serve should BE UNDERSTOOD. 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~~ TO INCREASE THEIR cultural MINDFULNESS AND understanding OF HEALTHCARE CUSTOMS OF THE POPULATIONS THEY ARE SERVING. (2)(6)

Standards for Crisis Care

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

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

healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations." (7)

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

"Crisis" care occurs when resources, personnel and structures are stretched, or nonexistent and conventional or contingency standards are no longer possible. Implementation of the crisis standard of care is not an optional decision but is forced by 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 force of law and authoritative enforcement to preserve the benefit of the challenged community.

Guidelines for PAs Responding to Disasters

1. PAs should participate in disaster relief through established channels
    a. Consider joining non-governmental organizations, government agencies, State Medical Assistance Teams, Disaster Medical Assistance Teams, CERT (Citizens Emergency Response Team) or other organized groups with a focus in providing disaster services. AAPA's Disaster Medicine Association of PAs can help provide direction as well.
    b. Participate in workplace disaster planning.
    c. Stay current with information from reliable resources.
    d. Make every effort not to become a victim of the event or to cause harm to others.
2. PAs should support comprehensive, team-based healthcare.
    a. Become proficient in the National Incident Management System's Incident Command System.
    b. Learn to be flexible in working in unfamiliar places and circumstances – many times you have to become comfortable with "hurry up and wait" scenarios.
3. PAs should prepare for and expect the possibility of coping with scarce medical resources and nonmedical assignment in disaster situations.
    a. Participate in local disaster planning events.
    b. Participate in various webinars, tabletop 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. EMERGENCY MANAGEMENT INSTITUTE
        iv. Department of Homeland Security (DHS)

v. Health and Human Resources (HHS)
vi. 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~~ MINDFULNESS 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 (STOP THE BLEED); 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 a deleterious effect on other casualties.

Summary

AAPA endorses and promotes the support of disaster preparedness, NATIONAL RESILIENCY BY PROVIDING EDUCATION AND TRAINING RESOURCES, and response activities and the integration of PAs as key personnel in mitigating the impact of disasters. PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts. As such, AAPA supports educational activities that prepare the profession for participation in disaster medical planning, training and response and will work with all appropriate disaster response agencies to update their policies to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.

AAPA believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals and practices in preparation for all disasters that affect our communities, nation and the world. AAPA recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response. Finally, AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state, or local emergencies and public health crises.

AAPA SUPPORTS THE FUTURE OF DISASTER MEDICINE TRAINING PROGRAMS THAT STRIVE TO:

1. DEVELOP CONSENSUS ON WHICH EDUCATIONAL MODELS OR TOOLS WOULD BEST PREPARE OUR MEDICAL WORKFORCE.
2. DEVELOP STANDARDIZED TRAINING PROGRAMS APPLICABLE TO ALL MEDICAL PROVIDERS REGARDLESS OF TRAINING OR BACKGROUND.
3. DEVELOP COMPETENCY BASED MEDICAL EDUCATION WHICH CAN BE MEASURED AGAINST BENCHMARKS FOCUSED ON ALL-HAZARD DISASTER CURRICULA AND TRAINING COURSES.
4. BE INTER-PROFESSIONAL IN TRAINING AND FOSTER AN ACADEMIC ENVIRONMENT TO DISSEMINATE INFORMATION.
5. RECOGNIZE THE URGENT NEED TO IMPLEMENT EPIDEMIOLOGICAL DISEASE RESEARCH. AAPA RECOGNIZES THAT RESEARCH GUIDES EVIDENCE AND CONTRIBUTES TO THE DESIGN AND SELECTION OF RISK-REDUCTION INTERVENTIONS AS WELL AS THE CREATION OF BEST PRACTICES AND STANDARDS.
6. STRIVE TO DEVELOP A NATION THAT CAN BECOME RESILIENT TO ALL DISASTERS WITH STRONG AND CAPABLE MEDICAL WORKFORCE MEMBERS.

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Resources

FEDERAL EMERGENCY MANAGEMENT EMERGENCY MANAGEMENT INSTITUTE **https://training.fema.gov/is/searchis.aspx?search=pds**
IS-120.C AN INTRODUCTION TO EXERCISES
IS230.D FUNDAMENTALS OF EMERGENCY MANAGEMENT
IS-235C EMERGENCY PLANNING
IS-250.B LEADERSHIP AND INFLUENCE

SUGGESTED TEXTBOOKS
CIOTTONE, G.R. (2016). DISASTER MEDICINE. PHILADELPHIA: ELSEVIEW MOSBY. ISBN: 9780323286657

AUERACH, P.S. (2020). WILDERNESS MEDICINE. 7TH ED. PHILADELPHIA: MOSBY ELSEVIER. ISBN: 9780323359429

DAVENPORT, G. (2006). WILDERNESS SURVIVAL. 2ND ED. STACKPOLE BOOKS. ISBN: 9780811732925

NATIONAL CENTER FOR DISASTER MEDICINE AND PUBLIC HEALTH (JANUARY 2022) **https://ncdmph.usuhs.edu/**

Ass'n for Prevention Teaching and Research, Clinician Competencies for Emergency Preparedness Brochure

Basic Disaster Life Support Course, Nat'l Disaster Life Support Found., http://www.ndlsf.org/common/content.asp?PAGE=347 (last visited Mar. 24, 2015).

Public Health Ethics in Disasters, U.N.C. Gillings Sch. of Global Pub. Health, http://www.sph.unc.edu/ethics/public_health_ethics_in_disasters/ (last visited Mar. 24, 2015).

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2022-C-15-GRPA **The Role of In-Store or Retail-Based Convenient Care Clinics**

2022-C-15 Resolved

Amend the policy paper entitled *The Role of In-Store or Retail-Based Convenient Care Clinics*. See policy paper.

Rationale/Justification

Minor updates of the policy language are needed to reflect the proliferation of retail-based clinics and the evolution of practice in this setting.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

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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 HP-3400.1.3, 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 episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference." [HP-3400.1.3, adopted 2003, reaffirmed 2008, 2013, amended 2018]

Delivery of healthcare in America keeps changing. Consumer preferences affect all businesses and healthcare is no exception. ~~Store based r~~Retail health clinics, PARTICULARLY THOSE STORE-BASED LOCATIONS, 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.~~ FURTHER, RETAIL HEALTH CLINICS HAVE PLAYED A SIGNIFICANT ROLE IN THE COVID-19 PANDEMIC.

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.~~ TODAY THERE ARE MORE THAN 3,300 SUCH CLINICS IN THE US, CANADA AND MEXICO WITH THE MAJORITY OF THE INDUSTRY LOCATED IN THE UNITED STATES SPECIFICALLY[i]. CURRENTLY RETAIL HEALTH CLINICS ARE PRESENT IN 44 STATES AND THE DISTRICT OF COLUMBIA AND HAVE PROVIDED MORE THAN 50 MILLION PATIENT VISITS. 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. IN ADDITION, NUMEROUS ~~Some~~ companies ~~make these~~ PARTNER WITH THESE CLINICS TO ENSURE these ~~clinic~~ services are 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 preventive care, wellness screening, acute visits, physicals, and many more services. Many point of care tests are available to assist in diagnosis and treatment.

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

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

The store-based health clinics provide employment opportunities for physicians, nurse practitioners and PAs. A review of the retail clinic websites 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. IT IS VITAL THAT STATE PA PRACTICE LAWS ARE NOT OVERLY RESTRICTIVE TO PREVENT PA EMPLOYMENT IN THESE IMPORTANT CENTERS.

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~~ PROVIDER 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 preventive, 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 PRIMARY CARE PROVIDER (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~~ METHOD 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~~ INCREASING OPPORTUNITIES 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

1. Jacoby, Richard, Albert G. Crawford, et al. "Quality of Care for 2 Common Pediatric Conditions Treated by Convenient Care Providers." American Journal of Medical Quality. 2010.
2. Mehrotra, Ateev, Llu Hangsheng, John L. Adams, et al. "Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses." Annals of Internal Medicine.151 no. 5 (2009):321-328.

[i] **Convenient Care Association (CCA). www.ccaclinics.org/**

2022-C-16-GRPA **AAPA Encourages Use of Telemedicine Services by PAs**

2022-C-16 Resolved

Amend policy HX-4500.1 as follows:

AAPA believes that telemedicine IMPROVES ~~can improve~~ access to cost-effective, quality healthcare. ~~and improves 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 AND PA STUDENTS to BECOME PROFICIENT ~~take an active role in the utilization and evaluation of this technology~~ IN BEST PRACTICES OF TELEMEDICINE TECHNOLOGY AND THE CLINICAL DELIVERY OF TELEMEDICINE SERVICES. ~~AAPA supports further research and development in telemedicine, including resolution of problems related to regulation, reimbursement, liability, and confidentiality.~~

Rationale/Justification

Update policy language to reflect the current healthcare environment and increased utilization of telemedicine services. Separate concepts of utilization of telemedicine technology from advocacy efforts to enhance utilization and advancement of these services. Advocacy considerations warrant a self-standing, separate policy.

Related AAPA Policy

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]

Possible Negative Implications

None

Financial Impact

None

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2022-C-17-GRPA **Advocacy for Telemedicine Implementation and Removal of Barriers**

2022-C-17 Resolved

AAPA encourages PAs and PA students to advocate for appropriate resource allocation to support development of telemedicine programs. AAPA supports the elimination of barriers to implementation and utilization of telemedicine services for patients, providers and the healthcare system.

Rationale/Justification

Telemedicine utilization has dramatically increased the past two years. Covid, in particular, has punctuated the importance of developing these services to allow for increased access to care for patients and best utilization of provider resources. Covid demands have also highlighted limitations and barriers in regulatory oversight, laws, and coverage/reimbursement for these services. Its important for the profession to be active participants in the revision and development of all issues related to the advancement of telemedicine services.

Related AAPA Policy

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-4500.1

AAPA believes that telemedicine can improve access to cost-effective, quality healthcare 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.

[Adopted 1997, reaffirmed 2002, 2007, 2012, 2017]

Possible Negative Implications

None

Financial Impact

None

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2022-C-18-GRPA **Pharmaceutical Samples Access**

2022-C-18 Resolved

Amend policy HX-4600.5.1 as follows:

AAPA supports ~~legislative efforts to block the diversion of prescription drugs to illicit channels and prevent the sale or trade of samples, while preserving appropriate access by PAs and other appropriate healthcare practitioners to samples of prescription drugs from pharmaceutical manufacturers.~~ THE PRACTICING PA'S APPROPRIATE AND COMPLIANT ACCESS TO SAMPLES OF PRESCRIPTION DRUGS FROM PHARMACEUTICAL MANUFACTURERS.

Rationale/Justification

Updated policy language reflects the current environment of the allocation and dispersal of pharmaceutical samples. Compliance requirements at multiple levels from the pharmaceutical manufacturer to the pharmaceutical sales representatives address the concerns about diversion and misuse of sample medications when the original policy was adopted. A policy addressing the access to pharmaceutical samples should remain; however, concerns related to legal or regulatory limitation of PA access to sample medications is no longer a primary issue.

Related AAPA Policy

HX-4600.5.8

AAPA shall actively engage in efforts to educate healthcare advertisers about PA prescribing authority and practices. AAPA shall encourage healthcare advertisers to avoid such language as "only your doctor can diagnose" or "only your doctor can prescribe."

[Adopted 1994, reaffirmed 1999, 2004, 2006, 2011, 2016, 2021]

Possible Negative Implications

None

Financial Impact

None

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2022-C-19-GRPA **NCCPA Lobby Activity**

2022-C-19 Resolved

Amend policy HP-3500.3.6 as follows:

AAPA opposes unsolicited lobbying ACTIVITIES by the NCCPA RELATED TO PA STATE OR FEDERAL PRACTICE STATUTES OR REGULATIONS, SCOPE OF PRACTICE, EMPLOYMENT, PAYER CREDENTIALING OR REIMBURSEMENT REQUIREMENTS.

Rationale/Justification

The existing policy suggest that AAPA desires an all-encompassing policy against the NCCPA engaging in any (unsolicited) lobbying activities. AAPA's concern should be more focused on ensuring that NCCPA not be involved in unsolicited lobbying efforts affecting PA practice, including state and laws and regulations, cope of practice, employment and payment policies.

Related AAPA Policy

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.

[Adopted 1990, reaffirmed 1995, 2000, 2005, 2010, 2015, 2020]

HP-3200.4.2

Specialty Certification, Clinical Flexibility, and Adaptability (paper on page 204)

(Adopted 2017)

Possible Negative Implications

None

Financial Impact

None

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