2022 Summary of Actions

**AAPA House of Delegates Meeting**

**Indianapolis, IN**

**May 20-22, 2022**

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

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| --- | --- | --- | --- |
| **Resolution** | **Title** | **Line Number** | **Action Taken** |
| 2022-A-01 | [Article X, XI -- Governance Commission & Oversight of Nominating Work Group](#A01) | 1 | Tabled Indefinitely |
| 2022-A-02\* | [Article III, Section 4, Article V, Section 4a, Article XIII, Section 5a -- Credentialed Student Members Voting in General Elections](#A02) | 58 | Adopted as Amended |
| 2022-A-03\* | [Article I -- Corporate Name Change](#A03) | 99 | Adopted on Consent Agenda |
| 2022-A-04 | [Spanish Translation for Professional Title](#A04) | 108 | Adopted on Consent Agenda |
| 2022-A-05 | [Branding Asociado Medico](#A05) | 115 | Adopted on Consent Agenda |
| 2022-A-06 | [Diversity, Equity, and Inclusion through Language Access](#A06) | 121 | Adopted on Consent Agenda |
| 2022-A-07a | [Reducing Barriers to Board of Directors Candidacy & Other AAPA Opportunities](#A07a) | 128 | Adopted |
| 2022-A-07b | [Reducing Barriers to Board of Directors Candidacy & Other AAPA Opportunities](#A07b) | 136 | Referred |
| 2022-A-08 | [Access to Care](#A08) | 147 | Adopted as Amended |
| 2022-A-09 | [Health Disparities](#A09) | 161 | Adopted on Consent Agenda |
| 2022-A-10 | [Providing Culturally Effective Care and Eliminating Health Disparity Gaps](#A10) | 169 | Adopted on Consent Agenda |
| 2022-A-11a | [Educational Experiences Targeting Diversity and Inclusion in Strategic Partnerships to Eliminate Health Disparities](#A11a) | 187 | Adopted |
| 2022-A-11b | [Educational Experiences Targeting Diversity and Inclusion in Strategic Partnerships to Eliminate Health Disparities](#A11b) | 204 | Adopted as Amended |
| 2022-A-12 | [Legislation and Policies to Eliminate Discrimination](#A12) | 210 | Adopted on Consent Agenda |
| 2022-A-13 | [Usage of Advanced Practice Provider (APP) and Advanced Care Provider (ACP) during PA Events](#A13) | 218 | Adopted as Amended |
| 2022-A-14 | [Guidelines for State Regulation of PAs](#A14)  | 233 | Adopted as Amended |
|  |  |  |  |
| 2022-B-01 | [Initial Education](#B01) | 546 | Adopted |
| 2022-B-02 | [Specialty Certification, Clinical Flexibility, and Adaptability](#B02) | 553 | Adopted |
| 2022-B-03 | [Increased CME Credit for Precepting](#B03) | 990 | Adopted as Amended |
| 2022-B-04 | [PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers](#B04) | 998 | Adopted on Consent Agenda |
| 2022-B-05 | [Identifying and Cultivating CORE Leadership Skills for PAs](#B05) | 1552 | Adopted as Amended |
| 2022-B-06 | [Replacement Policy for the Importance of PAs in Executive Leadership Policy Paper](#B06) | 1560 | Adopted on Consent Agenda |
| 2022-B-07 | [Development of Transition to Practice Programs/Onboarding Templates](#B07) | 1568 | Adopted as Amended |
| 2022-B-08 | [Reproductive Healthcare Restrictions](#B08) | 1577 | Adopted as Amended |
| 2022-B-09 | [Breastfeeding](#B09) | 1584 | Adopted as Amended |
| 2022-B-10a | [Button Battery Safety Legislation](#B10a) | 1596 | Adopted |
| 2022-B-10b | [Button Battery Safety Education](#B10b) | 1602 | Adopted as Amended |
| 2022-B-11 | [Cannabinoids](#B11) | 1609 | Adopted as Amended |
| 2022-B-12 | [False or Deceptive Healthcare Advertising](#B12) | 1621 | Adopted on Consent Agenda |
| 2022-B-13 | [Hepatitis](#B13) | 1728 | Adopted on Consent Agenda |
| 2022-B-14 | [Interprofessional Medical Education to Incorporate the PAs Role](#B14) | 1740 | Adopted as Amended |
| 2022-B-15 | [Health Equity for Students Pursuing PA Education](#B15)  | 1753 | Adopted as Amended |
| 2022-B-16 | [Recruitment and Retention - Amendment to Include Disabilities and Application Barriers](#B16) | 1758 | Adopted as Amended |
|  |  |  |  |
| 2022-C-01 | [Support for Hemorrhage Control/Stop the Bleed Campaign](#C01) | 1771 | Adopted |
| 2022-C-02 | [Immunizations in Children and Adults](#C02) | 1780 | Adopted as Amended |
| 2022-C-03 | [Global Epidemic HIV-AIDS](#C03) | 2182 | Adopted on Consent Agenda |
| 2022-C-04 | [Reduced Restrictions on Methadone](#C04)  | 2757 | Adopted |
| 2022-C-05 | [Advancing Progress of Palliative Care Education and Practice](#C05) | 2762 | Adopted on Consent Agenda |
| 2022-C-06 | [Patient Hospice Benefits and PA Barriers](#C06) | 2772 | Adopted as Amended |
| 2022-C-07 | [Role of EMS PAs in Pre-Hospital Care](#C07) | 2779 | Adopted on Consent Agenda |
| 2022-C-08 | [Reimbursement or Regulation of PAs Based on Academic Credentials](#C08) | 2786 | Adopted |
| 2022-C-09 | [AAPA’s Promotion of PA Utilization](#C09) | 2797 | Adopted on Consent Agenda |
| 2022-C-10 | [Team-Based Care](#C10) | 2807 | Adopted as Amended |
| 2022-C-11 | [PA Practice Act Language](#C11) | 2818 | Adopted on Consent Agenda |
| 2022-C-12 | [Unrestricted Shared Decision-Making Between Patient and Provider](#C12) | 2825 | Adopted on Consent Agenda |
| 2022-C-13 | [Electronic Prescribing Compliance](#C13) | 2840 | Adopted on Consent Agenda |
| 2022-C-14 | [The PA in Disaster Repose: Core Guidelines](#C14) | 2851 | Adopted on Consent Agenda |
| 2022-C-15 | [The Role of In-Store or Retail-Based Convenient Care Clinics](#C15) | 3389 | Adopted on Consent Agenda |
| 2022-C-16 | [AAPA Encourages Use of Telemedicine Services by PAs](#C16) | 3518 | Adopted as Amended |
| 2022-C-17 | [Advocacy for Telemedicine Implementation and Removal of Barriers](#C17) | 3533 | Adopted on Consent Agenda |
| 2022-C-18 | [Pharmaceutical Samples Access](#C18) | 3540 | Adopted as Amended |
| 2022-C-19 | [NCCPA Lobby Activity](#C19) | 3551 | Adopted on Consent Agenda |
| 2022-C-20 | [Alternatives to Mass Deportation of Immigrants](#C20) | 3560 | Adopted as Amended |
| 2022-C-21 | [Care of Undocumented Persons](#C21) | 3570 | Reaffirmed |
| 2022-C-22 | [Opportunity for Immigrants](#C22) | 3579 | Reaffirmed |
| **Reaffirmed Policies** |
| HP-3200.1.1 | HX-4200.6.1 | HX-4600.5.5 |
| HP-3300.1.17 | HX-4200.6.2 | HX-4600.5.6 |
| HP-3300.2.2 | HX-4300.1.3 | HX-4600.5.7 |
| HP-3800.1.3 | HX-4300.1.4 | HX-4700.2.1 |
| HX-4100.1.2 | HX-4300.1.5 | HX-4700.2.2 |
| HX-4100.1.5 | HX-4400.2.3 | HX-4700.2.3 |
| HX-4200.1.1 | HX-4600.2.3 | HX-4700.2.4 |
| HX-4200.1.3 | HX-4600.3.4 | HX-4700.2.5 |
| HX-4200.1.9 |  |  |
| **Expired Policies** |
| HP-3200.1.2 | HP-3400.2.1 | HX-4600.1.1 |
| HP-3300.2.3.1 | HP-3700.2.5 | HX-4600.1.4 |
| **Resolution of Condolence** | **Line Number** | **Purpose** |
| NB-1 | 3589 | [Condolence for](#NB01) [John Dennis Trimbath](#NB01) |
| **House Elections** | **Line Number** |  |
| [Results](#ELECTION) | 3670 |  |

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# Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 22, 2022.

# Presiding Officers

Todd Pickard, MMSc, PA-C, DFAAPA, FASCO Speaker of the House

Leslie Clayton, MPAS, PA-C, DFAAPA First Vice Speaker

Peggy Walsh, MS, PA-C Second Vice Speaker

**2022-A-01 – Tabled Indefinitely**

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.

1. Composition. The Governance Commission shall be appointed by the AAPA Board of Directors in accordance with policies and procedures established by the Board.
2. Duties & RESPONSIBILITIES. The DUTIES and RESPONSIBILITIES of the Governance Commission shall include:
	1. Review AAPA governing documents and make recommendations to improve the effectiveness of AAPA’s governance.
	2. Establish policies and procedures governing all AAPA elections and APPROVE competencies for candidates seeking elected office.
	3. Oversee the charges and activities of the Nominating Work Group.
	4. Carry out such PROCESSES as are set forth in these bylaws.
	5. 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:

1. 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.
2. Support communication and education efforts to inform all members of elected leadership opportunities and how to qualify for those positions.
3. Identify and recruit qualified members and encourage a broad slate of candidates to run for elected positions within AAPA.
4. 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.
5. Endorsing a single or multiple slate of candidates for each ~~nominated~~ OPEN BOARD POSITION.

**2022-A-02 – Adopted as Amended** (Requires AAPA Board of Directors Ratification)

 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~~ THE STUDENT BOARD OF DIRECTORS AND APPORTIONED 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.

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

**2022-A-03 – Adopted on Consent Agenda** (Requires AAPA Board of Directors Ratification)

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.

**2022-A-04 – Adopted on Consent Agenda**

Amend policy HP-3100.1.2 as follows:

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

**2022-A-05 – Adopted on Consent Agenda**

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.

**2022-A-06 – Adopted on Consent Agenda**

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 beginning providing materials in Spanish.

**2022-A-07a – Adopted**

Reaffirm policy HP-3200.6.4

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.

**2022-A-07b – Referred**

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.

**2022-A-08 – Adopted as Amended**

AAPA recognizes the unique healthcare needs of at-risk and under resourced communities, including DIFFERENCES IN immigrant status, adversely affecting their physical, mental health, and overall wellbeing. AAPA SUPPORTS DEVELOPMENT OF PROGRAMS TO ADDRESS ~~S~~social, political, economic, educational, environmental, and systemic barriers INCLUDING DISCRIMINATION WHICH widen the gap of health disparities resulting in detrimental negative outcomes. AAPA ENCOURAGES PAs ~~are uniquely qualified~~ to continue promoting and delivering innovative community-oriented, high quality healthcare ~~services~~ to all PEOPLE, eliminating barriers, advancing access, and improving outcomes. ANY INCENTIVES OFFERED BY GOVERNMENT OR PRIVATE ENTITIES PROMOTING MORE EQUITABLE AND ACCESSIBLE CARE SHOULD BE AVAILABLE TO PAS.

**2022-A-09 – Adopted on Consent Agenda**

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.

**2022-A-10 – Adopted on Consent Agenda**

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.

**2022-A-11a – Adopted as Amended**

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 PROVIDE, SUPPORT, AND PROMOTE EDUCATIONAL POLICIES AND PROGRAMS THAT TARGET JUSTICE, EQUITY, DIVERSITY AND INCLUSION ELIMINATING HEALTH DISPARITIES.

**2022-A-11b – Adopted as Amended**

~~FURTHERMORE,~~ AAPA SHALL SUPPORT THE FORMATION OF “STRATEGIC PARTNERSHIPS” WITH OTHER ORGANIZATIONS THAT SEEK TO ADDRESS AND ELIMINATE HEALTH DISPARITY GAPS.

**2022-A-12 – Adopted on Consent Agenda**

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.

**2022-A-13 – Adopted as Amended**

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/APC USE SHOULD BE LIMITED TO ADMINISTRATIVE CONTEXT AND SHOULD BE AVOIDED AT PA SPECIFIC EVENTS AND DURING PERIODS OF RECOGNITION MEANT FOR PAS.~~**  **AAPA BELIEVES THAT PAS SHOULD BE REFERRED TO AS PAS (PHYSICIAN ASSOCIATES/ASOCIADO MEDICOS.) AAPA BELIEVES THAT PA/APRN SHOULD BE USED IF BOTH PROFESSIONS ARE REFERRED TO COLLECTIVELY.**

**2022-A-14 – Adopted as Amended**

Amend the policy paper entitled *Guidelines for State Regulation of PAs as follows:*

**Guidelines for State AND TERRITORY 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 AND TERRITORY law and delegation of authority to regulate their practice to a state AND TERRITORY 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 AND TERRITORY, endorses standardization of PA regulation as a way to enhance appropriate and flexible professional practice.
* **WHEN REFERENCING STATES THROUGHOUT THE PAPER, THE INTENT IS TO ALSO BE INCLUSIVE OF U.S. TERRITORIES AND THE DISTRICT OF COLUMBIA.**

**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 AND TERRITORY law and delegation of authority to regulate their practice to a state AND TERRITORY 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 AND TERRITORIES 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 AND TERRITORY governmental control of PA practice. AAPA recognizes that the uniqueness of each state~~’s~~ AND TERRITORY’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 AND TERRITORY practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states AND TERRITORIES as they pursue improvements in state AND TERRITORY governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult AAPA’s model state AND TERRITORY 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 AND TERRITORIES 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 OR TERRITORY. 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~~ continuing medical education, development of a personalized re-entry plan, WHICH MAY INCLUDE SUPERVISED PRACTICE, 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~~/~~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 AND ~~physicians~~ other healthcare providers work together should be determined at the practice level.

WITHIN STATE AND TERRITORY 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 COMPETENCIES. 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,~~ CURRENTLY, 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 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 AND TERRITORY 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.

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

**PA Practice 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 AND TERRITORY 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 OR TERRITORY 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 OR TERRITORIES 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 OR TERRITORY 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 AND TERRITORY 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 AND TERRITORY 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**~~.~~, AND** **~~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~~ be determined at the practice level**. ~~and not defined by collaborating physician’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 OR TERRITORY 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 AND TERRITORY 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 OR TERRITORY as a PA. The title may also be utilized by those who are exempted from state OR TERRITORY 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 OR TERRITORY 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 AS A PA by a federal employer. The state OR TERRITORY should have the clear authority to impose penalties on individuals who violate these provisions.

**Regulatory Agencies**

Each state AND TERRITORY must define the regulatory agency responsible for implementation of the law governing PAs. Although a variety of state AND TERRITORY 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 OR TERRITORY 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 AND TERRITORY 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 AND TERRITORY regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state OR TERRITORY 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 **LICENSED** healthcare professionals in the state OR TERRITORY**.** **~~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 OR TERRITORY 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 AND TERRITORIES 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 AND TERRITORY 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 – Adopted**

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.~~

**2022-B-02 – Adopted**

Amend the policy paper entitled *Specialty Certification, Clinical Flexibility, and Adaptability* as follows:

**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 availableto 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% TO 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 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 TASK FORCE 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, ~~R~~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 AND AWARDS 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 forPAsto 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 – Adopted as Amended**

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 WITH NO MAXIMUM. ~~The preceptor may earn a maximum of 20 30 Category 1 credits during any single calendar year.~~

**2022-B-04 – Adopted on Consent Agenda**

Amend the policy paper entitled *PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers* as follows:

**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 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 – Adopted**

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.

**2022-B-06 – Adopted on Consent Agenda**

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.

**2022-B-07 – Adopted as Amended**

AAPA should INVESTIGATE AND DEVELOP RESOURCES FOR TRANSITION TO PRACTICE MODELS AND HAVE THEM AVAILABLE TO ASSIST INSTITUTIONS WITH SUCCESSFUL ONBOARDING OF PAS. ~~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.~~

**2022-B-08 – Adopted as Amended**

Amend policy HX-4600.6.1 as follows:

AAPA opposes RESTRICTIONS ~~OR~~ AND attempts to restrict the availability of AND ACCESS TO reproductive healthcare.

**2022-B-09 – Adopted as Amended**

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, UNLESS MEDICALLY CONTRAINDICATED. 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.~~

**2022-B-10a – Adopted**

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.

**2022-B-10b – Adopted as Amended**

~~Furthermore,~~ AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines OF BUTTON BATTERY/COIN INGESTION to current ~~didactic~~ curriculum of PA programs and continuing medical education for practicing PAs.

**2022-B-11 – Adopted as Amended**

Amend policy HX-4600.7.3 as follows:

AAPA supports continued education programs and public health based strategies ADDRESSING AND REDUCING ~~relating to~~ the ~~abuse~~ NON-MEDICAL USE of ~~marijuana~~ CANNABINOIDS. ~~and addressing and reducing the use of marijuana~~.

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.

**2022-B-12 – Adopted on Consent Agenda**

Amend the policy paper entitled *False or Deceptive Healthcare Advertising* as follows:

**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.

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**2022-B-13 – Adopted on Consent Agenda**

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.

**2022-B-14 – Adopted as Amended**

Amend policy HP-3200.1.7 as follows:

AAPA acknowledges the importance, AND SUPPORTS THE DELIVERY of interprofessional curricula that includes PA practice and the PA’s role in the seamless delivery of high-quality patient care. AAPA SHOULD PROVIDE EDUCATION TO OTHER HEALTH PROFESSIONS REGARDING THE PA’S ROLE ON THE HEALTHCARE TEAM. ~~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.~~

**2022-B-15 – Adopted as Amended**

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

**2022-B-16 – Adopted as Amended**

Amend policy HP-3200.6.1 as follows:

In order to ensure ~~the~~ DIVERSITY OF age, gender, racial, cultural, ~~and~~ SEXUAL ORIENTATION, RELIGION, SEX, EDUCATIONAL BACKGROUND, 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.

**2022-C-01 – Adopted**

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.

**2022-C-02 – Adopted as Amended**

# 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. PAs SHOULD ALSO BE IMMUNIZED WITHTHE SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS(SARS-COV-2) vaccination SERIES. ALL VACCINATIONS SHOULD BE ADMINSTERED 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 RISKOFprovider-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 ENSURECOMPLIANCE, 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.(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.(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 20~~20~~30 initiative has set vaccination coverage goals of 90**-**95 percent universally recommended vaccines among young children ages 19 to 35 months including those fordiphtheria 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. 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%). (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. (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~~ vaccineSwould 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~~30IS 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~~ VACCINE

 ~~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 AN 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 RECOMMENDS~~ED~~ THAT ALL PEOPLE **ELIGIBLE** GET A COVID-19 VACCINE TO HELP PROTECT AGAINST SEVERE ILLNESS ~~THE VIRUS~~. FOR THIS REASON, IT IS IMPERATIVE THAT ALL PAS SERVE AS TRUSTED HEALTH CARE 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.~~ As COVID-19 is a highly contagious respiratory virus, transmission and outbreaks in the community and especially within healthcare facilities are well DOCUMENTED (16, 17). Because PAs regularly provide care to patients at high risk for complications of COVID-19, PAs should be immunized as per the recommendation of the Centers for Disease Control and Prevention Advisory Committee on Immunization Practice. Use of the FDA-approved COVID-19 vaccine is recommended for persons aged **>5** years as the benefits of the prevention of infection and associated

hospitalization or death outweigh vaccine-associated risks.

# 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. PAs should educate their patients and their families about the SARS-COV-2 virus vaccine series, unsubstantiated INFORMATION and promote public confidence in the SARS-COV-2 vaccine series to protect infants, children, adolescents, and adults against the SARS-COV-2 virus. PA should support local initiatives to make these vaccines accessible to all approved populations including themselves.

# ~~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 – Adopted on Consent Agenda**

Amend the policy paper entitled *Global Epidemic HIV/AIDS* as follows:

**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. (1~~4~~) 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. (1~~4~~) 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 reducE~~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 comeS 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, controlLED 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 courseS 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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**Resources**

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[~~http://www.cdc.gov/hiv/topics/surveillance/resources/reports/~~](http://www.cdc.gov/hiv/topics/surveillance/resources/reports/)

**2022-C-04 – Adopted**

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

**2022-C-05 – Adopted on Consent Agenda**

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.

**2022-C-06 – Adopted as Amended**

AAPA believes that federal and state regulations should remove existing barriers for PA management of THE 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.~~

**2022-C-07 – Adopted on Consent Agenda**

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.

**2022-C-08 – Adopted**

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.~~

**2022-C-09 – Adopted on Consent Agenda**

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.

**2022-C-10 – Adopted as Amended**

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.~~**

**2022-C-11 – Adopted on Consent Agenda**

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~~.

**2022-C-12 – Adopted on Consent Agenda**

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.

**2022-C-13 – Adopted on Consent Agenda**

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.

**2022-C-14 – Adopted on Consent Agenda**

Amend the policy paper entitled *The PA in Disaster Response: Core Guidelines* as follows:

**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.
	1. ~~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.
	1. Maintain certifications in: BLS, ACLS, and PALS
	2. RECOGNIZING THE NEED FOR PROFICIENCY IN TRAUMA, MAINTENANCE OF ADVANCE TRAUMA LIFE SUPPORT (ATLS) CERTIFICATION WOULD BE RECOMMENDED EVERY 4 YEARS.
	3. 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.
	4. 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:
	1. Their professional and moral responsibility to treat victims
	2. Their rights and responsibilities to protect themselves from harm
	3. Issues surrounding their responsibilities and rights as volunteers
	4. 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
	1. 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.
	2. Participate in workplace disaster planning.
	3. Stay current with information from reliable resources.
	4. 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.
	1. Become proficient in the National Incident Management System’s Incident Command System.
	2. 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.
	1. Participate in local disaster planning events.
	2. Participate in various webinars, tabletop drills, etc.…
	3. Bookmark federal and state websites that have an abundance of current information for medical providers, which might include:
		1. Centers for Disease Control (CDC)
		2. Federal Emergency Management Agency (FEMA),
		3. EMERGENCY MANAGEMENT INSTITUTE
		4. Department of Homeland Security (DHS)
		5. Health and Human Resources (HHS)
		6. State Medical Assistance Team (SMAT)
4. PAs should be prepared to provide documentation of their qualifications at any disaster site.
	1. 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
	1. Disaster triage guides (i.e., Start, Jump Start, and others)
	2. Triage coding guides
	3. Decontamination principles
	4. 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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3. Task Force on Quality Control of Disaster Mgmt. & the World Ass’n for Disaster and Emergency Med. & the Nordic Soc’y for Disaster Med., Health Disaster Management Guidelines for Evaluation and Research in the Utstein Style (Knut Ole Sundnes & Marvin L. Birnbaum eds., 2003).
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8. Bruce M. Altevogt et al., Inst. of Med. of the Nat’l Acad., Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report (2009).
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**Resources**

FEDERAL EMERGENCY MANAGEMENT EMERGENCY MANAGEMENTINSTITUTE<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).

*Public Health Ethics for Emergency Responders*, U.N.C. Gillings Sch. of Global Pub. Health, http://www.sph.unc.edu/ethics/public\_health\_ethics\_in\_disasters\_-emergency\_responders\_12753\_10533.html (last visited Mar. 24, 2015).

Lawrence O. Gostin & Dan Hanfling, *National Preparedness for a Catastrophic Emergency: Crisis Standards of Care, 302* J. Am. Med. Ass’n 2365, 2365-66 (2009).

Raina M. Merchant, Janet E. Leigh & Nicole Lurie, *Health Care Volunteers and Disaster Response — First, Be Prepared,* 362 New Eng. J. Med. 872, 872-73 (2010).

Col. U. Sch. of Nursing Ctr. for Health Pol’y & Centers for Disease Control and Prevention, Bioterrorism & Emergency Readiness: Competencies for All Public Health Workers (2002), *available at* http://training.fema.gov/emiweb/downloads/bioterrorism%20and%20emergency%20readiness.pdf.

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**2022-C-15 – Adopted on Consent Agenda**

Amend the policy paper entitled *The Role of In-Store or Retail-Based Convenient Care Clinics* as follows:

**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[[1]](#endnote-1). 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.

Convenient Care Association (CCA). www.ccaclinics.org/

**2022-C-16 – Adopted as Amended**

Amend policy HX-4500.1 as follows:

AAPA believes that telemedicine THAT FOLLOWS BEST PRACTICE GUIDELINES 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 COMPETENT ~~PROFICIENT~~ ~~take an active role in the utilization and evaluation of this technology~~ IN THE 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.~~

**2022-C-17 – Adopted on Consent Agenda**

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.

**2022-C-18 – Adopted as Amended**

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 FOR THE PRACTICING PA.

**2022-C-19 – Adopted on Consent Agenda**

Amend policy HP-3500.3.6as 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.

**2022-C-20 – Adopted as Amended**

~~Expire~~ Amend policy HX-4600.8.1 as follows.

AAPA recognizes that policies disrupting families and communities living in the United States have significant negative physical and mental health implications, ~~in~~ particularLY 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.

**2022-C-21 – Reaffirmed**

~~Expire~~ Reaffirm policy 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.

**2022-C-22 – Reaffirmed**

~~Expire~~ Reaffirm policy 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.

**Resolution of Condolence**

**2022-NB-01**

**2022 Resolution of Condolence for John Dennis Trimbath, PA-C**

Whereas, the Ohio Association of PAs graciously acknowledges and celebrates the life and memory of John D. Trimbath, beloved father, husband, papa, brother, friend and fierce advocate for the Physician Assistant Profession.

Whereas: the thickest biography could not capture the legend and life of John Dennis Trimbath, yet let this resolution behold some of his many attributes and accomplishments.

Whereas; he served his country as a mechanic in the U.S. Air Force during the war in Vietnam, returning to Cleveland to attend Cuyahoga Community College PA program and receive an Associate degree in 1972, then went on to attend George Washington’s PA program to receive a Bachelor’s degree in PA studies.

Whereas; He served for more than 40 plus years as a PA, provider, educator, preceptor to thousands, and a leader of leaders. He served selflessly as a leader in his state and also on the AAPA board of directors.

Whereas; John helped define what it means to be a PA today in Ohio, creating numerous legislative ordinances, meeting with lobbyists, legislators and fighting the good fight to break down barriers to PA practice. For 23 plus years he along with others struggled to gain prescriptive rights for Ohio PAs: succeeding in 2006.

Whereas, in 2004, John was the first non-physician to receive the Distinguished Alumni Award from his alma mater, the George Washington School of Medicine and Health Sciences. He also was the twice recipient of the Charles Hudson Award, Ohio’s highest honor for outstanding service to the PA profession. He also received the AAPA’s House of Delegates Outstanding Service Award in 2003 and the Presidents award in 2013. These are only a few of the many awards he received.

Whereas, John was an advisor to hospital systems on how to set up their new PA services, how to hire key PAs to run it and enforce operations. This was right before his life changing accident. Whereas, in 2008 he experienced an accident that changed his life forever, paralyzing him from the chest down, yet this was just a short pause in his stellar career and life, within a year of this accident, he rose up and continued to practice and participate in every avenue of advocacy for the PA profession.

Whereas, in 2008 he experienced an accident that changed his life forever, paralyzing him from the chest down, yet this was just a short pause in his stellar career and life, within a year of this accident, he rose up and continued to practice and participate in every avenue of advocacy for the PA profession.

Whereas, after his accident he changed the direction of his employment from Emergency Medicine to Psychology. He took on the challenge to educate himself in the current methods, practices, drugs and extended patient care policies for community mental health. An aspect of medicine he had never practiced before. And he had a great love for his patients, caring for their well-being and enjoyed watching them thrive overtime, with follow up treatment. Something he never had the opportunity to witness while working in emergency medicine.

Whereas, as a quadriplegic, John still loved giving back to his profession and taught PA students at several local colleges in Ohio, such as Baldwin Wallace, Lake Earie College of Medicine, and Case Western Reserve University. He was also involved in the selection process of PAs awarded an opportunity to be educated at these colleges.

Whereas, John loved his students and enjoyed teaching every aspect of the profession. Sharing his knowledge and getting students and PAs across the country involved in professional advocacy for the growth of the profession was his lifelong goal.

Whereas, we remember his own words: “I was born to be a PA, to be a pioneer and I’m honored to work alongside many other early PAs who helped established the underpinnings of the Academy and our profession.”

Whereas, John was in the HOD when the Ohio resolution passed to change the title of our profession to Physician Associates. Bringing tears to his eyes, he stated: “we did it”.

Whereas, John was to many a mentor, an advisor, and sometimes an adversary. But he was mostly a colleague and dearest of friend.

And whereas, no one person will be able to fill the void, the space left behind by this amazing person, yet we strive to continue his work, and his advocacy in every way in order to honor his memory.

To say that John will be missed is a colossal understatement. We honor his memory by continuing the fight to break down all barriers to practice in Ohio, in the U.S. and all throughout the world. We will continue his example of what is means to be a leader.

Respectfully submitted,

The Ohio Association of PAs

**House Elections 2022 Results**

**Vice President/Speaker of the House** Todd Pickard

**Director/First Vice Speaker** Leslie Clayton

**Director/Second Vice Speaker** Peggy Walsh

**Nominating Work Group**  Kimberly Lakhan

 Jacqi Kernaghan

 Rachel Weinzimmer

1. [↑](#endnote-ref-1)