

2016 Summary of Actions

**AAPA House of Delegates
San Antonio, TX
May 14-16, 2016**

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

Resolutions marked with ** will be referred by the Speaker to the appropriate body and reported back to the 2017 HOD.

Resolution	Title	Line Number	Action Taken
2016-A-01-A	Article XIII -- Elections	1	Rejected
2016-A-01-B	Article XIII -- Elections	114	Adopted
2016-A-02	Article XI -- Nominating Work Group	226	Adopted
2016-A-03	Article VII -- Dual Roles with AAPA Constituent Organizations	315	Rejected
2016-A-04*	Article VI -- HOD Responsibilities	467	Adopted as Amended
2016-A-05	Article VII -- BOD and Officers Duties and Responsibilities	489	Adopted
2016-A-06	Article IV -- Constituent Organizations	509	Adopted on Consent Agenda
2016-A-07	PA Self Governance and Accountability to the Public	519	Adopted as Amended
2016-A-08**	PA Full Practice Responsibility	531	To be Referred
2016-A-09	HOD Accountability in Voting	548	Rejected
2016-A-10	Article XIII -- BOD Vacancies	558	Rejected
2016-A-11	Article XIII -- BOD Vacancies	672	Adopted
2016-A-12	Support for Uniformity in Addressing PAs	790	Adopted
2016-A-13	Generic Term PA	796	Adopted as Amended by Deletion
2016-B-01	Elimination of High Stakes Recertification Testing of PAs	806	Adopted
2016-B-02	PA Licensure	827	Rejected
2016-B-03	Maintenance of NCCPA Certification	844	Rejected
2016-B-04	Maintenance of Licensure	908	Adopted as Amended
2016-B-05	NCCPA Recertification Exam	941	Adopted as Amended
2016-B-06	Elimination of the NCCPA Recertification Exam	955	Withdrawn
2016-B-07	Certification Model	966	Rejected

2016-B-08	Use of Proper Terminology Regarding PA Certification	983	Adopted
2016-B-09	Self-Assessment	990	Adopted as Amended by Deletion
2016-C-01	Definition of Collaborating Physician	997	Rejected
2016-C-02	Guidelines for State Regulation of PAs Position Paper	1004	Adopted as Amended
2016-C-03	PA License Portability	1426	Adopted
2016-C-04	Veterans Becoming PAs	1433	Adopted on Consent Agenda
2016-C-05	Social Security Act	1440	Adopted as Amended
2016-C-06	Third Party Payers	1449	Adopted as Amended
2016-C-07	Equitable Reimbursement	1461	Adopted as Amended
2016-C-08	Access to Primary Care	1470	Adopted as Amended
2016-C-09	Prescription Drug Benefit Plans	1478	Adopted on Consent Agenda
2016-C-10	Marijuana Research	1488	Adopted as Amended
2016-C-11	Medical Marijuana Laws	1498	Adopted
2016-C-12	Marijuana Guidelines	1506	Adopted
2016-C-13	Pain Management and Opioid Abuse Crises	1525	Adopted as Amended
2016-C-14	Access to Opioid Treatment Programs	1547	Adopted on Consent Agenda
2016-D-01	Head Trauma	1554	Adopted as Amended
2016-D-02	Violence Epidemic	1569	Adopted on Consent Agenda
2016-D-03	PA Health	1589	Adopted on Consent Agenda
2016-D-04	Maintaining Professional Flexibility Position Paper	1605	Adopted
2016-D-05	NCCPA Accepting European Union Medical Specialist CME Credit	1931	Adopted
2016-D-06	Clinical Rotations Joint Task Force	1955	Adopted as Amended
2016-D-07**	Barriers to PA Student Clinical Rotations Position Paper	1971	To be Referred
2016-D-08	Nicotine Dependence Position Paper	2196	Adopted on Consent Agenda

2016-D-09	Immunizations in Children and Adults Position Paper	2581	Adopted as Amended
2016-D-10	Health Literacy Position Paper	2944	Adopted
2016-D-11	Health Disparities Position Paper	3232	Adopted on Consent Agenda
2016-D-12	Opposition to Limit/Restrict Patient Access	3449	Adopted
2016-D-13	Discrimination	3456	Adopted

Reaffirmed Policies		
HA-2100.1.1	HP-3700.1.1	HX-4400.1.6
HP-3100.3.2	HP-3700.2.1	HX-4400.1.11
HP-3200.1.5	HP-3700.2.3	HX-4400.3.1
HP-3200.7.1	HP-3700.3.1	HX-4600.1.5
HP-3300.1.5	HP-3700.4.1	HX-4600.2.4
HP-3300.1.18	HX-4100.1.6	HX-4600.3.2
HP-3300.2.7	HX-4100.1.11	HX-4600.3.3
HP-3300.2.9	HX-4200.1.8	HX-4600.3.5
HP-3500.3.1	HX-4200.5.2	HX-4600.5.8
HP-3600.1.2	HX-4300.2.4	
HP-3600.1.8	HX-4400.1.4	
Resolutions of Condolence	Line Number	Purpose
2016-COND-01	3467	Condolence for Richard L. Curtis, PA-C
2016-COND-02	3509	Condolence for Dean Minton, PA-C
2016-COND-03	3554	Condolence for Tony Di Tomasso
Resolution of Commendation	Line Number	Purpose
2016-COMM-01	3585	Commendation for Laura Gail Curtis, MPAS, PA-C, DFAAPA
House Elections	Line Number	
Results	3642	

Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 16, 2016.

Presiding Officers

L. Gail Curtis, MPAS, PA-C, DFAAPA
David I. Jackson, DHSc, PA-C, DFAAPA
William T. Reynolds, Jr., MPAS, PA-C, DFAAPA

Speaker
First Vice Speaker
Second Vice Speaker

1 **2016-A-01-A – Rejected**

2
3 Amend Bylaws Article XIII as follows:

4
5 Article XIII Elections.

6
7 Section 1: Positions to be Filled by Election. Elected positions include Directors-at-
8 large; one Student Director; the Academy Officer positions of President-elect and
9 Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and
10 Second Vice Speaker; and such number of members of the Nominating Work Group as
11 may be set forth in Article XI of these Bylaws. The House Officer positions shall be
12 filled by the House of Delegates in the manner prescribed by Article VI, Section 3. The
13 Student Director shall be elected in the manner prescribed by Article V, Section 3. The
14 Nominating Work Group positions shall be filled by the House of Delegates in the
15 manner prescribed by Article XI. All other elected positions shall be filled in the manner
16 prescribed by this Article XIII.

17
18 Section 2: Term of Office. The term of office for the Academy Officer positions of
19 President, President-elect, and Immediate Past President shall be one year. The term of
20 office for the Student Director shall be one year. The term of office for Directors-at-large
21 and for the Academy Officer position of Secretary-Treasurer shall be two years. The
22 term of service for House Officer positions shall be one year.

23
24 Section 3: Eligibility and Qualifications of Candidates for Elected Positions Other
25 Than Student Director or Nominating Work Group Member.

- 26
27 a. A candidate must be a fellow member of the AAPA.
28 b. A candidate must be a member of an AAPA **CONSTITUENT ORGANIZATION.**
29 **Chapter.**
30 c. A candidate must have been an AAPA fellow member and/or student member for the
31 last three years.
32 d. A candidate must have accumulated at least three distinct years of experience in the
33 past five years in at least two of the following major areas of professional
34 involvement. This experience requirement will be waived for currently sitting AAPA
35 Board members who choose to run for a subsequent term of office.
36 i. An AAPA or constituent organization officer, board member,
37 committee, council, commission, work group, task force chair.
38 ii. A delegate to the AAPA House of Delegates or a representative to
39 the Student Academy of the AAPA's Assembly of Representatives.
40 iii. A board member, trustee, or committee chair of the Student
41 Academy of the AAPA, PA Foundation, Society for the Preservation
42 of Physician Assistant History, AAPA Political Action Committee,
43 Physician Assistant Education Association or National Commission
44 on Certification of Physician Assistants.
45 iv. AAPA Board appointee.
46

47 Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with
48 policy, shall be permitted in the election of Academy Officers, Directors-at-large, and
49 House Officers.

50
51 Section 5: Time of Elections. The time of House Officers' elections is prescribed in
52 Article VI, Section 3. The Board of Directors shall determine the timing of elections of
53 all other positions, in accordance with the requirements of these Bylaws.

54
55 Section 6: Eligibility of Voters. For all positions other than the Student Director,
56 House Officer, and Nominating Work Group positions, eligible voters are fellow
57 members listed on the Academy membership roster as of the date that is fifteen (15) days
58 before the election.

59
60 Section 7: Election Procedures. The Governance Commission shall determine the
61 procedures for the election of Academy Officers and Directors-at-large, including the
62 dates for distribution and return of ballots, subject to the requirements of the North
63 Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The
64 Academy staff shall manage the ballot distribution. The procedures for electing the
65 House Officers are prescribed in Article VI, Section 3; and the procedures for electing the
66 Student Director are prescribed in Article V, Section 3; and the procedures for electing
67 members of the Nominating Work Group shall be determined by the House of Delegates
68 in accordance with Article XI, Section 2.

69
70 Section 8: Vote Necessary to Elect. A plurality of the votes cast shall elect the
71 Directors-at-large and the Academy Officers (excluding the Vice President), so long as
72 the number of votes cast equals or exceeds a quorum of one (1) percent of the members
73 entitled to vote in the election. In the case of a tie vote, the House of Delegates shall vote
74 to decide the election from among the candidates who tied. The vote necessary to elect
75 the House of Delegates Officers (including the Speaker, who shall serve as the Vice
76 President of the Academy) shall be prescribed in Article VI, Section 3.

77
78 Section 9: Commencement of Terms. The term of office for all elected positions,
79 including Directors-at-large, the Student Director, Academy Officers, and House
80 Officers, shall begin on July 1. In the event that the election of the House Officers occurs
81 later than July 1, the new House Officers will take office at the close of the meeting
82 during which they were elected.

83
84 Section 10: Vacancies. Academy Officers and Directors, the Student Director and
85 House Officers may resign or be removed as provided in these Bylaws. The method of
86 filling positions vacated by the holder prior to completion of term shall be as follows:

- 87 a. OFFICE OF THE PRESIDENT. The President-elect shall become the
88 President to serve the unexpired term. The President-elect shall then serve
89 his/her own successive term as President.
- 90 b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the
91 office of President-elect, the Immediate Past President shall assume the
92 duties, but not the office of the President-elect while continuing to perform
93 the duties of Immediate Past President. The Nominating Work Group will
94 prepare a slate of candidates. The House of Delegates shall elect a new

- 95 President-elect from the candidates proposed and any candidates that self-
 96 declare, who will take office immediately upon election and will serve the
 97 remainder of the un-expired term.
- 98 c. SPEAKER; FIRST VICE SPEAKER; SECOND VICE-SPEAKER. A
 99 vacancy in the positions of the Speaker, First Vice Speaker, or Second
 100 Vice Speaker shall be filled in the manner prescribed by the House of
 101 Delegates Standing Rules, and in accordance with Article VI, Section 3 of
 102 these Bylaws.
- 103 d. STUDENT ACADEMY BOARD MEMBER. A vacancy in the Student
 104 Director position shall be filled in the manner prescribed by the Student
 105 Academy Bylaws.
- 106 e. OTHER BOARD VACANCIES. All other vacancies occurring in the
 107 Board of Directors shall be filled by a vote of the majority of the
 108 remaining members of the Board from a slate of candidates prepared by
 109 the Nominating Work Group. All terms of office for such appointees to
 110 the Board of Directors shall expire June 30, or until their successor has
 111 been duly elected and assumed office. The remaining term of the vacated
 112 seat, if any, will be filled at the next regularly scheduled election.

113
 114 **2016-A-01-B – Adopted**

115
 116 Amend Bylaws Article XIII as follows:

117
 118 Article XIII Elections.

119
 120 Section 1: Positions to be Filled by Election. Elected positions include Directors-at-
 121 large; one Student Director; the Academy Officer positions of President-elect and
 122 Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and
 123 Second Vice Speaker; and such number of members of the Nominating Work Group as
 124 may be set forth in Article XI of these Bylaws. The House Officer positions shall be
 125 filled by the House of Delegates in the manner prescribed by Article VI, Section 3. The
 126 Student Director shall be elected in the manner prescribed by Article V, Section 3. The
 127 Nominating Work Group positions shall be filled by the House of Delegates in the
 128 manner prescribed by Article XI. All other elected positions shall be filled in the manner
 129 prescribed by this Article XIII.

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

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

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 140 a. A candidate must be a fellow member of the AAPA.
 141 b. A candidate must be a member of an AAPA Chapter.

- 142 c. A candidate must have been an AAPA fellow member and/or student member for the
143 last three years.
- 144 d. A candidate must have accumulated at least three distinct years of experience in the
145 past five years in at least two of the following major areas of professional
146 involvement. This experience requirement will be waived for currently sitting AAPA
147 Board members who choose to run for a subsequent term of office.
- 148 i. An AAPA or constituent organization officer, board member,
149 committee, council, commission, work group, task force chair.
 - 150 ii. A delegate to the AAPA House of Delegates or a representative to
151 the Student Academy of the AAPA's Assembly of Representatives.
 - 152 iii. A board member, trustee, or committee chair of the Student
153 Academy of the AAPA, PA Foundation, Society for the Preservation
154 of Physician Assistant History, AAPA Political Action Committee,
155 Physician Assistant Education Association or National Commission
156 on Certification of Physician Assistants.
 - 157 iv. AAPA Board appointee.
- 158

159 Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with
160 policy, shall be permitted in the election of Academy Officers, Directors-at-large, and
161 House Officers.

162

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

166

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

171

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

181

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

189

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

195
196 Section 10: Vacancies. Academy Officers and Directors, the Student Director and
197 House Officers may resign or be removed as provided in these Bylaws. The method of
198 filling positions vacated by the holder prior to completion of term shall be as follows:

- 199 a. OFFICE OF THE PRESIDENT. The President-elect shall become the
200 President to serve the unexpired term. The President-elect shall then serve
201 his/her own successive term as President.
- 202 b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the
203 office of President-elect, the Immediate Past President shall assume the
204 duties, but not the office of the President-elect while continuing to perform
205 the duties of Immediate Past President. The Nominating Work Group will
206 prepare a slate of candidates. The House of Delegates shall elect a new
207 President-elect from the candidates proposed and any candidates that self-
208 declare, who will take office immediately upon election and will serve the
209 remainder of the un-expired term.
- 210 c. SPEAKER; FIRST VICE SPEAKER; SECOND VICE-SPEAKER. A
211 vacancy in the positions of the Speaker, First Vice Speaker, or Second
212 Vice Speaker shall be filled in the manner prescribed by the House of
213 Delegates Standing Rules, and in accordance with Article VI, Section 3 of
214 these Bylaws.
- 215 d. STUDENT ACADEMY BOARD MEMBER. A vacancy in the Student
216 Director position shall be filled in the manner prescribed by the Student
217 Academy Bylaws.
- 218 e. OTHER BOARD VACANCIES. All other vacancies occurring in the
219 Board of Directors shall be filled by a vote of the majority of the
220 remaining members of the Board from a slate of candidates prepared by
221 the Nominating Work Group. All terms of office for such appointees to
222 the Board of Directors shall expire June 30, or until their successor has
223 been duly elected and assumed office. The remaining term of the vacated
224 seat, if any, will be filled at the next regularly scheduled election.

225
226 **2016-A-02 – Adopted**

227
228 Amend Bylaws Article XI as follows:

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230 ARTICLE XI Nominating Work Group

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

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- a. Receiving applications from potential candidates seeking nomination for the positions of president-elect, secretary-treasurer, and directors-at-large;
- b. Evaluating all candidates seeking nomination according to the qualification criteria set forth in these Bylaws and according to such other selection guidelines as may be established **BY THE BOARD OF DIRECTORS in accordance with this section;**
- c. **Selecting ENDORSING** a single or multiple slate of candidates for each nominated position.

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

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

- a. A candidate must be a fellow member of the AAPA.
- b. A candidate must have been an AAPA fellow member and/or student member for the last **five-THREE** years.
- c. A candidate must have accumulated at least three distinct years of **RECOGNIZED LEADERSHIP** experience in the past five years **THROUGH SERVICE TO THE AAPA; AN AAPA CONSTITUENT ORGANIZATION; AN AAPA AFFILIATED ORGANIZATION; AND/OR A HEALTHCARE-RELATED PROFESSIONAL OR COMMUNITY ORGANIZATION.** **EXAMPLES INCLUDE, BUT ARE NOT LIMITED TO: SERVICE IN THE AAPA HOUSE OF DELEGATES; THE PA FOUNDATION; PAEA; A LOCAL HOSPICE SUPPORT ORGANIZATION; A HOSPITAL BOARD.**
 - i. **RECOGNIZED LEADERSHIP EXPERIENCE MUST BE EARNED IN, AT LEAST, TWO MAJOR AREAS OF PROFESSIONAL INVOLVEMENT.**
 - ii. **RECOGNIZED LEADERSHIP EXPERIENCE INCLUDES A BOARD MEMBER OR ORGANIZATION OFFICER; AN ELECTED OR APPOINTED REPRESENTATIVE; OR A CHAIR OF A COMMISSION, COMMITTEE, WORK GROUP OR TASK FORCE.**

in at least two of the following major areas of professional involvement:

 - ~~i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, or task force chair~~
 - ~~ii. A delegate to the AAPA House of Delegates or a representative to the Student Academy of the American Academy of Physician Assistants Assembly of Representatives~~
 - ~~iii. Trustee, board member or committee chair of the Student Academy of the American Academy of Physician Assistants, PA Foundation, Society for the~~

284 ~~Preservation of Physician Assistant History, Physician Assistant Education~~
285 ~~Association or American Academy of Physician Assistants Political Action~~
286 ~~Committee~~

287 ~~iv. AAPA Board appointees.~~
288

- 289 d. Any calendar year or Academy year in which the candidate served in more than
290 one area of professional involvement shall be counted as one distinct year of
291 experience.
292 e. With the exception of the Board-appointed members, a Nominating Work Group
293 member cannot hold any other elected office or commission or work group
294 position in the AAPA during the time of service on the Nominating Work Group.
295

296 Section 4: Term of Service. The term of service for members of the Nominating
297 Work Group shall be two (2) years. Terms shall be staggered. Individuals appointed to
298 temporarily fill a vacancy shall be eligible to run for the vacated seat. The unexpired
299 term the appointee previously filled shall not be counted as a filled term for purposes of
300 determining work group tenure.
301

302 Section 5: Vacancies. Nominating Work Group vacancies shall be filled in the
303 following manner:
304

- 305 a. Board-appointed Member. The Board of Directors shall appoint a replacement
306 member to fill the remainder of the unexpired term.
307 b. Elected Members. The House Officers shall appoint a temporary replacement
308 member. The temporary appointees shall serve until replaced by the House of
309 Delegates in the following manner: (1) the position shall be declared open for
310 election at the next House of Delegates election and shall be filled by appropriate
311 election process; and (2) upon completion of the election, the temporary appointee
312 shall continue to serve until the newly elected work group member takes office at
313 the next change of office.
314

315 **2016-A-03 – Rejected**
316

317 Amend Bylaws Article VII as follows:
318

319 ARTICLE VII Board of Directors and Officers of the Corporation.
320

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

- 328 a. To grant charters to Chapters, recognize specialty organizations, establish
329 criteria for caucuses, and establish Academy commissions or work groups
330 as may be in the best interests of the Academy, taking into consideration
331 any recommendations of the House of Delegates thereon;

- 332 b. To appoint or remove the Chief Executive Officer (CEO) pursuant to the
333 affirmative vote of a two-thirds (2/3) majority of the Directors;
334 c. To direct the activities of the Academy's national office through the CEO;
335 d. To provide for the management of the affairs of the Academy in such a
336 manner as may be necessary or advisable;
337 e. To establish committees necessary for the performance of its duties;
338 f. To establish, regularly review, and update the Academy's management
339 plan to attain the goals of the Academy;
340 g. To call special meetings of the House of Delegates as provided under
341 Article VI, Section 4;
342 h. To report the activities of the Board of Directors for the preceding year to
343 the House of Delegates and members at the Academy's annual meeting;
344 i. To establish the amount and timing of Academy membership dues and
345 assessments;
346 j. To review and determine, on no less than an annual basis, how to
347 implement those policies enacted by the House of Delegates on behalf of
348 the Academy that establish the collective values, philosophies, and
349 principles of the PA profession. If it determines that implementation of
350 one or more such policies will require an inadvisable expenditure of
351 Academy resources, or is otherwise not presently prudent or feasible, the
352 Board shall, at its earliest convenience, report to the House the reasons for
353 its decision.

354
355 ~~Section 2: Dual Roles with AAPA Constituent Organizations. Members of the~~
356 ~~AAPA Board of Directors may not hold elected voting positions in the Academy's~~
357 ~~constituent organizations. Directors may hold elected or appointed non-voting positions~~
358 ~~in the Academy's constituent organizations.~~

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

365
366 ~~Section 4 3:~~ Officers of the Corporation. The Officers of the Corporation shall be a
367 President, a President-elect, a Vice President, a Secretary-Treasurer, and the Immediate
368 Past President ("Academy Officers"). The Academy Officers are voting members of the
369 Board of Directors by virtue of position.

370
371 ~~Section 5 4:~~ Duties of Officers of the Corporation.

- 372
373 a. The President shall be the chief spokesperson for the Academy. The
374 President shall report to the House of Delegates and the members at the
375 annual meeting of the Academy with an account of the activities of the
376 Board for the past year and its recommendations for the House of
377 Delegates.

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

406 Section **6 5**: Meetings of the Board of Directors.

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424
- a. Regular and Special Meetings. The Board of Directors shall hold such regular meetings at such time and at such places as designated by Board policy, but in no event shall there be fewer than two such meetings in any calendar year. Regular meetings of the Board may be held without notice. Special meetings shall be called by the Secretary-Treasurer at the request of the President or upon written request to the President of at least 20 percent of the members of the Board then in office. The object of such special meetings shall be stated in the meeting notice, and no business other than that specified in the notice shall be transacted at the meeting. Notice of a special meeting shall be provided not less than two (2) days before the meeting.
 - b. Quorum. A majority of the membership of the Board then in office shall constitute a quorum for the purposes of transacting business.
 - c. Manner of Acting. The affirmative vote of a majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except as otherwise provided by law, by the Articles of Incorporation, or by these Bylaws. Each Director shall have one (1)

- 425 vote on all matters submitted to a vote of the Board of Directors. No
426 Director voting by proxy shall be permitted.
- 427 d. Teleconferencing. To the extent permitted by law, any person participating
428 in a meeting of the Board of Directors may participate by means of
429 conference telephone or by any means of communication by which all
430 persons participating in the meeting are able to hear one another, and
431 otherwise fully participate in the meeting. Such participation shall
432 constitute presence in person at the meeting.
- 433 e. Action by Unanimous Written Consent. Any action required to be taken
434 at a meeting of the Board of Directors or any action which may be taken at
435 a meeting of the Board of Directors may be taken without a meeting if a
436 consent in writing, setting forth the action so taken, is signed by all of the
437 Directors entitled to vote with respect to the subject matter thereof. A
438 Director's consent to action taken without a meeting may be in electronic
439 form and delivered by electronic means.

441 Section **7 6**: Chair of the Board. The Board of Directors may elect a Chair of the
442 Board from among its members. The Chair of the Board shall have such duties and
443 responsibilities and may be elected according to such procedures as may be determined
444 by the Board from time to time.

445
446 Section **8 7**: Executive Committee. The Executive Committee of the Board of
447 Directors shall consist of the President, Vice President, President-elect, Immediate Past
448 President, Chair of the Board, and Secretary-Treasurer. The Executive Committee shall
449 be empowered to act for the Board of Directors on emergency matters only. Actions of
450 the Executive Committee shall be reported to the Board of Directors no later than the
451 Board's following meeting. All such Committee actions must be reviewed and ratified
452 by the Board of Directors and shall be included in the official Board minutes.

453
454 Section **9 8**: Resignation or Removal of Directors and Officers of the Corporation.
455 Any Director or Academy Officer may resign at any time by giving written notice to the
456 President or the Board of Directors. Such resignation shall take effect at the time
457 specified in such notice, or, if no time is specified, at the time such resignation is
458 tendered. Any Director-at-large, Student Director, or Academy Officer (excluding the
459 Vice President) may be removed from office at any time, with or without cause, by the
460 affirmative majority vote of those members entitled to elect them. Removal may only
461 occur at a meeting called for that purpose, and the meeting notice shall state that the
462 purpose, or one of the purposes, of the meeting is removal of the Director or Officer.
463 Vacancies in these positions shall be filled in accordance with Article XIII, Section 10 of
464 these Bylaws. Removal of the Vice President/Speaker shall be done in accordance with
465 Article VI, Section 3 of these Bylaws pertaining to House Officers.

466
467 **2016-A-04* – Adopted as Amended (requires AAPA Board of Directors' ratification)**

468
469 Amend Bylaws Article VI as follows:

470
471 ARTICLE VI House of Delegates.

472

473 Section 1: Duties and Responsibilities. The Academy shall have a House of
474 Delegates, which shall represent the interests of the membership. The House of
475 Delegates shall exercise the sole authority on behalf of the Academy to enact policies
476 establishing the collective values, philosophies, and principles of the PA profession. The
477 House of Delegates **MAY shall, IF IT DEEMS NECESSARY**, make recommendations
478 to the Board for granting charters to Chapters and for granting official recognition to
479 specialty organizations. The House of Delegates **MAY shall, IF IT DEEMS**
480 **NECESSARY**, make recommendations to the Board for the establishment of Academy
481 commissions and work groups, and shall establish such committees of the House of
482 Delegates as necessary to fulfill its duties. The House of Delegates shall be entitled to
483 vote on amendments to these Bylaws on behalf of the members in accordance with
484 Article XIII of these Bylaws. The House of Delegates shall be solely responsible for
485 establishing such rules of procedure, which are not inconsistent with these Bylaws, the
486 Articles of Incorporation, or existing law, as may be necessary for carrying out the
487 activities of the House (i.e. House of Delegates Standing Rules).
488

489 **2016-A-05 – Adopted**

490 Amend Bylaws Article VII as follows:

491
492
493 ARTICLE VII Board of Directors and Officers of the Corporation.
494

495 Section 1: Board Duties and Responsibilities. The Academy shall have a Board of
496 Directors, which, in accordance with North Carolina law, shall be responsible for the
497 management of the Corporation, including, but not limited to, management of the
498 Corporation’s property, business, and financial affairs. In addition to the duties and
499 responsibilities conferred upon it by statute, by the Articles of Incorporation, or by these
500 Bylaws, it is expressly declared that the Board of Directors shall have the following
501 duties and responsibilities:
502

- 503 a. To grant charters to Chapters, recognize specialty organizations, establish
504 **AFFILIATION WITH criteria for** caucuses **AND SPECIAL INTEREST**
505 **GROUPS**, and establish Academy commissions or work groups as may be in the
506 best interests of the Academy, taking into consideration any recommendations of
507 the House of Delegates thereon;
508

509 **2016-A-06 – Adopted on Consent Agenda**

510 Amend Bylaws Article IV as follows:

511
512
513 ARTICLE IV Constituent Organizations
514

515 Constituent organizations consist of state, **THE DISTRICT OF COLUMBIA, U.S.**
516 **TERRITORIES** and federal service chapters; specialty organizations; caucuses; and
517 special interest groups; as defined in AAPA policy.
518

519 **2016-A-07 – Adopted as Amended**

520

521 AAPA believes that sustaining public trust in the PA profession is the responsibility of
522 PAs. **THEREFORE, THE GOVERNING BODIES OF AAPA, PAEA, NCCPA,**
523 **AND ARC-PA SHOULD BE COMPRISED OF A MAJORITY OF PAS. National**
524 **organizations primarily representing the interests of the PA profession and the**
525 **public it serves should ensure their governing bodies are PA-led. A majority**
526 **composition of decision-making bodies within these national organizations therefore**
527 **must be PAs. THESE PA-led national** organizations will continue to value the
528 involvement of other stakeholders in medicine, healthcare, and the public through
529 consultative and advisory relationships.
530

531 **2016-A-08** – Referred (to be referred by the Speaker to the appropriate body and reported**
532 **back to the 2017 HOD)**
533

534 The AAPA shall be responsible for developing and upholding the broad definition of the
535 PA profession scope of practice.
536

537 And Further Resolved
538

539 PAs are currently restricted to practice medicine under their supervising physician’s
540 scope of practice. This is a requirement for all PAs regardless of their clinical experience,
541 education or credentials. After nearly 50 years of providing high quality medicine, PAs
542 have earned the right to define their own scope of practice. This new concept shall be
543 referred to as Full Practice Responsibility (FPR). This new system would allow PAs to
544 function more autonomously by removing the currently imposed practice barrier of
545 physician supervision. Full Practice Responsibility will be an alternative option to
546 supervision in states that seek autonomous PA practice.
547

548 **2016-A-09 – Rejected**
549

550 The AAPA shall record the votes of the HOD members during the annual conference and
551 any special meetings.
552

553 And Further Resolved
554

555 The AAPA shall make available these recorded votes to AAPA members within 30 days
556 following the annual conference and any special meeting.
557

558 **2016-A-10 – Rejected**
559

560 Amend AAPA Bylaws Article XIII as follows:
561

562 **ARTICLE XIII Elections.**
563

564 **Section 1: Positions to be filled by Election. Elected positions include Directors-at-large;**
565 **one Student Director; the Academy Officer positions of President-elect and Secretary-**
566 **Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second**
567 **Vice Speaker; and such number of members of the Nominating Work Group as may be**
568 **set forth in Article XI of these Bylaws. The House Officer positions shall be filled by the**

569 House of Delegates in the manner prescribed by Article VI, Section 3. The Student
570 Director shall be elected in the manner prescribed by Article V, Section 3. The
571 Nominating Work Group positions shall be filled by the House of Delegates in the
572 manner prescribed by Article XI. All other elected positions shall be filled in the manner
573 prescribed by this Article XIII.

574
575 Section 2: Term of Office. The term of office for the Academy Officer positions of
576 President, President-elect, and Immediate Past President shall be one year. The term of
577 office for the Student Director shall be one year. The term of office for Directors-at-large
578 and for the Academy Officer position of Secretary-Treasurer shall be two years. The term
579 of service for House Officer positions shall be one year.

580
581 Section 3: Eligibility and Qualifications of Candidates for Elected Positions Other Than
582 Student Director or Nominating Work Group Member.

- 583
584 a. A candidate must be a fellow member of the AAPA.
585 b. A candidate must be a member of an AAPA Chapter.
586 c. A candidate must have been an AAPA fellow member for the last three years.
587 d. A candidate must have accumulated at least three distinct years of experience in
588 the past five years in at least two of the following major areas of professional
589 involvement. This experience requirement will be waived for currently sitting
590 AAPA board members who choose to run for a subsequent term of office.
- 591
592 i. An AAPA or constituent organization officer, board member, committee,
593 council, commission, work group, task force chair.
594 ii. A delegate or alternate to the AAPA House of Delegates.
595 iii. A board member, trustee, or committee chair of the PA Foundation, Society
596 for the Preservation of Physician Assistant History, AAPA Political Action
597 Committee, Physician Assistant Education Association or National Commission
598 on Certification of Physician Assistants.
599 iv. AAPA board appointee.

600
601 Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with policy
602 shall be permitted in the election of Academy Officers, Directors-at-large, and House
603 Officers.

604
605 Section 5: Time of Elections. The time of House Officers' elections is prescribed in
606 Article VI, Section 3. The Governance Commission shall determine the timing of
607 elections of all other positions, in accordance with the requirements of these Bylaws.

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

612
613 Section 7: Election Procedures. The Governance Commission shall determine the
614 procedures for the election of Academy Officers and Directors-at-large, including the
615 dates for distribution and return of ballots, subject to the requirements of the North
616 Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The

617 Academy staff shall manage the ballot distribution. The procedures for electing the
618 House Officers are prescribed in Article VI, Section 3; and the procedures for electing the
619 Student Director are prescribed in Article V, Section 3; and the procedures for electing
620 members of the Nominating Work Group shall be determined by the House of Delegates
621 in accordance with Article XI, Section 2.
622

623 Section 8: Vote Necessary to Elect. A plurality of the votes cast shall elect the Directors-
624 at-large and the Academy Officers (excluding the Vice President), so long as the number
625 of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to
626 vote in the election. In the case of a tie vote, the Governance Commission shall determine
627 the process for selecting the winner. The vote necessary to elect the House of Delegates
628 Officers (including the Speaker, who shall serve as the Vice President of the Academy)
629 shall be prescribed in Article VI, Section 3.
630

631 Section 9: Commencement of Terms. The term of office for all elected positions,
632 including Directors-at-large, the Student Director, Academy Officers, and House
633 Officers, shall begin on June 10. In the event that the election of the House Officers
634 occurs later than June 10, the new House Officers will take office at the close of the
635 meeting during which they were elected.
636

637 Section 10: Vacancies. Academy Officers and Directors, the Student Director and House
638 Officers may resign or be removed as provided in these Bylaws. The method of filling
639 positions vacated by the holder prior to completion of term shall be as follows:
640

641 a. Office of the President. The President-elect shall become the President to serve
642 the unexpired term. The President-elect shall then serve his/her own successive term as
643 President.
644

645 b. Office of the President-elect. In the event of a vacancy in the office of
646 President-elect, the Immediate Past President shall assume the duties, but not the office
647 of the President-elect while continuing to perform the duties of Immediate Past
648 President. The Nominating Work Group will prepare a slate of candidates. The House of
649 Delegates shall elect a new President-elect from the candidates proposed and any
650 candidates that self-declare, who will take office immediately upon election and will
651 serve the remainder of the un-expired term.
652

653 c. Speaker; First Vice Speaker; Second Vice-Speaker. A vacancy in the positions
654 of the Speaker, First Vice Speaker, or Second Vice Speaker shall be filled in the manner
655 prescribed by the House of Delegates Standing Rules, and in accordance with Article VI,
656 Section 3 of these Bylaws.
657

658 d. Student Academy Board Member. A vacancy in the Student Director position
659 shall be filled in the manner prescribed by the Student Academy Bylaws.
660

661 e. Other Board Vacancies. All other vacancies occurring in the Board of Directors
662 shall be filled by a vote of the majority of the remaining members of the Board from a
663 slate of candidates prepared by the Nominating Work Group. All terms of office for such
664 appointees to the Board of Directors shall expire June 10 or until their successor has been

duly elected and assumed office. The remaining term of the vacated seat, if any, will be filled at the next regularly scheduled election. THE NOMINATING WORK GROUP WILL PREPARE A SLATE OF CANDIDATES. THE HOUSE OF DELEGATES SHALL ELECT FROM THE CANDIDATES PROPOSED AND ANY CANDIDATE WHO HAS SELF- DECLARED, WHO WILL TAKE OFFICE IMMEDIATELY UPON ELECTION AND WILL SERVE THE REMAINDER OF THE UN-EXPIRED TERM.

2016-A-11 – Adopted

Amend Article XIII. Elections as follows:

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

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

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

- a. A candidate must be a fellow member of the AAPA.
- b. A candidate must be a member of an AAPA Chapter.
- c. A candidate must have been an AAPA fellow member and/or student member for the last three years.
- d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. This experience requirement will be waived for currently sitting AAPA Board members who choose to run for a subsequent term of office.
 - i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, task force chair.
 - ii. A delegate to the AAPA House of Delegates or a representative to the Student Academy of the AAPA’s Assembly of Representatives.
 - iii. A board member, trustee, or committee chair of the Student Academy of the AAPA, PA Foundation, Society for the Preservation of Physician Assistant History, AAPA Political Action Committee, Physician

712 Assistant Education Association or National Commission on
713 Certification of Physician Assistants.
714 iv. AAPA Board appointee.
715

716 Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with
717 policy, shall be permitted in the election of Academy Officers, Directors-at-large, and
718 House Officers.
719

720 Section 5: Time of Elections. The time of House Officers' elections is prescribed in
721 Article VI, Section 3. The Board of Directors shall determine the timing of elections of
722 all other positions, in accordance with the requirements of these Bylaws.
723

724 Section 6: Eligibility of Voters. For all positions other than the Student Director,
725 House Officer, and Nominating Work Group positions, eligible voters are fellow
726 members listed on the Academy membership roster as of the date that is fifteen (15) days
727 before the election.
728

729 Section 7: Election Procedures. The Governance Commission shall determine the
730 procedures for the election of Academy Officers and Directors-at-large, including the
731 dates for distribution and return of ballots, subject to the requirements of the North
732 Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The
733 Academy staff shall manage the ballot distribution. The procedures for electing the
734 House Officers are prescribed in Article VI, Section 3; and the procedures for electing the
735 Student Director are prescribed in Article V, Section 3; and the procedures for electing
736 members of the Nominating Work Group shall be determined by the House of Delegates
737 in accordance with Article XI, Section 2.
738

739 Section 8: Vote Necessary to Elect. A plurality of the votes cast shall elect the
740 Directors-at-large and the Academy Officers (excluding the Vice President), so long as
741 the number of votes cast equals or exceeds a quorum of one (1) percent of the members
742 entitled to vote in the election. In the case of a tie vote, the House of Delegates shall vote
743 to decide the election from among the candidates who tied. The vote necessary to elect
744 the House of Delegates Officers (including the Speaker, who shall serve as the Vice
745 President of the Academy) shall be prescribed in Article VI, Section 3.
746

747 Section 9: Commencement of Terms. The term of office for all elected positions,
748 including Directors-at-large, the Student Director, Academy Officers, and House
749 Officers, shall begin on July 1. In the event that the election of the House Officers occurs
750 later than July 1, the new House Officers will take office at the close of the meeting
751 during which they were elected.
752

753 Section 10: Vacancies. Academy Officers and Directors, the Student Director and House
754 Officers may resign or be removed as provided in these Bylaws. The method of filling
755 positions vacated by the holder prior to completion of term shall be as follows:
756

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

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- b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. The House of Delegates shall elect a new President-elect from the candidates proposed and any candidates that self-declare, who will take office immediately upon election and will serve the remainder of the un-expired term.
- c. SPEAKER; FIRST VICE SPEAKER; SECOND VICE-SPEAKER. A vacancy in the positions of the Speaker, First Vice Speaker, or Second Vice Speaker shall be filled in the manner prescribed by the House of Delegates Standing Rules, and in accordance with Article VI, Section 3 of these Bylaws.
- d. STUDENT ACADEMY BOARD MEMBER. A vacancy in the Student Director position shall be filled in the manner prescribed by the Student Academy Bylaws.
- e. OTHER BOARD VACANCIES. All other vacancies occurring in the Board of Directors shall be filled by a vote of the majority of the remaining members of the Board from a slate of candidates prepared by the Nominating Work Group. All terms of office for such appointees to the Board of Directors shall expire June 30, or until their successor has been duly elected and assumed office. The remaining term of the vacated seat, if any, will be filled at the next regularly scheduled election. THE NOMINATING WORK GROUP WILL PREPARE A SLATE OF CANDIDATES. ELIGIBLE MEMBERS, AS DESCRIBED IN SECTION 6 OF THIS ARTICLE, SHALL ELECT A NEW OFFICER AND/OR DIRECTOR FROM THE CANDIDATES PROPOSED AND ANY CANDIDATES THAT SELF- DECLARE. THE ELECTED CANDIDATE WILL TAKE OFFICE IMMEDIATELY AND WILL SERVE THE REMAINDER OF THE UN-EXPIRED TERM.

2016-A-12 – Adopted

AAPA encourages that “PA *Surname*” be established as the recommended address for PAs, unless a more suitable formal address is appropriate, such as military rank or academic role.

2016-A-13 – Adopted as Amended by Deletion

~~HP-3100.2.2~~

~~AAPA recognizes graduates of all programs accredited by the Accreditation Review Commission (ARC-PA), or by one of its predecessor agencies as fulfilling the definition of the generic term “physician assistant.” In consumer and professional education and relations, and in negotiations with or policies presented to state and/or federal governmental agencies, AAPA treats PAs generically, using the same criteria spelled out in the Academy’s Bylaws for fellow membership.~~

2016-B-01 – Adopted

808 AAPA supports assessing general medical knowledge for initial certification and
809 licensing of PAs.
810
811 AAPA supports the use of evidence-based alternatives to testing for maintenance of
812 certification.
813
814 AAPA opposes any requirement that PAs take a closed-book, proctored exam in a
815 specialty area for maintenance of certification.
816
817 AAPA opposes any requirement that PAs take multiple examinations during a 10-year
818 recertification cycle.
819
820 AAPA supports uncoupling maintenance of certification requirements from maintenance
821 of license and prescribing privileges in state laws.
822
823 AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable
824 research to determine the relationship, if any, between taking the NCCPA recertification
825 test and patient outcomes, safety and satisfaction.
826

827 **2016-B-02 – Rejected**

828
829 AAPA believes the assessment of competency for licensure is a separate and distinct
830 process from certification.

831
832 And further resolved

833
834 AAPA supports the concept of development of a National PA Licensing Examination.

835
836 And further resolved

837
838 Expire policy HP-3500.2.1.

839
840 **HP-3500.2.1**

841 ~~AAPA endorses the National Commission on Certification of Physician Assistants~~
842 ~~(NCCPA) certification exam as the only entrance standard for PAs.~~

843
844 **2016-B-03 – Rejected**

845
846 Amend by substitution policy HP-3500.2.1 as follows:

847
848 ~~AAPA endorses the National Commission on Certification of Physician Assistants~~
849 ~~(NCCPA) certification exam as the only entrance standard for PAs.~~

850 **THE AAPA SUPPORTS ESTABLISHING ENTRY-LEVEL STANDARDS FOR THE**
851 **PROFESSION BY MEASURING A PA STUDENT’S BROAD-BASE OF MEDICAL**
852 **KNOWLEDGE UPON GRADUATION FROM AN ARC-PA ACCREDITED**
853 **PROGRAM THROUGH A CERTIFYING EXAMINATION ADMINISTERED BY**
854 **THE NATIONAL COMMISSION ON THE CERTIFICATION OF PHYSICIAN**

855 ASSISTANTS (NCCPA) OR ANY SUCCESSOR ORGANIZATION RECOGNIZED
856 BY THE ACADEMY.

857
858 And Further Resolved

859
860 Expire policy HP-3500.2.2.

861
862 ~~AAPA opposes examinations given by any organization other than the NCCPA for the~~
863 ~~purpose of establishing entrance level standards for individuals not eligible for the~~
864 ~~National Commission on Certification of Physician Assistants examination.~~

865
866 And Further Resolved

867
868 Amend by substitution policy HP-3500.2.3 as follows:

869
870 ~~AAPA believes that the NCCPA certificate should be time limited and that maintenance~~
871 ~~of a current valid certificate requires that PAs pass the Physician Assistant National~~
872 ~~Recertifying Exam (PANRE) within four attempts if initiated within the final two years~~
873 ~~of the recertification cycle.~~

874 THE AAPA OPPOSES ANY MANDATORY PERIODIC RECERTIFYING
875 EXAMINATIONS REQUIRED BY THE NCCPA OR ANY SUCCESSOR
876 ORGANIZATION RECOGNIZED BY THE ACADEMY, OR BY ANY STATE OR
877 FEDERAL REGULATORY AGENCIES FOR CERTIFIED PAS BEYOND THE
878 ENTRY-LEVEL.

879
880 THE AAPA DOES NOT OPPOSE THE NCCPA OR ANY SUCCESSOR
881 ORGANIZATION RECOGNIZED BY THE ACADEMY REQUIRING CERTIFIED
882 PAS TO PERIODICALLY OBTAIN CATEGORY 1 CONTINUING MEDICAL
883 EDUCATION (CME) THAT INCORPORATES PROFESSIONAL SELF-
884 ASSESSMENT AND/OR PRACTICE-IMPROVEMENT ACTIVITIES TO MAINTAIN
885 THEIR GENERALIST CORE OF MEDICAL KNOWLEDGE. THIS CME REQUIRED
886 SHOULD NOT EXCEED THE CURRENT REQUIREMENTS ESTABLISHED BY
887 THE NCCPA AS OF 2015.

888
889 THE AAPA DOES NOT BELIEVE CME OR MANDATORY RECERTIFYING
890 EXAMINATIONS MEASURES A PA'S COMPETENCY. COMPETENCY IS
891 DEFINED AS THE ABILITY FOR AN INDIVIDUAL TO PERFORM THEIR
892 DUTIES. THE AAPA BELIEVES A PA'S COMPETENCY IS ASSESSED AT THE
893 PRACTICE LEVEL BY THE EMPLOYING AGENT AND/OR PRIVILEGING AND
894 CREDENTIALING ENTITIES WHERE THE PA PRACTICES.

895
896 And Further Resolved

897
898 THE HOUSE OF DELEGATES RECOMMENDS THE AAPA BOARD OF
899 DIRECTORS WORK WITH THE NCCPA TO ADDRESS THEIR CURRENT
900 POLICIES REGARDING THE PA NATIONAL RECERTIFICATION PROCESS TO
901 ASSURE THAT A PA'S CERTIFICATION: IS NOT TIME-LIMITED; DOES NOT
902 REQUIRE A MANDATORY EXAMINATION AT THE END OF THE PA'S 10 YEAR

903 RECERTIFICATION CYCLE; MAINTAINS A PA'S GENERALIST
904 CERTIFICATION; AFFORDS THOSE PAS PRACTICING IN A SUBSPECIALTY TO
905 TAKE A PORTION OF THEIR REQUIRED CME FOCUS ON THAT
906 SUBSPECIALTY.

907
908 **2016-B-04 – Adopted as Amended**

909
910 The AAPA endorses the Federation of State Medical Board's (FSMB) *Maintenance of*
911 *Licensure (MOL) Guiding Principles:*

- 912
- 913 • Maintenance of licensure should support PA's commitment to lifelong learning
914 and facilitate improvement in PA practice.
- 915 • Maintenance of licensure systems should be administratively feasible and should
916 be developed in collaboration with other stakeholders.
- 917 • Maintenance of licensure should not compromise patient care or create barriers to
918 PA practice.
- 919 • The infrastructure to support PA compliance with MOL requirements must be
920 flexible and offer a choice of options for meeting requirements.
- 921 • Maintenance of licensure processes should balance transparency with privacy
922 protections.
- 923

924 **AAPA strongly encourages all state Constituent Organizations to advocate for**
925 **legislation to adopt MOL processes consistent with the FSMB.**

926
927 And Further Resolved

928
929 The AAPA believes:

- 930
- 931 • The authority for establishing MOL requirements is strictly within the purview of
932 state **LEGISLATIVE OR** PA regulatory authorities.
- 933 • ~~Maintenance of certification (MOC) should not be a requirement for~~
934 ~~maintenance of licensure.~~
- 935 • ~~High stakes testing~~ Testing should not be part of the MOL process.
- 936 • **AAPA STRONGLY ENCOURAGES ALL STATE CONSTITUENT**
937 **ORGANIZATIONS TO ADVOCATE FOR LEGISLATION TO ADOPT**
938 **MOL PROCESSES CONSISTENT WITH THE FSMB GUIDING**
939 **PRINCIPLES AND ACADEMY POLICY.**
- 940

941 **2016-B-05 – Adopted as Amended**

942

- 943 • ~~AAPA believes that the NCCPA should cease moving forward with the current~~
944 ~~implementation of any changes in the national recertification examination~~
945 ~~process.~~

- 946 • AAPA believes the NCCPA should maintain its current national recertification
947 examination process until representatives from the AAPA and NCCPA can agree
948 on one that both demonstrates competency and comprehensively represents the needs
949 of PAs in all practice settings.

950 • ~~AAPA believes the NCCPA should make no changes in its current fee schedule~~

951 ~~for PAs and no future changes unless agreed upon by the AAPA and NCCPA.~~
952 ~~• If the AAPA and NCCPA cannot arrive at an agreeable solution, the AAPA~~
953 ~~should explore alternatives to the current recertification process.~~
954

955 **2016-B-06 – Withdrawn**

956 Amend policy HP-3200.2.3 as follows:
957

958 AAPA encourages the NCCPA to recognize CME Category 1 credit for continuing
959 education activities that incorporate professional self-assessment and self-improvement
960 activities. **AAPA BELIEVES THESE ACTIVITIES SHOULD BE INTEGRATED**
961 **PERIODICALLY THROUGHOUT THE PA’S 10 YEAR RECERTIFICATION**
962 **PROCESS AND IN LIEU OF A WRITTEN RECERTIFICATION EXAM AT THE**
963 **END OF THE 10 YEAR RECERTIFICATION CYCLE.**
964

965 **2016-B-07 – Rejected**

966 The AAPA supports the following certification model for graduates of ARC-PA
967 recognized programs:
968

- 969 1. Initial passing of the PANCE.
- 970 2. Completion of one hundred (100) hours of CME every two (2) years.
- 971 3. Passing of PANRE upon the 9th ninth or 10th (tenth) anniversary of
972 PANRE certification.
- 973 4. Once the PANRE is passed, no further recertification tests would be
974 required.
- 975
- 976
- 977

978 In the event a PA does not pass the PANRE, AAPA recommends a remediation plan
979 through attainment of CME. Upon completion of the remediation plan, ongoing CME
980 requirements of one-hundred (100) hours per two (2) years for the designation of PA-C
981 would remain in effect.
982

983 **2016-B-08 – Adopted**

984 AAPA believes that the terms “Board Certified,” “Board Exams,” and “the Boards “when
985 used in reference to PA certification are inaccurate and misleading and therefore
986 discourages the use of these terms to refer to NCCPA certification and related
987 examinations.
988

989 **2016-B-09 – Adopted as Amended by Deletion**

990 **HP 3200.2.3**
991 ~~AAPA encourages the NCCPA to recognize CME Category 1 credit for continuing~~
992 ~~education activities that incorporate professional self-assessment and self-~~
993 ~~improvement activities.~~
994

995 **2016-C-01 – Rejected**
996
997
998

999 AAPA believes the definition of a collaborating physician should be amended to include
1000 Doctors of Podiatric Medicine (DPM) as the scope of practice for DPMs is similar to the
1001 scope of practice for orthopaedic physicians specializing in foot and ankle care, and the
1002 utilization of PAs by DPMs is appropriate for the training and skill set of PAs.
1003

1004 **2016-C-02 – Adopted as Amended**

1005
1006 Amend policy HP 3500.3.4, “Guidelines for State Regulation of PAs” as follows:
1007

1008 Guidelines for State Regulation of PAs

1009 (Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011 and 2013)
1010

1011 Executive Summary of Policy Contained in this Paper

1012 Summaries will lack rationale and background information, and may lose nuance of
1013 policy. You are highly encouraged to read the entire paper.
1014

- 1015 ● State law must include a definition of PA in order to differentiate PAs from the
1016 many other health care professionals.
- 1017 ● Licensure is the most common and appropriate regulatory term and system for PAs.
- 1018 ● A supervising physician is an MD or DO who accepts responsibility for the
1019 supervision of services provided by PAs.
- 1020 ● For PAs who practice in Federal jurisdictions, supervision may be provided by a
1021 physician (MD or DO) who meets the licensing requirements of the federal agency.
- 1022 ● Laws and regulations governing PA practice should permit utilization of PA
1023 services in a wide variety of practice settings without overburdening lists of tasks.
- 1024 ● The ability to prescribe medications should be one of the medical services that
1025 physicians may delegate to PAs.
- 1026 ● Each state must define the regulatory agency responsible for implementation of the
1027 law governing PAs.

- 1028
- 1029
- 1030 ● INCLUSION OF PAS IN STATE LAW AND DELEGATION OF AUTHORITY
1031 TO REGULATE THEIR PRACTICE TO A STATE AGENCY SERVES TO
1032 BOTH PROTECT THE PUBLIC FROM INCOMPETENT PERFORMANCE BY
1033 UNQUALIFIED MEDICAL PROVIDERS AND TO DEFINE THE ROLE OF
1034 PAS IN THE HEALTHCARE SYSTEM.

- 1035 ● AAPA, WHILE RECOGNIZING THE DIFFERENCES IN POLITICAL AND
1036 HEALTHCARE CLIMATES IN EACH STATE, ENDORSES
1037 STANDARDIZATION OF PA REGULATION AS A WAY TO ENHANCE
1038 APPROPRIATE AND FLEXIBLE PROFESSIONAL PRACTICE.

- 1039 ● THIS DOCUMENT DISCUSSES KEY CONCEPTS OF STATE
1040 REGULATION.

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Introduction

Recognition of PAs as **health care MEDICAL** providers led to **THE** development of state laws and regulations to govern their practice. Inclusion of PAs in state law and delegation of authority to regulate their practice to a state regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified **non-physicians MEDICAL PROVIDERS**, and (2) to define the role of PAs in the healthcare system. Since the inception of the profession, dramatic changes have occurred in the way states have dealt with PA practice. In concert with these developments has been the creation of a body of knowledge on legislative and regulatory control of PA practice. It is now possible to state which specific concepts in PA statutes and regulations enable appropriate **use of PRACTICE BY** PAs as **health care MEDICAL** providers while protecting the public health and safety.

What follows are general guidelines on state governmental control of PA practice. The AAPA recognizes that the uniqueness of each state's political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible **utilization of PA services PRACTICE** nationwide. This document does not contain specific language for direct incorporation into statutes or regulations, nor is it inclusive of all concepts generally contained in state practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states as they pursue improvements in state governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult the AAPA's model state legislation for PAs.

Definition of PA

~~The state law must include a definition of PA in order to differentiate PAs from other healthcare clinicians who provide direct care to patients. The legal definition of PA should include individuals who have graduated from accredited PA programs and have passed the national PA certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA). An exceptions clause should be included for PAs who are not accredited program graduates, but who passed the physician assistant national certifying examination (PANCE) administered by the NCCPA when it was available to non-program graduates prior to 1986. MEAN A HEALTHCARE PROFESSIONAL WHO MEETS THE QUALIFICATIONS DEFINED IN STATE LAW FOR LICENSURE AND IS LICENSED TO PRACTICE MEDICINE.~~

Accreditation

~~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 1986. 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 Physician Assistant (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.~~

QUALIFICATIONS FOR LICENSURE

1089 Because the law must recognize the eligibility for licensure of PAs who
1090 QUALIFICATIONS FOR LICENSURE SHOULD INCLUDE graduated from AN
1091 ACCREDITED PA programs AND PASSAGE OF THE PA NATIONAL
1092 CERTIFYING EXAMINATION (PANCE) ADMINISTERED BY THE NATIONAL
1093 COMMISSION ON CERTIFICATION OF PAS (NCCPA) **OR ANOTHER**
1094 **NATIONALLY RECOGNIZED CERTIFYING ORGANIZATION APPROVED**
1095 **BY THE ACADEMY.**

1096
1097 PA PROGRAMS WERE ORIGINALLY ACCREDITED BY THE AMERICAN
1098 MEDICAL ASSOCIATION'S COUNCIL ON MEDICAL EDUCATION (1972-1976),
1099 WHICH TURNED OVER ITS RESPONSIBILITIES TO THE AMA'S COMMITTEE
1100 ON ALLIED HEALTH EDUCATION AND ACCREDITATION (CAHEA) IN 1976.
1101 CAHEA WAS REPLACED IN 1994 BY THE COMMISSION ON
1102 ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS (CAAHEP).
1103 ON JANUARY 1, 2001, THE ACCREDITATION REVIEW COMMISSION ON
1104 EDUCATION FOR THE PA (ARC-PA), WHICH HAD BEEN PART OF BOTH THE
1105 CAHEA AND CAAHEP SYSTEMS, BECAME A FREESTANDING ACCREDITING
1106 BODY AND THE ONLY NATIONAL ACCREDITING AGENCY FOR PA
1107 PROGRAMS.

1108
1109 BECAUSE THE LAW MUST RECOGNIZE THE ELIGIBILITY FOR LICENSURE
1110 OF PAS WHO GRADUATED FROM A PA PROGRAM accredited by the earlier
1111 agencies, the definition of PAs LAW should specify individuals who have graduated
1112 from a PA program accredited by the ARC-PA or one of its predecessor agencies,
1113 CAHEA or CAAHEP.

1114 Certification

1115
1116 The definition of PA should also refer to those individuals who have passed the PA
1117 QUALIFICATIONS SHOULD SPECIFICALLY INCLUDE PASSAGE OF THE
1118 national certifying examination administered by the National Commission on
1119 Certification of Physician Assistants. NCCPA **OR ANOTHER NATIONALLY**
1120 **RECOGNIZED CERTIFYING ORGANIZATION APPROVED BY THE**
1121 **ACADEMY.** No other certifying body or examination should be considered equivalent
1122 to the NCCPA or the PANCE **UNLESS APPROVED BY THE ACADEMY.**

1123 Exceptions

1124
1125 The NCCPA, since 1986, has allowed only graduates of accredited PA programs to take
1126 its examination. However, between 1973-1986, the exam was open to individuals who
1127 had practiced as PAs in primary care for four of the previous five years, as documented
1128 by their supervising physician. Nurse practitioners and graduates of unaccredited PA
1129 programs were also eligible for the exam. An exceptions clause should be included to
1130 **make ALLOW** these individuals **TO BE** eligible for licensure.

1131 Licensure

1132
1133 When a regulatory board has verified a PA's qualifications, it should issue a license to
1134 the applicant. Although, in the past, registration and certification have been used as the
1135 regulatory term for PAs, licensure is now the **most prevalent** designation and system
1136 **USED IN ALL STATES.** This is appropriate because licensure is the most stringent

1137 form of regulation. Practice without a license is subject to severe penalties. Licensure
1138 both protects the public from unqualified providers and utilizes a regulatory term that is
1139 easily understood by healthcare consumers. ~~Licensure does not imply nor create~~
1140 ~~independent practice for PAs. The profession retains its commitment to PA practice~~
1141 ~~with physician supervision.~~

1142
1143 ~~Licensure should be independent of identification or approval of supervising physicians or~~
1144 ~~supervisory arrangements and independent of employment. APPLICANTS WHO MEET~~
1145 ~~THE QUALIFICATIONS FOR LICENSURE SHOULD BE ISSUED A LICENSE.~~
1146 ~~STATES SHOULD NOT REQUIRE EMPLOYMENT OR IDENTIFICATION OF A~~
1147 ~~COLLABORATING PHYSICIAN (S) AS A CONDITION OR COMPONENT OF~~
1148 ~~LICENSURE.~~ A category of inactive licensure should be available for PAs who are not
1149 currently in active practice in the state. If issuance of a full license requires approval at a
1150 scheduled meeting of the regulatory agency, a temporary license should be available to
1151 applicants who meet all licensure requirements but are awaiting the next meeting of the
1152 board.

1153
1154 If the board uses continuous clinical practice as a requirement for licensure, it should
1155 recognize the nature of PA practice when determining requirements for PAs who are
1156 reentering clinical practice (defined as a return to clinical practice as a PA following an
1157 extended period of clinical inactivity ~~UNRELATED TO DISCIPLINARY ACTION OR~~
1158 ~~IMPAIRMENT ISSUES).~~ ~~PAs uniformly practice with physician supervision; reentry~~
1159 ~~provisions the board designs for physicians may not be appropriate for PAs.~~ Each PA
1160 reentering clinical practice will have unique circumstances. Therefore, the board should
1161 be authorized to customize requirements imposed on PAs reentering clinical practice.
1162 Acceptable options could include requiring current certification, mandating specific
1163 requirements for ~~supervision~~ **COLLABORATION OR OVERSIGHT**, or temporary
1164 authorization to practice for a specified period of time. Although it has not yet been
1165 determined conclusively that absence from clinical practice is associated with a
1166 decrease in competence, there is concern that this is the case. Reentry requirements
1167 should not be imposed for an absence from clinical practice that is less than two years in
1168 duration.

1169
1170 Because of the high level of responsibility of PAs, it is reasonable for licensing agencies
1171 to conduct criminal background checks on individuals who apply for licensure as PAs.
1172 Licensing agencies should have the discretion to grant or deny licensure based on the
1173 findings of background checks and information provided by applicants.

1174
1175 ~~Supervision~~ **COLLABORATION**
1176 The definition of ~~supervision~~ **COLLABORATION** should convey ~~the idea that direction~~
1177 ~~of the medical practice of the PA is provided and assured by supervising physicians, but~~
1178 ~~that this does not necessarily require the physical presence of a supervising physician at~~
1179 ~~the place where services are rendered.~~ A PROCESS IN WHICH PAS AND
1180 **PHYSICIANS JOINTLY CONTRIBUTE TO THE HEALTHCARE AND MEDICAL**
1181 **TREATMENT OF PATIENTS WITH EACH COLLABORATOR PERFORMING**
1182 **ACTIONS HE OR SHE IS LICENSED TO OTHERWISE PERFORM.**
1183 **COLLABORATION SHALL BE CONTINUOUS BUT SHALL NOT BE**
1184 **CONSTRUED TO REQUIRE THE PHYSICAL PRESENCE OF THE PHYSICIAN AT**

1185 THE TIME AND PLACE THAT SERVICES ARE RENDERED. It is imperative,
1186 however, that the PA and a supervising COLLABORATING physician are or can be in
1187 contact with HAVE ACCESS TO each other by telecommunication. EVEN WHEN
1188 PRACTICING IN COLLABORATION WITH A PHYSICIAN, PAS ARE
1189 RESPONSIBLE FOR THE CARE THEY PROVIDE. NOTHING IN THE LAW
1190 SHOULD REQUIRE OR IMPLY THAT THE COLLABORATING PHYSICIAN IS
1191 RESPONSIBLE OR LIABLE FOR THE CARE PROVIDED BY THE PA UNLESS
1192 THE PA IS ACTING ON THE SPECIFIC INSTRUCTIONS OF A PHYSICIAN.
1193 Supervising COLLABORATING physician should be defined as an allopathic or
1194 osteopathic physician (MD or DO) licensed to practice in the state, who accepts
1195 responsibility for the supervision of services provided by PAs. AGREES TO
1196 COLLABORATE WITH PA(S). For PAs who practice in federal jurisdictions,
1197 supervision COLLABORATION may be provided by a physician (MD or DO) who
1198 meets the licensing requirements of the federal agency. Licensure in the state should
1199 not be required for federal supervising COLLABORATING physicians if it is not
1200 required by the federal agency. In solo practice settings, provisions should be made
1201 for alternate supervision in the supervising physician's absence. In group practice
1202 situations or in the hospital or its emergency department, provisions should be made for
1203 all staff physicians who so choose to supervise COLLABORATE WITH PAs who
1204 practice in the group or institution. PAs should not see the patients of physicians who do
1205 not wish PAs to see their patients.

1206
1207 The guiding principles of supervision TEAM PRACTICE must be that it (a) protects
1208 the public health and safety, and (b) preserves the PA's access to physician consultation
1209 when indicated. Consequently, it is recommended that the ratio of PAs to supervising
1210 COLLABORATING physicians be determined by supervising physician(s) and PAs
1211 according to the nature of the services being provided and according to the tenets of
1212 good patient care, adequate supervision and legal responsibility. Language that specifies
1213 mandatory ratios of PAs to supervising COLLABORATING physicians should be
1214 avoided. In addition, there should be no limit on the number of supervising
1215 COLLABORATING physicians each PA may have.

1216
1217 Accountability for physician supervision of PAs may be determined by a variety of
1218 methods. In small practices, the physician supervising a PA at a specific point in time
1219 may be obvious. In large groups or in settings with multiple supervising physicians, a
1220 mechanism should be in place to document physician supervision. It should be clear
1221 which physician is supervising the PA.

1222
1223 The system of licensure for PAs and identification of supervising physicians should be
1224 flexible enough to permit appropriate substitution of licensed providers. Ideally, any
1225 physician with an unrestricted license should be able to supervise any licensed PA if
1226 both agree to the arrangement, the arrangement is documented in writing, and the
1227 documentation is available to the regulatory agency upon request. This allows for easy
1228 substitution of providers and facilitates PA participation in teams that provide care in
1229 group practices, and expedites the extension of care to free clinics, homeless shelters,
1230 migrant clinics, and a variety of other settings. This system also enables ready coverage

1231 in rural areas where flexible substitution may be required to provide continuous clinic
1232 staffing.

1233
1234 Because the state licenses both physicians and PAs and can discipline or revoke or
1235 restrict the license of both types of providers, it is redundant and unnecessary for the
1236 law to require physicians or PAs to file notice of supervisory COLLABORATIVE
1237 arrangements with an agency. State law should require documentation of a supervising
1238 physician-PA relationship that is kept on file at the clinical site and available to the
1239 regulatory agency upon request.

1240
1241 NOTWITHSTANDING THE ABOVE PROVISIONS, THESE GUIDELINES
1242 RECOGNIZE THAT MEDICINE IS RAPIDLY CHANGING. A MODIFIED MODEL
1243 MAY BE BETTER FOR SOME STATES AND THEY SHOULD THEREFORE FEEL
1244 FREE TO CRAFT ALTERNATIVE PROVISIONS. PAS PRACTICE TEAM BASED
1245 MEDICINE WITH A WIDE VARIETY OF TEAM MEMBERS TO INCLUDE
1246 PHYSICIANS. LANGUAGE IN STATE LAW SHOULD ACKNOWLEDGE
1247 CONSULTATION AND/OR COLLABORATION BETWEEN PHYSICIANS AND
1248 PAS IN A MANNER THAT ASSURES QUALITY MEDICAL CARE AND
1249 PROMOTES ACCESS.

1250
1251 PA PRACTICE OWNERSHIP AND EMPLOYMENT

1252 Employment and supervision COLLABORATION should be regarded as separate
1253 entities. A physician's ability to supervise COLLABORATE WITH a PA is independent
1254 of the specifics of PA employment. In the early days of the profession the PA was
1255 commonly the employee of the physician. In current systems physicians and PAs may
1256 be employees of the same hospital or health system. In some situations the PA may be
1257 part or sole owner of a practice. PA practice owners may be the employers of their
1258 supervising collaborating physicians.

1259
1260 To allow for flexibility and creativity in tailoring healthcare systems that meet the needs
1261 of specific patient populations, a variety of practice ownership and employer-employee
1262 relationships should be available to physicians and to PAs. The physician-PAPA-
1263 PHYSICIAN relationship is built on trust, respect, and appreciation of the unique role
1264 of each team member. No licensee should allow an employment arrangement to
1265 interfere with sound clinical judgment or to diminish or influence their ethical
1266 obligations to patients. State law provisions should authorize the regulatory authority to
1267 discipline a physician or a PA who allows employment arrangements to exert undue
1268 influence on sound clinical judgment or on their professional role and patient
1269 obligations.

1270
1271 DISASTERS, EMERGENCY FIELD RESPONSE AND VOLUNTEERING

1272 PAs should be allowed to provide medical care in disaster and emergency situations.
1273 This may require the state to adopt language exempting PAs from supervision
1274 COLLABORATION provisions when they respond to medical emergencies that occur
1275 outside the place of employment. This exemption should extend to PAs who are
1276 licensed in other states or who are federal employees. Physicians who supervise
1277 COLLABORATE WITH PAs in such disaster or emergency situations should be
1278 exempt from routine documentation or supervision COLLABORATIVE requirements.

1279 PAs should be granted Good Samaritan immunity to the same extent that it is available
1280 to other health professionals.

1281

1282 PAS WHO ARE VOLUNTEERING WITHOUT COMPENSATION OR
1283 REMUNERATION SHOULD BE SIMILARLY EXEMPTED FROM
1284 COLLABORATION PROVISIONS.

1285

1286 Scope of Practice

1287 State law should permit utilization of PA services in a wide variety of PRACTICE IN
1288 ALL SPECIALTIES AND settings. In general, PAs should be permitted to provide any
1289 legal medical service that is delegated to them by the supervising physician when the
1290 service is within the PA's skills, EDUCATION, and TRAINING AND EXPERIENCE.
1291 MEDICAL SERVICES PROVIDED BY PAS MAY INCLUDE BUT ARE NOT
1292 LIMITED TO ORDERING, PERFORMING AND INTERPRETING DIAGNOSTIC
1293 STUDIES, ORDERING AND PERFORMING THERAPEUTIC PROCEDURES,
1294 FORMULATING DIAGNOSES, PROVIDING PATIENT EDUCATION ON
1295 HEALTH PROMOTION AND DISEASE PREVENTION, PROVIDING
1296 TREATMENT AND PRESCRIBING MEDICAL ORDERS FOR TREATMENT.
1297 THIS INCLUDES THE ORDERING, PRESCRIBING, AND DISPENSING,
1298 ADMINISTRATION AND PROCUREMENT OF DRUGS AND MEDICAL
1299 DEVICES. PA EDUCATION INCLUDES EXTENSIVE TRAINING IN
1300 PHARMACOLOGY AND CLINICAL PHARMACOTHERAPEUTICS.
1301 ADDITIONAL TRAINING, EDUCATION OR TESTING SHOULD NOT BE
1302 REQUIRED AS A PREREQUISITE TO PA PRESCRIPTIVE AUTHORITY. PAS
1303 WHO ARE PRESCRIBERS OF CONTROLLED MEDICATIONS SHOULD
1304 REGISTER WITH THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION.

1305

1306 DISPENSING IS ALSO APPROPRIATE FOR PAS. THE PURPOSE OF
1307 DISPENSING IS NOT TO REPLACE PHARMACY SERVICES, BUT RATHER TO
1308 INCREASE PATIENT ABILITY TO RECEIVE NEEDED MEDICATION WHEN
1309 ACCESS TO PHARMACY SERVICES IS LIMITED. PHARMACEUTICAL
1310 SAMPLES SHOULD BE AVAILABLE TO PAS JUST AS THEY ARE TO
1311 PHYSICIANS FOR THE MANAGEMENT OF CLINICAL PROBLEMS.
1312 and is provided with supervision of a physician. A list of specific tasks is overly
1313 restrictive and should be avoided. A PA's skills should not be utilized to extend the
1314 scope of the supervising physician beyond what is reasonable in the practice.
1315 Education of PAs, like that of physicians, promotes the development of practical skills
1316 in clinical problem solving and decision making. For this reason, the use of written
1317 clinical protocols should not be required as part of state laws or regulations delineating
1318 PA scope of practice. Protocols are useful for dealing with very specific clinical entities
1319 (e.g., anaphylaxis). However, protocols by their nature are rigid and rapidly outdated.
1320 Extensive clinical protocols are useful to PAs to the same extent that they are useful to
1321 physicians. They should be utilized as indicated in the clinical setting, but should not be
1322 mandated by state law or regulation.

1323

1324 State laws, regulations, and policies should allow PAs to sign any forms that require a
1325 physician signature when delegated to do so by a supervising physician.

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Prescribing and Dispensing

The ability to prescribe medications should be one of the medical services that physicians may delegate to PAs. Supervised prescribing, as regulated by the state and by the physician supervisor, can improve patient access to comprehensive care and provide for increased efficiency and cost effectiveness. Categories of medications to be prescribed should be consistent with the supervising physician's practice and should include controlled substances. PAs who are delegated prescribers of controlled medications should register with the federal Drug Enforcement Administration. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics. Additional training, education or testing should not be required as a prerequisite to PA prescriptive authority. Limited dispensing is also appropriate for delegation to PAs. The purpose of limited 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.

Title and Practice Protection

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

Regulatory Agencies

Each state must define the regulatory agency responsible for implementation of the law governing PAs. ALTHOUGH A variety of state agencies can be charged with this task, THE PREFERABLE REGULATORY STRUCTURE IS A SEPARATE PA LICENSING BOARD. These include the State Board of Medical Examiners, the Department of Health, or boards that are selected or created to regulate PA practice. The regulatory agency has a significant impact on the practice and utilization of PAs, and some general guidelines, along with each state's administrative realities, should be considered when defining which agency will be responsible for PA regulation. This agency should include COMPRISED OF a group of 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.

A number of states have created separate PA licensing boards. Such board should be composed primarily of PAs and supervising physicians. If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs

1372 and physicians who supervise COLLABORATE WITH PAs be constituent FULL
1373 VOTING members of the board. It is also recommended in these situations that PA
1374 advisory committees be established and actively utilized to assure PA participation in
1375 the regulatory process.

1376
1377 Any state regulatory agency charged with PA licensure should be sensitive to the
1378 manner in which it makes information available to the public. Consumers should be
1379 able to obtain information on health professionals from the licensing agency, but the
1380 agency must assure that information released does not create a risk of targeted
1381 harassment for the PA licensee or their family.

1382
1383 Although there is no conclusive evidence that malpractice claims history correlates with
1384 professional competence, many state regulatory agencies are required by statute to make
1385 malpractice history on licensees available to the public. If mandated to do so, the board
1386 should create a balance between the public's right to relevant information about
1387 licensees and the risk of diminishing access to subspecialty care. Because of the
1388 inherent risk of adverse outcomes, medical professionals who care for patients with
1389 high- risk medical conditions are at greater risk for malpractice claims. The board
1390 should take great care in assuring that patient access to this specialized care is not
1391 hindered as a result of posting information that could be misleading to the public.
1392 Licensee profiles should contain only information that is useful to consumers in making
1393 decisions about their healthcare professional. Healthcare professional profile data
1394 should be presented in a format that is easy to understand and supported by contextual
1395 information to aid consumers in evaluating its significance.

1396
1397 Discipline

1398 AAPA strongly endorses the authority of designated state regulatory agencies, in
1399 accordance with due process, to discipline PAs who have committed acts in violation of
1400 state law. Disciplinary actions may include, but are not limited to, suspension or
1401 revocation of a license or approval to practice. In general, the basic offenses are similar
1402 for all health professions and the language used to specify violations and disciplinary
1403 measures to be used for PAs should be similar to that used for physicians. The law
1404 should authorize the regulatory agency to impose a wide range of disciplinary actions so
1405 that the board is not motivated to ignore a relatively minor infraction due to inadequate
1406 disciplinary choices. Programs and special provisions for treatment and rehabilitation of
1407 impaired PAs should be similar to those available for physicians. The Academy also
1408 endorses the sharing of information among state regulatory agencies regarding the
1409 disposition of adjudicated actions against PAs. The medical practice act should
1410 authorize the physician regulatory agency to IMPOSE APPROPRIATE MEASURES
1411 on doctors for failing to comply with the legal requirements placed on those who
1412 supervise COLLABORATE WITH PAs. Such discipline MEASURES should include
1413 restrictions on a physician's authority to supervise COLLABORATE WITH PAs.

1414
1415 Inclusion of PAs in Relevant Statutes and Regulations

1416 In addition to laws and regulations that specifically regulate PA practice, PAs should be
1417 included in other relevant areas of law. This should include, but not be limited to, laws
1418 that grant patient-provider immunity from testifying about confidential information;
1419 mandates to report child and elder abuse and certain types of injuries, such as wounds

1420 from firearms; provisions allowing the formation of professional corporations by related
1421 healthcare professionals; and mandates that promote health wellness and practice
1422 standards. Laws that govern specific medical technology should authorize **THOSE**
1423 **APPROPRIATELY TRAINED** supervising **COLLABORATING** physicians **AND PAS**
1424 to ~~delegate their use~~ **THEM.** ~~to appropriately trained and supervised PAs.~~

1426 **2016-C-03 – Adopted**

1427
1428 AAPA supports license portability for PAs through various modes, including a Uniform
1429 Application for State Licensure for PAs, development and deployment of an interstate PA
1430 licensure compact and enhancement of the Federation of State Medical Boards’
1431 Federation Credentials Verification Service.

1432
1433 **2016-C-04 – Adopted on Consent Agenda**

1434 Amend policy HP-3200.6.2 as follows:

1435
1436 The AAPA supports efforts to help US military veterans **S medics, and hospital corpsmen**
1437 become PAs.

1438
1439
1440 **2016-C-05 – Adopted as Amended**

1441 Amend policy HP-3600.1.1 as follows:

1442
1443 AAPA seeks to modernize the Social Security Act through amendments to authorize
1444 coverage of all **MEDICAL, PSYCHIATRIC AND SURGICAL** ~~physician~~ services
1445 provided by PAs and to reimburse PAs directly for covered medical services in the same
1446 manner as all other Medicare providers.

1447
1448
1449 **2016-C-06 – Adopted as Amended**

1450 Amend policy HP-3600.1.4 as follows:

1451
1452 AAPA believes it is vital to track the volume and quality of medical, **PSYCHIATRIC**
1453 and surgical services provided by PAs to assess the impact of those services on patients
1454 and on the health care system. To facilitate that effort, AAPA supports the
1455 **ENROLLMENT**, recognition of, and direct payment to, PAs by public and private third
1456 party payers and health care organizations. ~~AAPA is committed to maintaining the~~
1457 ~~established supervising physician PA relationship that is a central concept in the PA~~
1458 ~~profession and incorporated into every state’s law.~~

1459
1460
1461 **2016-C-07 – Adopted as Amended**

1462 Amend policy HP-3600.1.6 as follows:

1463
1464 The AAPA shall educate the following groups to promote equitable reimbursement **FOR**
1465 **MEDICAL, PSYCHIATRIC AND SURGICAL** ~~physician~~ services provided by PAs:
1466

1467 Centers for Medicare and Medicaid Services (CMS), third-party payers, employers, **AND**
1468 third-party administrators. **and health benefit design organizations.**

1469

1470 **2016-C-08 – Adopted as Amended**

1471

1472 Amend policy HX-4600.2.5 as follows:

1473

1474 AAPA supports retention of the original requirement that rural health clinics utilize PAs
1475 **and NPs to PROVIDE extend** access to primary care medical services. **in areas that have**
1476 **a shortage of physicians.**

1477

1478 **2016-C-09 – Adopted on Consent Agenda**

1479

1480 Amend policy HX-4600.5.2 as follows:

1481

1482 AAPA supports prescription drug benefit plans that are universal, mandatory for all
1483 beneficiaries, integrated into the basic benefit package, are not a financial hardship to
1484 beneficiaries, include catastrophic coverage, have a defined, comprehensive benefit, and
1485 permit health care **providers PRESCRIBERS** to select medications using appropriate
1486 medical judgment that includes consideration of cost effectiveness, safety, and efficacy.

1487

1488 **2016-C-10 – Adopted as Amended**

1489

1490 Amend Policy HX-4500.9 as follows:

1491

1492 AAPA believes that additional clinical research should be conducted on the therapeutic
1493 value, efficacy and safety of **marijuana and related** cannabinoids. **AAPA URGES**
1494 **THAT MARIJUANA’S STATUS AS A FEDERAL SCHEDULE 1 CONTROLLED**
1495 **SUBSTANCE BE REVIEWED WITH THE GOAL OF FACILITATING TO**
1496 **FACILITATE AND ALLOWING THE CONDUCTING OF CLINICAL RESEARCH.**

1497

1498 **2016-C-11 – Adopted**

1499

1500 AAPA recommends that in any state where medical marijuana laws exist, PAs are
1501 included as healthcare providers that can authorize or recommend the use of marijuana
1502 for patients. AAPA believes effective patient care requires the free and unfettered
1503 exchange of information on treatment options and that discussion of marijuana as an
1504 option between PAs and patients should not subject either party to criminal sanctions.

1505

1506 **2016-C-12 – Adopted**

1507

1508 AAPA supports continued education programs and public health based strategies relating
1509 to the abuse of marijuana, and addressing and reducing the use of marijuana.

1510

1511 AAPA supports public health based strategies, instead of incarceration, when dealing
1512 with persons in possession of marijuana.

1513

1514 AAPA discourages the use of marijuana by women who are planning to become
1515 pregnant, are pregnant, or breastfeeding and shall treat and counsel women on cessation
1516 of marijuana.

1517
1518 AAPA discourages the use of marijuana by those persons under the age of 21 and
1519 discourages the use of marijuana by adults who are in the presence of persons under the
1520 age of 21.

1521
1522 AAPA supports legislation that requires labeling and child-proof packaging of marijuana
1523 and marijuana related products and that limit advertising to adolescents.

1524
1525 **2016-C-13 – Adopted as Amended**

1526
1527 **HP-3200.2.5**

1528 **AAPA encourages PAs to be knowledgeable of the management of pain including**
1529 **the appropriate use and potential misuse of controlled substances.**

1530 *[Adopted 2002, amended 2007, reaffirmed 2012]*

1531
1532 **HX-4600.5.3**

1533 **AAPA endorses the appropriate treatment of all types of pain. The treatment of**
1534 **pain should utilize a team approach that incorporates the following: appropriate**
1535 **medications, modalities, therapies and lifestyle changes, regular assessment and**
1536 **adjustments of treatment, and referral to pain management specialists when needed.**

[Adopted 2002, amended 2007, reaffirmed 2012]

1537 The AAPA encourages student and graduate PAs to recognize the crises of pain
1538 management and opioid abuse. The AAPA encourages student and graduate PAs to work
1539 toward **S** a solution to these crises at the local, state, and national level **S** through
1540 advocacy, collaboration and education **by educating FOR studentS and practicing PAs**
1541 **about responsible opioid prescribing. and accepted standards of monitoring patients**
1542 **that are on opioid medications. The treatment of pain should utilize a team**
1543 **approach that incorporates the following: appropriate medications, modalities,**
1544 **therapies and lifestyle changes, regular assessment and adjustments of treatment,**
1545 **and referral to pain management specialists when needed.**

1546
1547 **2016-C-14 – Adopted on Consent Agenda**

1548
1549 AAPA supports increased access to opioid treatment programs for patients with opioid
1550 use disorder, and therefore recommends identification and removal of obstacles to full
1551 PA utilization in such programs.

1552
1553
1554 **2016-D-01 – Adopted as Amended**

1555 Amend policy HX-4300.2.2 as follows:

1556
1557
1558 AAPA shall support state laws requiring **helmets** **PROTECTIVE EQUIPMENT** for
1559 individuals participating in activities that put them at risk of traumatic **BRAIN head**
1560 injury (recreational/transportation). In addition, the AAPA shall encourage all PAs to

1561 educate their patients, parents/guardians and the public on the value of the appropriate
1562 ~~head gear/helmets~~ **PROTECTIVE EQUIPMENT** as protection from traumatic **BRAIN**
1563 ~~head~~ injury. Such education should address activities in which ~~the~~ **THERE IS A** risk of
1564 traumatic **BRAIN head** injury, ~~is increased, such as~~ **RIDING motorcycles, ATV's,**
1565 ~~bicycles, horses, scooters, skateboards, snowboards, skis and inline roller skates;~~
1566 **PLAYING A CONTACT SPORT, SUCH AS FOOTBALL, ICE HOCKEY, OR**
1567 **BOXING; BATTING AND RUNNING BASES IN BASEBALL OR SOFTBALL.**
1568

1569 **2016-D-02 – Adopted on Consent Agenda**

1570 Amend policy HX-4400.1.7 as follows:

1571 AAPA recognizes that ~~family~~ abuse **AND VIOLENCE is ARE** a public health epidemic
1572 in the United States.

1573 AAPA supports medical care of abused and battered individuals which emphasizes
1574 linkages with community-based ~~family abuse~~ programs and referral agreements
1575 whenever possible.

1576 AAPA encourages its members to participate in community-based efforts to increase the
1577 awareness of the epidemic of child, intimate partner, and elder abuse.

1578 AAPA encourages its members to recognize that a relationship exists between substance
1579 ~~abuse~~ **USE DISORDERS** and ~~family~~ abuse **OF INDIVIDUALS.**

1580 AAPA supports the development of educational programs addressing prevention, early
1581 recognition, reporting, treatment and the appropriate referral to prevent ~~family~~ abuse.

1582 **2016-D-03 – Adopted on Consent Agenda**

1583 Amend policy HP-3900.1.1 as follows:

1584 The AAPA believes that all PAs should use the standard and transmission-based
1585 precautions recommended by the **HEALTHCARE INFECTION PREVENTION**
1586 **CONTROL ADVISORY COMMITTEE (HICPAC) AND THE** Centers for Disease
1587 Control and Prevention (CDC) for preventing the spread of infectious diseases **AND**
1588 **HEALTHCARE ASSOCIATED INFECTIONS.** AAPA believes employers should
1589 establish procedures to ensure that standard precautions, **TRANSMISSION-BASED**
1590 **PRECAUTIONS,** and other applicable infection control measures are enforced and that
1591 educational programs covering proper infection control procedures are available for all
1592 health care workers. Employers should ensure that timely post-exposure counseling and
1593 prophylaxis, in accordance with relevant CDC and OSHA guidelines, are available to
1594 health care workers after an exposure.

1605 **2016-D-04 – Adopted**

1606 Amend by substitution policy HP-3200.4.1 Maintaining Professional Flexibility: The
1607 Case Against Accreditation of Postgraduate PA Programs as follows:
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Accreditation and Implications of Clinical Postgraduate

PA Training Programs

(Adopted 2005 and amended 2010)

Executive Summary of Policy Contained in this Paper

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

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

Background

Task Force Composition, Collaboration with the Commission, and Guiding Principles

1651 In November 2015, a Task Force on Accreditation of Postgraduate Training Programs
1652 was convened by the AAPA Commission on Continuing Professional Development and
1653 Education to support their efforts in reviewing and revising the current AAPA policy HP-
1654 3200.4.1 regarding the accreditation of postgraduate PA training programs as described
1655 in the position paper entitled “Maintaining Professional Flexibility: Issues Related to
1656 Accreditation of Postgraduate PA Programs.” Responsible review of the policy called for
1657 assessment of the current landscape and investigation of issues impacting the PA
1658 profession related to clinical postgraduate PA training. The task force was comprised of a
1659 diverse group of experienced healthcare professionals and clinical administrators,
1660 primarily PAs but also inclusive of members from allopathic medicine, osteopathic
1661 medicine, and healthcare administration. The task force primarily focused its review on
1662 clinical postgraduate PA training programs and considered issues beyond accreditation,
1663 since a previously existing national accreditation model for postgraduate PA training
1664 programs was put in abeyance after the last amendment of this policy paper.
1665 To frame discussions and ensure broad perspectives were addressed throughout the
1666 process, the following guiding pillars were established: leadership, evidence, quality,
1667 impact on the PA profession, adoption and adaptation. The rationale for these pillars is
1668 built upon the following observations and best practices. Scaling of transformative
1669 change will occur when leaders envision, encourage, and support innovation that supports
1670 all stakeholders, namely PAs and the patients, families, and communities they serve.
1671 Additionally, clinical postgraduate PA training experiences that facilitate leadership
1672 development among PAs are considered critically important to the future of healthcare
1673 innovation and the PA profession. Empiric evidence should be foundational to decision
1674 making, understanding that there will likely be gaps in existing data and inherent barriers
1675 to high quality research for postgraduate clinical training models. Evidence from other
1676 healthcare professions or healthcare workforce populations from large employers may be
1677 valuable; however, the unique attributes of the PA profession should be acknowledged in
1678 attempting to generalize evidence from other professions. Expert opinion balanced with
1679 stakeholder input will likely represent the most practical approach to this review and
1680 revision process. Recommendations that encourage better, more consistent data collection
1681 and reporting for future years should be considered. A prioritization of future research
1682 should be made for investigations or observational studies that relate to optimizing

1683 quality of care, increasing access to care, and supporting optimal health for patients and
1684 communities. Careful consideration should be given for any guidance or policy
1685 recommendations that addresses structured or formalized regulatory oversight, because of
1686 its potential macro-level impact on PA practice. The careful consideration of potential
1687 long term effects of recommendations on PA practice and the practice environment
1688 should be weighed carefully, as well as the appropriate authority and rights of states in
1689 the licensure, regulation, and monitoring of PA practice. Scaling of transformative
1690 change will occur when adoption and adaptation respect and influence the cultures of the
1691 different settings in which care is delivered. This observation can be easily identified in
1692 the creation, evolution, and scaling of the PA profession since its inception nearly fifty
1693 years ago in the United States. Clinical postgraduate PA training represents a voluntary
1694 permutation of advanced training in the clinical setting that is limited to a very small
1695 percentage of the overall PA population. These disciplined, educational innovations have
1696 often evolved to meet regional and unique workforce development needs and
1697 opportunities. Task Force recommendations should respect the autonomy and unique
1698 needs of the different healthcare settings and training programs, including facets related
1699 to employers, specialty, state/region, stage of development of the learner, or regional
1700 maldistribution or shortage of physicians or other healthcare practitioners.

1701 Methods, Findings and Recommendations

1702 *Data Collection and Stakeholder Engagement*

1703 During the period of review, deliberation and formulation of recommendations by the
1704 task force from November 2015 through February 2016, data and feedback were
1705 collected by stakeholder engagement and through systematic review of the relevant
1706 published literature. The task force reports that data gathering and engagement of
1707 stakeholders was not meant to be all inclusive or represent a census activity; rather, this
1708 data collection paired with analysis of systematic review served to better inform
1709 discussions of the task force which subsequently led to formulation of expert opinion
1710 recommendations. Stakeholders engaged included practicing and retired PAs (including
1711 those with clinical administrative roles), current or recent participants in a clinical
1712 postgraduate PA training program, PA educators, PA students, patients and families cared
1713 for by PAs, physicians and physician executives across multiple primary care and
1714 specialty areas (primarily from academic health centers or teaching hospitals), and hiring

1715 managers within large healthcare employers. Feedback was gathered from leaders within
1716 the AAPA and PAEA. Feedback was gathered from the chair of a committee convened
1717 by the Accreditation Review Commission on Education for the Physician Assistant to
1718 reevaluate accreditation for postgraduate PA training programs. Systematic review
1719 identified approximately thirty disseminated works on postgraduate training that were
1720 critically appraised, summarized, discussed, and prepared for submission to a peer
1721 reviewed clinical journal. Finally, the task force presented its preliminary findings and
1722 recommendations during a panel session held for attendees of the AAPA Leadership and
1723 Advocacy Summit held in Arlington, Virginia in early February 2016. Participants of
1724 this summit also had the opportunity to provide feedback and pose questions which were
1725 taken back to the task force for discussion.

1726 *Highlights of Findings from Data Collection and Stakeholder Engagement*

- 1727 • Clinical postgraduate PA training programs prepare only a small number of PAs each
1728 year, compared to the number of students graduated from PA programs annually.
- 1729 • There were 58 clinical postgraduate PA training programs identified in the United
1730 States, and most lasted 12 months with a range of 12 to 18 months.
- 1731 • Clinical specialties represented by programs identified included acute care medicine,
1732 cardiology, cardiothoracic surgery, critical care and trauma, emergency medicine,
1733 family medicine, general surgery, hematology and oncology, internal medicine and
1734 hospital medicine, neonatology, obstetrics and gynecology, orthopedic surgery,
1735 otolaryngology, pediatrics, psychiatry, urgent care, and urology.
- 1736 • Despite a previously existing voluntary accreditation process administered by the
1737 ARC-PA, the task force was unable to gather summary data through requests or
1738 identify comparable, readily accessible data across publicly accessible platforms on
1739 program effectiveness, trainee demographics, or longitudinal outcome data.
- 1740 • There were eight programs from the 58 identified that reported having accreditation at
1741 one point through the voluntary model previously operated by the ARC-PA and
1742 subsequently placed in abeyance.
- 1743 • Clinical postgraduate PA training does not appear to result in increased salary
1744 compensation (compared to PAs without this voluntary training), but evidence
1745 suggests completion of such a program favorably improved hiring process and
1746 improved the confidence levels of PAs completing the training.

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- PA professional organizations generally support clinical postgraduate PA training as an optional activity for structured advanced training in the clinical setting for PAs who have an interest in pursuing such training at any stage in their careers.
 - The vast majority of PAs who completed a clinical postgraduate PA training program, based a single national survey study, would recommend postgraduate PA training to others.
 - Numerous individuals from various stakeholder groups felt varying vernacular for describing these types of programs (e.g. postgraduate training program, residency, fellowship, etc.) was both confusing and problematic.
 - Themes gathered from feedback from a sample of physician executives overseeing clinical operations (e.g. clinical chairs, section chiefs, service line directors primarily in academic medical centers in different parts of the United States within the following specialties: dermatology, emergency medicine, family medicine, hospital medicine, internal medicine with and without intensive care, oncology, otolaryngology with head and neck surgery, and surgery) included these:
 - Experience gained through a clinical postgraduate PA training program was valued by physician leaders in some but not all specialties
 - Physicians in some specialty areas preferred to orient and train their own PAs because of the highly variable care models used within their teams (e.g. dermatology, intensive care, emergency medicine with trauma)
 - Several physician leaders commented on clinical postgraduate PA training was unnecessary and unlikely to impact a large segment of PA practice because of high market demand for PAs and satisfaction with employers of new graduates
 - Physician leaders identified key skills or behaviors that were ideal or observed favorably in PAs hired that had completed clinical postgraduate PA training: better understanding of systems based practice, experience with clinical research and administrative skills, greater appreciation for interprofessional practice and multidisciplinary care, greater assimilation into the institution's overall culture, improved leadership competencies, better understanding of the care continuum (e.g. across settings and points of care transition) and importance of continuity of care

- 1778 ○ The vast majority of physician leaders did not believe clinical postgraduate PA
1779 training programs would create practice barriers for those not trained in
1780 postgraduate programs (e.g. recruitment issues, credentialing or licensure barriers,
1781 employer mandates, expectations from physician specialty organizations)
- 1782 ○ A small number of physician leaders described potential advantages for
1783 employment opportunities in some specialties for PAs who complete clinical
1784 postgraduate training programs (versus those who do not) if ongoing growth in
1785 the number of entry-level PA programs continues and pushes supply over demand
- 1786 ○ Factors described by physician leaders related to factors favorably impacting
1787 hiring practices did not include completion of a clinical postgraduate PA program
1788 (e.g. most common factors described were high level of motivation, strong desire
1789 to excel, willingness to learn, ability to receive and proactively gather feedback,
1790 flexibility, interest in pursuing scholarly or administrative opportunities, and
1791 professional experience prior to entry-level PA training)
- 1792 ○ The vast majority of physician leaders reported that a national process for
1793 recognizing / certifying / accrediting clinical postgraduate PA training programs
1794 was very important

1795 Systematic review for published / disseminated literature relevant to clinical postgraduate
1796 PA training produced a small yield, considering the length of time such programs have
1797 existed, and key findings include the following. The term limited study here
1798 acknowledges publications that have limited generalizability, such as being conducted at
1799 a single site, evaluating small sample sizes, or study designs that are not intended to
1800 demonstrate cause and effect.

- 1801 • Trainees perceive improvements in their abilities to establish a diagnosis, to recognize
1802 disease, to think critically, and generate a differential diagnosis
- 1803 • Some programs appear to help trainees develop teaching skills, promote
1804 professionalism, increase pool of available and qualified PA faculty and overcome
1805 barriers to retention
- 1806 • Limited study in critical care demonstrates clinical postgraduate PA (and APRN)
1807 training positively impacted patient care and enhanced the training of other healthcare
1808 professionals in critical and intensive care settings

- 1809 • Limited study in emergency medicine demonstrated that the vast majority program
1810 faculty surveyed felt PA students had sufficient training from entry level PA
1811 education for emergency medicine practice and more than half did not see a need for
1812 clinical postgraduate PA training
- 1813 • Limited study reported improved recruitment and retention of PAs in rheumatology
1814 through a specialty postgraduate PA training program
- 1815 • Several studies did not reveal salary differences for PAs who had completed clinical
1816 postgraduate training compared those who had not
- 1817 • Limited study revealed most PA students are aware of opportunities for clinical
1818 postgraduate training but few chose to complete such training

1819 Feedback from informal interviews and small focus groups with stakeholders revealed
1820 the following themes. Please note some feedback may be representative of only a small
1821 number of individuals or may represent perspective of a single participant. In the cases of
1822 student and patient interviews, convenience samples available to task force members
1823 were utilized. Closed online discussion groups were also leveraged to solicit feedback
1824 and facilitate discussion.

- 1825 • Professional organization leaders and most PAs felt clinical postgraduate PA training
1826 should remain voluntary and available only to those PAs who want to pursue it
- 1827 • Employers and hiring managers saw greater confidence as a key benefit of clinical
1828 postgraduate PA training
- 1829 • Interest among clinical year PA students in postgraduate training varied widely across
1830 three sites examined (e.g. one in Southeast, one in Northeast, one in Midwest) from
1831 5% in one class, to 20% in one class to 50% in one class
- 1832 • Many students were unsure what completing clinical postgraduate PA training would
1833 mean for their careers in the long-term
- 1834 • Hiring managers and some postgraduate program directors felt a well-designed,
1835 structured clinical onboarding process can be equally effective as a formal
1836 postgraduate training program in terms of bringing newly hired PAs to practice
1837 readiness and efficiency
- 1838 • Most postgraduate PA program directors felt the former accreditation process was
1839 cumbersome and disconnected from important elements of workplace based training

- 1840 • The pursuit of accreditation among programs that had sought accreditation was most
1841 often reported as a requirement for institutional support
- 1842 • Among postgraduate PA program directors interviewed that had not sought
1843 accreditation, the most common reasons for not applying for accreditation included:
1844 the process was too onerous, accreditation was not important to the institution, and/or
1845 there was insufficient staff effort to carry out required elements of the application
1846 process
- 1847 • None of the patients interviewed in focus groups had any knowledge if their provider
1848 was trained in a postgraduate PA training program; general consensus of patients was
1849 that if the provider was compassionate and addressed their needs, it was unimportant
- 1850 • Many PA hiring managers conveyed concern about any steps that increased
1851 specialization requirements for practice entry; some who oversaw blended workforces
1852 of PAs and APRNs cited difficulties in meeting patient needs or inability for some
1853 APRN providers to see certain types of patients that were common in the service lines
1854 they were assigned or ask to periodically cover
- 1855 • Most PA hiring managers said the supply of graduates from clinical postgraduate PA
1856 training programs was so small, it would never meet workforce needs; many said a
1857 year of experience was viewed equivocally as completion of a clinical postgraduate
1858 PA training program
- 1859 • Many PA hiring managers cited a lack of evidence documenting any measureable
1860 benefits of postgraduate training that they could take to their executive leaders to
1861 justify changes in hiring practices (e.g. medical error rates, efficiency, patient
1862 engagement, clinical quality, or unnecessary costs related to practice patterns or
1863 utilization)
- 1864 • A small sample of PA hiring managers representing large employers (e.g. > 250 PAs
1865 in a single organization or health system) preferred hiring new or inexperienced PAs
1866 because they felt they were easy to assimilate into their institution's culture or
1867 practice standards
- 1868 • Several hiring managers and PAs reported concern over online only programs
1869 available to APRNs that were described as clinical fellowships or residencies, citing
1870 the main value of postgraduate programs comes from experiential elements

- 1871 • Several hiring managers who were also involved with pharmacist workforce hiring
1872 (all in teaching hospitals) stated that pharmacists without a pharmacy practice
1873 residency (and/or specialty residency) were not or were rarely considered for
1874 employment opportunities within their institutions
- 1875 • The vast majority of PA and physician stakeholders as well as leaders involved with
1876 the Association of Postgraduate PA Programs described the need for and importance
1877 of a national model for evaluating and recognizing these programs. Representatives
1878 from the Department of Veterans Affairs even cited concerns about the availability of
1879 ongoing funding for such programs (or continuation of pilot project funding) without
1880 such recognition. The Task Force endorses a national model for evaluating,
1881 supporting ongoing quality improvement, and monitoring outcome measures from
1882 clinical postgraduate PA programs.

1883 The Task Force summarizes what we view as key elements and considerations for an
1884 optimal national model:

- 1885 • The process should be PA-led and involve individuals with extensive and current
1886 experience in clinical practice
- 1887 • The current standards used for evaluation of entry level PA programs are viewed as
1888 largely inappropriate for adaptation for assessment and recognition of postgraduate
1889 training, over more contemporary models applicable to workplace based training and
1890 assessment, professional identity formation and entrustability
- 1891 • Accreditation through a single, national process is recommended with attention to
1892 high quality data collection, analysis and reporting
- 1893 • Standards should ensure the trainee is positioned for active learning, an appropriate
1894 blend of didactic and experiential curricular activities, healthy duty-hours, and
1895 reasonable compensation and benefits
- 1896 • Standards should ensure programs include PA faculty or directors, and standards
1897 should ensure sufficient administrative effort is protected to support effective
1898 program oversight
- 1899 • Standards should require the collection and reporting of patient care and quality
1900 oriented outcomes of care for trainees
- 1901 • The application process and requirements for assessment and reporting should be
1902 more efficient and streamlined than the previously existing model

- 1903 • Standards should place greater emphasis on standardizing trainee protections,
1904 institutional resource requirements, data collection and reporting, and quality
1905 improvement requirements versus on curricular standardization

1906 Summary

1907 Clinical postgraduate PA training programs represent one of many innovations created by
1908 the PA profession to support continuing professional development and lifelong learning,
1909 foster interprofessional and collaborative care, advance workforce development and
1910 explore novel educational approaches to optimize healthcare delivery. Since 1971,
1911 clinical postgraduate PA training programs have provided a relatively small number of
1912 interested PAs with diverse opportunities to gain advanced clinical skills and experience
1913 in the workplace, building upon the generalist medical education offered to all PAs
1914 through entry-level PA education. Similar to the impetus of physician shortages that led
1915 to the birth of the PA profession, many of the early clinical postgraduate PA training
1916 programs arose to address provider shortages that resulted from duty-hour restrictions of
1917 medical residents. Advanced training in the clinical setting is a core facet of the
1918 professional identity formation and continuing medical education for every PA
1919 throughout his or her career. Advanced training in the clinical setting, a generalist
1920 foundation for entry-level PA education, and generalist model for certification together
1921 position the PA profession as one of the most flexible and adaptable professions in
1922 modern healthcare. This flexibility and capacity to adopt and adapt to dynamic changes
1923 in healthcare delivery make PAs invaluable assets within the U.S. healthcare workforce
1924 to improve access and improve the quality of patient-centered care for patients, families,
1925 and communities. The development of an efficient, PA-led, national model for
1926 accreditation, continuous quality improvement, and reporting on outcomes is needed.
1927 Greater investment in research infrastructures is needed to support knowledge generation,
1928 dissemination of best practices, and optimization of these voluntary, workplace-based
1929 educational innovations for PAs.

1930
1931 **2016-D-05 – Adopted**

1932
1933 Amend policy HP-3200.2.2 as follows:

1934
1935 APA reviews and approves for Category 1 CME credit educational activities which
1936 serve to develop, maintain, or increase the knowledge, skills and professional

1937 performance of a PA. These may include live presentations, enduring material programs,
1938 and other educational activities. AAPA stipulates that the following activities meet the
1939 requirements for Category 1 CME credit for PAs:
1940

- 1941 • those approved for Category 1 credit by the American Medical Association
- 1942 (AMA) (i.e. activities sponsored by providers accredited by the Accreditation
- 1943 Council for Continuing Medical Education (ACCME))
- 1944 • those approved for Category 1-A credit by the American Osteopathic
- 1945 Association (AOA)
- 1946 • those approved for prescribed credit by the American Academy of Family
- 1947 Physicians (AAFP)
- 1948 • accredited programs of the Royal College of Physicians and Surgeons of
- 1949 Canada (RCPSC), the College of Family Physicians of Canada (CFPC), or the
- 1950 Physician Assistant Certification Council of Canada (PACCC)
- 1951 • **THOSE APPROVED FOR CREDIT BY THE EUROPEAN UNION OF**
- 1952 **MEDICAL SPECIALISTS/EUROPEAN ACCREDITATION COUNCIL FOR**
- 1953 **CONTINUING MEDICAL EDUCATION (UMES/EACCME)**
- 1954

1955 **2016-D-06 – Adopted as Amended**

1956
1957 ~~The Student Academy recommends that AAPA creates and supports a joint task force~~
1958 ~~with PAEA to undertake research, identify policy solutions, and develop practical~~
1959 ~~approaches to increase the availability and accessibility of clinical rotations for PA~~
1960 ~~students.—~~

1961
1962 **THE STUDENT ACADEMY RECOMMENDS THAT AAPA CREATE AND**
1963 **SUPPORT A JOINT TASK FORCE WITH PAEA TO INVESTIGATE FACTORS**
1964 **THAT AFFECT PRACTICING PAS’ ABILITY TO SERVE AS PRECEPTORS FOR**
1965 **PA STUDENTS, IDENTIFY OPPORTUNITIES TO IMPROVE POLICY TO**
1966 **SUPPORT PRECEPTORSHIP, AND COLLABORATE WITH PAEA EFFORTS TO**
1967 **DEVELOP INNOVATIVE AND PRACTICAL LONG-TERM APPROACHES TO**
1968 **INCREASE THE AVAILABILITY AND ACCESSIBILITY OF SUSTAINABLE**
1969 **CLINICAL EDUCATION MODELS FOR PA STUDENTS.**

1970
1971 **2016-D-07** – Referred (to be referred by the Speaker to the appropriate body and reported**
1972 **back to the 2017 HOD)**

1973
1974 Adopt the position paper entitled “Barriers to PA Student Clinical Rotations”.

1975
1976 Barriers to PA Student Clinical Rotations

1977
1978 Executive Summary of Policy Contained in this Paper

1979 Summaries will lack rationale and background information and may lose nuance of
1980 policy. You are highly encouraged to read the entire paper.
1981

1982 This position paper is intended to shed light on the effect that the current lack of
1983 clinical rotation sites and preceptors, the competition for positions within those limited

1984 sites, and barriers to interstate rotations, are having on PA students and their
1985 opportunities to train at the top of their ability. PAs are uniquely positioned to lead in the
1986 new healthcare environment of team-based care. In order to keep pace with the rapidly
1987 expanding demand for more medical providers, PA students must be provided every
1988 opportunity to successfully complete their education and training, especially as more PA
1989 programs come on line and existing programs attempt to expand their cohorts.

- 1990 • The AAPA believes that patients will be best served if current and future PA
1991 students have access to the highest caliber clinical rotations possible.
- 1992 • The AAPA believes that PA programs and clinically practicing PAs should work
1993 together in order to:
 - 1994 1. Mitigate the effect that PA inter-program competition for clinical rotation
1995 sites has on PA students; and
 - 1996 2. Increase the number of hospital and office rotation sites available to PA
1997 students and ensure a diversity of rotation sites.
 - 1998 3. Decrease the barriers for PAs to participate in clinical rotations in states
1999 other than where their PA program is located.

2000

2001 Introduction

2002 PA programs, like allopathic and osteopathic medical schools and nurse
2003 practitioner (NP) programs, are faced with a shortage of preceptors and clinical rotation
2004 opportunities. With the rapid growth of the PA profession and the creation of new PA
2005 programs in 46 out of 50 states, the longstanding problem of rotation shortages has
2006 become even more challenging. For several years, the PA Education Association (PAEA)
2007 has attempted to address this issue by developing innovative clinical training
2008 opportunities and encouraging an atmosphere of collaboration rather than competition
2009 among PA programs. The AAPA is uniquely positioned to work with PAs and PA
2010 employers to expand the availability of preceptors and clinical rotation sites for PA
2011 students.

2012 A Problem for PA Students, PA Programs, and the PA Profession

2013 Quality clinical education is an important aspect of PA educational curriculum. Many
2014 required clinical rotations are in primary care settings, including family practice,
2015 pediatrics, and women's health. This is in line with the 'primary care' or 'generalist'
2016 nature of PA training and the historical foundation of the PA profession. Although the

2017 clinical rotation site shortage is not a new challenge, only recently has the phenomenon
2018 been studied in a systematic manner, with the Joint Report of the 2013 Multi-Discipline
2019 Clerkship/Clinical Training Site Survey confirming what clinical coordinators and PA
2020 students already recognized.

2021 The Joint Report suggests that finding rotations particularly in primary care settings is
2022 a significant issue for most PA programs. According to the report, 95 percent of PA
2023 program respondents are concerned about the number of clinical sites available, and 91
2024 percent of PA program respondents are concerned about the availability of qualified
2025 primary care preceptors (1). Research conducted by Herrick et al. and published in the
2026 November 2015 issue of JAAPA confirmed these findings (2). The Joint Report suggests
2027 that obstetrics/gynecology and pediatrics are two of the most difficult rotations for which
2028 to find student placement (1). According to the 2013 AAPA National Survey, only 2
2029 percent of PAs currently work in obstetrics/gynecology, and 2 percent work in pediatrics
2030 (3). The scarcity of PAs working in those specialty areas is likely both a cause and effect
2031 of the lack of clinical rotations in those areas.

2032 The availability of preceptors and clinical rotations is not a new problem in PA
2033 education. It was first formally addressed by clinical coordinators at the 1998 Association
2034 of Physician Assistant Programs (APAP, now PAEA) Education Forum. Since that time,
2035 the Physician Assistant Education Association (PAEA) has prioritized the issue, making
2036 the development of ‘a broad range of innovative clinical training opportunities’ part of its
2037 strategic plan and encouraging an environment of collaboration rather than competition
2038 among PA programs (4). The continued effort of the PAEA in addressing preceptor
2039 shortage is crucial to improving the clinical education environment in the coming years.
2040 However, due to the extent of the problem and the continued growth of the PA profession
2041 the issue will be best handled if approached by the entire PA community. As the national
2042 membership organization for both PAs and PA students, with a strong advocacy program
2043 and growing relationships with PA employers, AAPA is uniquely positioned to aid in the
2044 address of this issue.

2045 As the PA profession continues to grow rapidly, with new programs developing and
2046 the number of PA students increasing, the demand for preceptors and clinical rotation
2047 sites will only increase in the coming years. From 2015 to 2016 alone, the number of
2048 accredited PA programs grew from 199 to 226 (5, 6). In addition to an increasing

2049 number of PA students seeking clinical rotations each year, there continues to be growth
2050 in the number of allopathic and osteopathic medical students, as well as nurse practitioner
2051 students, competing for many of the same rotations and preceptors. With the increase in
2052 PA students, the number of PAs is projected to increase 38.4% from 2012 to 2022 (7).
2053 Similarly, according to Merritt Hawkins, the demand for PAs was estimated to increase
2054 more than 300 percent between 2011 and 2014 (8). The continued growth of the PA
2055 profession depends on the growth of PA programs, and one of the essential rate-limiting
2056 factors in the growth of PA programs is clinical rotation barriers. If this issue is not
2057 addressed, the growth of the PA profession will slow and the PA profession will be less
2058 equipped to meet the sharp increase in health care demand.

2059 Barriers to PA Clinical Rotations

2060 According to Herrick et al., competition and shortage of preceptors are the two most
2061 commonly cited barriers to student placement, with the shortage of preceptors being due
2062 in part to a perceived reduction of productivity and/or revenue while training students (2).
2063 Preceptors are likely to weigh the perceived rewards of practice-based teaching against
2064 the perceived costs and challenges in deciding whether to accept a student placement and
2065 how to teach. Reduced productivity and increased time pressures remain key perceived
2066 negative impacts of teaching (2, 9). While many preceptors perceive patient care
2067 responsibilities to be too time consuming to allow them to be good teachers, studies have
2068 found a correlation between productivity and highly-rated teachers, with positive impacts
2069 including enhanced enjoyment of practice and keeping one's knowledge up-to-date (10,
2070 11).

2071 There has been a steady increase in the number of allopathic and osteopathic medical,
2072 NP and PA students over the past several decades which have not been matched by a
2073 corresponding increase in number of preceptors and clinical rotation sites. As a result, the
2074 clinical training sites that are available are overwhelmed with student applicants. The
2075 insufficient number of clinical training sites for PA students is exacerbated by inter-
2076 professional competition for such sites. According to the Association of American
2077 Medical Colleges (AAMC) there are currently 86,746 medical students enrolled in United
2078 States osteopathic and allopathic medical programs in the 2015-2016 school year (12).
2079 There has been a steady increase in medical student enrollment for the past decade. Since
2080 2006-2007 there has been a 16 percent increase in the total number of matriculated

2081 medical students in the last decade (12). Additionally, there were an estimated 17,000
2082 new Nurse Practitioners (NPs) completing their academic programs in 2013-2014 (13).

2083 The growth rate of PA schools and matriculated students has also boomed over the
2084 past decade. According to the PAEA there are currently 157 programs with continuing or
2085 probationary accreditation, 42 new programs with provisional accreditation, and 27
2086 developing programs that are not yet accredited for a total of 226 programs nationwide at
2087 varying levels of accreditation (6). This is up from 134 programs in November 2005 (14).
2088 Cohort sizes in PA programs range from approximately 15 to 100 students. Many smaller
2089 programs would increase their class sizes, but they are limited by the availability of
2090 clinical preceptors and rotation sites. Many programs have even had to decrease their
2091 cohort sizes due to insufficient clinical sites. With an estimated growth to 273 programs
2092 by 2020, the consistent increase in students has the potential to further worsen the
2093 preceptor and clinical rotation site shortage (15).

2094 Furthermore, there are legislative barriers to clinical rotations, particularly those
2095 between states. One example encompasses the recent development of State Authorization
2096 Reciprocity Agreements between states and institutions. This arrangement, which
2097 requires states and institutions to pay an annual fee in order to participate in accreditation,
2098 has inadvertently led to several PA programs having to curtail or eliminate out-of-state
2099 rotations. In response to this arrangement, several health professions education
2100 associations sent an April 2015 letter to Congress recommending a nationwide exemption
2101 for clinical rotations from future Department of Education regulations pertaining to state
2102 authorization (16). Unfortunately, of the seven associations listed, the PAEA was not
2103 listed, and for the organizations listed, the dilemma with state authorization's effect on
2104 clinical rotation sites continues.

2105 The Unique Position of the AAPA in Working Toward a Solution

2106 AAPA is the only national organization that represents PAs and which PAs
2107 voluntarily join. With more than 37,000 Fellow members (all licensed PAs), AAPA is
2108 uniquely positioned to communicate with PAs about the need for and value of precepting
2109 PA students. In addition, AAPA has the opportunity to offer PAs incentives to serve as
2110 preceptors. Already, AAPA has created a "Preceptor of the Year" award to encourage
2111 PAs to precept students. While the possibility of this award clearly signals the value of
2112 acting as a preceptor, the fact that only one individual will be recognized each year may

2113 limit its incentive effects. Additionally, AAPA encourages PAs to help educate the next
2114 generation of PAs through its Clinical Preceptor Recognition Program, awarding the
2115 CPAAPA designation.

2116 Currently, there are only 108 active AAPA members who have been recognized as
2117 Clinical Preceptors. AAPA also offers Category 1 CME accreditation for Preceptors
2118 through PA programs. However, there are a number of other potential incentives that
2119 AAPA could consider, including access to exclusive material, public recognition
2120 programs for all who precept, and/or discounts on AAPA products, services or
2121 membership. Many programs provide funding and incentive pay to take students from
2122 their programs. The Joint Report notes that the compensation per student per rotation for
2123 the programs that provide financial incentives is \$125 per student (1). AAPA providing a
2124 discount on AAPA products, services, or membership might help to incentivize
2125 preceptors and hospitals to take students from programs who are unable to pay for student
2126 rotations due to budgetary restraints. As well, the CME offering could be promoted more
2127 visibly among PAs, and AAPA may want to consider increasing the amount of CME
2128 credit given for such participation.

2129 AAPA's new Center for Leadership and Management (CHLM) also presents some
2130 unique opportunities for AAPA to encourage employers to add clinical rotation
2131 opportunities for PAs. Clinical rotations offer employers an opportunity to see first-hand
2132 how well a PA candidate fits into their culture, how adept they are in communicating
2133 with patients and colleagues, and how quickly they learn new skills. Many employers
2134 who now offer clinical rotations to PAs say that they often hire from these cohorts of
2135 trainees, in part because they have already been trained to the standards of that particular
2136 hospital or organization. In addition to these advantages, AAPA could consider offering
2137 discounted services and/or recognition awards to employers who provide clinical rotation
2138 opportunities to PAs.

2139 Finally, AAPA and its constituent organizations have the most robust advocacy
2140 programs on behalf of PAs, at both the federal and state level. Since it is in the interest of
2141 state governments and the federal government to ensure that there are adequate numbers
2142 of qualified clinical providers to meet the healthcare needs of the nation, AAPA should
2143 consider advocating for financial and other incentives for individual medical providers to
2144 precept PA students, as well as financial and other incentives for employers to provide

2145 such opportunities. The AAPA should also help to ensure that the PA profession is
2146 represented in any further discussion at the federal and state levels regarding state
2147 authorization agreements.

2148 Conclusion

2149 The AAPA believes that clinically practicing PAs should precept PA students in order
2150 to enrich their clinical education experience and ensure the graduation of competent
2151 health care providers. The AAPA should provide incentives to clinically practicing PAs
2152 who are AAPA members to precept PA students. The AAPA should work with PA
2153 employers, including hospitals, HMO's, and clinics, to expand the number of
2154 opportunities for PA students to gain clinical experience through rotational assignments.
2155 The AAPA should work with other PA organizations such as the PAEA to find creative
2156 solutions to the chronic problem of clinical rotation shortages and undertake a campaign
2157 urging PAs to precept PA students and to work with employers to expand clinical rotation
2158 opportunities for PA students. With these steps, the chronic issue of preceptor and
2159 clinical rotation shortages within the PA profession can begin to be addressed.

2160

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2195
2196 **2016-D-08 – Adopted on Consent Agenda**
2197

2198 Amend by substitution policies HX-4200.4.1, HX-4200.4.2, HX-4200.4.3, HX-4200.4.4,
2199 HX-4200.4.5, HX-4200.4.6.1, HX-4200.4.6.2, HX-4200.4.6.3, and HX-4200.4.7 with
2200 position paper entitled “Nicotine Dependence” as follows:
2201

2202 **HX 4200.4.1**

2203 AAPA shall support the position of the Surgeon General and encourage PAs to increase
2204 patient awareness as to the dangers in the use of tobacco products. All PAs should strive
2205 to eliminate the use of tobacco products from their personal lives and the lives of their
2206 colleagues and patients.

2207
2208 **HX 4200.4.2**

2209 AAPA recognizes the public health hazards of tobacco as a leading cause of preventable
2210 disease and encourages efforts to eliminate tobacco use in this country and around the
2211 world.

2212
2213 **HX 4200.4.3**

2214 AAPA encourages PAs to work to support legislation which will eliminate the public's
2215 exposure to secondhand smoke, eliminate minors' access to tobacco products including
2216 electronic nicotine delivery systems and prohibit advertising of tobacco products.

2217
2218 HX 4200.4.4

2219 AAPA supports state utilization of tobacco settlement money for prevention and
2220 treatment of tobacco use. The Academy urges its constituent organizations to work with
2221 state governments and other health care and advocacy organizations to assure tobacco
2222 settlement funds are used for the prevention and treatment of tobacco use.

2223
2224 HX 4200.4.5

2225 AAPA encourages all PAs to be actively involved in community outreach that is directed
2226 toward providing tobacco education based upon current evidence-based guidelines to
2227 people of all ages about the dangers of smoking with the goal of eliminating tobacco use.

2228
2229 HX 4200.4.6.1

2230 AAPA supports (a) development and promotion of smoking cessation materials and
2231 programs to advance consumer health awareness among all segments of society, but
2232 especially for youth; (b) dissemination of evidence-based clinical practice guidelines
2233 concerning the treatment of patients with nicotine dependence; (c) effective use of both
2234 smoking cessation materials and evidence-based clinical practice guidelines by PAs, for
2235 the treatment of patients with nicotine dependence.

2236
2237 HX 4200.4.6.2

2238 AAPA encourages PAs to model smoking cessation activities in their practices, including
2239 (a) quitting smoking and assisting their colleagues to quit; (b) inquiring of all patients at
2240 every visit about their use of tobacco in any form; (c) at every visit, counseling those who
2241 smoke to quit smoking and eliminate the use of tobacco in all forms; (d) working to
2242 prohibit all smoking in the office by patients, clinicians, and office staff; and
2243 discouraging smoking in hospitals where they work; (e) providing smoking cessation
2244 pamphlets in the waiting room; (f) becoming aware of smoking cessation programs in the
2245 community and of their success rates and, where possible, referring patients to those
2246 programs.

2247
2248 HX 4200.4.6.3

2249 AAPA supports national, state, and local efforts to help PAs and PA students develop
2250 skills necessary to counsel patients to quit smoking identify gaps, including (a)
2251 identifying gaps, if any, in existing materials and programs designed to train PAs and PA
2252 students in the behavior modification skills necessary to successfully counsel patients to
2253 stop smoking; (b) supports the production of materials and programs that would fill gaps,
2254 if any, in materials and programs to train PAs and PA students in the behavior
2255 modification skills necessary to successfully counsel patients to stop smoking; (c)
2256 encourages constituent organizations to sponsor, support, and promote efforts that will
2257 help PAs to more effectively counsel patients to stop smoking; and (d) encourages PAs to
2258 participate in education programs to enhance their ability to help patients quit smoking.

2259
2260 HX 4200.4.7

2261 The AAPA supports third-party coverage for the treatment of nicotine addiction and the
2262 management of behavioral dependence associated with tobacco use.
2263

2264 Nicotine Dependence

2265 Executive Summary of Policy Contained in this Paper

2266 Summaries will lack rationale and background information, and may lose the nuance of
2267 the policy. You are highly encouraged to read the entire paper.
2268

- 2269
- 2270 • AAPA shall support the position of the Surgeon General and the
2271 U.S Preventive Service Task Force and encourage PAs to increase patient
2272 awareness as to the dangers in the use of nicotine products.
2273
- 2274 • AAPA recognizes the public health hazards of nicotine products as a leading
2275 cause of preventable disease and encourages efforts to eliminate nicotine use in
2276 this country and around the world.
2277
- 2278 • AAPA encourages PAs to work to support legislation which will eliminate the
2279 public's exposure to secondhand smoke, eliminate minors' access to nicotine
2280 products including electronic nicotine delivery systems and prohibit advertising of
2281 nicotine products.
2282
- 2283 • AAPA supports state utilization of tobacco settlement money for prevention and
2284 treatment of nicotine use. The Academy urges its constituent organizations to
2285 work with state governments and other health care and advocacy organizations to
2286 assure tobacco settlement funds are used for the prevention and treatment of
2287 nicotine use.
2288
- 2289 • AAPA encourages all PAs to be actively involved in community outreach that is
2290 directed toward providing nicotine product education based upon current evidence
2291 based guidelines to people of all ages about the dangers of nicotine with the goal
2292 of eliminating nicotine use.
2293
- 2294 • AAPA supports (a) development and promotion of nicotine cessation materials
2295 and programs to advance consumer health-awareness among all segments of

2296 society, but especially for youth; (b) dissemination of evidence-based clinical
2297 practice guidelines concerning the treatment of patients with nicotine dependence;
2298 (c) effective use of both nicotine cessation materials and evidence-based clinical
2299 practice guidelines by PAs, for the treatment of patients with nicotine
2300 dependence.

2301
2302 • AAPA encourages PAs to model nicotine cessation activities in their practices,
2303 including (a) quitting nicotine products and assisting their colleagues to quit; (b)
2304 inquiring of all patients at every visit about their use of nicotine in any form; (c) at
2305 every visit, counseling those who smoke to quit smoking and-eliminate use of
2306 nicotine to eliminate use in all forms; (d) working to prohibit the use of nicotine
2307 products by all individuals in healthcare settings; (e) providing nicotine
2308 information; (f) becoming aware of nicotine cessation programs in the community
2309 and of their success rates and, where possible, referring patients to those
2310 programs.

2311
2312 • AAPA supports national, state, and local efforts to help PAs and PA students
2313 develop skills necessary to counsel patients to quit nicotine products , including
2314 (a) identifying gaps, if any, in existing materials and programs designed to train
2315 PAs and PA students in the behavior modification skills necessary to successfully
2316 counsel patients to stop using nicotine products; (b) supports the production of
2317 materials and programs that would fill gaps, if any, in materials and programs to
2318 train PAs and PA students in the behavior modification skills necessary to
2319 successfully counsel patients to stop using nicotine products; (c) encourages
2320 constituent organizations to sponsor, support, and promote efforts that will help
2321 PAs to more effectively counsel patients to quit using nicotine products; and (d)
2322 encourages PAs to participate in education programs to enhance their ability to
2323 help patients quit nicotine products.

2324
2325 • AAPA supports third-party coverage for the treatment of nicotine addiction and
2326 the management of behavioral dependence associated with nicotine use.

2327

- 2328 • AAPA supports regulation of electronic nicotine delivery systems (E-cigarettes)
2329 by the U.S. Food and Drug Administration (FDA) Center for Tobacco Products.

2330

2331 Introduction

2332 In 1964, the Surgeon General's report on the health impact of smoking was released.

2333 Tobacco use has been described as "the single most important preventable risk to human
2334 health in developed countries and an important cause of premature death worldwide." [1]

2335 Between 1964 and 2014, 20 million persons in the United States died from complications
2336 related to tobacco use; approximately 10% of those were individuals who did not smoke,

2337 but rather were exposed to secondhand smoke. [2] The impact of tobacco smoke

2338 exposure is not limited to adults. Approximately 100,000 infant deaths can be attributed

2339 to exposure to tobacco smoke and the resulting low birth weight, premature birth, and

2340 sudden infant death syndrome (SIDS). [2]

2341 Tobacco Exposure and Nicotine Use

2342 Not only are cigarettes manufactured to increase the addictive properties, but combustion

2343 produces thousands of toxic chemicals which lead to disease and early death. [2] After

2344 half a century of research on tobacco use, new research continues to emerge

2345 demonstrating the detrimental effects of smoking. Adverse effects of tobacco smoke have

2346 been documented in all organ systems of the body. In the 2014 report from the U.S.

2347 Surgeon General the following new research findings are provided: 1) liver cancer and

2348 colorectal cancer are caused by smoking; 2) secondhand smoke exposure is a cause of

2349 cerebral vascular accident; 3) smoking increases the risk of death among cancer

2350 survivors; 4) smoking causes diabetes mellitus; and 5) smoking impairs immune function

2351 and causes rheumatoid arthritis. [2] As a result, productivity suffers from tobacco use.

2352 From 2009-2012 economic costs were estimated at over \$289 billion. Losses from early

2353 death between 2005 and 2009 totaled roughly \$150 billion [2]

2354 The negative impact of tobacco smoke is not limited to the person who smokes. The U.S.

2355 Surgeon General reported no safe level of exposure to secondhand smoke. [2]

2356 Secondhand has been identified as a cause of cerebrovascular accident, ENT disease,

2357 coronary heart disease, sudden infant death syndrome, and low-birth weight [2]. The

2358 economic impact of secondhand smoke exposure in 2006 was estimated at \$5.6 billion in

2359 lost productivity.

2360 Although use of chewing tobacco has declined since the 1980s, use of snuff has increased
2361 [2]. In 2006, tobacco companies began selling snuff under cigarette brand names and
2362 produced advertisements indicating these products may be a “socially acceptable”
2363 alternative to cigarette use [2]. Use of smokeless tobacco products including chewing
2364 tobacco, snuff, and dissolvable tobacco products carry their own set of harmful
2365 consequences. Similar to tobacco cigarettes, smokeless tobacco products are highly
2366 addictive. Young adults who use smokeless tobacco are more likely to become
2367 traditional cigarette smokers [3]. Periodontal disease, tooth loss, leukoplakia, and
2368 increased risk of heart diseases have been identified as consequences of smokeless
2369 tobacco use. Smokeless tobacco use has been identified as a cause of oropharyngeal,
2370 esophageal, and pancreatic cancers [3]. Women who use smokeless tobacco during
2371 pregnancy are at increased risk for stillbirth, perinatal death, and can impact the brain
2372 development of the fetus [2].

2373 The rise in popularity of “e-cigarettes” and other electronic nicotine delivery devices
2374 particularly among adolescents, is concerning. Public perception of e-cigarette safety
2375 seems to be favorable to tobacco cigarettes despite a lack of evidence [4]. The American
2376 Lung Association identified 500 brands and over 7,000 flavors of e-cigarettes available to
2377 the public, none of which are regulated by the Food and Drug Administration (FDA) [5].
2378 Without FDA oversight, it is unknown what chemicals are present in e-cigarettes. Data
2379 from the 2014 National Youth Tobacco Survey showed 13.4% of high school students
2380 reported past month e-cigarette use [6]. Use of e-cigarettes now exceeds the use of other
2381 tobacco products, including cigarettes. This is troubling given most adult cigarette
2382 smokers began using during adolescence. Although restrictions on tobacco advertising
2383 have been in place since the Master Settlement Agreement, similar restrictions do not
2384 exist for e-cigarettes. Data from the 2014 National Youth Tobacco Survey showed
2385 68.9% of middle and high school students were exposed to advertisements for e-
2386 cigarettes [7]. Little is known about secondhand exposure to e-cigarette vapors.
2387 According to the American Lung Association, carcinogens have been identified in the
2388 vapor exhaled by e-cigarette users. To date, no evidence has found that secondhand
2389 inhalation of e-cigarette vapors are safe [8].

2390 Nicotine Cessation

2391 Overall, tobacco smoking rates have declined since the first Surgeon General's report in
2392 1964 however, racial, ethnic, and socioeconomic disparities persist. Major gains
2393 including warning labels on tobacco product packaging, tobacco education, smoking
2394 bans, advertising restrictions, and increased pricing have contributed to lower levels of
2395 tobacco use and the available evidence supports the use of these techniques [2]. Most
2396 individuals who smoke report attempting to quit at some point in the past and have often
2397 attempted to quit multiple times, however, providers often do not address smoking
2398 cessation during office visits. [1] Often smoking cessation requires repeated interventions
2399 however, effective treatments including prescription medication and nicotine replacement
2400 products are available and should be made available to individuals who are ready to quit.
2401 Smoking cessation improves health outcomes for the individual who smokes, those
2402 exposed to secondhand smoke, and is also cost effective. [1]

2403 With a rise in the use of nicotine replacement products and e-cigarettes, concern has been
2404 raised regarding whether or not nicotine has a carcinogenic effect. Although in vitro
2405 studies suggest nicotine may play a role in carcinogenesis, most animal studies do not
2406 demonstrate this. Use of smokeless tobacco products have been linked to several cancers
2407 however, to date, only one study has addressed this concern among individuals who use
2408 nicotine replacement products. The results of the study showed no association between
2409 use of nicotine replacement products and malignancy [2]. Many e-cigarette users begin
2410 using the devices as tool to help quit traditional cigarettes despite lack of research to
2411 support their use in smoking cessation programs. Polosa, Caponnetto, Morjaria, Papale,
2412 Campagna & Russo (2011) conducted a pilot study of e-cigarette use for smoking
2413 cessation among 40 tobacco cigarette smokers. The authors concluded that e-cigarette use
2414 decreased tobacco cigarette use with few side effects [9]. Bullen, McRobbie, Thornley,
2415 Glover, Lin, & Laugesen (2010) found similar results in their study the effects of e-
2416 cigarettes on desire to smoke [10] Although promising, it should be noted that the e-
2417 cigarettes used in these studies contained solutions with known concentrations of nicotine
2418 and other ingredients, unlike what is currently available to the public. The authors of
2419 both papers discuss the need for further research into long-term safety and use.
2420 Additionally, there is concern regarding advertising strategies that may be targeting
2421 younger individuals and that use of e-cigarettes may increase the risk of future tobacco
2422 use.

2423 The Centers for Disease Control and Prevention (CDC) recommend states use a
2424 comprehensive approach to tobacco cessation including the following components: 1)
2425 community programs to reduce tobacco use; 2) chronic disease control programs to
2426 reduce the burden of tobacco-related diseases; 3) school programs; 4) enforcement; 5)
2427 statewide programs; 6) counter-marketing; 7) cessation programs; 8) surveillance and
2428 evaluation; and 9) administration and management [11]. CDC suggests including e-
2429 cigarettes in these comprehensive nicotine cessation programs and restricting e-cigarette
2430 advertisements [7]

2431 Master Settlement Agreement

2432 Advertising by tobacco manufacturers has been shown to initiate and perpetuate cigarette
2433 smoking among adolescents and young adults. Past legal action against tobacco
2434 manufacturers has contributed to reduce tobacco use in the U.S. [2]. In 1999, the District
2435 of Columbia, 46 U.S. states, and 6 U.S. territories sued the major tobacco companies.
2436 The resulting settlement is known as the Master Settlement Agreement (MSA). [12]
2437 Under the MSA, states received billions of dollars from the major tobacco companies
2438 with the intent that the funds would support tobacco education programs and the cost of
2439 treating tobacco-related illness. Unfortunately, the MSA did not specifically require
2440 states to use the funds on tobacco-related issues and years passed states reallocated MSA
2441 funds to other budget categories. As of 2006, fifteen states did not use any MSA funds for
2442 tobacco-related programs. [12] Overall, the MSA funds have not led to robust state
2443 programs for tobacco cessation. In fact, the authors of a 2014 research study concluded
2444 states receiving higher MSA payments were associated with less effective tobacco
2445 control mechanisms. [13] The same researchers found MSA funds were allocated to
2446 health programs, but not always those pertaining to tobacco cessation. In 2015, less than
2447 2% of MSA funds and tobacco taxes were used by states for tobacco control programs
2448 [7].

2449 These funds should be utilized to prevent nicotine dependence and assist those with
2450 cessation. PAs are encouraged to help guide the use of these funds to achieve this goal.

2451 Conclusions

2452 Myriad studies conclusively demonstrate the adverse health effects of nicotine use and
2453 dependence. Despite achievements in reducing the number of individuals who use
2454 tobacco products since the 1964 Surgeon General's report on the health effects of

2455 smoking, more work is needed. An area of growing public health concern is the use of e-
2456 cigarettes, particularly among youth. Our knowledge with regard to e-cigarettes continues
2457 to evolve as more research is conducted. Given what is known, PAs have a responsibility
2458 to act at the individual, community, and structural levels to raise awareness and promote
2459 cessation of nicotine use.

2460 • AAPA shall support the position of the Surgeon General and the
2461 U.S Preventive Service Task Force and encourage PAs to increase patient
2462 awareness as to the dangers in the use of nicotine products.

2463
2464 • AAPA recognizes the public health hazards of nicotine products as a leading
2465 cause of preventable disease and encourages efforts to eliminate tobacco use in
2466 this country and around the world.

2467
2468 • AAPA encourages PAs to work to support legislation which will eliminate the
2469 public's exposure to secondhand smoke, eliminate minors' access to nicotine
2470 products including electronic nicotine delivery systems and prohibit advertising of
2471 nicotine products.

2472
2473 • AAPA supports state utilization of tobacco settlement money for prevention and
2474 treatment of nicotine use. The Academy urges its constituent organizations to
2475 work with state governments and other health care and advocacy organizations to
2476 assure tobacco settlement funds are used for the prevention and treatment of
2477 nicotine use.

2478
2479 • AAPA encourages all PAs to be actively involved in community outreach that is
2480 directed toward providing nicotine product education based upon current evidence
2481 based guidelines to people of all ages about the dangers of nicotine with the goal
2482 of eliminating nicotine use.

2483
2484 • AAPA supports (a) development and promotion of nicotine cessation materials
2485 and programs to advance consumer health-awareness among all segments of
2486 society, but especially for youth; (b) dissemination of evidence-based clinical

2487 practice guidelines concerning the treatment of patients with nicotine dependence;
2488 (c) effective use of both nicotine cessation materials and evidence-based clinical
2489 practice guidelines by PAs, for the treatment of patients with nicotine
2490 dependence.

2491
2492 • AAPA encourages PAs to model nicotine cessation activities in their practices,
2493 including (a) quitting nicotine products and assisting their colleagues to quit; (b)
2494 inquiring of all patients at every visit about their use of nicotine in any form; (c) at
2495 every visit, counseling those who smoke to quit smoking and-eliminate use of
2496 nicotine to eliminate use in all forms; (d) working to prohibit the use of nicotine
2497 products by all individuals in healthcare settings; (e) providing nicotine
2498 information; (f) becoming aware of nicotine cessation programs in the community
2499 and of their success rates and, where possible, referring patients to those
2500 programs.

2501
2502 • AAPA supports national, state, and local efforts to help PAs and PA students
2503 develop skills necessary to counsel patients to quit nicotine products , including
2504 (a) identifying gaps, if any, in existing materials and programs designed to train
2505 PAs and PA students in the behavior modification skills necessary to successfully
2506 counsel patients to stop nicotine products; (b) supports the production of materials
2507 and programs that would fill gaps, if any, in materials and programs to train PAs
2508 and PA students in the behavior modification skills necessary to successfully
2509 counsel patients to stop using nicotine products; (c) encourages constituent
2510 organizations to sponsor, support, and promote efforts that will help PAs to more
2511 effectively counsel patients to quit using nicotine products; and (d) encourages
2512 PAs to participate in education programs to enhance their ability to help patients
2513 quit nicotine products.

2514
2515 • AAPA supports third-party coverage for the treatment of nicotine addiction and
2516 the management of behavioral dependence associated with nicotine use.

2517

- 2518 • AAPA supports regulation of electronic nicotine delivery systems (E-cigarettes)
2519 by the U.S. Food and Drug Administration (FDA) Center for Tobacco Products.

2520

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2016-D-09 – Adopted as Amended

Amend policy HP-3300.1.15 Immunization in Children and Adults as follows:

Immunizations in Children and Adults
(Adopted 1994, amended 2004, 2006, and 2011)

Executive Summary of Policy Contained in this Paper

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

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

- PAs should be aware of current medical guidelines **AND RECOMMENDATIONS** for immunization of **INFANTS**, children, **ADOLESCENTS**, and adults. Providers also should be aware that patients in high-risk groups, such as the chronically ill, **IMMUNOSUPPRESSED**, asplenic, or elderly, may need to be on different immunization schedules ~~than~~ **COMPARED TO 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

2603 importance of immunizations and allay fears ~~and-OR~~ doubts about potential ~~side~~
2604 ~~ADVERSE~~ effects.

- 2605 • PAs should be immunized against vaccine-preventable diseases for which health
2606 providers are at high risk, ~~INCLUDING ANNUAL INFLUENZA~~
2607 ~~VACCINATION~~. This not only protects PAs, but also protects patients by
2608 preventing provider-to-patient transmission.
- 2609 • PAs need to educate patients and their families about the safety of our national
2610 immunization program, dispel unsubstantiated fears ~~ABOUT VACCINATION~~,
2611 and promote public confidence in vaccines for the continued protection of ~~our~~
2612 ~~children-ALL~~ against vaccine-preventable diseases.
- 2613 • PA students should have all appropriate immunizations prior to their clinical
2614 experience.
- 2615 • PAs working in primary care should develop systems within their practices to
2616 promote optimum immunization of their patients. These systems might include
2617 devices such as personal immunization records for patients to carry with them and
2618 a way to easily locate each patient's immunization record in his or her medical
2619 chart. High-risk patients should be identified and special programs implemented
2620 ~~TO OPTIMIZE VACCINE COVERAGE~~, such as mailing a flu vaccine reminder
2621 to all high-risk patients every fall.
- 2622 • PAs working in specialty practices in hospitals and offices should recognize
2623 patients who are at high risk for vaccine-preventable diseases. They should
2624 coordinate efforts with the patients' primary care providers to insure that these
2625 patients are adequately immunized and that the primary care providers have
2626 complete immunization records.
- 2627 • PAs should support the development of and participate in state and local
2628 immunization registries. Effective immunization registries have demonstrated an
2629 ability to prevent fragmentation of care, incomplete immunizations, ~~or-AND~~
2630 unnecessary over-immunization of patients because of lack of communication
2631 between various providers and programs. An objective of Healthy People 2020 is
2632 to enroll 95% of children under the age of six in population-based immunization
2633 registries.¹

- All private and public payers should provide coverage for **RECOMMENDED** child and adult immunizations **AS RECOMMENDED BY THE CDC**.

2636

2637 INTRODUCTION

2638 The immunization of **INFANTS**, children, **ADOLESCENTS**, and adults against
2639 vaccine-preventable diseases is one of the most important medical advances of the 20th
2640 century and among the most valuable health care investments that can be made. In the
2641 20th century, the development of effective vaccines has led to a 97% or greater reduction
2642 in reported cases of diphtheria, measles, mumps, pertussis, poliomyelitis, rubella, and
2643 tetanus in the United States.² **In an economic evaluation of the recommended 7 vaccine**
2644 **routine immunizations in childhood, it is estimated that a savings of \$5 in direct costs and**
2645 **\$11 dollars in societal costs including the cost of immunization are realized each year.²**

2646 **RECENT ECONOMIC ANALYSES FOUND THAT ROUTINE VACCINATION OF**
2647 **CHILDREN BORN FROM 1994 TO 2013 WILL PREVENT ABOUT 322 MILLION**
2648 **CASES OF DISEASE AND OVER 700,000 EARLY DEATHS, FOR A SOCIETAL**
2649 **COST SAVINGS OF OVER 1.3 TRILLION DOLLARS.³** Given their proven benefit in
2650 reducing morbidity, mortality and health care costs, **AGE-APPROPRIATE** immunization
2651 programs **for children and adults** should be part of the medical practice of all PAs.

2652

2653 Childhood Immunizations

2654 Despite great successes at controlling once common childhood diseases, such as
2655 poliomyelitis, diphtheria, measles, mumps, rubella and tetanus; significant gaps remain in
2656 **VACCINATION COVERAGE IN THE UNITED STATES. the public health system. In**
2657 **the United States THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES'**
2658 **Healthy People 2010-2020 initiative had HAS** set vaccination coverage goals of 90
2659 percent for **each vaccine in the 4:3:1:3:3:1 series-UNIVERSALLY RECOMMENDED**
2660 **VACCINES AMONG YOUNG CHILDREN AGES 19 TO 35 MONTHS and a goal of**
2661 **80% for completion of the entire series (these goals remain for the 2020 initiative), which**
2662 **consists of INCLUDING-THOSE FOR DIPHTHERIA TETANUS AND PERTUSSIS**
2663 **(DTAP), HAEMOPHILUS INFLUENZAE TYPE B (HIB), HEPATITIS A AND B,**
2664 **MEASLES MUMPS AND RUBELLA (MMR), POLIO, VARICELLA,**
2665 **PNEUMOCOCCAL CONJUGATE VACCINE, AND ROTAVIRUS. ¹ RECENT**

2666 NATIONAL COVERAGE ESTIMATES SHOWED THAT HP-2020 TARGETS OF
2667 90% WERE MET FOR POLIOVIRUS, MMR, HEPB, AND VARICELLA, BUT NOT
2668 DTAP, HIB, HEPB BIRTH DOSE, PCV, HEPA, ROTAVIRUS, AND THE
2669 COMBINED VACCINATION SERIES.⁴

2670
2671 • four or more doses of diphtheria, tetanus and pertussis, or DTaP, vaccine;
2672 • three or more doses FOUR DOSES of *Haemophilus influenzae* type b, or
2673 Hib, vaccine;

2674 • three or more doses of hepatitis B vaccine; and
2675 • one or more doses of measles, mumps and rubella, or MMR, vaccine;
2676 • three or more doses of polio vaccine;
2677 • one or more doses of varicella vaccine;

2678 In 2008, coverage for the entire series was 76.1%, which was down
2679 slightly from the 2007 coverage estimate of 77.4 %.

2680 Disparity in Vaccination rates remains lower among children living below the
2681 poverty level, in ~~non-Caucasian children~~ NON-HISPANIC BLACK CHILDREN, and
2682 those living in high-risk geographic areas, such as rural, underserved, and low socio-
2683 economic regions. These surveys continue to reveal immunization rates well below the
2684 national average and/or targeted goal rates.⁴

2685 Gaps in the system of childhood immunizations are not new. Barriers to
2686 immunization that have been identified include: lack of knowledge about immunizations,
2687 fears about vaccine safety, logistical problems that limit access to immunization services,
2688 provider lack of knowledge regarding indications for and contraindications to
2689 immunization, fragmentation of patient care causing incomplete immunization records
2690 and missed opportunities.⁵

2691
2692 **ADOLESCENT IMMUNIZATION PROGRAMS**
2693 **VACCINATION OF ADOLESCENTS IS AN IMPORTANT AND EFFECTIVE**
2694 **WAY TO PROTECT PRETEENS, TEENS, THEIR FRIENDS AND FAMILY**
2695 **MEMBERS FROM VACCINE-PREVENTABLE DISEASES SUCH AS TETANUS,**
2696 **DIPHTHERIA, PERTUSSIS (TDAP), AND CANCERS CAUSED BY HUMAN**
2697 **PAPPILLOMAVIRUS (HPV). THE ADVISORY COMMITTEE ON IMMUNIZATION**

2698 PRACTICES (ACIP) AND THE CENTERS FOR DISEASE CONTROL AND
2699 PREVENTION (CDC) RECOMMEND THAT ADOLESCENTS ROUTINELY
2700 RECEIVE TETANUS TOXOID, REDUCED DIPHTHERIA TOXOID, AND
2701 ACELLULAR PERTUSSIS VACCINE (TDAP), MENINGOCOCCAL CONJUGATE
2702 VACCINE, AND HPV VACCINE. HEALTHY PEOPLE 2020 GOALS FOR 80%
2703 VACCINATION COVERAGE AMONG ADOLESCENTS AGED 13-15 WERE
2704 ACHIEVED OR NEARLY ACHIEVED IN RECENT YEARS FOR TDAP AND
2705 MENINGOCOCCAL CONJUGATE VACCINE, HOWEVER WERE LAGGING FOR
2706 COMPLETE COVERAGE FOR THE 3-DOSE HPV VACCINE AMONG FEMALES.¹
2707 ⁶ THIS DISPARITY IN VACCINATION COVERAGE INDICATES MANY MISSED
2708 OPPORTUNITIES TO ADMINISTER HPV VACCINATION IN ADDITION TO
2709 TDAP AND MENINGOCOCCAL CONJUGATE VACCINE DURING THE SAME
2710 CLINICAL VISIT.

2711

2712 Adult Immunization Programs

2713 Adult immunization programs do not receive the same priority as efforts to
2714 immunize children, despite the fact that most deaths from vaccine-preventable disease
2715 occur in adults. Between 50,000 and 90,000 adults die each year from VACCINE
2716 PREVENTABLE DISEASES SUCH AS pneumococcal infection, influenza and hepatitis
2717 B combined.⁷

2718 Despite availability and effectiveness of vaccines, current immunization rates fall
2719 below those recommended in Healthy People 2020. In addition to deaths from
2720 pneumococcal pneumonia, flu and hepatitis B; each year a smaller number of adult deaths
2721 occur that are a continuum of the problem of DUE TO inadequately immunized children.
2722 A majority of the US cases of tetanus and diphtheria today occur in adults who were
2723 inadequately immunized as children. Furthermore, the recent resurgence in measles,
2724 mumps and rubella, although seen primarily among unimmunized preschool children,
2725 also occurred in a significant number of young adults. Most vaccine failures in adults
2726 occurred among those who did not have a primary response to the MMR vaccine
2727 administered in childhood. Waning immunity does not seem to be an important factor. It
2728 is now strongly recommended that everyone born since 1956 receive a two-dose measles

2729 immunization. Because mumps and rubella have shown similar, though less pronounced,
2730 epidemiologic patterns of reemergence, the vaccine of choice is MMR.⁷

2731 ~~Barriers to immunizations for adults are similar to the barriers for children. It~~
2732 ~~should also be noted that adult immunization rates are lower than pediatric immunization~~
2733 ~~rates for another very basic reason: adult immunizations are largely voluntary, while~~
2734 ~~children (through their parents) are subject to public health imperatives requiring them to~~
2735 ~~be immunized before they can enter school.~~

2736 UNFORTUNATELY, ADULT VACCINATION COVERAGE ESTIMATES
2737 FOR THE FOUR VACCINES INCLUDED IN HEALTHY PEOPLE 2020
2738 (INFLUENZA, PNEUMOCOCCAL, HERPES ZOSTER, AND AMONG
2739 HEALTHCARE PROVIDERS, HEPATITIS B) REMAIN BELOW TARGET
2740 LEVELS.⁸ THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
2741 RECOMMENDS VACCINATIONS FROM BIRTH THROUGH ADULTHOOD TO
2742 PROVIDE A LIFETIME OF IMMUNITY. BUT WHILE CHILDHOOD
2743 VACCINATION RATES ARE RELATIVELY HIGH, MOST ADULTS ARE NOT
2744 VACCINATED AS RECOMMENDED PER THE ADULT SCHEDULE. PAS ARE
2745 ENCOURAGED TO FOLLOW THE MOST UP-TO-DATE VACCINE SCHEDULE
2746 FROM CDC.⁷

2747 IMPROVING VACCINATION RATES

2748 The ~~Centers for Disease Control and Prevention (CDC)~~ recommends that
2749 institutions develop standing orders and reminder systems to help improve vaccination
2750 rates among adults. Overcoming the low immunization rates among adults will require
2751 better reimbursement and a sustained, cooperative effort in both the public and private
2752 sectors to educate providers, patients, and policymakers about indicated vaccine uses and
2753 the need for effective delivery.

2754 More widespread immunization strategies include new methods of vaccine
2755 delivery (nasally administered sprays) and new combination vaccines. Nasal
2756 administration of the influenza vaccine would reduce the expense associated with
2757 intramuscular vaccination and would be more practical, especially amongst pediatric
2758 patients (over five years of age). The immunization action coalition (IAC)⁹ continues to
2759 promote a national immunization registry as a national goal in Healthy People 2020,
2760 specifying that 95% of children from birth to age six should fully participate in an
2761 operational, population-based immunization registry.

2762 Challenges

2763 **CHALLENGES TO IMMUNIZATIONS PROGRAMS FOR ADULTS ARE**
2764 **SIMILAR TO THOSE IN CHILDREN.**¹⁰ Challenges for assuring access and availability
2765 of vaccines include: 1) unprecedented vaccine delays, 2) diminished number of vaccine
2766 suppliers, 3) disparities in geographic and socioeconomic populations, and 4) erosion of
2767 insurance coverage for immunizations.

2768 **ADULT IMMUNIZATION RATES ARE LOWER THAN PEDIATRIC**
2769 **IMMUNIZATION RATES IN PART BECAUSE ADULT IMMUNIZATIONS ARE**
2770 **LARGELY VOLUNTARY, HAVE INCONSISTENT INSURANCE COVERAGE (OR**
2771 **OTHER FINANCIAL BARRIERS), WHILE CHILDREN ARE SUBJECT TO PUBLIC**
2772 **HEALTH POLICIES AND SCHOOL MANDATES REQUIRING IMMUNIZATIONS**
2773 **BEFORE SCHOOL ENTRY. BARRIERS FOR ADULT IMMUNIZATION INCLUDE:**

- 2774 • **LACK OF HEALTHCARE PROVIDER FAMILIARITY WITH CURRENT**
2775 **VACCINE GUIDELINES;**
- 2776 • **LACK OF AWARENESS AMONG BOTH PATIENTS AND PROVIDERS**
2777 **OF POTENTIAL RISKS INVOLVING VACCINE PREVENTABLE**
2778 **DISEASE;**
- 2779 • **LACK OF RESOURCES TO MAINTAIN AN ADEQUATE SUPPLY OF**
2780 **VACCINE**
- 2781 • **OR LACK OF INFRASTRUCTURE WITHIN HEALTHCARE SYSTEMS**
2782 **TO ACHIEVE HIGH IMMUNIZATION RATES IN ADULTS**¹⁰

2783 Influenza Vaccination of Health Care Personnel

2784 Influenza transmission and outbreaks in health care facilities are well
2785 documented. Health care workers (HCW) acquire influenza from their patients or
2786 transmit the disease to patients, staff and their contacts. Because HCW provide care to
2787 patients at high risk for complications of influenza, HCW should be considered a high
2788 priority group when expanding influenza vaccine use. In 2010 the Infectious Disease
2789 Society of America (IDSA) supported universal immunization of health care workers
2790 against influenza by health care institutions through mandatory vaccination programs. It
2791 was felt that this was the most effective means to protect patients from the transmission
2792 of seasonal and pandemic influenza by health care workers.¹¹

2793

2794 Vaccine Safety

2795 PAs need to educate patients and their families about the safety of our national
2796 immunization program, dispel unsubstantiated fears **ABOUT** and promote public
2797 confidence in vaccines for the continued protection of ~~our~~ **INFANTS**, children,
2798 **ADOLESCENTS, AND ADULTS** against vaccine-preventable diseases.

2799
2800 Summary

2801 The results of inadequate immunizations among **INFANTS**, children,
2802 **ADOLESCENTS**, and adults are unnecessary deaths, avoidable hospitalizations and the
2803 associated costs; and life-long disabilities caused by the sequelae of potentially
2804 preventable diseases. ~~The fact remains that S~~ safe, effective vaccines are available but
2805 underutilized, **AND Even** patients who routinely see health care providers ~~may~~ **ARE** not
2806 ~~be adequately~~ **OFTEN** educated about recommended immunizations, ~~missing~~
2807 ~~opportunities for receiving this type of protection.~~ **HEALTHCARE PROVIDERS**
2808 **SHOULD BE FAMILIAR WITH THE LATEST IMMUNIZATION SCHEDULE.**
2809 **THEY SHOULD MAKE CLEAR, EVIDENCE-BASED VACCINE**
2810 **RECOMMENDATIONS FOR ALL ELIGIBLE PATIENTS AND IMMUNIZE AT ALL**
2811 **OPPORTUNITIES INCLUDING WELL, SICK AND FOLLOW-UP VISITS.**

2812
2813 Recommendations

2814 AAPA recognizes the importance of child and adult immunization programs and
2815 the need to educate individual PAs and the public about these programs. To that end,
2816 AAPA makes the following recommendations:

- 2817 • PAs should be aware of current medical guidelines **AND**
2818 **RECOMMENDATIONS** for immunization of **INFANTS**, children,
2819 **ADOLESCENTS**, and adults. Providers also should be aware that patients in
2820 high-risk groups, such as the chronically ill, **IMMUNOSUPPRESSED**, asplenic,
2821 or elderly, may need to be on different immunization schedules ~~than~~
2822 **COMPARED TO THAN** the general population.
- 2823 • Individual PAs and their practices, in cooperation with public health agencies,
2824 should promote public information campaigns to increase awareness of the

2825 importance of immunizations and allay fears ~~and-OR~~ doubts about potential ~~side~~
2826 ~~ADVERSE~~ effects.

- 2827 • PAs should be immunized against vaccine-preventable diseases for which health
2828 providers are at high risk, ~~INCLUDING ANNUAL INFLUENZA~~
2829 ~~VACCINATION~~. This not only protects PAs, but also protects patients by
2830 preventing provider-to-patient transmission.
- 2831 • PAs need to educate patients and their families about the safety of our national
2832 immunization program, dispel unsubstantiated fears ~~ABOUT VACCINATION~~,
2833 and promote public confidence in vaccines for the continued protection of ~~our~~
2834 ~~children-ALL~~ against vaccine-preventable diseases.
- 2835 • PA students should have all appropriate immunizations prior to their clinical
2836 experience.
- 2837 • PAs working in primary care should develop systems within their practices to
2838 promote optimum immunization of their patients. These systems might include
2839 devices such as personal immunization records for patients to carry with them and
2840 a way to easily locate each patient's immunization record in his or her medical
2841 chart. High-risk patients should be identified and special programs implemented
2842 ~~TO OPTIMIZE VACCINE COVERAGE~~, such as mailing a flu vaccine reminder
2843 to all high-risk patients every fall.
- 2844 • PAs working in specialty practices in hospitals and offices should recognize
2845 patients who are at high risk for vaccine-preventable diseases. They should
2846 coordinate efforts with the patients' primary care providers to insure that these
2847 patients are adequately immunized and that the primary care providers have
2848 complete immunization records.
- 2849 • PAs should support the development of and participate in state and local
2850 immunization registries. Effective immunization registries have demonstrated an
2851 ability to prevent fragmentation of care, incomplete immunizations, ~~or-AND~~
2852 unnecessary over-immunization of patients because of lack of communication
2853 between various providers and programs. An objective of Healthy People 2020 is
2854 to enroll 95% of children under the age of six in population-based immunization
2855 registries.¹

- 2856 • All private and public payers should provide coverage for **RECOMMENDED**
2857 **INFANT**, child, **ADOLESCENT** and adult immunizations **AS**
2858 **RECOMMENDED BY THE CDC.**

2859

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2944 **2016-D-10 – Adopted**

2945 Amend policy HP-3300.1.9.1 Health Literacy: Broadening Definitions, Intensifying

2946 Partnerships, and Identifying Resources as follows:

2947 Health Literacy: Broadening Definitions,

2948 Intensifying Partnerships and Identifying Resources

2949 (Adopted 2006 and amended 2011)

2950 Executive Summary of Policies Contained in this Paper

2951

2952

2953

2954

2955 Summaries will lack rationale and background information, and may lose nuance of
2956 policy. You are highly encouraged to read the entire paper.

2957
2958 AAPA believes that the PA profession can participate in addressing the problems
2959 of health literacy by

- 2960 ● adopting expanded definitions of health literacy **THAT INCLUDE THE**
2961 **INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES**
- 2962 ● optimizing efforts to **INCREASE HEALTH KNOWLEDGE, SELF**
2963 **EFFICACY, SELF MANAGEMENT BEHAVIORS, AND POSITIVE**
2964 **OUTCOMES** ~~create information and communication partnerships~~ with
2965 patients
- 2966 ● participating in **LOCAL COMMUNITY GROUPS TO PROVIDE**
2967 **SOCIAL SUPPORT AND ADVOCACY** ~~strategic and multi-sector~~
2968 ~~partnerships centered on assessing and addressing health literacy~~
2969 **LEADING TO SUSTAINABLE CHANGES BEHAVIOR CHANGES**
2970 **CONDUCTIVE TO BETTER HEALTH**
- 2971 ● identifying and utilizing resources **TO INCREASE OPPORTUNITIES**
2972 **FOR PATIENT ACTIVATION, ACCESS TO CARE, AND**
2973 **DEVELOPMENT OF SKILLS TO INCREASE PHYSICAL AND**
2974 **MENTAL WELL BEING** ~~such as the US Department of Health and~~
2975 ~~Human Services' Universal Precautions Toolkit and Healthy People 2020~~
2976 ~~directives.~~

2977
2978 Call to Action

2979 Recent efforts by AAPA and other organizations to focus on health literacy have
2980 resulted in a broadened health literacy definition, and increasing focus on the shared
2981 responsibility of providers and patients to create information and communication
2982 partnerships. Sophisticated and clinician-focused resources now exist to provide PAs and
2983 other clinicians with tools to improve patient health literacy. National efforts to form
2984 strategic organizational partnerships provide rich opportunity for AAPA to participate in
2985 efforts to address this problem impacting the health of millions of Americans.

2986 Accordingly, AAPA believes that the PA profession can further address this
2987 critical social and medical problem by

- 2988 ● adopting expanded definitions of health literacy **THAT INCLUDE THE**
2989 **INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES**
- 2990 ● optimizing efforts to **INCREASE HEALTH KNOWLEDGE, SELF EFFICACY,**
2991 **SELF MANAGEMENT BEHAVIORS, AND POSITIVE OUTCOMES** ~~create~~
2992 ~~information and communication partnerships~~ with patients

- 2993 ● participating in LOCAL COMMUNITY GROUPS TO PROVIDE SOCIAL
- 2994 SUPPORT AND ADVOCACY ~~strategic and multi-sector partnerships centered~~
- 2995 ~~on assessing and addressing health literacy~~ LEADING TO SUSTAINABLE
- 2996 CHANGES BEHAVIOR CHANGES CONDUCTIVE TO BETTER HEALTH
- 2997 ● identifying and utilizing resources TO INCREASE OPPORTUNITIES FOR
- 2998 PATIENT ACTIVATION, ACCESS TO CARE, AND DEVELOPMENT OF
- 2999 SKILLS TO INCREASE PHYSICAL AND MENTAL WELL BEING ~~such as~~
- 3000 ~~the US Department of Health and Human Services' Universal Precautions Toolkit~~
- 3001 ~~and Healthy People 2020 directives.~~

3002 AAPA believes that individual and organizational participation in these steps has
 3003 the potential to decrease and eliminate the negative health impact of inadequate
 3004 communication ~~partnerships~~ between providers and patients. By using available
 3005 resources, PAs empower patients, increase provider awareness of the impact of
 3006 communication gaps, and improve the health of patients.

3007

3008 Increased Estimates of Number of Patients Impacted

3009 In May 2004 the Institute of Medicine (IOM) released the comprehensive report,
 3010 *Health Literacy: A Prescription to End Confusion*, defining health literacy as “The
 3011 degree to which individuals have the capacity to obtain, process, and understand basic
 3012 health information and service needed to make appropriate health decisions.” [1] At that
 3013 time it was estimated that half of the United States adult population, nearly 90 million
 3014 people, had difficulty understanding and acting on health information. According to the
 3015 more recent May 2010 *National Action Plan to Improve Health Literacy* from the
 3016 Department of Health and Human Services’ Office of Disease Prevention and Health
 3017 Promotion, new estimates indicate that inadequate health literacy now affects the health
 3018 of most adults, with almost 90% of Americans having “...difficulty using the everyday
 3019 health information that is routinely available in our health care facilities, retail outlets,
 3020 media, and communities”. [2]

3021 The increasing problem of health literacy is not surprising given the variety of
 3022 tools needed to navigate the U.S. health care system and process the often complex
 3023 information and treatment decisions patients face. In order to accomplish these tasks,
 3024 individuals need ~~SKILLS AND ABILITIES SUCH AS: to be:~~

- 3025 ● CULTURAL AND CONCEPTUAL KNOWLEDGE
- 3026 ● NUMERACY SKILLS
- 3027 ● LISTENING, WRITING, AND READING SKILLS
- 3028 ● COMMUNICATION SKILLS
- 3029 ● COMPREHENSION OF HEALTHCARE INFORMATION AND DECISION
- 3030 MAKING
- 3031 ● SOCIAL SKILLS TO FUNCTION AS A HEALTHCARE CONSUMER
- 3032 ● ~~visual literate (able to understand graphs or other information);~~

- 3033 ● computer literate (able to operate a computer);
- 3034 ● information literate (able to obtain and apply relevant information), and
- 3035 ● numerically or computationally literate (able to calculate or reason numerically).

3036 [3]

3037 AN INDIVIDUAL WITH ADEQUATE HEALTH LITERACY HAS THE ABILITY TO
3038 TAKE RESPONSIBILITY FOR THEIR OWN HEALTH AS WELL AS THE HEALTH
3039 OF THEIR COMMUNITY. [3, 4], THE FOCUS OF HEALTH LITERACY HAS
3040 BROADENED FROM THE INDIVIDUAL PERSPECTIVE TO A SOCIETAL FOCUS
3041 BY LINKING HEALTH LITERACY TO ECONOMIC GROWTH, SOCIO-
3042 CULTURAL, AND POLITICAL CHANGE. [4, 5]
3043 PUBLIC HEALTH LITERACY RECOGNIZES THE MULTI-DIMENSIONAL
3044 IMPACT OF HEALTH LITERACY ON GROUPS AND COMMUNITIES.
3045 ACCORDING TO NUTBEAN [6] THERE ARE THREE DIMENSIONS OF HEALTH
3046 LITERACY: FUNCTIONAL HEALTH LITERACY REFERS TO HAVING THE
3047 BASIC SKILLS OF READING AND WRITING NECESSARY TO FUNCTION IN
3048 EVERYDAY SITUATIONS; INTERACTIVE HEALTH LITERACY REFERS TO
3049 HAVING ADVANCED COGNITIVE SKILLS USED TO EXTRACT MEANING AND
3050 INFORMATION FROM DIFFERENT FORMS OF COMMUNICATION; CRITICAL
3051 HEALTH LITERACY REFERS TO MORE ADVANCED COGNITIVE SKILLS
3052 COMBINED WITH THE SOCIAL SKILLS NEEDED TO APPLY AND ANALYZE
3053 INFORMATION TO EXERT GREATER CONTROL OVER ONE'S LIFE.

3054 3055 “Universal Precautions” and Health Literacy

3056 In April 2010, the U.S. Department of Health and Human Services' Agency for
3057 Health Care Research and Quality released a *Health Literacy Universal Precautions*
3058 *Toolkit* offering primary care practices a way to assess and improve their health literacy
3059 efforts with patients. [4-7] The toolkit assumes that it is difficult to identify those patients
3060 who may not understand health information and instead recommends that each practice
3061 create an environment where patients of all literacy levels can thrive. [4-7] The resources
3062 provided in the toolkit are designed to help practices take a systematic approach to
3063 reducing the complexity of medical care and ensure that patients can succeed in the
3064 health care environment.

3065 3066 Expanded Understanding of THE Role of PAS IN HEALTH LITERACY the Clinician

3067 AAPA created policy in 2010 that acknowledged the evolving view of health
3068 literacy, embracing more shared responsibility of the patient and the provider. HP-
3069 3300.1.7.2 reads:

3070 “The AAPA encourages PAs to identify and utilize reliable and accurate
3071 consumer health information to encourage patient compliance and
3072 improve health education. Health education information should be
3073 evidence based and appropriate to the patient's culture and level of
3074 literacy. Provision of such resources is consistent with AAPA efforts to
3075 promote health literacy. [5 8]

3076 The cultural component of this policy also reshapes the CONVENTIONAL belief
3077 that health literacy is simply about reading, missing the larger context of factors that
3078 impact patient-provider communication. PAs CAN PLAY A ROLE IN IMPROVING

3079 HEALTH LITERACY BY PROVIDING COMMUNITY AND INDIVIDUAL
3080 SUPPORT PROMOTING EMPOWERMENT AND AUTONOMY. RESEARCH HAS
3081 SHOWN THAT IMPROVING HEALTH LITERACY LEADS TO LOWER
3082 HEALTHCARE COSTS, INCREASED HEALTH KNOWLEDGE, SHORTER
3083 HOSPITALIZATION, INCREASED SELF EFFICACY, AND POSITIVE HEALTH
3084 BEHAVIORS [9, 10]. ADVANCING HEALTH LITERACY IN THE COMMUNITY
3085 MAY LEAD TO GREATER EQUALITY AND SUSTAINABLE CHANGES IN
3086 PUBLIC HEALTH [11].

3087 Referring to patients as having “low” or “poor” health literacy may stigmatize
3088 patients who struggle to understand medical information, and may also remove
3089 responsibility for establishment of information partnerships away from providers.
3090 Assigning the responsibility of “low” health literacy to patients decreases provider
3091 accountability, and places the burden of creating such partnerships primarily on the
3092 shoulders of the patient.

3093 The December 2010 release of the U.S. Department of Health and Human
3094 Services report, *Healthy People 2020*, demonstrates this conceptual shift in the view of
3095 health literacy, moving away from viewing health literacy as a patient skill set, judged on
3096 a spectrum of “good-bad,” and “high-low.” A more partnered patient-provider approach
3097 to health care communication is emerging in national policy. This is underscored by
3098 Healthy People 2020 Health Communication and Health Information Technology
3099 objectives found in table 1. [6 12]

3100

Table 1

Healthy People 2020 Objectives for
Health Communication and Health Information Technology

- HC/HIT–1.1 Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition.
- HC/HIT–1.2 Increase the proportion of persons who report their health care provider always asked them to describe how they will follow the instructions.
- HC/HIT–1.3 Increase the proportion of persons who report their health care providers’ office always offered help in filling out a form.
- HC/HIT–2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills.
- HC/HIT–2.1 Increase the proportion of persons who report that their health care provider always listened carefully to them.
- HC/HIT–2.2 Increase the proportion of persons who report that their health care provider always explained things so they could understand them.
- HC/HIT–2.3 Increase the proportion of persons who report that their health care provider always showed respect for what they had to say.

- HC/HIT–2.4 Increase the proportion of persons who report that their health care provider always spent enough time with them.

Source: US Department of Health and Human Services. *Healthy People 2020*.

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Emergency EMERGENCE of the “Health Information Literacy” Concept

While the medical community continues to expand its understanding of the complexity of health literacy, medical librarians have combined the American Library Association’s definition of “information literacy” with the traditional notion of “health literacy.” The result has been the concept of “health information literacy,” described by the Medical Library Association (MLA) as “the set of abilities needed to recognize a health information need, identify likely information sources and use them to retrieve relevant information, assess the quality of the information and its applicability to a specific situation, and analyze, understand, and use the information to make good health decisions.” [7 13] Resources available from the MLA may help to raise clinician awareness of their key role in assessing and addressing patient health literacy status, their obligation to partner with patients in this effort, and opportunities to engage with health information experts to improve the health of patients.

Call to Develop Strategic Partnerships

Many recent guidelines call for the development of partnerships to increase the effectiveness of efforts to address health literacy. As noted in the National Action Plan, “this...plan seeks to engage organizations, professionals, policymakers, communities, individuals, and families in a linked, multisector effort to improve health literacy.” [2] These partnerships may include other medical associations, state chapters, special interest groups, specialty organizations, patient-advocacy groups, medical librarians, health information technology organizations, and other information specialists.

Resources for PAs

Efforts by individual PAs and PA organizations can be enhanced by guidelines and projects that have been developed to assist the medical community in addressing health literacy. They include:

- *Healthy People 2020* guideline that provides a structure focused on clinical activity. Its metrics to measure national success in addressing health literacy issues provide a valuable perspective that can be used to guide clinical efforts at the practice level. [6 12]
- The *Health Literacy Universal Precautions Toolkit* targets clinical activity with its proposed framework to support clinicians in understanding the scope and breadth of health literacy challenges and in proposing a specific shift in how clinicians view patient care. [4-7]
- The *National Action Plan* provides broader direction to organizations, professions, policymakers, and communities, highlighting strategies and actions

3140 that organizations and professions can take to set and achieve organizational
3141 goals. [2]

3142 ● The MLA’s “Resources for Health and Information Professionals” may support
3143 clinician efforts to improve their health communication with patients.

3144 ● MEDLINEPLUS – [HTTPS://WWW.NLM.NIH.GOV/MEDLINEPLUS](https://www.nlm.nih.gov/MEDLINEPLUS)

3145 THE NATIONAL LIBRARY OF MEDICINE’S CONSUMER HEALTH
3146 PORTAL FOR PATIENTS AND HEALTH PROFESSIONALS. THIS SITE
3147 LINKS TO THE NATIONAL INSTITUTE OF HEALTH AND PROVIDES
3148 TUTORIALS, GRAPHS, AUDIO INSTRUCTIONS, AND RESOURCES IN
3149 DIFFERENT LANGUAGES.

3150 ● NIH SENIORHEALTH - [HTTP://NIHSENIORHEALTH.GOV/](http://nihseniorhealth.gov/) - A SITE

3151 DESIGNED FOR OLDER ADULTS AND CAREGIVERS. SITE

3152 INCLUDES LARGE TEXTS AND A FEATURE FOR VISUALLY

3153 IMPAIRED. THIS SITE INCLUDES A SENIOR HEALTH TOOLKIT

3154 [HTTP://NIHSENIORHEALTH.GOVTOOLKIT.HTML](http://nihseniorhealth.gov/toolkit.html) FOR CAREGIVERS

3155 AND PROVIDERS TO ACCESS.

3156 ● UNDERSTANDING MEDICAL WORDS

3157 [HTTP://WWW.NLM.NIH.GOV/MEDLINEPLUS/MEDICALWORDS.HTML](http://www.nlm.nih.gov/MEDLINEPLUS/MEDICALWORDS.HTML)

3158 . AN INTERACTIVE SITE THAT HELPS PATIENTS UNDERSTAND

3159 HOW MEDICAL WORDS ARE FORMED.

3160

3161 SUMMARY

3162 AAPA believes that the PA profession can participate in addressing the
3163 problems of health literacy by

3164 ● adopting expanded definitions of health literacy THAT INCLUDE THE

3165 INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES

3166 ● optimizing efforts to INCREASE HEALTH KNOWLEDGE, SELF

3167 EFFICACY, SELF MANAGEMENT BEHAVIORS, AND POSITIVE

3168 OUTCOMES ~~create information and communication partnerships~~ with

3169 patients

3170 ● participating in LOCAL COMMUNITY GROUPS TO PROVIDE

3171 SOCIAL SUPPORT AND ADVOCACY ~~strategic and multi-sector~~

3172 ~~partnerships centered on assessing and addressing health literacy~~

3173 LEADING TO SUSTAINABLE BEHAVIOR CHANGES CONDUCIVE

3174 TO BETTER HEALTH

- 3175 • identifying and utilizing resources TO INCREASE OPPORTUNITIES
- 3176 FOR PATIENT ACTIVATION, ACCESS TO CARE, AND
- 3177 DEVELOPMENT OF SKILLS TO INCREASE PHYSICAL AND
- 3178 MENTAL WELL BEING. such as the US Department of Health and
- 3179 Human Services' Universal Precautions Toolkit and Healthy People 2020
- 3180 directives.

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2016-D-11 – Adopted on Consent Agenda

Amend policy BA-2200.2 “Health Disparities: Promoting the Equitable Treatment of All Patients” as follows:

Health Disparities: Promoting the Equitable Treatment of All Patients
(Adopted 2011)

Executive Summary of Policy Contained in this Paper

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

AAPA will STRIVE work to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, INVOLVING BUT NOT LIMITED TO EDUCATION, EMPLOYMENT, HOUSING, GEOGRAPHIC LOCATION AND PUBLIC ACCOMODATION.
2. ELIMINATE HEALTH DISPARITIES IN ALL AREAS INCLUDING BUT NOT LIMITED TO: RACE, ETHNICITY, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, DISABILTY STATUS OR SPECIAL HEALTH CARE NEEDS.
3. Increase PA awareness of health disparities.
4. Create and promote health equity tools and resources for PAs.
5. Utilize THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES “HEALTHY PEOPLE” COLLABORATIVE Healthy People 2020 as a template for increased organizational efforts to

3260 support health surveillance systems that track outcomes. **by race and**
3261 **ethnicity, gender, sexual identity and orientation, disability status or**
3262 **special health care needs, and geographic location.**

3263 **6. SUPPORT LEGISLATION AND POLICY THAT ELIMINATES**
3264 **DISPARITIES.**

3265
3266 Introduction

3267 Health disparities are differences in health among groups of people that
3268 are closely tied to social or demographic factors such as race, **SEX gender,**
3269 income, or geographic region. Decades ago, the issue of health disparities was
3270 seen primarily as one of race and ethnicity. As the focus on health disparities has
3271 sharpened **over the last decade,** definitions have broadened to include gender,
3272 sexual orientation, **or** gender identity, religion, socioeconomic status, mental
3273 health, geographic location, and other characteristics typically linked to
3274 discrimination or exclusion. [1]

3275 Accompanying this more sophisticated understanding of health disparities
3276 has been a growing body of research demonstrating healthcare inequities. Data
3277 suggest that increasing provider awareness of health disparities, social
3278 determinants of health, and implicit bias can decrease the impact of health
3279 disparities.

3280 Current public policy interest in health disparities offers unprecedented
3281 opportunities for AAPA and individual PAs to join in global efforts to promote
3282 health equity. Increased understanding of the social determinants of health and
3283 the role that clinician beliefs and behaviors may play in disparities has made the
3284 need for increasing provider awareness and action more urgent than ever.

3285
3286 Mounting Evidence of Health Disparities

3287 The release of the Institute of Medicine’s (IOM) 2003 report, “Unequal
3288 Treatment: Confronting Racial and Ethnic Disparities in Health Care,” provided
3289 sobering evidence of persistent, extensive health disparities. The report identified
3290 complex contributing factors including how health systems operate, bureaucratic
3291 processes, biases of health care professionals, and patients’ behaviors. [12]

3292 The National Plan for Action, **currently a draft document from the**
3293 **National Partnership for Action to End Health Disparities,** includes compelling
3294 data that substantiates the far-reaching and negative impact of health disparities
3295 on the health of minority populations. Striking examples include disparities in
3296 cardiovascular disease, diabetes, HIV/AIDS, infant mortality, oral health, mental
3297 health, and healthcare quality and access. [23]

3298 The American Public Health Association’s brief, “Health Disparities: The
3299 Basics,” offers a snapshot of data related to health disparities for broader
3300 populations: high infant mortality rates among ethnic and racial minorities, risk
3301 for obesity among people with lower income and education, cervical cancer rate
3302 among Vietnamese-American women five times higher than among Caucasian
3303 American women, and the high incidence of chronic illnesses among rural
3304 residents. [34]

3305 One example of the recent expansion of the definition of disparities is the
3306 inclusion of lesbian, bisexual, gay and transgender (LGBT) populations in the
3307 overall examination of health disparities. A study “How to Close the LGBT
3308 Health Disparities Gap,” from the Center for American Progress, reports on health
3309 disparities in the lesbian, gay, bisexual and transgender populations. The report
3310 states that the LGBT population faces higher rates of cancer, mental illnesses,
3311 substance abuse, and delaying care, and lower rates for mammograms, and health
3312 insurance than the adult heterosexual population. [45] Additionally, Healthy
3313 People 2020 included LGBT disparities in its overview for the first time [54]
3314

3315 Social Determinants of Health

3316 Social determinants of health include social, economic and political forces
3317 under which people live, which are key to creating and maintaining health status
3318 gaps between specific populations. They include wealth/income, education,
3319 legislation, nutrition, physical environment, health care, housing, employment,
3320 stress and racism/discrimination. [5]

3321 There is a growing body of research on ~~racism~~ **RACIAL INEQUITY** and
3322 its related stresses as a social determinant of health. When studies control for
3323 socioeconomic status, blacks have poorer health than white counterparts. Middle-
3324 class blacks have poorer health than middle-class whites, with middle-class
3325 whites living an average of 10 years longer than their middle-class black
3326 counterparts. [6]
3327

3328 Implicit Bias and Unconscious Stereotyping

3329 Implicit bias and stereotyping by clinicians are seen increasingly as likely
3330 contributors to health inequities. [7,8]6,7] Stereotyping allows clinicians to make
3331 complex decisions in short periods of time. Researchers have extensively
3332 described how this mechanism operates, and have shown that stereotypes are
3333 often activated subliminally, with quick associations caused by a variety of
3334 triggers. For example, clinicians subliminally exposed to African American
3335 stereotype-laden words are more likely to evaluate the same hypothetical patient
3336 more negatively than when exposed to more neutral language.

3337 While still a relatively new area of research, studies have demonstrated
3338 unequal care for patients presenting to the same facilities, and seeing the same
3339 providers. [89] Clinical stereotyping can be exacerbated by the uncertainty
3340 occurring when a cultural gap between the provider and the patient occurs, as well
3341 as by increased time pressures placed on provider-patient interactions. These
3342 triggers may lead to situations where well-intentioned PAs create a discriminatory
3343 pattern of care, causing “... powerful effects on thinking and actions at an
3344 implicit, unconscious level, even among well-meaning, well-educated persons
3345 who are not overtly biased.” [109]

3346 Data from psychology research suggest that increasing provider awareness
3347 of implicit bias and stereotyping can decrease the activation of PAs’ own biases.
3348 Such research supports aggressive efforts by the AAPA to increase provider
3349 awareness of bias and stereotyping, with the goal of promoting more equitable
3350 care of all patients. [10-14] The Harvard Implicit Association Test
3351 (<https://implicit.harvard.edu/implicit/demo/>) provides an opportunity to explore
3352 personal unconscious biases. [15]

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Action Plan

Therefore, AAPA will ~~work~~ STRIVE to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, INVOLVING BUT NOT LIMITED TO EDUCATION, EMPLOYMENT, HOUSING, GEOGRAPHIC LOCATION AND PUBLIC ACCOMODATION
2. ELIMINATE HEALTH DISPARITIES IN ALL AREAS INCLUDING BUT NOT LIMITED TO: RACE, ETHNICITY, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, DISABILTY STATUS OR SPECIAL HEALTH CARE NEEDS.
3. Increase PA awareness of health disparities.
4. Create and promote health equity tools and resources for PAs.
5. Utilize THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES “HEALTHY PEOPLE” COLLABORATIVE ~~Healthy People 2020~~ as a template for increased organizational efforts to support health surveillance systems that track outcomes. ~~by race and ethnicity, gender, sexual identity and orientation, disability status or special health care needs, and geographic location.~~
6. SUPPORT LEGISLATION AND POLICY THAT ELIMINATES DISPARITIES.

These actions are consistent with AAPA ~~Strategic Plan, Goal VIII, Health of the Public, which charges the Academy to demonstrate leadership in decreasing health disparities.~~ [16] VALUES AS EXPLAINED IN THE STRATEGIC PLAN “WE COMMIT TO THE HIGHEST STANDARDS AND SEEK TO ELIMINATE DISPARITIES AND BARRIERS TO QUALITY HEALTH CARE.” [16]

Conclusion

AAPA believes that enhancing strategic partnerships, supporting increased provider and organizational awareness of health disparities, creating and promoting clinically relevant resources, and supporting data collection related to health disparities will result in decreased health inequities and result in the improved health of all patients.

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3449 **2016-D-12 – Adopted**

3450 Amend policy HX-4600.1.9 as follows:

3451 The AAPA opposes actions by Pharmacists that limit or restrict patient access to care,
3452 such as refusing to fill prescriptions, based on personal or religious beliefs.
3453

3457 **2016-D-13 – Adopted**

3458

3459 Amend policy HX-4600.1.6 as follows:

3460

3461 AAPA supports legislative and health policies that will eliminate the social,
3462 **RECOGNIZES THAT DISCRIMINATION** education, employment, and housing,
3463 ~~inequities that contributeS to HEALTH disparities in health.~~ AAPA SUPPORTS
3464 **LEGISLATION AND POLICIES THAT WILL ELIMINATE DISCRIMINATION.**

3465

3466 **Resolutions of Condolence**

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3468 **2016-COND-01**

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3470 **Resolution of Condolence**

3470

3471 **Richard L. Curtis, PA-C**

3471

3472

May 2016

3473

3474 Whereas, the New Jersey State Society of PAs suffered a great loss with the passing of Richard
3475 L. Curtis, PA-C, on Thursday, February 04, 2016 at Capital Healthcare Center in Hopewell, NJ.

3476

3477 Whereas, Richard L. Curtis, enlisted in the United States Army where he became a Special
3478 Forces Green Beret and served two tours in Vietnam

3479

3480 Whereas, Richard L. Curtis started his career as a medical specialist within the Special Forces
3481 and then trained to be a PA (United States Army PA Program) and after 26 years retired with the
3482 rank of Chief Warrant Officer (CW3)

3483

3484 Whereas, Mr. Curtis, consistently received accommodations from the Military including the
3485 Army Commendation Medal for Superior Service on five occasions

3486

3487 Whereas, Richard L. Curtis was acknowledged as the 2005 recipient of NJSSPA 's Lifetime
3488 Achievement Award in the PA Profession for his dedication to the advancement of the PA
3489 profession from all aspects including education, clinical, political, and legal over one's entire
3490 career

3491

3492 Whereas, Richard L. Curtis practiced during a time when PA were not well accepted in the State
3493 of NJ and was one of the first PAs on staff at Robert Wood Johnson University and Saint Peter's
3494 University Hospitals

3495

3496 Whereas, Richard L. Curtis demonstrated his quest for knowledge and desire to educate not only
3497 his patients but other healthcare professionals as well not only through personal interaction but
3498 through numerous journal publications

3499

3500 Whereas, Richard L. Curtis had a love for traveling the world and a County Western enthusiast
3501 who also enjoyed hand crafting leather art will truly be missed by his family, friends,
3502 congregation, and co-workers

3503

3504 Resolved, that the House of Delegates of the American Academy of PAs recognize Richard L.
3505 Curtis' contributions to the country and to the community, and be it further
3506

3507 Resolved that a copy of this resolution be provided to his loving wife of 51 years, Francis Curtis
3508 and his family with deepest sympathy from the members of the American Academy of PAs.
3509

3510 **2016-COND-02**

3511

Resolution of Condolence

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Dean Minton, PA-C

3515

May 2016

3516 Whereas, Dean Minton was born and raised in rural North Wilkesboro, North Carolina; and,
3517

3518

3518 Whereas, Dean attended Mars Hill Junior College, Wake Forest University and subsequently
3519 earned his Master of Divinity at Southern Baptist Theological Seminary in Louisville, Kentucky;
3520 and,
3521

3522

3522 Whereas, Dean Minton became an ordained Baptist minister and served as a chaplain in the US
3523 Air Force for 27 years, after which he retired as a Lieutenant Colonel; and,
3524

3525

3525 Whereas, Dean decided to enter a second career, and attended the Bowman Gray (Wake Forest)
3526 PA Program, graduating in 1983; and,
3527

3528

3528 Whereas, Dean worked as a PA in the Department of Family and Community Medicine at
3529 Bowman Gray, and then as a PA and Family Therapist for the Winston Center for
3530 Psychotherapy; and,
3531

3532

3532 Whereas, Dean moved to Charlotte in 1988 where he was a PA and Family Therapist with
3533 Mecklenburg Psychiatric Associates, and in 1992 went to work as a PA for Carolinas Medical
3534 Center Department of Psychiatry until he retired in 1999; and,
3535

3536

3536 Whereas, Dean served as on the board of the North Carolina Academy of PAs, and eventually as
3537 its President in 1990; and,
3538

3539

3539 Whereas, Dean was instrumental in starting Charlotte's regional chapter, the Metrolina
3540 Association of PAs (MAPA) and set up MAPA's first webpage and served as MAPA President
3541 and Secretary until he retired in 1999; and,
3542

3543

3543 Whereas, Dean had a passion to help others, advocating for patients and mentoring new PAs, all
3544 of which made him instrumental to the growth of the PA profession in North Carolina; and,
3545

3546

3546 Whereas, the PA profession lost a kind soul, a pioneer, and an all-around great guy when Dean
3547 passed away on March 23, 2016,
3548

3549

3549 Resolved, that the House of Delegates of the American Academy of PAs recognize Dean
3550 Minton's many contributions to his profession and his community, and be it further
3551

3551

3552 Resolved, that a copy of this resolution be provided to his family with deepest sympathy from
3553 the members of the American Academy of PAs.

3554

3555 **2016-COND-03**

3556

Resolution of Condolence

3557

Tony Di Tomasso

3558

May 2016

3559

3560 Whereas Tony Di Tomasso, as a representative of Glaxo Smith Kline gave unsurpassed support
3561 to the PA profession;

3562

3563 Whereas “Tony D” led GSK in developing education platforms for healthcare providers, many
3564 focused on PAs;

3565

3566 Whereas as a Trustee of the PA Foundation, Tony served six years supporting the philanthropic
3567 efforts of PAs;

3568

3569 Whereas as the Veterans Affairs Representative to GSK, “Tony D” made sure monetary and
3570 compassionate support was brought to the Veterans Caucus and other Federal Service PA
3571 organizations to enable them to carry on their mission,;

3572

3573 Whereas “Tony D” was instrumental in developing a GSK web portal to support women in
3574 healthcare practice, focusing on female veterans in their service to our great country;

3575

3576 Whereas “Tony D” was a great colleague, both professional and a dear personal friend of many,
3577 many PAs;

3578

3579 Whereas “Tony D” was a “Brother from another mother” to many, many PAs;

3580

3581 And, whereas “Tony D” left us this past November we remember and honor him with this
3582 resolution for all his love, joy, and support he brought to PAs everywhere.

3583

3584 **Resolutions of Commendation**

3585

3586 **2016-COMM-01**

3587

3588

Resolution of Commendation

3589

Laura Gail Curtis, MPAs, PA-C, DFAAPA

3590

May 2016

3591

3592 Whereas, Laura Gail Curtis became a PA in 1981 graduating from the Bowman Gray School of
3593 Medicine beginning her formal career in healthcare, and

3594

3595 Whereas, five years later she began educating future PAs at Wake Forest University, resulting in
3596 her touching the lives of and mentoring hundreds of future PAs, and

3597

3598 Whereas, she served her state chapter, filling the roles of Professional Practices and Relations
3599 Committee Chair, Health Committee Chair, President-Elect, President, and Past President for the
3600 North Carolina Academy, and

3601
3602 Whereas, she served with distinction from 1992-2007 on the North Carolina Medical Board and
3603 its PA Advisory Committee, and

3604
3605 Whereas, she started her leadership career in the HOD as a delegate for the great state of North
3606 Carolina beginning in 1988 and continuing until 2011, and

3607
3608 Whereas, she participated in thoughtful and honest debate throughout her service as a delegate
3609 challenging issues when necessary yet always keeping the good of the House, the profession and
3610 the academy in the forefront, and

3611
3612 Whereas, she steeped herself in parliamentary procedure and gave freely of her time to the
3613 delegates and the house officers in whatever capacity was necessary, and

3614
3615 Whereas, she served with distinction as a House reference committee member and chair
3616 numerous times, and

3617
3618 Whereas, she advanced her AAPA HOD leadership with election as Second Vice Speaker to the
3619 HOD in 2010 with continued service until 2011, and

3620
3621 Whereas, she pressed forward with her HOD service through election as First Vice Speaker to
3622 the AAPA HOD in 2011 serving until 2013, and

3623
3624 Whereas, she rose to the top of the leadership team in the AAPA HOD with her election as
3625 Speaker of the HOD and Vice President of the AAPA in 2013 continuing to 2016, and

3626
3627 Whereas, she has served in all of these roles in an untiring manner, fully committed to the
3628 responsibilities associated with each role and conducting herself as a role model to others,
3629 including her fellow house officers, the delegates, tellers, Sergeants-at-Arms, and

3630
3631 Whereas she mentored many future House Officers of the AAPA HOD sharing her wisdom,
3632 kindness, and humor, and

3633
3634 Whereas, she has been elected to continue her service to the profession and the Academy as its
3635 future President, and

3636
3637 Whereas, in addition, PA Curtis has exemplified all that is good about the PA profession through
3638 her caring and compassionate service, be it

3639
3640 Resolved that the AAPA HOD honors and commends Gail Curtis, MPAS, PA-C for her
3641 sustained and selfless service and commitment to the HOD, the Academy and the PA profession.

3642
3643 **House Elections 2016** **Results**

3644
3645 **Vice President/Speaker** David Jackson

3646	First Vice Speaker	William Reynolds
3647	Second Vice Speaker	Todd Pickard
3648		
3649	Nominating Work Group	Brandi Ritter
3650		Peggy Walsh