2011 Summary of Actions
AAPA House of Delegates
Las Vegas, NV
May 31 – June 2, 2011

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(Note: resolutions marked with ** require AAPA Board of Directors ratification)

Resolution	Title	Page Number	Action Taken
2011-A-01	House of Delegates Authority	4	Adopted
2011-A-02**	Board of Directors Responsibility to Implement Policy Established by the House of Delegates; Accountability	61	Adopted as amended
2011-A-03**	AAPA Board of Directors – Chair of the Board Position	63	Rejected
2011-A-04	Nominating Work Group Roles and Responsibilities	4	Adopted
2011-A-05**	Elections – Eligibility and Qualifications of Candidates for Elected Positions Other than Student Director	66	Adopted as amended
2011-A-06	Revised Election Process and Procedure for Electing Academy Officers and Directors	9	Referred
2011-A-07**	Organizational Sponsor of the Society for the Preservation of Physician Assistant History	66	Adopted
2011-A-08	Creation of a Public and Physician Education Work Group	14	Rejected
2011-B-01**	Constituent Organization Term of Office (Referred 2010-B-01)	67	Adopted as amended
2011-B-02**	Caucus Exhibit Space	67	Adopted as amended
2011-B-03**	Constituent Organization Applications	67	Adopted
2011-B-04	Specialty Organization Officers	15	Referred
2011-B-05	Paying Clinical Preceptors and/or Clinical Training Sites	15	Rejected
2011-B-06	Statement on PA to MD/DO “Bridge Programs” Position Paper	15	Referred
2011-B-07	Continuing Competence	19	Adopted
2011-B-08	Continuing Medical Education	20	Adopted
2011-B-09	Programs and Student Safety	20	Adopted
2011-B-10	CME Credit for Maintenance of Certification	21	Adopted as amended
2011-B-11	Recertification (Maintenance of Certification) Choice	21	Rejected

2011-C-01	Strategic Goals and Disparities in Health	21	Adopted as amended
2011-C-02	Anti-smoking Package Program and Practice Guidelines for Treatment of Nicotine	21	Adopted
2011-C-03	Child Abuse	22	Adopted as amended
2011-C-04	Family Violence as a Public Health Issue	22	Adopted as amended
2011-C-05	Immunizations in Children and Adults - Position Paper	23	Adopted
2011-C-06	AAPA Supports prevention of Venous Thromboembolism	28	Adopted
2011-C-07	Gender Equity	29	Adopted as amended
2011-C-08	Genetic Testing in Clinical Practice - Position Paper	29	Adopted
2011-C-09	Health Disparities - Position Paper	38	Adopted as amended
2011-C-10	Health Literacy - Position Paper	43	Adopted
2011-C-11	Guidelines for PAs Working Internationally	49	Adopted as amended
2011-C-12	Optimal Health	50	Adopted as amended
2011-C-13	Responsibility of PAs Maintain Health and Wellness	51	Adopted
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2011-C-15	Patients with a Variety of Cultural Attributes	51	Adopted as amended
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2011-C-18	Professional Practice – Non-Clinical Category	52	Rejected
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2011-C-21	Support for Recognition of, and Direct Payment to, PAs by Third Party Payers and Health Care Organizations	53	Adopted
2011-C-22	Support for State Legislation to Ban the Use of Hand-Held Telecommunication Devices While Driving	53	Adopted as amended
2011-C-23	Guidelines for State Regulation of the Physician Assistant Profession -Title Protection Provisions	53	Adopted as amended
2011-C-24	Prescription Drug Benefit Plan	60	Adopted
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Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on June 2, 2011.

Presiding Officers

Alan Hull, PA-C	Speaker
James E. Delaney, PA-C	First Vice Speaker
L. Gail Curtis, PA-C, DFAAPA	Second Vice Speaker

2011-A-01 - Adopted

Amend AAPA Bylaws to read as follows granting policymaking authority to the House of Delegates:

ARTICLE VI House of Delegates.

Section 1: Duties and Responsibilities. The Academy shall have a House of Delegates, which shall represent the interests of the membership. The House of Delegates shall ~~be responsible for developing and recommending to the Board policies that establish Academy vision, mission, goals, values, priorities~~ EXERCISE THE SOLE AUTHORITY ON BEHALF OF THE ACADEMY TO ENACT POLICIES ESTABLISHING THE COLLECTIVE VALUES, philosophies, and principles OF THE PHYSICIAN ASSISTANT PROFESSION. The House of Delegates shall make recommendations to the Board for granting charters to Chapters and for granting official recognition to CAUCUSES AND specialty physician assistant organizations. The House of Delegates shall make recommendations to the Board for the establishment of Academy commissions and work groups, and shall establish such committees of the House of Delegates as necessary to fulfill its duties. The House of Delegates shall be entitled to vote on amendments to these Bylaws on behalf of the members in accordance with Article XIII of these Bylaws. THE HOUSE OF DELEGATES SHALL BE SOLELY RESPONSIBLE FOR ESTABLISHING SUCH RULES OF PROCEDURE, WHICH ARE NOT INCONSISTENT WITH THESE BYLAWS, THE ARTICLES OF INCORPORATION, OR EXISTING LAW, AS MAY BE NECESSARY FOR CARRYING OUT THE ACTIVITIES OF THE HOUSE (I.E. HOUSE OF DELEGATES STANDING RULES).

2011-A-04 – Adopted

Amend the AAPA Bylaws to reads as follows putting all details (duties, composition, method of election, eligibility and qualifications, term of service, vacancies) of the Nominating Work Group into its own Bylaws Article.

ARTICLE XI NOMINATING WORK GROUP

SECTION 1: DUTIES AND RESPONSIBILITIES. THE NOMINATING WORK GROUP SHALL CARRY OUT SUCH DUTIES AND RESPONSIBILITIES AS (1) ARE SET FORTH IN THESE BYLAWS; AND (2) ARE ESTABLISHED BY THE BOARD OF DIRECTORS IN ACCORDANCE WITH ARTICLE X, SECTION 2, SUBJECT TO THE APPROVAL OF THE HOUSE OF DELEGATES. SUCH DUTIES AND RESPONSIBILITIES SHALL INCLUDE:

a. RECEIVING APPLICATIONS FROM POTENTIAL CANDIDATES SEEKING NOMINATION FOR THE POSITIONS OF PRESIDENT-ELECT, SECRETARY-TREASURER, AND DIRECTORS-AT-LARGE;
b. EVALUATING ALL CANDIDATES SEEKING NOMINATION ACCORDING TO THE QUALIFICATION CRITERIA SET FORTH

IN THESE BYLAWS AND ACCORDING TO SUCH OTHER SELECTION GUIDELINES AS MAY BE ESTABLISHED IN ACCORDANCE WITH THIS SECTION;

c. SELECTING 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 FOR THE LAST FIVE YEARS.
c. A CANDIDATE MUST HAVE ACCUMULATED AT LEAST FIVE DISTINCT YEARS OF EXPERIENCE IN THE PAST SEVEN YEARS 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 OR ALTERNATE TO THE AAPA HOUSE OF DELEGATES
    iii. PA FOUNDATION, SOCIETY FOR THE PRESERVATION OF PHYSICIAN ASSISTANT HISTORY, OR AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS POLITICAL ACTION COMMITTEE TRUSTEE OR COMMITTEE CHAIR
    iv. AAPA BOARD APPOINTEES.

~~iv~~ D. ANY CALENDAR YEAR OR ACADEMY YEAR IN WHICH THE CANDIDATE SERVED IN MORE THAN ONE AREA OF PROFESSIONAL INVOLVEMENT SHALL BE COUNTED AS ONE DISTINCT YEAR OF EXPERIENCE.

~~d.~~ E. WITH THE EXCEPTION OF THE BOARD-APPOINTED MEMBERS, A NOMINATING WORK GROUP MEMBER CANNOT HOLD ANY OTHER ELECTED OFFICE OR COMMISSION OR WORK GROUP POSITION IN THE AAPA DURING THE TIME OF SERVICE ON THE NOMINATING WORK GROUP.

SECTION 4: TERM OF SERVICE. THE TERM OF SERVICE FOR MEMBERS OF THE NOMINATING WORK GROUP SHALL BE TWO (2) YEARS. TERMS SHALL BE STAGGERED. INDIVIDUALS APPOINTED TO TEMPORARILY FILL A VACANCY SHALL BE ELIGIBLE TO RUN FOR THE VACATED SEAT. THE UNEXPIRED TERM THE APPOINTEE PREVIOUSLY FILLED SHALL NOT BE COUNTED AS A FILLED TERM FOR PURPOSES OF DETERMINING WORK GROUP TENURE.

SECTION 5: VACANCIES. NOMINATING WORK GROUP VACANCIES SHALL BE FILLED IN THE FOLLOWING MANNER:

a. BOARD-APPOINTED MEMBER. THE BOARD OF DIRECTORS SHALL APPOINT A REPLACEMENT MEMBER TO FILL THE REMAINDER OF THE UNEXPIRED TERM.
b. ELECTED MEMBERS. THE HOUSE OFFICERS SHALL APPOINT A TEMPORARY REPLACEMENT MEMBER. THE TEMPORARY APPOINTEES SHALL SERVE UNTIL REPLACED BY THE HOUSE OF DELEGATES IN THE FOLLOWING MANNER: (1) THE POSITION SHALL BE DECLARED OPEN FOR ELECTION AT THE NEXT HOUSE OF DELEGATES ELECTION AND SHALL BE FILLED BY APPROPRIATE ELECTION PROCESS; AND (2) UPON COMPLETION OF THE ELECTION, THE TEMPORARY APPOINTEE SHALL CONTINUE TO SERVE UNTIL THE NEWLY ELECTED WORK GROUP MEMBER TAKES OFFICE AT THE NEXT CHANGE OF OFFICE.

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

ARTICLE ~~XII~~ XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer;~~ and~~ the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker~~. (The individual elected Speaker of the House of Delegates shall also serve, by virtue of such position, as Vice President of the Academy.) ~~; 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 XII.

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 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:
    i. An AAPA or constituent organization officer, board member, or commission, work group, or task force chair
    ii. A delegate or alternate to the AAPA House of Delegates
    iii. PA Foundation, Society for the Preservation of Physician Assistant History, or American Academy of Physician Assistants Political Action Committee trustee or committee chair
    iv. AAPA board appointees.

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

Section 5: ~~Nominating Work Group. 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. Members of the Nominating Work Group must be fellow members of the AAPA. Nominating Work Group members may not run for any of the positions they are evaluating for the upcoming election. Nominating Work Group duties and responsibilities and other member eligibility requirements shall be determined in accordance with Article X, Section 2. The term of office for members of the Nominating Work Group shall be two (2) years. Terms shall be staggered. The Governance Commission shall determine procedures for the election of members to the Nominating Work Group. Section 6:~~ Time of Elections. The time of House Officers' elections is prescribed in Article VI, Section 3. The Governance Commission shall determine the timing of elections of all other positions, in accordance with the requirements of these Bylaws.

Section ~~7~~6: Eligibility of Voters. For all positions other than the Student Director ~~and the~~, House Officer, AND NOMINATING WORK GROUP positions, eligible voters are fellow members listed on the Academy membership roster as of the date that is thirty (30) days before the election.

Section ~~8~~7: Election Procedures. The Governance Commission shall determine the procedures for the election of Academy Officers and Directors-at-large, including the dates for distribution and return of ballots, subject to the requirements of the North

Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The Academy staff shall manage the ballot distribution. The procedures for electing the House Officers are prescribed in Article VI, Section 3; and the procedures for electing the Student Director are prescribed in Article V, Section 3; AND THE PROCEDURES FOR ELECTING MEMBERS OF THE NOMINATING WORK GROUP SHALL BE DETERMINED BY THE HOUSE OF DELEGATES IN ACCORDANCE WITH ARTICLE XI, SECTION 2.

Section ~~9~~8: Vote Necessary to Elect. A plurality of the votes cast shall elect the Directors-at-large and the Academy Officers (excluding the Vice President), so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the Governance Commission shall determine the process for selecting the winner. The vote necessary to elect the House of Delegates Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

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

Section ~~11~~10: Vacancies. Academy Officers and Directors, and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

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

b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. 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 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.

~~f. NOMINATING WORK GROUP. Vacancies shall be filled in the following manner:~~

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

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

~~iii. Temporary appointees shall be eligible to run for the vacated seat. The unexpired term the appointee previously filled shall not be counted as a filled term for purposes of determining work group tenure.~~

2011-A-06 – Referred (to a committee of the HOD)

Amend AAPA Bylaws Articles III, VI, VII, and XII to read as follows:

ARTICLE III Membership

Section 3: Fellow Members. A fellow member shall be a physician assistant who is a graduate of a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy. Fellow members must satisfy such continuing medical and/or medically related educational requirements as may be prescribed by the Academy. Non-clinical fellow members will not be required to maintain continuing medical education (CME). Fellow members shall BE ENTITLED TO vote for PRESIDENT-ELECT AND SECRETARY-TREASURER ~~Academy Officers and Directors, with the exception of the Vice President and Student Director~~, IN ACCORDANCE WITH ARTICLE VI, SECTION 3, and shall be eligible to hold office.

ARTICLE VI House of Delegates.

Section 3: House ~~Officers~~ OF DELEGATES ELECTIONS. The House of Delegates shall elect ~~from among its members~~ the following: 1) House Officers FROM AMONG ITS MEMBERS: a Speaker (who shall also serve as Vice President of the Academy), a First Vice Speaker, and a Second Vice Speaker (the First Vice Speaker and the Second Vice Speaker are not Officers of the Corporation), 2) FIVE (5) REGIONAL DIRECTORS TO SERVE ON THE ACADEMY'S BOARD OF DIRECTORS, ONE (1) REGIONAL DIRECTOR SHALL BE ELECTED FROM EACH OF THE REGIONS BY THE DELEGATES WITH THE EXCEPTION THAT STUDENT DELEGATES WILL NOT BE ELIGIBLE TO VOTE FOR REGIONAL DIRECTORS. THE FIVE REGIONS SHALL BE ESTABLISHED BY THE GOVERNANCE COMMISSION.

a. Election and Term of Service. Each House Officer AND REGIONAL DIRECTOR shall be elected by a majority of votes cast. No absentee or proxy vote shall be cast. The Governance Commission shall determine the general procedures for House ~~Officers~~ OF DELEGATES elections. The terms of office shall be as specified in Article XII, Section 2.
b. Delegate-at-large Designation. Each House Officer elected shall become a delegate-at-large during the term(s) as a House Officer, plus one additional year as an immediate past House Officer. The delegate-at-large shall be accorded all the rights and privileges of elected delegates.
c. Duties of House Officers.
    i. The Speaker shall preside at all meetings of the House of Delegates.
    ii. The First Vice Speaker shall assume the duties of the Speaker in the event of the absence of the Speaker, or in the event of vacancy in the position of Speaker.
    iii. The Second Vice Speaker will assume the duties of the First Vice Speaker in the absence of the First Vice Speaker, or in the event of vacancy in the position of First Vice Speaker.
    iv. The Second Vice Speaker shall be responsible for verification of the credentials of the delegates, for compiling the records of all general meetings of the House of Delegates, and for submitting such records to the Secretary-Treasurer of the Academy for filing with the Academy's books and records
d. DUTIES OF REGIONAL DIRECTORS SHALL BE IN ACCORDANCE WITH ARTICLE VII, SECTION 4.
e. Resignation or Removal of House Officers, AND REGIONAL DIRECTORS. Any House Officer OR REGIONAL DIRECTOR may resign at any time by giving written notice to the Speaker, the President of the Academy, or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any House Officer OR REGIONAL DIRECTOR may be removed from his or her position at any time, with or without cause, by the affirmative majority vote of the House of Delegates. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the House Officer, OR REGIONAL DIRECTOR. Vacancies in these positions shall be filled in accordance with Article VI, Section 3 and Article XII, Section 11 of these Bylaws.

ARTICLE VII Board of Directors and Officers of the Corporation.

Section 2: Board Composition. There shall be the following members of the Board of Directors: five (5) Academy Officers, five (5) ~~Directors-at-large~~ REGIONAL DIRECTORS, one (1) Student Director, and the First Vice Speaker and Second Vice Speaker. The First Vice Speaker and Second Vice Speaker are voting members of the Board of Directors by virtue of position. The terms of office shall be as specified in Article XII, Section 2.

Section 4: Duties of Officers AND DIRECTORS of the Corporation.

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

b. The President-elect shall succeed to the office of President at the expiration of the President's term or earlier should that office become vacant for any reason.

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

d. The Secretary-Treasurer shall:

i. be responsible for adequate and proper accounts of the properties and funds of the Academy;

ii. give a full report to the membership at the annual meeting;

iii. deposit or call to be deposited all monies and other valuables in the name and to the credit of the Academy with such depositories as may be designated by the Board of Directors;

iv. disburse 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. maintain 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. affix the corporate seal 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.

F. THE REGIONAL DIRECTORS SHALL:

i. REPRESENT THE INTERESTS OF THE MEMBERSHIP AS A WHOLE AND CONSTITUENT ORGANIZATIONS FROM WITHIN THE REGION FOR WHICH THEY WERE ELECTED; AND

ii. PERFORM SUCH OTHER DUTIES AS MAY BE PRESCRIBED BY THE PRESIDENT OR THE BOARD OF DIRECTORS.

Section 8: Resignation or Removal of REGIONAL Directors, STUDENT DIRECTOR and Officers of the Corporation. Any REGIONAL Director, STUDENT DIRECTOR or

Academy Officer may resign at any time by giving written notice to the President or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or if no time is specified, at the time such resignation is tendered. Any ~~Director-at-large~~, Student Director, or Academy Officer (excluding the Vice President) may be removed from office at any time, with or without cause, by the affirmative majority vote of those members entitled to elect them. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the STUDENT Director or Officer. Vacancies in these positions shall be filled in accordance with Article XII, Section11 of these Bylaws. Removal of the Vice President/Speaker OR REGIONAL DIRECTOR shall be done in accordance with article VI, section 3 of these Bylaws pertaining to House Officers AND REGIONAL DIRECTORS.

ARTICLE XII Elections.

Section 1: Positions to be Filled by Election. Elected positions include ~~Directors-at-large~~ REGIONAL DIRECTORS; 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. (The individual elected Speaker of the House of Delegates shall also serve, by virtue of such position, as Vice President of the Academy.) The House Officer, AND REGIONAL DIRECTORS 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. ~~All other elected positions shall be filled in the manner prescribed by this Article XII.~~ THE GOVERNANCE COMMISSION SHALL DETERMINE THE GENERAL PROCEDURES TO ELECT THE PRESIDENT-ELECT AND SECRETARY-TREASURER.

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~~ REGIONAL DIRECTORS 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 4: Self-declaration of Candidacy. Self-declaration, in accordance with policy, shall be permitted in the election of Academy Officers, ~~Directors-at-large~~ REGIONAL DIRECTORS, and House Officers.

Section 6: Time of Elections. The time of House officers' AND REGIONAL DIRECTORS elections is prescribed in Article VI, Section 3. The Governance Commission shall determine the timing of election ~~of all other positions~~ FOR PRESIDENT-ELECT AND SECRETARY-TRESURER in accordance with the requirements of these Bylaws.

Section 7: Eligibility of Voters. ~~For all positions other than the Student Director, and the House Officer positions,~~ FOR THE POSITION OF PRESIDENT-ELECT AND SECRETARY TREASURER, eligible voters are fellow members listed on the Academy membership roster as of the date that is thirty (30) days before the election. FOR THE POSITION OF SPEAKER, FIRST VICE SPEAKER AND SECOND VICE SPEAKER

OF THE HOUSE OF DELEGATES, ELIGIBLE VOTERS ARE ALL CREDENTIALLED DELEGATES OR SEATED ALTERNATES IN THE HOUSE OF DELEGATES. FOR THE POSITIONS OF REGIONAL DIRECTORS, ELIGIBLE VOTERS ARE ALL CREDENTIALLED DELEGATES OR SEATED ALTERNATES IN THE HOUSE OF DELEGATES EXCEPT THAT STUDENT DELEGATES WILL NOT BE ELIGIBLE TO VOTE FOR REGIONAL DIRECTORS.

Section 8: Election Procedures. The Governance Commission shall determine the procedures for the election of ~~Academy Officers and Directors-at-large~~ PRESIDENT-ELECT AND SECRETARY-TREASURER including the dates for distribution and return of ballots, subject to the requirements of the North Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The Academy staff shall manage the ballot distribution. The procedures for electing the House Officers AND REGIONAL DIRECTORS are prescribed in Article VI, Section 3; and the procedures for electing the Student Director are prescribed in Article V, Section 3.

Section 9: Vote Necessary to Elect. A plurality of the votes cast shall elect the ~~Directors-at-large and the Academy Officers (excluding the Vice President)~~ PRESIDENT-ELECT AND SECRETARY-TREASURER so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the Governance Commission shall determine the process for selecting the winner. The vote necessary to elect the House ~~of Delegates~~ Officers ~~(including the Speaker, who shall serve as the Vice President of the Academy),~~ AND REGIONAL DIRECTORS shall be prescribed in Article VI, Section 3.

Section 10: Commencement of Terms. The term of office for all elected positions, including ~~Directors-at-large~~ REGIONAL DIRECTORS, the Student Director, Academy Officers, and House Officers, shall begin on June 10. In the event that the HOUSE OF DELEGATES ELECTIONS ~~election of the House Officer~~s occurs later than June 10, the new House Officers AND REGIONAL DIRECTORS will take office at the close of the meeting during which they were elected.

Section 11: Vacancies. Academy Officers and Directors, and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. OFFICE OF THE PRESIDENT. The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve his/her own successive term as President.
b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. 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. REGIONAL DIRECTORS. A VACANCY IN THE POSITION OF REGIONAL DIRECTOR MAY, IF DEEMED NECESSARY, BE FILLED IN ACCORDANCE WITH ARTICLE VI, SECTION 3 OF THESE BYLAWS FROM A SLATE OF CANDIDATES PREPARED BY THE NOMINATING WORK GROUP. THE HOUSE OF DELEGATES EXCLUDING STUDENT DELEGATES SHALL ELECT A NEW REGIONAL DIRECTOR 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.

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

F~~. OTHER BOARD VACANCIES~~ IMMEDIATE PAST-PRESIDENT OR SECRETARY-TREASURER. ~~All other vacancies~~ A VACANCY occurring in ~~the Board of Directors~~ IMMEDIATE PAST-PRESIDENT OR SECRETARY-TREASURER ~~shall~~ MAY 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~~ THE term~~s~~ of office for such appointee~~s~~ 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.~~

G. NOMINATING WORK GROUP. Vacancies shall be filled in the following manner:

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

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

iii. Temporary appointees shall be eligible to run for the vacated seat. The unexpired term the appointee previously filled shall not be counted as a filled term for purposes of determining work group tenure.

2011-A-08 – Rejected

The House of Delegates recommends to the BOD the creation of a Public and Physician Education Work Group (of the Advocacy and Government Affairs Commission) with the following charges:

Public and Physician Education Work Group (of the Advocacy and Government Affairs Commission):

1. advises AAPA staff in content and distribution educational materials to the public and physicians regarding the roles, responsibilities and utilization of physician assistants.
2. advises AAPA staff about the best distribution mediums to directly education to the public and physicians regarding the roles, responsibilities and utilization of physician assistants including, but not limited to, television, radio, print, online and social media outlets.
3. advise AAPA staff to the best medical conferences for AAPA to maintain a presence at with the goal of educating physicians to the roles, responsibilities and utilization of physician assistants.
4. advise AAPA staff about utilization of public relation vendors and content distributed by those vendors.

2011-B-04 – Referred

CRC recommends to the HOD to recommend approval and adoption by the AAPA Board of Directors to amend policy HA-2300.4.5 to read as follows:

All officers of an officially recognized specialty PA organization are required to be and remain FELLOW members in good standing of AAPA~~, with a majority of officers being fellow members~~. Only those specialty PA organization officers who are fellow members in good standing of AAPA may participate in issues relating to AAPA such as voting for AAPA delegates, submitting resolutions, or representing the specialty organization in the governance structure. ANY SPECIALTY ORGANIZATION THAT IS UNABLE TO FILL ALL OF ITS OFFICER POSITIONS WITH AAPA FELLOW MEMBERS MAY PETITION THE CONSTITUENT RELATIONS WORK GROUP FOR CONSIDERATION OF EXEMPTION FROM THIS POLICY.

2011-B-05 – Rejected

AAPA encourages the PAEA to develop an appropriate strategy to explore the undesirable practice of paying clinical preceptors and/or clinical training sites.

2011-B-06 – Referred

Adopt the position paper entitled “Statement on the PA to MD/DO “Bridge Programs”

Statement on PA to MD/DO Bridge Programs

<u>Executive Summary of Policy Contained in this Paper</u>

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

The American Academy of Physician Assistants can neither support nor endorse the development of bridge programs. PAs who are interested in pursuing training leading to

the MD or DO degree should examine closely and compare them to traditional medical educational programs.

Introduction

Discussion has recently emerged in the PA profession of a type of educational program that would enable practicing physician assistants to become physicians. In such educational programs, PAs would enter a medical school on an accelerated pathway that would lead to either the award of the MD or DO degree. Such programs are sometimes referred to as “bridge programs.”

A bridge program is defined as a formal educational curriculum whereby a graduate physician assistant with clinical experience would be admitted with advanced standing to an educational program leading to the MD or DO degree. Traditionally, most medical schools have been reluctant to grant any measure of advanced standing regardless of past credentials. Recently, one osteopathic medical school has developed such a curriculum.

PAs may have any of a number of motivations to further their medical education and become physicians. Each year, a small percentage of PAs choose to enter medical school, starting over as first-year medical students, and following the traditional medical school curriculum. Data from AAPA’s 2009 Annual Census indicate that less than one percent of PAs responding report being a physician or resident.

Doctoral Summit Recommendation

In March 2009, an independent body comprising nearly 50 individuals from within and outside the physician assistant (PA) profession and supported by resources from the Physician Assistant Education Association (PAEA) and the American Academy of Physician Assistants (AAPA) convened at a PA Clinical Doctorate Summit. The goal of the summit was to develop recommendations to the PA profession on whether the clinical doctorate is appropriate as an entry-level degree, as a postgraduate degree, or not at all. Based on a demonstrated interest by PAs in literature and in survey data, the summit participants recommended that “the PA profession should explore the development of a model for advanced standing for PAs who desire to become physicians (sometimes called a “bridge program”).” (1)

Responding to this suggestion, the Physician Assistant Education Association considered this recommendation at its annual business meeting on November 2009. The motion [2009-BOD-6] called for PAEA to study such programs further. After formal introduction, testimony was mostly con to the motion, with concerns expressed about creating pathways out of the profession, the need to focus resources on the needs of the PA profession and its patients, and whether medical schools would be likely to consider the idea favorably. Some members felt that there was no harm in simply exploring the idea. By majority vote, the motion failed. (2)

In May 2010, the American Osteopathic Association Commission on Osteopathic College Accreditation (AOA COCA) approved the application of the Lake Erie College of Osteopathic Medicine (LECOM) to implement the Accelerated Physician Assistant Pathway (APAP), an accelerated three-year medical school curriculum for Certified Physician Assistants to obtain a Doctorate of Osteopathic Medicine degree. (3) Currently, all other medical schools require PAs to progress through the entire curriculum, with no advanced standing.

In October 2010, during a PAEA Open Forum session, support for the LECOM program and similar programs was expressed; a motion to further investigate the implications of such programs was introduced and again defeated at the PAEA Business Meeting.

In discussions of bridge programs, supporters note that such programs provide a career enhancement pathway for those PAs who wish to become physicians. Given that content of medical school education is similar to that of PA programs in that both are medical-model in structure and overlapping in many areas, proponents point out that such programs have the added benefit of helping to address health workforce issues by offering a shorter period of training for the physician. Supporters also note that such programs could be structured with a special focus on primary care and that bridge programs could help to produce an increased supply of primary care physicians for the medical workforce.

Those who oppose bridge programs argue that they are unnecessary, represent a distortion of the role of the PA, and point out that PAs who become physicians will not necessarily be drawn to primary care. Moreover, bridge programs represent a pathway for PAs to leave the profession, and that PA training may be treated as a “stepping stone”

towards becoming a physician. This places the profession's organizations in an awkward position since advocacy of such programs could be seen as promoting educational pathways for individuals to leave the PA profession.

Advantages and Disadvantages

The PA to MD/DO bridge program offers advantages and disadvantages to PAs depending on what lens is used to examine this career option. From the standpoint of the individual PA, the opportunity for upward mobility and professional advancement, or the opportunity to practice medicine on an independent basis, with less time and money invested in medical school would have value. A number of PAs, particular those who are early in their PA careers, may be interested in pursuing such pathways. It is also possible that such "converted" PAs would use their autonomy in practice to hire PAs and work very well in a team with PAs. This could provide an attractive work environment for both types of clinicians.

From the societal perspective there is no net gain in health care providers, merely moving a provider from one profession to another. There may be marginal increases in productivity but the data are not clear on that. Also, completing PA education first then medical school is a more costly educational endeavor than just completing one or the other.

It is not clear whether there would be benefits to the patient. As the future health care system seeks increased efficiency and cost-effectiveness the exact mix of providers is unclear as is the impact on patient outcomes.

At present there are no obvious advantages to the PA profession, nor is there any apparent compelling demand for bridge programs among practicing PAs. Moreover, there are no data examining how the career path of a PA who has become a physician differs from non-PA physicians. The AAPA recognizes that while some PAs may find PA to MD/DO bridge programs attractive, and may seek to enter such programs after training as a means of career development, bridge programs may not offer substantial benefits to the medical care workforce. Regardless of whether or not bridge programs exist PAs will always have the option of returning to medical school via the traditional route.

Summary: Position Statement

Without additional information or data on workforce need, PA preferences, or outcomes from bridge programs, the American Academy of Physician Assistants can neither support nor endorse the development of bridge programs. PAs who are interested in pursuing training leading to the MD or DO degree should examine closely and compare them to traditional medical educational programs.

References

1. Physician Assistant Education Association. Informing the Clinical Doctorate Dialogue. Accessed at: http://www.paeaonline.org/index.php?ht=d/sp/i/66891/pid/66891
2. Physician Assistant Education Association. 2009 Business Meeting Summary. Accessed at http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/96083
3. Lake Erie College of Osteopathic Medicine. Accessed at http://www.lecom.edu/college_medicine.php/accelerated-physician-assistant-pathway-apap/76/0/2018/17899.

2011-B-07 - Adopted

Amend by substitution policy HP-3700.4.1 to read as follows:

~~Continuing competence is a multidimensional construct that represents the totality of knowledge, skills, and abilities necessary for professional practice and implies a minimum level of proficiency. AAPA believes it is the ethical responsibility of the practicing PA to maintain a level of competence sufficient to practice medicine safely and effectively, PAs are committed to updating knowledge and skills through lifelong learning and keeping abreast of emerging knowledge and technologies. A component of that commitment is demonstrated by participating in continuing medical education activities.~~

AAPA RECOGNIZES LIFE-LONG LEARNING PROVIDES OPPORTUNITIES TO IMPROVE COMPETENCE, SUPPORT PREPAREDNESS FOR CERTIFICATION/LICENSURE, AND TO INCREASE THE VITALITY AND EFFICIENCY OF A PRACTICE BY PROVIDING LEARNING OPPORTUNITIES WHICH ARE INTENDED TO IMPROVE PERFORMANCE IN PRACTICE AS MEASURED ULTIMATELY BY PATIENT OUTCOMES.

AAPA BELIEVES IT IS THE ETHICAL RESPONSIBILITY OF THE PRACTICING PA TO MAINTAIN A LEVEL OF COMPETENCE SUFFICIENT TO PRACTICE MEDICINE SAFELY AND EFFECTIVELY. A COMPONENT OF THAT COMMITMENT IS DEMONSTRATED BY PARTICIPATING IN CONTINUING EDUCATIONAL ACTIVITIES WHICH ARE SCIENTIFICALLY VALID,

EVIDENCE-BASED, COMMERCIALLY UNBIASED, AND BASED ON PRINCIPLES OF EFFECTIVE ADULT LEARNING.

2011-B-08 – Adopted (Housekeeping changes were made by the House Officers)

Amend policy HP-3200.2.2 to read as follows:

AAPA REVIEWS AND approves FOR CATEGORY 1 CME CREDIT EDUCATIONAL ACTIVITIES WHICH SERVE TO DEVELOP, MAINTAIN, OR INCREASE THE KNOWLEDGE, SKILLS AND PROFESSIONAL PERFORMANCE OF A PHYSICIAN ASSISTANT. THESE MAY INCLUDE live presentations, enduring material programs, and other educational activities.~~. for Category 1 (pre-approved) CME credit.~~ The AAPA stipulates THAT the following ACTIVITIES MEET THE REQUIREMENTS FOR ~~as~~ Category 1 ~~(pre-approved)~~ CME credit for physician assistants:~~ Category 1 credit for programs that are approved by the American Osteopathic Association Council on Continuing Medical Education, prescribed credit by the American Academy of Family Physicians, or American Medical Association Physician's Recognition Award Category 1 credit from organizations accredited by the Accreditation Council for Continuing Medical Education~~.

- THOSE APPROVED FOR CATEGORY I CREDIT BY THE AMERICAN MEDICAL ASSOCIATION (AMA) (I.E. ACTIVITIES SPONSORED BY PROVIDERS ACCREDITED BY THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME))
- THOSE APPROVED FOR CATEGORY 1-A CREDIT BY THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA)
- THOSE APPROVED FOR PRESCRIBED CREDIT BY THE AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)
- ACCREDITED PROGRAMS OF THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA (RCPSC), THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC), OR THE PHYSICIAN ASSISTANT CERTIFICATION COUNCIL OF CANADA (PACCC)

2011-B-09 - Adopted

Amend by deletion policy HP-3200.3.7 and amend policy HP-3200.3.5 to read as follows:

AAPA recommends that PA programs ~~ensure the safety~~ PROTECT THE HEALTH of their students AND THE PATIENTS THEY SERVE AGAINST INFECTIOUS DISEASES by:

1. Verifying adequate immunization and or immunity status upon entering the program.
2. FOLLOWING THE IMMUNIZATION RECOMMENDATIONS OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S ADVISORY COMMITTEE ON IMMUNIZATION PRACTICE.
3. ~~Providing~~ ENSURING STUDENTS HAVE access to adequate health care ~~insurance~~ in the event of ~~injury or major illness, including~~ exposure to pathogens.

4. ~~Insuring that students are adequately trained~~ TRAINING STUDENTS in standard precautions.
5. Having specific protocols in place regarding post-exposure prophylaxis and counseling.

~~HP-3200.3.7~~
~~AAPA strongly recommends that all physician assistant students be appropriately vaccinated per the recommendations of the Advisory Committee on Immunization Practice (ACIP) of the Center for Disease Control and Prevention (CDC) prior to the beginning of any clinical training.~~

2011-B-10 – Adopted as amended

AAPA encourages the NCCPA to ~~**offer**~~ RECOGNIZE CME category 1 credit for ~~**both the Quality Improvement project (QI) and Self - Assessment activity (SA). These are parts of the proposed new Maintenance of Certification program.**~~ CONTINUING EDUCATION ACTIVITIES THAT INCORPORATE PROFESSIONAL SELF-ASSESSMENT AND SELF-IMPROVEMENT ACTIVITIES.

2011-B-11 - Rejected

AAPA encourages the NCCPA to modify the maintenance of certification process to allow PAs a choice of a cycle of either six or ten years in length. AAPA would encourage this change to take place as soon as possible.

And be it further resolved:
The House of Delegates charges the Speaker to communicate this request to the NCCPA Board of Directors.

2011-C-01 – Adopted as amended

Amend policy HA-2400.4.4 to read as follows:

~~AAPA believes that members working on behalf of the Academy should be knowledgeable of diversity and health care disparity issues.~~

AAPA ~~BELIEVES~~ **SUPPORTS** ~~**PAs should advocate for**~~ legislative and health policies that will ~~**diminish**~~ **ELIMINATE** the social, educational, employment **AND** housing ~~**and health access**~~ inequities that contribute to disparities in health.

2011-C-02 – Adopted

Amend by substitution policies HX-4200.4.6.1 and HX-4200.4.6.2 to read as follows:

HX-4200.4.6.1
~~The AAPA supports (a) development of an anti-smoking package program for constituent organizations; (b) making patient educational and motivational materials and programs on smoking cessation available to physician assistants; and (c) development and~~

~~promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth. *[Adopted 2006]*~~

HX-4200.4.6.2
~~The AAPA encourages physician assistants to use practice guidelines for the treatment of patients with nicotine dependence and will disseminate evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health. *[Adopted 2006]*~~

THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS SUPPORTS (a) DEVELOPMENT AND PROMOTION OF SMOKING CESSATION MATERIALS AND PROGRAMS TO ADVANCE CONSUMER HEALTH-AWARENESS AMONG ALL SEGMENTS OF SOCIETY, BUT ESPECIALLY FOR YOUTH; (b) DISSEMINATION OF EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES CONCERNING THE TREATMENT OF PATIENTS WITH NICOTINE DEPENDENCE; (c) EFFECTIVE USE OF BOTH SMOKING CESSATION MATERIALS AND EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES BY PAS, FOR THE TREATMENT OF PATIENTS WITH NICOTINE DEPENDENCE.

2011-C-03 – Adopted as amended

Amend policy HX-4400.1.6 to read as follows:

AAPA supports EFFORTS IN the ~~development of educational programs concerning~~ **~~early~~** prevention, **EARLY** recognition, reporting and ~~treatment~~ MANAGEMENT of children who are victims of CHILD ABUSE, INCLUDING NEGLECT, **EMOTIONAL,** PHYSICAL AND/OR SEXUAL ABUSE. ~~deprivation, neglect or abuse~~. Physician assistants should be familiar with the RISK FACTORS, CLINICAL PRESENTATIONS, AS WELL AS, SHORT AND LONG-TERM CONSEQUENCES ~~signs and symptoms~~ related to ~~deprivation, neglect or abuse of children~~, CHILD ABUSE.

AAPA SUPPORTS THE USE OF COMMUNITY RESOURCES IN THE MANAGEMENT OF CHILD ABUSE, INCLUDING ~~as well as the~~ appropriate local and state REPORTING AGENCIES. ~~laws for reporting children who have been abused, deprived or neglected~~.

2011-C-04 – Adopted as amended

Amend policies HX-4400.1.6 and HX-44001.7 to read as follows:

AAPA recognizes that family **~~violence~~ ABUSE** is a public health epidemic in the United States.

AAPA supports medical care of abused and battered individuals which emphasizes linkages with community-based family **~~violence~~ ABUSE** programs and referral agreements whenever possible.

AAPA encourages its members to participate in community-based efforts to increase the awareness of the epidemic of CHILD, ~~**AND**~~ INTIMATE PARTNER, **AND ELDER** ~~**violence**~~ **ABUSE**.

AAPA encourages its members to recognize THAT A RELATIONSHIP EXISTS BETWEEN substance abuse and family ~~**violence**~~ **ABUSE**. ~~PAs should be educated in the appropriate screening methods to identify families at risk.~~

AAPA SUPPORTS THE DEVELOPMENT OF EDUCATIONAL PROGRAMS ADDRESSING ~~**EARLY**~~ PREVENTION, **EARLY** RECOGNITION, REPORTING, TREATMENT AND THE APPROPRIATE REFERRAL TO PREVENT FAMILY ~~VIOLENCE~~ **ABUSE.**

2011-C-05 – Adopted

Amend by substitution policy HP-3300.1.14 Immunizations in Children and Adults.

Immunizations in Children and Adults

Executive Summary of Policy Contained in this Paper

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

The immunization of children and adults against vaccine-preventable diseases is one of the most important medical advances of the 20th century and among the most valuable health care investments that can be made. In the 20th century, the development of effective vaccines has led to a 97% or greater reduction in reported cases of diphtheria, measles, mumps, pertussis, poliomyelitis, rubella, and tetanus in the United States.[1] In an economic evaluation of the recommended 7-vaccine routine immunizations in childhood, it is estimated that a savings of $5 in direct costs and $11 dollars in societal costs including the cost of immunization are realized each year.[2] Given their proven benefit in reducing morbidity, mortality and health care costs, immunization programs for children and adults should be part of the medical practice of all physician assistants.

Childhood Immunizations

Despite great successes at controlling once common childhood diseases, such as poliomyelitis, diphtheria, measles, mumps, rubella and tetanus; significant gaps remain in the public health system. In the United States the HHS' Healthy People 2010 initiative had set vaccination coverage goals of 90 percent for each vaccine in the 4:3:1:3:3:1 series

and a goal of 80% for completion of the entire series (these goals remain for the 2020 initiative), which consists of

- four or more doses of diphtheria, tetanus and pertussis, or DTaP, vaccine;
- three or more doses of polio vaccine;
- one or more doses of measles, mumps and rubella, or MMR, vaccine;
- three or more doses of *Haemophilus influenzae* type b, or Hib, vaccine;
- three or more doses of hepatitis B vaccine; and
- one or more doses of varicella vaccine.

In 2008, coverage for the entire series was 76.1%, which was down slightly from the 2007 coverage estimate of 77.4 %.[3]

Disparity in vaccination rates remains lower among children living below the poverty level, in non-Caucasian children, and those living in high-risk geographic areas, such as rural, underserved, and low socio-economic regions. These surveys continue to reveal immunization rates well below the national average and/or targeted goal rates.[4]

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

Adult Immunization Programs

Adult immunization programs do not receive the same priority as efforts to immunize children, despite the fact that most deaths from vaccine-preventable disease occur in adults. Between 50,000 and 90,000 adults die each year from pneumococcal infection, influenza and hepatitis B combined.[6]

Despite availability and effectiveness of vaccines current immunization rates fall below those recommended in Healthy People 2020. In addition to deaths from pneumococcal pneumonia, flu and hepatitis B; each year a smaller number of adult deaths occur that are a continuum of the problem of inadequately immunized children. A majority of the US

cases of tetanus and diphtheria today occur in adults who were inadequately immunized as children. Furthermore, the recent resurgence in measles, mumps and rubella; although seen primarily among unimmunized preschool children, also occurred in a significant number of young adults. Most vaccine failures in adults occurred among those who did not have a primary response to the MMR vaccine administered in childhood. Waning immunity does not seem to be an important factor. It is now strongly recommended that everyone born since 1956 receive a two-dose measles immunization. Because mumps and rubella have shown similar, though less pronounced, epidemiologic patterns of reemergence, the vaccine of choice is MMR.[7]

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

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

More widespread immunization strategies include new methods of vaccine delivery (nasally administered sprays) and new combination vaccines. Nasal administration of the influenza vaccine would reduce the expense associated with intramuscular vaccination and would be more practical, especially amongst pediatric patients (over five years of age). The immunization action coalition (IAC)[8] continues to promote a national immunization registry as a national goal in Healthy People 2020, specifying that 95% of children from birth to age six should fully participate in an operational, population-based immunization registry.

Challenges

Challenges for assuring access and availability of vaccines Include: 1) Unprecedented Vaccine Delays, 2) Diminished Number of Vaccine Suppliers, 3) Disparities in Geographic and Socioeconomic Populations, and 4) Erosion of Insurance Coverage for Immunizations.

Influenza Vaccination of Health Care Personnel

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

Vaccine Safety

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

Summary

The results of inadequate immunizations among children and adults are unnecessary deaths, avoidable hospitalizations and the associated costs, and life-long disabilities caused by the sequelae of potentially preventable diseases. The fact remains that safe, effective vaccines are available but underutilized. Even patients who routinely see health care providers may not be adequately educated about recommended immunizations, missing opportunities for receiving this type of protection.

Recommendations

The American Academy of Physician Assistants recognizes the importance of child and adult immunization programs and the need to educate individual physician assistants and the public about these programs. To that end, the American Academy of Physician Assistants makes the following recommendations:

1. Physician assistants should be aware of current medical guidelines for immunization of children and adults. Providers also should be aware that patients in high-risk groups, such as the chronically ill, asplenic, or elderly, may need to be on different immunization schedules than the general population.

2. Individual physician assistants and their practices, in cooperation with public health agencies, should promote public information campaigns to increase awareness of the importance of immunizations and allay fears and doubts about potential side effects.

3. Physician assistants should be immunized against vaccine-preventable diseases for which health providers are at high risk. This not only protects PAs, but also protects patients by preventing provider-to-patient transmission.

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

5. Physician assistant students should have all appropriate immunizations prior to their clinical experience.

6. Physician assistants working in primary care should develop systems within their practices to promote optimum immunization of their patients. These systems might include devices such as personal immunization records for patients to carry with them and a way to easily locate each patient's immunization record in his or her medical chart. High-risk patients should be identified and special programs implemented, such as mailing a flu vaccine reminder to all high-risk patients every fall.

7. Physician assistants working in specialty practices in hospitals and offices should recognize patients who are at high risk for vaccine-preventable diseases. They should coordinate efforts with the patients' primary care providers to insure that these patients are adequately immunized and that the primary care providers have complete immunization records.

8. Physician assistants should support the development of and participate in state and local immunization registries. Effective immunization registries have demonstrated an ability to prevent fragmentation of care, incomplete immunizations, or unnecessary over-immunization of patients because of lack of communication between various providers and programs. An objective of Healthy People 2020 is to enroll 95% of children under the age of six in population-based immunization registries. [10]

9. All private and public payers should provide coverage for child and adult immunizations.

Bibliography

1. Peter G. Childhood immunizations. N Engl J Med 1992; 327:1794-800.

2. Zhou, F., Santoli, J., Messonnier, ML., et.al. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001. Arch Pediatr Adolesc Med. 2005; 159:1136-1144.

3. MMWR: National, State, and Local Area Vaccination Coverage Among Children Aged 19--35 Months --- United States, 2008. August 28, 2009 / 58(33); 921-926 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5833a3.htm

4. Centers for Disease Control. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5936a2.htm?s_cid=mm5936a2_w Accessed 01/31/2011.

5. Burns, IT., Zimmerman, RK. Immunization Barriers and Solutions. J of Family Practice. 2005; 54(1):S58-S62.

6. American College of Preventive Medicine. http://www.acpm.org/adult.htm Accessed 01/31/2011.

7. MMWR: Morbidity and Mortality Weekly Report – January 15, 2010/59(01); 1-4. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5901a5.htm Accessed 01/31/2011.

8. Immunization Action Coalition: Vaccination Information for Healthcare Professionals. http://www.immunize.org/ Accessed 01/31/2011.

9. Infectious Diseases Society of America (IDSA): Policy on Mandatory Immunization of Health Care Workers Against Seasonal and Pandemic Influenza. http://www.idsociety.org/hcwimmunization.htm Accessed 01/31/2011.
10. Healthy People. Gov. http://www.healthypeople.gov/2020/default.aspx Accessed 01/31/2011.

2011-C-06 – Adopted (Housekeeping changes were made by the House Officers)

The AAPA supports the Surgeon General's 2008 Call to Action for prevention of venous thromboembolism (VTE). Support shall include but not be limited to:

- Encouraging PAs to increase patient awareness as to the risks of VTE.

- Encouraging PAs to use clinically appropriate practice guidelines for the prevention and treatment of patients with VTE.

- Encouraging PAs to model evidence-based VTE prevention in their practices, including:
    1. performing VTE risk assessment on all patients in their care undergoing surgical procedures or being admitted to the hospital
    2. ensuring personal and family history of VTE is incorporated into all health history examinations
    3. prescribing, according to established evidence-based guidelines, appropriate prevention strategies for VTE inclusive of both chemoprophylaxis and mechanical prophylaxis,
    4. providing patient education on the risks of VTE
    5. providing patient education on the importance of compliance with prevention strategies for VTE.
    6. providing patient education on the symptoms and actions that should be taken if they suspect VTE.

2011-C-07 – Adopted as amended

AAPA believes in gender based equity in income for physician assistants ~~performing similar work~~ HAVING COMPARABLE RESPONSIBILITIES WITHIN THE SAME SPECIALTY. AAPA encourages additional research on gender based disparities in income.

Furthermore, the House of Delegates recommends that the Board of Directors charge the appropriate body to further investigate other potential areas of disparity in PA income and report back to the House in 2012.

2011-C-08 – Adopted

Amend by substitution policy HP-3300.1.5.

<u>Genetic Testing in Clinical Practice</u>

<u>Executive Summary of Policies Contained in this Paper</u>

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

- The AAPA believes that practicing physician assistants should be aware of the advantages, limitations, and harms of testing for human genetic conditions.
- PAs should be knowledgeable about genetic screening, pre-symptomatic and diagnostic testing.
- Physician assistants must be prepared to utilize genetic testing and counseling as a routine part of patient care.
- PAs should be aware of the unique nature of genetic testing and its legal and ethical considerations.

- PAs must be able to differentiate between genetic disorders they themselves can diagnose and manage and those that require referral to a genetic specialist.
- PAs are advised to be familiar with the benefits and risks of genetic tests, to appropriately counsel patients, and to obtain informed consent before ordering tests, as noted in the AAPA's "Guidelines for Ethical Conduct for the Physician Assistant Profession"
- PAs should discuss with patients the need or purpose of whether family members should be notified while remaining aware of the complex issue of patient confidentiality.
- AAPA believes that genetic information should not be used to discriminate against individuals or their families.
- The AAPA supports state and federal legislation designed to protect the confidentiality of genetic information and to prevent discrimination based on that information.

Introduction

The initial mapping of the human genetic sequence was finished in 2003 by a cadre of international scientists. Completion of the Human Genome Project marked the beginning of a new era of genetic medicine. The completed sequence represented the first step in understanding the fully decoded human genome. The next steps entail unraveling the positive and negative attributes associated with individual genes and the specific functions and interactions of each sequence.

The Human Genome Project will continue to advance our understanding of human disease and treatment. Increasingly efficient technologies have allowed rapid development of tests for genetically linked disorders. Many tests for Mendelian, non-Mendelian, and complex disorders are now available.

The general population may not understand the meaning or the need for various testing that are becoming available. Certainly, the absolute benefit of genetic testing will not be clear for some time. Genetic testing, as with other tests, can be inconclusive, conflicting, or limited by analytic and clinical validity. Treatments and adaptations may not be available to address the impact of genetic conditions that may be diagnosed. Ethically and legally, there need to be regulatory considerations regarding the development and marketing of tests. For many disorders the presence of a genetic

mutation is only one of many factors, including other unknown genetic variants and environment, indicating susceptibility rather than inevitability of disease.

Despite these uncertainties, as more genes are identified, there will be pressure from consumers and entrepreneurs to increase the use of genetic tests. Advances have made it possible to predict the risk of developing common conditions such cancer, Alzheimer's disease, and mental illnesses. The genetic information that will be available about individuals raises critical ethical, legal, and social questions. Given these caveats, physician assistants must be more comprehensively prepared to utilize genetic testing and counseling as a routine part of patient care.

The State of the Art

The Secretary's Advisory Committee on Genetic Testing (SACGT) in the federal Department of Health and Human Services includes the following types of tests in its definition of genetic tests: 1) an analysis performed on DNA, RNA, genes, and/or chromosomes to detect heritable or acquired genotypes, mutations, phenotypes, or karyotypes that cause or are likely to cause a specific disease or condition; and 2) the analysis of human proteins and certain metabolites, which are predominantly used to detect heritable or acquired genotypes, mutations, or phenotypes. Current genetic testing includes screening, carrier screening, pre-symptomatic, predictive, and diagnostic analysis.

Though there are genetic defects for which early detection and intervention can prevent disease or its progression, much remains unknown about the association between a genetic disorder and disease. For example, a test for a specific mutation at the tip of chromosome 4 predicts with near certainty whether an individual will suffer from Huntington's disease. This severe, late-onset, neurological disorder results from the inheritance of abnormal triplet repeat segments and increased numbers of these triplet repeats are associated with early progression to disease. Yet, there is no way to predict when the disease will occur based on current tests. The BRCA1 gene is associated with an increase in susceptibility for breast cancer but whether individuals are susceptible to a specific type of breast cancer, or whether they will indeed be diagnosed over their lives with breast cancer, remains unclear.

There are many questions about the validity of some tests because of the lack of oversight of the genetic tests or the skill of the labs performing them. Genetic tests, in

particular predictive tests, are technically more difficult to perform and interpret than conventional medical tests, and their impact on patients and their families can be profound. The clinical laboratory improvement act (CLIA) requires that laboratories performing clinical tests be certified. Different categories of testing are subject to different degrees of regulation, depending on the complexity of the test. Tests that are classified as highly complex must meet additional proficiency standards to ensure test accuracy. Although genetic tests fall into this category, the Centers for Medicare and Medicaid Services have not yet set proficiency standards for them.

Genetic testing kits that are sold to multiple laboratories require pre-market approval as diagnostic devices by the Food and Drug Administration (FDA). According to the SACGT, new genetic tests are being developed and provided by clinical labs as in-house tests and thus do not require FDA approval. The current lack of regulation has led, for example, to the marketing of genetic testing for such unproven indications as diet planning and nutritional supplements based on genetic markers.

No one agency or organization monitors how many tests are on the market, the quality of the tests, or how many test results are correctly or incorrectly interpreted and reported. Limited regulation allows commercial biotechnology companies and other laboratories, which already are offering more than 900 tests to a largely uneducated public, the freedom to decide how accurate their tests need to be before marketing them to providers and the public. Some experts say that many of these tests are still in quasi-research stages, but firms continue to market and charge for them. Because so little interpretive information is available, SACGT has recommended the development of fact sheets for providers, similar to reference books or fact sheets now available for drugs that describe intended uses, risks, and benefits.

The confidentiality of genetic information raises legal and ethical concerns. The Genetic Information Nondiscrimination Act (GINA) of 2008 protects against genetic discrimination in health insurance and employment. Insurers are prohibited from using genetic information to determine eligibility for insurance coverage and employers may not base employment decisions on genetic information. Neither insurers nor employer may require genetic testing. Genetics tests specifically covered by GINA includes family history, prenatal genetic testing, carrier and susceptibility testing, and tumor analysis.

Information on current clinical conditions however, is not protected by GINA. (Golgar 2010)

The immediate future is likely to be characterized by confusion, brought about by false-positive and false-negative test results, practitioners who are not properly prepared to interpret the results, and patients whose expectations are uninformed. A patient with an identified genetic risk factor may never contract the disease or condition, possibly needlessly creating a life of worry. Learning personal genetic information can be a very emotional experience for patients. Practitioners will need to pay attention so that patients or their families do not automatically assume the worst, equating a "defective gene" with major illness, morbidity, or certain death. In most cases mutations should be considered a risk factor, rather than a predictor of disease. Clinicians need to find ways to effectively communicate the probabilities to patients.

Impact on Patients and Providers

Genetic discoveries are already making their way into mainstream health care. Providers – regardless of specialty area, role, or practice setting – will treat patients who have questions about genetic implications of their health. Surveys confirm that most providers are not prepared for this technology unless they are recent graduates, and even then they will be unevenly prepared. Most providers will have learned about "new" genetic technologies during their clinical training. The lack of definitive information can lead providers to wrongly reassure patients who are at risk for disease and needlessly scare others who may have little to fear.

The public is mostly ill-informed about genetics. Surveys show that three-fourths of Americans lack even a basic understanding of genes. Even when test results are conveyed accurately, people tend to misconstrue what they are being told. Patients with exaggerated fears of developing a genetic disease or condition may seek unnecessary tests. Additionally, these patients may underestimate the potential drawbacks of being tested. Many, for example, do not understand the odds of a false result. Many are unaware of the psychological anxiety or insurance problems that can follow.

Counseling patients about the potential risks and benefits of a genetic test is essential. Medical geneticists and genetic counselors have the best training to perform the task, experts agree, but there are far too few to do the job. Medical economics present another barrier to effective counseling. Insurance may not pays for counseling, and

genetics counseling is complicated and time-intensive, and not available to those without access. Further, testing often affects not only the person being tested, but extended family members. A single genetic test can quickly snowball into a crisis for dozens of relatives. Francis Collins, MD, PhD, director of the National Institutes of Health (NIH), and former director of the National Human Genome Research Institute, predicted the following in an article in the Journal of the American Medical Association:

As genetic tests and therapies become available, there will be too few genetic counselors and medical geneticists to meet demands for testing and services, and these specialists will have their hands full with more complex referrals. Because responsibilities for use and interpretation of genetic tests increasingly will fall to primary care clinicians, physicians will need a working knowledge of genetics, validated education and counseling tools, and access to genetic specialists. Given the time constraints in managed care, partnerships with members of a health care team such as physician assistants, nurses, psychologists, and social workers will be essential. According to surveys, however, most health professionals are not prepared to integrate genetics into clinical practice.

What PAs Should Know

Primary care providers often will be the ones screening patients for genetic disorders and providing access to counseling and testing. PAs will need to know which genetic disorders they themselves can diagnose and manage and those that require referral to a genetic specialist. Once a patient has been referred for a genetic workup, the primary care team should work closely with the specialists to ensure that the best possible ongoing medical management is provided. PAs should be aware of the advantages and disadvantages of the currently available types of genetic tests: carrier screening, diagnostic testing, presymptomatic testing, and predictive testing. (See glossary.)

There are many resources PAs can draw on to develop their understanding of genetic testing and counseling. PAs should not forget cultural considerations when counseling patients about genetic testing. The National Coalition for Health Professional Education in Genetics (NCHPEG) has created a list of core competencies it believes all health professionals should possess in order to integrate genetics into routine health care. NCHPEG states that "Each health professional, at a minimum, should be able to appreciate limitations of his or her genetic expertise, understand the social and

psychological implications of genetic services, and know how and when to make a referral to a genetics professional." The 44 points more specifically delineate the minimum knowledge the NCHPEG believes primary care providers should have about genetic testing, the skills required, and the attitudes that are essential to effective genetic care. Core competencies have been proposed for physician assistants including the knowledge, skills, and attitudes necessary to deliver competent genetic care to patients. (Rackover, 2009)

The Communities of Color and Genetics Policy Project, a government-funded program based at the University of Michigan, engages communities of color of diverse socio-economic levels in dialogue about genome research and its resulting technology. From these dialogues the project staff and board will develop recommendations for laws, professional standards, and institutional policies regarding the use and application of genome research and technology reflecting the perspective of communities of color.

The National Society of Genetic Counselors (NSGC) offers a "Template for Pretest Education and Counseling" outlining steps to effective genetic counseling. NSGC recommends that test results be provided face-to-face by a medical professional who is knowledgeable about test result implications and limitations, who is involved in the testing process, and who has an established relationship with the patient. Post-test follow-up also should offer emotional and medical support. Most of the ethical issues raised by genetic testing are not new or necessarily different from issues raised in other areas of health care. However, there are aspects that deserve special consideration. The personal nature of information generated by a genetic test, its power to affect major life decisions and family members, and its potential misuse raise important ethical considerations.

Confidentiality is an area of particular concern. PAs should counsel patients about confidentiality issues as a potential risk, and protections under GINA. The potential impact of a genetic diagnosis or even susceptibility on extended families should not be underestimated. Debate surrounds the question of whether family members have a right to know their genetic risk when another family member is tested. Further, decoding one person's DNA provides genetic information about their children, parents and siblings. PAs should be aware of their duty to protect the confidentiality of their patients and know whether there is any duty to inform other family members – with or without patient consent. Information about confidentiality laws and other requirements may be available

from hospital ethics committees, public health departments, medical associations, genetic counselors, and academic medical centers. The results of genetic testing are for the benefit of the individual and should be considered carefully in consultation with the medical provider. The AAPA supports efforts to afford confidentiality to an individual's genetic information, just as it does to any protected health information. Logically, such information would likely never be released without an individual's knowledge or consent, and by extension should never be the basis for discrimination or recriminations.

Conclusion

The AAPA believes that practicing physician assistants should be aware of the advantages, limitations, and harms of testing for human genetic conditions. PAs should be familiar with methods of genetic counseling and the legal and ethical issues involved in the practice of human genetic testing. PAs must be able to differentiate between genetic disorders they themselves can diagnose and manage and those that require referral to a genetic specialist.

The AAPA's "Guidelines for Ethical Conduct for the Physician Assistant Profession" advise PAs to be familiar with the benefits and risks of genetic tests, to appropriately counsel patients, and to obtain informed consent before ordering tests. PAs should be able to tell patients how well a particular genetic risk factor correlates with likelihood of developing a disease or condition and discuss possible consequences of positive results. PAs should discuss with patients the need or purpose of whether family members should be notified by the patient while remaining aware of the complex issue of confidentiality. AAPA believes that genetic information should not be used to discriminate against individuals or their families. The AAPA supports the Genetic Information Nondiscrimination Act, designed to protect the confidentiality of genetic information and to prevent discrimination based on that information.

Glossary

Carrier Testing - Certain genetic disorders only manifest if the individual carries two copies of the defective gene in question. Carrier testing is used to determine if a healthy individual carries a single copy of a genetic mutation, which when passed to a child might cause a genetic disease or condition.

DNA (deoxyribonucleic acid) - The chemical inside the nucleus of a cell that carries the genetic instructions for making living organisms.

Diagnostic Genetic Testing - Tests performed for diagnosis of genetic disorders in patients with symptoms or signs of an inherited disorder. These tests are used pre-natally on unborn fetuses, for diagnosis before implanting eggs after in vitro fertilization, routinely on newborns to screen for several inherited disorders, and on older children and adults who are showing symptoms of a specific disorder.

Gene - The functional and physical unit of heredity passed from parent to offspring. Genes are pieces of DNA, and most genes contain the information for making a specific protein.

Genetic Screening Testing a population group to identify a subset of individuals at high risk for having or transmitting a specific genetic disorder.

Genome - All the DNA contained in an organism or a cell, which includes both the chromosomes within the nucleus and the DNA in mitochondria.

Genotype The genetic identity of an individual that does not show as outward characteristics.

Karyotype - The chromosomal complement of an individual, including the number of chromosomes and any abnormalities. The term is also used to refer to a photograph of an individual's chromosomes.

Phenotype - The observable traits or characteristics of an organism, for example hair color, weight, or the presence or absence of a disease. Phenotypic traits are not necessarily genetic.

Predictive Genetic Testing - Testing of an asymptomatic individual for the presence of a genetic mutation association with a late-onset disorder. Predictive testing is referred to as "presymptomatic" when the presence of a genetic mutation ultimately results in a disease or condition. The test for Huntington's chorea is an example of a presymptomatic test. In contrast, "predisposition" testing is when tests for the presence of a genetic mutation are associated with an increased incidence of the condition. Recently, available tests for breast and ovarian cancer are examples of predisposition tests.

References and Resources

- Centers for Disease Control, Office of Genetics and Disease Prevention - www.c.c.gov/genetics
- Communities of Color and Genetics Policy Project - www.sph.umich.edu/genome
- GeneTests™ - www.genetests.org

- National Coalition for Health Professional Education in Genetics - www.nchpeg.org
- National Human Genome Research Institute - www.nhgri.nih.gov
- National Society of Genetic Counselors - www.nsgc.org
- HHS Secretary's Advisory Committee on Genetic Testing - www4.od.nih.gov/oba/sacgt.htm
- Genetics and Public Policy Center - www.dnapolicy.org
- Genetic Information Nondiscrimination Act (GINA) of 2008. http://www.genome.gov/24519851.
- Goldgar C. The Genetic Information Nondiscrimination Act (GINA): How PAs can protect patients and their families. JAAPA July 2010. http://www.jaapa.com/the-genetic-information-nondiscrimination-act-gina-how-pas-can-protect-patients-and-their-families/article/173485/#
- Collins FS. Preparing Health Professionals for the Genetic Revolution *JAMA*. 1997;278(15):1285-1286.
- Rackover M, Goldgar C, Wolpert C, Healy K, Feiger J, Jenkins J.Establishing Essential Physician Assistant Clinical Competencies Guidelines for Genetics and Genomics. Journal of Physician Assistant Education 2007;18 (2):47-48. http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/25416

2011-C-09 – Adopted as amended

Adopt the position paper entitled, "Health Disparities: Promoting the Equitable Treatment of All Patients."

Health Disparities: Promoting the Equitable Treatment of All Patients

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 work to

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities.
2. Increase physician assistant awareness of health disparities.
3. Create and promote health equity tools and resources for physician assistants.

4. Utilize 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.

Introduction

Health disparities are differences in health ~~**status**~~ among groups of people that are closely tied to social or demographic factors such as race, gender, income, or geographic region. Decades ago, the issue of health disparities was seen primarily as one of race and ethnicity. As the focus on health disparities has sharpened over the last decade, definitions have broadened to include gender, sexual ~~**identity and**~~ orientation, OR GENDER IDENTITY**,** ~~**disability status or special health care needs,**~~ religion, socioeconomic status, mental health, geographic location, and other characteristics typically linked to discrimination OR EXCLUSION. [1]

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

Current public policy interest in health disparities offers unprecedented opportunities for the American Academy of Physician Assistants (AAPA) and individual physician assistants (PAs) to join in global efforts to promote health equity. Increased understanding of the social determinants of health and the role that clinician beliefs and behaviors may play in disparities has made the need for increasing provider awareness and action more urgent than ever.

Mounting Evidence of Health Disparities

The release of the Institute of Medicine's (IOM) 2003 report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," provided sobering evidence of persistent, extensive health disparities. The report identified complex contributing factors including how health systems operate, bureaucratic processes, biases of health care professionals, and patients' behaviors. [2]

The National Plan for Action, currently a draft document from the National Partnership for Action to End Health Disparities, includes compelling data that substantiates the far-reaching and negative impact of health disparities on the health of

minority populations. Striking examples include disparities in cardiovascular disease, diabetes, HIV/AIDS, infant mortality, oral health, mental health, and healthcare quality and access. [3]

The American Public Health Association's brief, "Health Disparities: The Basics," offers a snapshot of data related to health disparities for broader populations: high infant mortality rates among ethnic and racial minorities, risk for obesity among people with lower income and education, cervical cancer rate among Vietnamese-American women five times higher than among Caucasian American women, and the high incidence of chronic illnesses among rural residents. [4]

ONE EXAMPLE OF THE RECENT EXPANSION OF THE DEFINITION OF DISPARITIES IS THE INCLUSION OF LESBIAN, BISEXUAL, GAY AND TRANSGENDER POPULATIONS IN THE OVERALL EXAMINATION OF HEATH DISPARITIES. A STUDY "How to Close the LGBT Health Disparities Gap," from the Center for American Progress, reports on health disparities in the lesbian, gay, bisexual and transgender populations. The report states that the LGBT population faces higher rates of cancer, mental illnesses, substance abuse, and delaying care, and lower rates for mammograms (LB), and health insurance than the adult heterosexual population. [5] ADDITIONALLY, HEALTHY PEOPLE 2020 INCLUDED LGBT DISPARITIES IN ITS OVERVIEW FOR THE FIRST TIME [1]

Social Determinants of Health

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

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

Implicit Bias and Unconscious Stereotyping

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

While still a relatively new area of research, studies have demonstrated unequal care for patients presenting to the same facilities, and seeing the same providers. [9] Clinical stereotyping can be exacerbated by the uncertainty occurring when a cultural gap between the provider and the patient occurs, as well as by increased time pressures placed on provider-patient interactions. These triggers may lead to situations where well-intentioned PAs create a discriminatory pattern of care, causing "… powerful effects on thinking and actions at an implicit, unconscious level, even among well-meaning, well-educated persons who are not overtly biased." [10]

Data from psychology research suggest that increasing provider awareness of implicit bias and stereotyping can decrease the activation of PAs' own biases. Such research supports aggressive efforts by the AAPA to increase provider awareness of bias and stereotyping, with the goal of promoting more equitable care of all patients. [11-14] The Harvard Implicit Association Test (https://implicit.harvard.edu/implicit/demo/) provides an opportunity to explore personal unconscious biases. [15]

Action Plan

Therefore the AAPA will work to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities.
2. Increase physician assistant awareness of health disparities.
3. Create and promote health equity tools and resources for physician assistants.
4. Utilize 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.

These actions are consistent with the AAPA Strategic Plan, Goal VIII, Health of the Public, which charges the Academy to demonstrate leadership in decreasing health disparities. [16]

Conclusion

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

References

1. Smedley, BD, Stith AY, Nelson AR, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press, 2003.
2. National Partnership to End Health Disparities. The National Plan for Action Draft as of February 17, 2010. Changing Outcomes - Achieving Health Equity. http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlID=31. Accessed December 28, 2010.
3. American Public Health Association. Health Disparities: The Basics. http://www.apha.org/NR/rdonlyres/54C4CC4D-E86D-479A-BABB-5D42B3FDC8BD/0/HlthDisparty_Primer_FINAL.pdf. Accessed December 28, 2010.
4. How to Close the LGBT Health Disparities. Center for American Progress. http://www.americanprogress.org/issues/2009/12/pdf/lgbt_health_disparities.pdf Accessed January 4, 2011.
5. US Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39 Accessed January 4, 2011.
6. Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. J Behav Med. 2009 Feb;32(1)20-47.

7. National Academies Press. Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare Report Brief. www.nap.edu/html/unequal_treatment/reportbrief.pdf Accessed January 31, 2011.
8. Green A, Carney D, Pallin D, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med. Sep 2007;22(9):1231-1238.
9. Todd K. Influence of ethnicity on emergency department pain management. Emerg Med (Fremantle). 2001 Sep;13(3):274-8.
10. Pomeranz H. Health Care Disparities: Stereotyping and Unconscious Bias. Physician Assistant Education Association 2008 Annual Conference Presentation. www.paeaonline.org/ht/a/GetDocumentAction/i/73940. Accessed January 25, 2011.
11. Burgess D, van Ryn M, Dovidio J, Saha S. Reducing racial bias among health care providers: lessons from social-cognitive psychology. J Gen Intern Med 2007 Jun;22(6):882-7.
12. Galinsky A, Moskowitz G. Perspective-taking: decreasing stereotype expression, stereotype accessibility, and in-group favoritism. J Pers Soc Psychol 2000 Apr;78(4):708-24.
13. Kunda Z, Spencer S. When do stereotypes come to mind and when do they color judgment? A goal-based theoretical framework for stereotype activation and application. Psychol Bull 2003 Jul;129(4):522-44.
14. Rudman L, Ashmore R, Gary M. "Unlearning" automatic biases: the malleability of implicit prejudice and stereotypes. J Pers Soc Psychol 2001 Nov;81(5):856-68.
15. Project Implicit. Implicit Association Test. https://implicit.harvard.edu/implicit/demo/ . Accessed January 4, 2011.
16. American Academy of Physician Assistants Strategic Plan. http://www.aapa.org/about-aapa/strategic-planning Accessed January 5, 2011.

2011-C-10 – Adopted

Amend by substitution policy HP-3300.1.7.1 “Health Literacy” with a new position paper entitled “Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources.”

Health Literacy: Broadening Definitions,

Intensifying Partnerships and Identifying Resources

Executive Summary of Policies Contained in this Paper

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

The American Academy of Physician Assistants believes that the physician assistant profession can participate in addressing the problems of health literacy by

- adopting expanded definitions of health literacy
- optimizing efforts to create information and communication partnerships with patients
- participating in strategic and multi-sector partnerships centered on assessing and addressing health literacy
- identifying and utilizing resources such as the US Department of Health and Human Services' Universal Precautions Toolkit and Healthy People 2020 directives.

Call to Action

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

Accordingly, the American Academy of Physician Assistants believes that the physician assistant profession can further address this critical social and medical problem by

- adopting expanded definitions of health literacy
- optimizing efforts to create information and communication partnerships with patients
- participating in strategic and multi-sector partnerships centered on assessing and addressing health literacy

- identifying and utilizing resources such as the US Department of Health and Human Services' Universal Precautions Toolkit and Healthy People 2020 directives.

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

Increased Estimates of Number of Patients Impacted

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

The increasing problem of health literacy is not surprising given the variety of tools needed to navigate the U.S. health care system and process the often complex information and treatment decisions patients face. In order to accomplish these tasks, individuals may need to be:

- visually literate (able to understand graphs or other visual information),
- computer literate (able to operate a computer),
- information literate (able to obtain and apply relevant information), and
- numerically or computationally literate (able to calculate or reason numerically). [3]

"Universal Precautions" and Health Literacy

In April 2010, the U.S. Department of Health and Human Services' Agency for Health Care Research and Quality released a *Health Literacy Universal Precautions*

Toolkit. offering primary care practices a way to assess and improve their health literacy efforts with patients.[4] The toolkit assumes that it is difficult to identify those patients who may not understand health information and instead recommends that each practice create an environment where patients of all literacy levels can thrive. [4] The resources provided in the toolkit are designed to help practices take a systematic approach to reducing the complexity of medical care and ensure that patients can succeed in the health care environment.

Expanded Understanding of Role of the Clinician

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

The AAPA encourages physician assistants to identify and utilize reliable and accurate consumer health information to encourage patient compliance and improve health education. Health education information should be evidence based and appropriate to the patient's culture and level of literacy. Provision of such resources is consistent with AAPA efforts to promote health literacy. [5]

The cultural component of this policy also reshapes the oft-held belief that health literacy is simply about reading, missing the larger context of factors that impact patient-provider communication.

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

The December 2010 release of the U.S. Department of Health and Human Services report, *Healthy People 2020*, demonstrates this conceptual shift in the view of health literacy, moving away from viewing health literacy as a patient skill-set, judged on a spectrum of “good-bad,” and “high-low.” A more partnered patient-provider approach to health care communication is emerging in national policy. This is underscored by

Healthy People 2020 Health Communication and Health Information Technology objectives found in table 1. [6]

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.

Emergency 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] 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]
- 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]
- The *National Action Plan* provides broader direction to organizations, professions, policymakers, and communities, highlighting strategies and actions that organizations and professions can take to set and achieve organizational goals. [2]
- The MLA's "Resources for Health and Information Professionals" may support clinician efforts to improve their health communication with patients.

REFERENCES

1. Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). Health literacy: A prescription to end confusion. Washington, DC: National Academies Press.
2. Department of Health and Human Services' Office of Disease Prevention and Health Promotion. *National Action Plan to Improve Health Literacy.* http://www.health.gov/communication/hlactionplan/pdf/Health_Lit_Action_Plan_Summary.pdf Accessed December 12, 2010.
3. National Network of Libraries of Medicine. Health Literacy. http://nnlm.gov/outreach/consumer/hlthlit.html#A6 . Accessed December 12, 2010.
4. Agency for Healthcare Research and Quality. Health Literacy Universal Precautions Toolkit. http://www.ahrq.gov/qual/literacy/. Accessed December 25, 2010.
5. AAPA Policy Manual, HP-3300.1.7.2. http://www.aapa.org/images/stories/documents/about_aapa/policymanual/2010-11_ProfessionSection.pdf Accessed December 20, 2010.
6. US Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=18 Accessed January 4, 2011.
7. Shipman JP, Kurtz-Rossi S, Funk CJ. The health information literacy project. J Med Libr Assoc. 2009 Oct;97(4):293-301.

2011-C-11 – Adopted as amended

Amend policy HP-3700.3.1 to read as follows:

1. PAs should establish and maintain the appropriate physician-PA team.
2. PAs should accurately represent their skills, training, professional credentials, identity, or service both directly and indirectly.
3. PAs should provide only those services for which they are qualified via their education and/or experiences, and in accordance with all pertinent legal and regulatory processes.
4. PAs should respect the culture, values, beliefs, and expectations of the patients, local health care providers, and the local health care systems.

5. ~~PAS SHOULD BE TOLERANT OF THE ROLE OF THE TRADITIONAL HEALER WHEN IT DOES NOT INTERFERE WITH THE QUALITY OF CARE BEING RENDERED TO THE PATIENT.~~

   PAS SHOULD BE AWARE OF THE ROLE OF THE TRADITIONAL HEALER AND SUPPORT A PATIENT'S DECISION TO UTILIZE SUCH CARE.

6. PAs should take responsibility for being familiar with, and adhering to the customs, laws, and regulations of the country where they will be providing services.
7. When applicable, PAs should identify and train local personnel who can assume the role of providing care and continuing the education process.
8. PA ~~TRAINEES~~ **STUDENTS** REQUIRE THE SAME SUPERVISION ABROAD AS THEY DO DOMESTICALLY.
9. PAS SHOULD PROVIDE THE BEST STANDARDS OF CARE AND STRIVE TO MAINTAIN QUALITY ABROAD.
10. ~~EXPIRED MEDICATIONS AND SUPPLIES SHOULD NOT BE USED~~ ~~**IN ACCORDANCE WITH WORLD HEALTH ORGANIZATION GUIDELINES UNLESS RESTRICTED BY LOCAL REGULATIONS**~~.
11. SUSTAINABLE PROGRAMS THAT INTEGRATE LOCAL PROVIDERS AND SUPPLIES SHOULD BE THE GOAL.
12. ~~PAS SHOULD INSIST THAT WITHIN THE MEDICAL TEAM NON-MEDICAL VOLUNTEERS HAVE~~ ~~**THE COMPETANCIES AND APPROPRIATE SUPERVISION NEEDED FOR THE TASKS FOR WHICH THEY ARE ASSIGNED. NON-MEDICAL RESPONSIBILITIES**~~**.**

    PAS SHOULD ASSIGN MEDICAL TASKS TO NONMEDICAL VOLUNTEERS ONLY WHEN THEY HAVE THE COMPETENCY AND SUPERVISION NEEDED FOR THE TASKS FOR WHICH THEY ARE ASSIGNED.

2011-C-12 – Adopted as amended

Amend policy HP-3300.1.18 to read as follows:

AAPA BELIEVES EVALUATION OF MENTAL HEALTH AND APPROPRIATE DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS AND CONSIDERATION OF PATIENTS' MENTAL HEALTH ARE ESSENTIAL TO OVERALL PATIENT WELL BEING AND IMPROVED HEALTH OUTCOMES. The AAPA believes that optimal health **IS COMPOSED OF** ~~is equally of mental health and physical health.~~ ~~**A STATE OF COMPLETE**~~ PHYSICAL, MENTAL AND SOCIAL WELL-BEING AND NOT MERELY THE ABSENCE OF DISEASE OR INFIRMITY.

2011-C-13 – Adopted

Amend policy HP-3900.1.2 to read as follows:

AAPA BELIEVES ~~To preserve the quality of their performance,~~ physician assistants have a responsibility to maintain their own health and wellness, including mental health, by preventing and treating acute and chronic disease including mental illness, disabilities and occupational stress.

2011-C-14 – Adopted as amended

Amend policy HP-3300.2.5 to read as follows:

AAPA encourages physician assistants to ~~practice in~~ PROVIDE CARE FOR medically underserved POPULATIONS AND/OR PRACTICE IN MEDICALLY UNDERSERVED areas. ~~both domestic and foreign.~~

2011-C-15 – Adopted as amended

Amend policy HP-3300.2.7 to read as follows:

AAPA BELIEVES PHYSICIAN ASSISTANTS SHOULD CONTINUALLY WORK TOWARDS ACQUIRING THE KNOWLEDGE, ~~AND~~ SKILLS AND ATTITUDES ~~AS WELL AS ASSIMILATING THE BEHAVIORS AND ATTITUDES~~ NEEDED TO PROVIDE CULTURALLY COMPETENT ~~that, during physician assistant education and through lifelong learning, physician assistants should acquire the knowledge, develop the skills, and assimilate the behaviors and attitudes that are necessary to provide~~ care for patients with a wide variety of cultural attributes.

2011-C-16 – Adopted as amended

Amend policy HP-3800.1.4 to read as follows:

AAPA believes that physician assistants should honorably conduct their professional duties WITH TRANSPARENCY IN ACCORDANCE WITH APPROPRIATE PATIENT PRIVACY PROTECTION and that ~~judgment~~ EVALUATION of their performance should be ~~done~~ ASSESSED by ~~peers who~~ ~~utilize~~ ~~good faith~~ ~~STANDARD~~ peer-review practices.

2011-C-17 - Adopted

Amend by deletion policy HP-3300.1.11 and amend policy HP-3900.1.1 to read as follows:

~~HP-3300.1.11~~
~~All physician assistants should use the standard and transmission based precautions recommended by the Centers for Disease Control and Prevention (CDC) for preventing the spread of infectious diseases.~~

The AAPA believes that ~~physician assistants and other health care workers, including students, who might be at risk of contact with infected blood or other body fluids must be afforded all available and practical protection to assure a low level of personal risk of occupational infection.~~ ALL PHYSICIAN ASSISTANTS SHOULD USE THE STANDARD AND TRANSMISSION-BASED PRECAUTIONS RECOMMENDED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) FOR PREVENTING THE SPREAD OF INFECTIOUS DISEASES. AAPA BELIEVES ~~E~~employers should establish procedures to ensure that standard precautions and ~~all~~ other applicable infection control measures are enforced and that educational programs covering proper infection control procedures are available for all health care workers. Employers should ensure that timely post-exposure counseling and prophylaxis, in accordance with relevant CDC and OSHA guidelines, are available to health care workers, ~~including students~~, after an exposure.

2011-C-18 – Rejected

Amend policy HP-3300.2.2 to read as follows:

AAPA recognizes and encourages the active participation of physician assistants in policy making, administration, government affairs, research, EDUCATION OF THE PUBLIC AND PHYSICIANS REGARDING THE ROLES AND RESPONSIBILITIES OF PHYSICIAN ASSISTANTS and other non-clinical roles.

2011-C-19 – Adopted

Amend policy HP-3600.1.5 to read as follows:

The AAPA shall educate the following groups to promote equitable reimbursement for physician services provided by PAs: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), third-party payers, employers, third-party administrators, and health benefit design organizations.

2011-C-20 – Adopted

Amend policy HX-4400.3.1 to read as follows:

AAPA ~~encourages Congress to appropriate funds to~~ supportS continued research and development to ensure the following.

- To improve understanding of the epidemiology, pathogenesis, and treatment of the diseases caused by chemical, biological, radiological, and nuclear agents
- New and more effective medical countermeasures, such as; vaccines, pharmaceuticals, and antidotes
- Enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes.

To improve the detection and defense capabilities against chemical, biological, radiological, and nuclear agents.

2011-C-21 – Adopted

AAPA believes it is vital to track the volume and quality of medical and surgical services provided by PAs to assess the impact of those services on patients and on the health care system. To facilitate that effort, AAPA supports the recognition of, and direct payment to, PAs by public and private third party payers and health care organizations. AAPA is committed to maintaining the established supervising physician-PA relationship that is a central concept in the physician assistant profession and incorporated into every state's law.

2011-C-22 – Adopted as amended

AAPA supports legislation that bans the NON-EMERGENT USE of hand-held telecommunication devices while operating a moving vehicle. ~~except in emergency situations.~~

2011-C-23 – Adopted as amended

Amend the position paper entitled "Guidelines for State Regulation of the Physician Assistant Profession" as follows:

Guidelines for State Regulation of Physician Assistants

Introduction

Recognition of physician assistants (PAs) as health care providers led to development of state laws and regulations to govern their practice. Inclusion of physician assistants 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, and (2) to define the role of PAs in the health care 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 physician assistant statutes and regulations enable appropriate use of physician assistants as health care 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 health care climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible utilization of PA services 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 physician assistants. To see how these

concepts can be adapted into legislative language, please consult the AAPA's model state legislation for physician assistants.

Definition of Physician Assistant

The state law must include a definition of physician assistant in order to differentiate PAs from the many others who assist physicians. The legal definition of physician assistant 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 physician assistants 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.

Accreditation

Physician assistant programs were originally accredited by the American Medical Association's Council on Medical Education (1972-1976), which turned over its responsibilities to the AMA's Committee on Allied Health Education and Accreditation (CAHEA) in 1976. CAHEA was replaced in 1994 by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). On January 1, 2001, the Accreditation Review Commission on Education for the 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.

Because the law must recognize the eligibility for licensure of PAs who graduated from programs accredited by the earlier agencies, the definition of physician assistants should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies, CAHEA or CAAHEP.

Certification

The definition of physician assistant should also refer to those individuals who have passed the physician assistant national certifying examination administered by the National Commission on Certification of Physician Assistants. No other certifying body or examination should be considered equivalent to the NCCPA or the PANCE.

Exceptions

The NCCPA, since 1986, has allowed only graduates of accredited PA programs to take its examination. However, between1973-1986, the exam was open to individuals who had practiced as PAs in primary care for four of the previous five years, as documented by their supervising physician. Nurse practitioners and graduates of unaccredited PA programs were also eligible for the exam. An exceptions clause should be included to make these individuals eligible for licensure.

Licensure

When a regulatory board has verified a PA's qualifications, it should issue a license to the applicant. Although, in the past, registration and certification have been used as the regulatory term for PAs, licensure is now the most prevalent designation and system. This is appropriate because licensure is the most stringent form of regulation. Practice without a license is subject to severe penalties. Licensure both protects the public from

unqualified providers and utilizes a regulatory term that is easily understood by health care consumers. Licensure does not imply nor create independent practice for physician assistants. The profession retains its commitment to PA practice with physician supervision.

Licensure should be independent of identification or approval of supervising physicians or supervisory arrangements and independent of employment. A category of inactive licensure should be available for PAs who are not currently in active practice in the state. If issuance of a full license requires approval at a scheduled meeting of the regulatory agency, a temporary license should be available to applicants who meet all licensure requirements but are awaiting the next meeting of the board.

If the board uses continuous clinical practice as a requirement for licensure, it should recognize the nature of PA practice when determining requirements for PAs who are reentering clinical practice (defined as a return to clinical practice as a physician assistant following an extended period of clinical inactivity). Physician assistants uniformly practice with physician supervision; reentry provisions the board designs for physicians may not be appropriate for PAs. Each PA reentering clinical practice will have unique circumstances. Therefore, the board should be authorized to customize requirements imposed on PAs reentering clinical practice. Acceptable options could include requiring current certification, mandating specific requirements for supervision, or temporary authorization to practice for a specified period of time**.** Although it has not yet been determined conclusively that absence from clinical practice is associated with a decrease in competence, there is concern that this is the case. Reentry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

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

Supervision

The definition of supervision should convey the idea that direction of the medical practice of the physician assistant is provided and assured by supervising physicians, but that this does not necessarily require the physical presence of a supervising physician at the place where services are rendered. It is imperative, however, that the PA and a supervising physician are or can be in contact with each other by telecommunication.

Supervising physician should be defined as an allopathic or osteopathic physician (MD or DO) licensed to practice in the state, who accepts responsibility for the supervision of services provided by physician assistants. In solo practice settings, provisions should be made for alternate supervision in the supervising physician’s absence. In group practice situations or in the hospital or its emergency department provisions should be made for all staff physicians who so choose to supervise PAs who practice in the group or institution. Physician assistants should not see the patients of physicians who do not wish PAs to see their patients.

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

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

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

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

Employment and supervision should be regarded as separate entities. A physician’s ability to supervise a physician assistant is independent of the specifics of PA employment. In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and physician assistants may be employees of the same hospital or health system. In some situations the physician assistant may be part or sole owner of a practice. PA practice owners may be the employers of their supervising physicians.

To allow for flexibility and creativity in tailoring health care systems that meet the needs of specific patient populations, a variety of practice ownership and employer-employee relationships should be available to physicians and to PAs. The physician-PA relationship is built on trust, respect, and appreciation of the unique role of each team member. No licensee should allow an employment arrangement to interfere with sound clinical judgment or to diminish or influence their ethical obligations to patients. State law provisions should authorize the regulatory authority to discipline a physician or a

physician assistant who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

Physician assistants should be allowed to provide medical care in disaster and emergency situations. This may require the state to adopt language exempting PAs from supervision provisions when they respond to medical emergencies that occur outside the place of employment. This exemption should extend to physician assistants who are licensed in other states or who are federal employees. Physicians who supervise physician assistants in such disaster or emergency situations should be exempt from routine documentation or supervision requirements. Physician assistants should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

Scope of Practice
State law should permit utilization of PA services in a wide variety of practice settings. In general, physician assistants should be permitted to provide any legal medical service that is delegated to them by the supervising physician when the service is within the PA's skills and is provided with supervision of a physician. A list of specific tasks is overly restrictive and should be avoided. A PA's skills should not be utilized to extend the scope of the supervising physician beyond what is reasonable in the practice. Education of physician assistants, like that of physicians, promotes the development of practical skills in clinical problem solving and decision making. For this reason, the use of written clinical protocols should not be required as part of state laws or regulations delineating physician assistant scope of practice. Protocols are useful for dealing with very specific clinical entities (e.g., anaphylaxis). However, protocols by their nature are rigid and rapidly outdated. Extensive clinical protocols are useful to PAs to the same extent that they are useful to physicians. They should be utilized as indicated in the clinical setting, but should not be mandated by state law or regulation.

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

Prescribing and Dispensing
The ability to prescribe medications should be one of the medical services that physicians may delegate to physician assistants. 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. Physician assistants who are delegated prescribers of controlled medications should register with the federal Drug Enforcement Administration.

Physician assistant education includes extensive training in pharmacology and clinical pharmacotherapeutics. Additional training, education or testing should not be required as a prerequisite to physician assistant prescriptive authority. Limited dispensing is also appropriate for delegation to physician assistants. 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 physician assistants just as they are to physicians for the management of clinical problems.

TITLE AND PRACTICE PROTECTION
THE ABILITY TO UTILIZE THE TITLE OF "PHYSICIAN ASSISTANT" **OR "ASOCIADO MÉDICO" WHEN THE PROFESSIONAL TITLE IS TRANSLATED INTO SPANISH** SHOULD BE LIMITED TO THOSE WHO ARE ~~LICENSED~~ ~~RECOGNIZED~~ **AUTHORIZED** TO PRACTICE **BY THEIR STATE** ~~MEDICAL BOARD~~ AS A PHYSICIAN ASSISTANT. THE TITLE MAY ALSO BE UTILIZED BY THOSE WHO ARE EXEMPTED FROM STATE LICENSURE BUT WHO ARE CREDENTIALED AS A PHYSICIAN ASSISTANT BY A FEDERAL EMPLOYER **AND BY THOSE WHO ARE FACULTY AT AN ARC-PA ACCREDITED PHYSICIAN ASSISTANT PROGRAM AND MEET ALL QUALIFICATIONS FOR LICENSURE IN THE STATE BUT ARE NOT CURRENTLY LICENSED**. ~~LIKEWISE,~~ A PERSON WHO IS NOT ~~LICENSED~~ **AUTHORIZED TO PRACTICE** AS A PHYSICIAN ASSISTANT SHOULD NOT ~~BE AUTHORIZED TO~~ ENGAGE IN PHYSICIAN ASSISTANT PRACTICE UNLESS SIMILARLY CREDENTIALED BY A FEDERAL EMPLOYER. THE STATE SHOULD HAVE THE CLEAR AUTHORITY TO IMPOSE PENALTIES ON INDIVIDUALS ~~NEITHER LICENSED BY THE STATE NOR CREDENTIALED BY A FEDERAL EMPLOYER AS A PHYSICIAN ASSISTANT WHO USE THE TITLE "PHYSICIAN ASSISTANT," OR PRACTICE AS SUCH.~~ WHO VIOLATE THESE PROVISIONS.

Regulatory Agencies
Each state must define the regulatory agency responsible for implementation of the law governing physician assistants. A variety of state agencies can be charged with this task. 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 physician assistants, 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 a group of members who are knowledgeable about physician assistant education, certification, and practice. Consideration should be given to including members who are representative of a broad spectrum of health care settings — primary care, specialty care, institutional and rural based practices.

A number of states have created separate PA licensing boards. Such boards should be composed primarily of physician assistants and supervising physicians. If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that physician assistants and physicians who supervise PAs be constituent members of the board. It is also recommended in these situations that physician assistant advisory committees be established and actively utilized to assure PA participation in the regulatory process.

Any state regulatory agency charged with PA licensure should be sensitive to the manner in which it makes information available to the public. Consumers should be able to obtain information on health professionals from the licensing agency, but the agency must

assure that information released does not create a risk of targeted harassment for the PA licensee or their family.

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public's right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public.

Licensee profiles should contain only information that is useful to consumers in making decisions about their health care professional. Health care professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

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

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

2011-C-24 - Adopted

Amend policy HX-4600.5.2 to read as follows:

AAPA supports ~~a Medicare~~ prescription drug benefit planS that ~~is~~ ARE universal, mandatory for all beneficiaries, integrated into the basic benefit package, ~~is~~ ARE not a financial hardship to beneficiaries, include~~s~~ catastrophic coverage, ~~has~~ HAVE a defined, comprehensive benefit, and permit~~s~~ health care providers to select medications using appropriate medical judgment that includes consideration of cost effectiveness, safety, and efficacy.

2011-C-25 – Adopted

The House of Delegates recommends to the Board of Directors the following policy changes:

Amend policy HA-2400.4.1 to read as follows:

AAPA shall advocate for laws, regulations, and policies supportive of the use of PAs in providing quality, cost-effective and accessible health care.

AAPA shall promote to all appropriate stakeholders:

- Optimal utilization of physician assistants as a cost effective way to provide quality care by improving patient access and enhancing continuity.
- The flexibility and responsiveness of the profession in meeting the changing needs of the health care marketplace.
- The opportunity to reduce health care disparities through the utilization of PAs as part of health delivery teams.

AAPA will be at the forefront of research on physician assistants. AAPA is committed to the collection and dissemination of information about physician assistants in order to ensure the future of the profession. AAPA will promote a research agenda that includes optimum utilization of PAs within the healthcare workforce, productivity, and quality outcomes.

AAPA shall educate and serve as a resource to all stakeholders on issues concerning reimbursement for services provided by PAs.

AAPA will be responsive to the needs of its members and its constituent components. AAPA programs and services will meet the personal and professional needs of PAs. AAPA recognizes and encourages the active participation of physician assistants in policy making, administration, government affairs, research, and other non-clinical roles.

These activities will be incorporated and prioritized as part of AAPA's strategic planning process.

And be it further resolved; amend by deletion the following policies:

~~HA-2400.4.1~~

~~Government policies will be supportive of the use of PAs in providing quality, cost-effective and accessible health care.~~

~~The PA profession will respond to the public's changing health care needs.~~

~~PAs will have a cooperative relationship with other health providers.~~

~~PAs will adhere to the professional and ethical standards of excellence.~~

~~The public will understand the role of PAs in health care delivery.~~

~~AAPA will be responsive to the needs of its members and its constituent components.~~

~~The PA profession will respect the diversity of all people.~~

~~AAPA programs and services will meet the personal and professional needs of PAs.~~

~~AAPA will have financial and human resources to achieve its mission.~~

~~HA-2400.3.1~~

~~AAPA is committed to the collection and dissemination of information about physician assistants in order to ensure the future of the profession.~~

2011-C-26 - Adopted as amended

The AAPA encourages all physician assistants ~~(PAs)~~ to take aN ACTIVE ~~leadership~~ role in the screening, PREVENTION**,** management, and referral of patients for oral health disease. ~~in the primary care setting.~~

2011-C-27 – Adopted as amended

~~HX-4600.1.5~~

~~AAPA encourages individual physician assistants to contribute their time and efforts toward eliminating health care disparities.~~

The following resolutions will need AAPA Board of Directors ratification. The outcomes will be reported to the House of Delegates via a separate communication.

2011-A-02 – Adopted as amended**

Amend AAPA Bylaws to read as follows describing the Board of Directors' responsibilities related to the implementation of the policy established by the House of Delegates.

ARTICLE VII Board of Directors and Officers of the Corporation.

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

a. To ~~establish such Academy policies~~, grant such charters to Chapters, recognize such CAUCUSES AND specialty physician assistant organizations, and establish such Academy commissions or work groups as may be in the best interests of the Academy, TAKING INTO CONSIDERATION ANY RECOMMENDATIONS OF THE HOUSE OF DELEGATES THEREON;
b. To appoint or remove the Executive Vice President pursuant to the affirmative vote of a two-thirds (2/3) majority of the Directors;
c. To direct the activities of the Academy's national office through the Executive Vice President;
d. To provide for the management of the affairs of the Academy in such a manner as may be necessary or advisable;
e. To establish committees necessary for the performance of its duties;
f. To establish, regularly review and update the Academy's management plan to attain the goals of the Academy;
g. To call special meetings of the House of Delegates as provided under Article VI, Section 4;
h. To report the activities of the Board of Directors for the preceding year to the House of Delegates and members at the Academy's annual meeting;
i. To establish the amount and timing of Academy membership dues and assessments;
~~j.~~ TO REVIEW AND DETERMINE, ON NO LESS THAN AN ANNUAL BASIS, HOW TO IMPLEMENT THOSE POLICIES ENACTED BY THE HOUSE OF DELEGATES ON BEHALF OF THE ACADEMY THAT ESTABLISH THE COLLECTIVE VALUES, PHILOSOPHIES, AND PRINCIPLES OF THE PHYSICIAN ASSISTANT PROFESSION. IF IT DETERMINES THAT IMPLEMENTATION OF ONE OR MORE SUCH POLICIES WILL REQUIRE AN INADVISABLE EXPENDITURE OF ACADEMY RESOURCES, OR IS OTHERWISE NOT PRESENTLY PRUDENT OR FEASIBLE, THE BOARD SHALL, AT ITS EARLIEST CONVENIENCE, REPORT TO THE HOUSE THE REASONS FOR ITS DECISION.
~~k. TO ENACT INTERIM POLICIES ESTABLISHING THE COLLECTIVE VALUES, PHILOSOPHIES, AND PRINCIPLES OF THE PHYSICIAN ASSISTANT PROFESSION IN BETWEEN MEETINGS OF THE HOUSE OF DELEGATES. A REPORT JUSTIFYING THE NEED FOR ANY INTERIM POLICY SHALL BE DISTRIBUTED TO ALL MEMBERS OF THE HOUSE OF DELEGATES WITHIN FORTY-FIVE (45) DAYS OF ENACTMENT. INTERIM POLICIES SHALL BE PRESENTED FOR FINAL APPROVAL BY THE HOUSE OF DELEGATES AT ITS NEXT REGULAR MEETING.~~

2011-A-03 – Rejected**

Amend AAPA Bylaws to read as follows:

ARTICLE VII Board of Directors and Officers of the Corporation.

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

a. To establish such Academy policies, grant such charters to Chapters, recognize such specialty physician assistant organizations, and establish such Academy commissions or work groups as may be in the best interests of the Academy;
b. To appoint or remove the Executive Vice President pursuant to the affirmative vote of a two-thirds (2/3) majority of the Directors;
c. To direct the activities of the Academy's national office through the Executive Vice President;
d. To provide for the management of the affairs of the Academy in such a manner as may be necessary or advisable;
e. To establish committees necessary for the performance of its duties;
f. To establish, regularly review, and update the Academy's management plan to attain the goals of the Academy;
g. To call special meetings of the House of Delegates as provided under Article VI, Section 4;
h. To report the activities of the Board of Directors for the preceding year to the House of Delegates and members at the Academy's annual meeting;
i. To establish the amount and timing of Academy membership dues and assessments.

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

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

Section 4: Duties of Officers of the Corporation.

a. The President shall be the chief spokesperson for the Academy. The President shall report to the House of Delegates and the members at the annual meeting of the Academy with an account of the activities of the Board for the past year and its recommendations for the House of Delegates.
b. The President-elect shall succeed to the office of President at the expiration of the President's term or earlier should that office become vacant for any reason.
c. The Vice President is the Speaker of the House of Delegates and shall represent the House of Delegates to the Board of Directors and shall perform such other duties as shall be assigned by the Board of Directors.
d. The Secretary-Treasurer shall:
    1. be responsible for adequate and proper accounts of the properties and funds of the Academy;
    2. give a full report to the membership at the annual meeting;
    3. 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;
    4. disburse the funds of the Academy as may be ordered by the Board of Directors;
    5. 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;
    6. maintain the records of the Academy including the records of the Board of Directors and of the House of Delegates;
    7. execute the general correspondence;
    8. attest the signature of the Academy Officers;
    9. affix the corporate seal on documents so requiring; and
    10. have such other powers and perform such other duties as may be prescribed by the President or the Board of Directors.
e. The Immediate Past President shall perform such other duties as may be assigned by the President or the Board of Directors.

Section 5: Meetings of the Board of Directors.

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

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

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

e. Action by Unanimous Written Consent. Any action required to be taken at a meeting of the Board of Directors or any action which may be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action so taken, is signed by all of the Directors entitled to vote with respect to the subject matter thereof. A Director's consent to action taken without a meeting may be in electronic form and delivered by electronic means.

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

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

Section 8: Resignation or Removal of Directors and Officers of the Corporation. Any Director or Academy Officer may resign at any time by giving written notice to the President or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any Director-at-large, Student Director, or Academy Officer (excluding the Vice President) may be removed from office at any time, with or without cause, by the affirmative majority vote of those members entitled to elect them. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the Director or Officer. Vacancies in these positions shall be filled in accordance with Article XII, Section 11 of these Bylaws. Removal of the Vice President/Speaker shall be done in accordance with Article VI, Section 3 of these Bylaws pertaining to House Officers.

2011-A-05 – Adopted as amended**

Amend AAPA Bylaws to read as follows:

Article XII Elections

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker. (The individual elected Speaker of the House of Delegates shall also serve, by virtue of such position, as Vice President of the Academy.) 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. All other elected positions shall be filled in the manner prescribed by this Article XII.

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.

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 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:
   i. An AAPA or constituent organization officer, board member, ~~or~~ COMMITTEE, COUNCIL, commission, work group, or task force chair
   ii. A delegate or alternate to the AAPA House of Delegates
   iii. PA Foundation, Society for the Preservation of Physician Assistant History, ~~or~~ American Academy of Physician Assistants Political Action Committee trustee or committee chair, PHYSICIAN ASSISTANT EDUCATION ASSOCIATION BOARD MEMBER OR COMMITTEE CHAIR, OR NATIONAL COMMISSSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS COMMISSION MEMBER
   iv. AAPA board appointees.

2011-A-07 – Adopted**

The AAPA should continue financial support for the Society for the Preservation of Physician Assistant History as an Organizational Sponsor.

2011-B-01 – Adopted as amended**

Delete policy HA-2200.1.3 in its entirety.

~~IN CONJUNCTION WITH THE AAPA LEADERSHIP YEAR, the time when constituent organization officers may take office may be either January or WILL BE ON July 1 AND CONTINUE THROUGH JUNE 30. However, constituent organizations are encouraged to have a standard term of office for their elected officers beginning July 1 and continuing through June 30.~~

2011-B-02 – Adopted as amended**

Amend policy HA-2200.5.12 to read as follows:

~~Constituent chapters ORGANIZATIONS~~ **ALL OTHER CAUCUSES, CHAPTERS, AND SPECIALTY ORGANIZATIONS** are encouraged to provide unused exhibit space or other display space near the exhibit area at no charge or at a reduced rate on a first-come, first-served basis TO CAUCUSES**.**

2011-B-03 – Adopted**

CRC makes recommendations to the HOD to recommend approval and adoption by the AAPA Board of Directors for the following:

Approve and charter:

- Jewish American Physician Assistant Caucus
- Physician Assistants in Hospice and Palliative Medicine Specialty Organization

Approve the name change of:

- Asian and Pacific Islander Physician Assistant Caucus name change to Asian & Middle Eastern Physician Assistant Caucus

Approve the disbandment of:

- Physician Assistants in Community College
- Physician Assistants AIDs Network Caucus*

<u>New Business</u>

2011-E-01 - Adopted as amended

The AAPA supports efforts to help US military veteran medics AND HOSPITAL CORPSMEN become PAs.

Resolutions of Condolence

2011-COND-01

Resolution of Condolence for Norine L. Friell

WHEREAS the Wisconsin Academy of Physician Assistants, the health care community of LaCrosse Wisconsin, the AAPA House of Delegates, and the PA profession as a whole suffered a loss with the death of Norine L. Friell on April 9, 2011 and

WHEREAS Norine exemplified the positive qualities, characteristics and attributes of a dedicated physician assistant: service to others, service to country, service to profession.

WHEREAS Norine demonstrated her dedication to the profession by holding several positions including WAPA President and WAPA representative to the AAPA House of Delegates.

WHEREAS Norine demonstrated her service to country as a Medic in the U.S. Air Force both active duty and in the Reserve.

WHEREAS Norine's passion for education led her to teach at the University of Wisconsin LaCrosse Physician Assistant Program. Norine served as a role model and mentor to countless PAs and PA students through her completely selfless giving to others - therefore be it

Resolved that the House of Delegates of the American Academy of Physician Assistants recognize Norine Friell's many contributions to WAPA, PA education and the PA profession as a whole and be it further

Resolved that a copy of this resolution be provided to her family with deepest sympathy from the members of the American Academy of Physician Assistants.

2011-COND-02

Resolution of Condolence for Jesse Craton Edwards

WHEREAS, Jesse Craton Edwards passed away on May 10, 2011, at the age of 83; and

WHEREAS, Jesse Craton Edwards was a national pioneering leader of physician assistant Programs; and

WHEREAS, Jesse Craton Edwards was the cofounder of the physician assistant program at the University of Nebraska Medical Center, Omaha, Nebraska; and

WHEREAS, Jesse Craton Edwards had a distinguished 23-year career in the United States Air Force (USAF), working as a health care provider and in medical administration; and

WHEREAS, Jesse Craton Edwards served in Washington, D.C. with the USAF Surgeon General's Office where he was a member of a select group of manpower specialists he played a

significant role in establishing the first every scientific approach to determining the manpower specialty mix for Air Force medical treatment facilities; and

WHEREAS, Jesse Craton Edwards served as President of the Physician Assistant Education Association (PAEA) from 1988 – 1989; and

WHEREAS, Jesse Craton Edwards developed and implemented the use of the first computerized test item bank specifically intended to assist physician assistant students in self-evaluation efforts and was used by almost all physician assistant programs for the purpose of evaluating student cognitive clinical knowledge; and

WHEREAS, Jesse Craton Edwards served as a consultant to several emerging physician assistant programs, and service to the ARC-PA Accreditation Organization; and

WHEREAS, Jesse Craton Edwards designed and implemented a distance learning program for Master of Physician Assistant Studies (MPAS) degree in 1992; and

WHEREAS, Jesse Craton Edwards was a well-known advocate for military physician assistants; and

WHEREAS, Jesse Craton Edwards was recognized for his contributions to USAF physician assistants in the creation of the “Jesse C. Edwards Outstanding Company Grade Physician Assistant of the Year Award”; and

WHEREAS, Jesse Craton Edwards is an Honorary Member of the American Academy of Physician Assistants, the Nebraska Academy of Physician Assistants, the Society of Air Force Physician Assistants and the Society of Army Physician Assistants; and

WHEREAS, Jesse Craton Edwards received the Outstanding Service Award of the School of Allied Health Professions, the University of Nebraska Medical Center Distinguished Teacher Award, and the University of Nebraska Medical Center Certificate of Outstanding Professional Achievement; and

WHEREAS, Jesse Craton Edwards received a Lifetime Achievement Award from the American Academy of Physician Assistant’s Veterans Caucus and was made an honorary Admiral in the Navy of the Great State of Nebraska; and

WHEREAS, Jesse Craton Edwards received the Physician Assistant Education Association and Physician Assistant Presidential Award; and

Resolved that the House of Delegates of the American Academy of Physician Assistants recognizes Jesse Craton Edwards for his many contributions to the PA profession.

2011-COND-03

Resolution of Condolence for David Glen Askins, Jr., MD

WHEREAS the South Carolina Academy of Physician Assistants and the Medical University of South Carolina has suffered the tremendous loss of Dr. Glen Askins upon his death on May 1, 2011, and,

WHEREAS Dr. Askins as a family physician and influential South Carolina physician was instrumental in the re-establishment of the physician assistant program at the Medical University and provided the leadership as the very active medical director and supportive department chairman for 14 years, and

WHEREAS Dr. Askins was instrumental in teaching the fundamentals of medicine to over 600 PAs who are currently providing care to more than one million patients, positively impacting healthcare, and

WHEREAS upon his retirement for MUSC, Dr. Askins continued to share his expertise and passion for PA education as the interim program director in 2008-09 at the University of New England, and

WHEREAS Dr. Askins was supportive of the PA profession and actively advocated for physician assistants in South Carolina and beyond, be it,

Resolved, that the House of Delegates of the AAPA recognize Dr. Glen Askin's many contributions to the physician assistant profession and education, and be it further,
Resolved, that a letter of condolence and gratitude of the members of the AAPA be sent to his family.

2011-COND-04

Resolution of Condolence for Radford J. Hayden, PA-C

WHEREAS the AAPA, the House of Delegates, the Michigan Academy of Physician Assistants, the University of Michigan and physician assistants nationwide suffered the tremendous loss of Radford J. Hayden, PA-C in February, 2011 and

WHEREAS Rad exemplified the concept of selfless service to others throughout his life and

WHEREAS Rad devoted countless hours to the professional education of both physician assistants and physicians and

WHEREAS Rad's fearless defense of the moral and ethical underpinnings by which he led his life and exemplified to others and

WHEREAS Rad served as an outstanding example of balance between work, family and leadership to all, therefore be it

Resolved that the House of Delegates of the American Academy of Physician Assistants recognize Radford Hayden's many contributions to the AAPA, MAPA, students, physicians and the physician assistant profession as a whole, and be it further

Resolved that a copy of this resolution be provided to Rad's family with the deepest sympathy and gratitude of the members of the American Academy of Physician Assistants.

House Elections 2011	**Results**
Vice President/Speaker	Alan Hull
First Vice Speaker	L. Gail Curtis
Second Vice Speaker	David Jackson
Nominating Work Group	Rachel Carlson Maryann Ramos John Trimbath

(The vote tabulation report is on file and available at the AAPA national office.)