

1                                   **Association of Physician Assistant Programs**  
2                                   **Degree Task Force**  
3                                   **Final Paper – September 28, 2000**  
4

5    **Background**

6    At the direction of the APAP membership during its May 1998 business meeting in Salt  
7    Lake City, Utah, then-APAP President Walter Stein commissioned a Degree Task Force  
8    to develop recommendations regarding the issue of the entry-level degree for the  
9    physician assistant (PA) profession. The specific charges to the Task Force included a  
10   charge to “make a recommendation to the Board of Directors of APAP as to what the  
11   generally accepted entry-level credential for PA profession should be.” (The complete list  
12   of charges appears in Appendix A.) Appointments to the Task Force were made by the  
13   APAP Board of Directors, which selected individuals representing a broad cross-section  
14   of member programs, and included representation from the American Academy of  
15   Physician Assistants (AAPA) and the Student Academy of the American Academy of  
16   Physician Assistants (SAAAPA). The APAP membership also requested that an  
17   employer and physician be included on the Task Force. The APAP Degree Task Force  
18   was chaired by Anthony A. Miller, M.Ed., PA-C (Medical College of Ohio), and had as  
19   members:

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21                   Linda Allison, MD – Chatham College PA Program, Pennsylvania  
22                   Leslie Ellwood, MD – Kaiser Permanente, Virginia  
23                   Susann Galloway, PA-C – Advocate Health Center, Illinois  
24                   Erin Fitzpatrick Lepp, PA-C – Emory University PA Program, Georgia  
25                   Terry Scott, PA-C – Medex Northwest PA Program, Washington  
26                   Donna Sewell, PA-C – The Community College of Baltimore County–Essex PA  
27                   Program, Maryland  
28                   Jennifer Huey-Voorhees – SAAAPA Representative  
29                   David Asprey, PA-C – AAPA Representative  
30                   Ray Johnson, PA-C – AAPA Representative  
31                   Jonathan Skillings, PA-C – AAPA Representative  
32

33    The degree issue has for many years been debated widely within the PA profession at  
34    large. In the late 1990s it came under formal scrutiny again with two resolutions put  
35    before the AAPA House of Delegates. AAPA policy at that time endorsed the  
36    baccalaureate degree as the current minimum degree for physician assistants and  
37    encouraged all physician assistants to possess a minimum of a baccalaureate degree.  
38    (AAPA Policy 1305-03-01) This policy was reconsidered by the House of Delegates at  
39    AAPA’s 1998 Annual PA Conference in Salt Lake City, Utah. A resolution submitted by  
40    the Ohio delegation, “...encourage[d] the Association of Physician Assistant Programs  
41    (APAP) and the Committee on Accreditation of Allied Health Education Programs  
42    (CAAHEP) to reevaluate the essentials for accreditation and approval of PA training  
43    programs and to establish as the standard, the minimum of a baccalaureate degree be  
44    awarded by all PA training programs to their students upon completion of the program.”  
45    (HOD resolution 98-B-14) This resolution was ultimately tabled and referred to the

1 AAPA Education Council for further research and analysis. Again in 1999, the Oklahoma  
2 Academy of Physician Assistants submitted a resolution to the 1999 House of Delegates  
3 requesting the “AAPA to promote the requirement that all accredited PA programs confer  
4 a minimum of a bachelor’s degree on graduation” (99-B-7). The 2000 House of  
5 Delegates adopted several resolutions related to the degree issue. Resolutions sponsored  
6 by the Education Council recognized “that PA education in programs accredited by  
7 CAAHEP (or its successor organization) is conducted at the graduate level,” (2000-B-  
8 15a) and supported “awarding students a credential reflective of this graduate level of  
9 education” (2000-B-15b). The HOD also adopted two resolutions relating to a standard  
10 professional degree, supporting “a graduate degree, professional or academic,” to be  
11 awarded to all graduates of accredited programs (2000-B-16a), and directing the Speaker  
12 to “communicate to the AAPA ARC-PA representatives the Academy’s desire to make a  
13 graduate degree, professional or academic, a requirement represented in the *Standards*”  
14 (200-B-16b). Also in 2000, the Assembly of Representatives of the Student Academy of  
15 AAPA passed a resolution supporting “awarding a graduate-level degree as the minimum  
16 degree awarded physician assistant graduates.”

17  
18 Simultaneously with the AAPA’s activities, the APAP membership was engaged in  
19 discussion regarding the degree issue and the role of the Association in the debate. While  
20 no current APAP policy on the degree issue exists, APAP has considered the issue at  
21 several points in its history, as directed by one of its stated core purposes: “[APAP will]  
22 participate in evaluating PA programs to assure the public of properly educated PAs.”<sup>1</sup>  
23 Even in the late 1980s, when the majority of programs offered the same credential — the  
24 baccalaureate degree — APAP had no policy on this issue. Not surprisingly, with  
25 significant changes in the health care environment, including greater competition in the  
26 PA marketplace and the rapid expansion in the number of PA programs, the 1990s saw a  
27 shift in the credentials trend. Although a variety of credentials were still offered by PA  
28 programs at two- and four-year colleges and universities, a growing number of master’s  
29 programs came into existence in the mid-90s and many existing programs converted to  
30 master’s level. This demographic was a driving force in the establishment of APAP’s  
31 Degree Task Force, contributing to the charges addressed, and the recommendations it  
32 has made. In September 2000, 49 percent of the 123 accredited programs offered a  
33 master’s or master’s option (46 programs award a master’s degree; 14 offer a master’s  
34 option<sup>2</sup>).

35  
36 The Task Force first met in October 1998 and has since met four more times to review  
37 data, discuss findings, and develop recommendations. Additional work was conducted  
38 via conference calls and e-mail. During the process, two subcommittees were formed to  
39 research and review the pertinent issues related to the establishment of the preferred  
40 academic credential to be awarded by PA educational programs. Following the  
41 development of an initial report and recommendations, the Task Force solicited feedback  
42 from a broad base of physicians, physician assistants, and educators throughout the

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<sup>1</sup> Association of Physician Assistant Programs. Bylaws. In: *2000 APAP Faculty Directory*. Alexandria, Va: APAP; 2000.

<sup>2</sup> Association of Physician Assistant Programs. Physician Assistant Programs Directory database. Unpublished. September 2000.

1 country (see Appendix B) which was important to the development of this document.  
2 Other aspects of the process included a review of the literature, a survey of PA programs  
3 (see Appendix C), and obtaining selected data analyses from the *Fifteenth Annual Report*  
4 *of Physician Assistant Educational Programs in the United States, 1998-1999*. The Task  
5 Force also used a modified Delphi technique to explore the implications of potential  
6 recommendations so that the process would be better informed and more comprehensive  
7 in scope.

8  
9 A working paper on the degree issue was presented to the APAP membership in October  
10 1999 and written feedback solicited. Although the feedback covered a variety of issues, a  
11 primary concern was the question of how an entry-level degree requirement would affect  
12 access and diversity within the profession — valued components of the PA profession's  
13 success. To assist the Task Force in these areas, at its March 2000 meeting three expert  
14 presenters offered experiences with PA education access and deployment issues and  
15 national trends. The additional input from the presenters regarding access and diversity  
16 was considered for the next draft of the paper, presented to the membership — in an  
17 executive summary format and with revised recommendations — prior to the May  
18 Semiannual Meeting in Chicago. At this meeting, a special open forum was held to allow  
19 APAP members another opportunity to comment on the paper, recommendations, and  
20 relevant issues. Testimony from the forum and external reviewer comments were  
21 considered in the final drafts.

22  
23 The paper is organized in sections, each one tackling one of the issues identified by the  
24 Task Force as important to the discussion of the degree issue, and presented largely in  
25 order from the more general to the more specific: current situation, equity with other  
26 professions, impact on graduate deployment, effect on policy, impact on diversity,  
27 financial impact for students, impact on PA programs, impact on PA faculty, impact on  
28 the curriculum, impact on the PA profession. The paper concludes with the conclusions  
29 derived from the data and arguments discussed, and finally with the recommendations  
30 presented to the APAP board of directors per the Task Force's charges. Four appendices  
31 can be found at the end of the paper: Appendix A – Charges; Appendix B – Reviewers;  
32 Appendix C – Survey of Programs; Appendix D – Definitions.

### 33 34 Introduction

35  
36 Educators and researchers in many disciplines have long wrestled with the “degree  
37 debate” regarding the appropriate entry-level credential. This process represents a natural  
38 progression in the maturation of many professions. These debates are often discomfoting  
39 and require many years to achieve general consensus within the representative  
40 educational programs. For example, as early as 1958, the field of occupational therapy  
41 began deliberations as to what educational level was best suited for the profession.  
42 Nearly thirty years later, the American Occupational Therapy Association (AOTA)  
43 endorsed a gradual shift to the master's degree as the entry-level degree for its profession.  
44 Similarly, the physical therapy profession began a transition to an entry-level master's  
45 degree over a ten-year period back in 1979, which met with continued debate. Their  
46 guidelines for educational programs, as revised in 1997, standardized the physical

1 therapy entry-level degree at the post-baccalaureate level. Speech therapy and social  
2 work have also debated the degree issue. Despite years of debate, nursing continues to  
3 offer several career entry points to become a registered nurse; however, one group of  
4 advanced practice nurses, that is nurse practitioners (NPs), has determined that NP  
5 education should be at the graduate level.<sup>3</sup>

6  
7 The PA profession has also discussed the appropriate entry-level credential for several  
8 years. The task of critically examining the issue of degree is particularly challenging for  
9 the PA profession due to our unique history and training philosophy. Envisioned as a  
10 solution to problems of provider maldistribution and a way improve primary care health  
11 delivery, the profession evolved several successful educational models during its  
12 formative years, and these have served us well. The profession has long adhered to the  
13 philosophy of “competency-based education,” defined as “a level of expertise obtained  
14 by completing a specific didactic and clinical curriculum as part of an accredited PA  
15 program.”

16  
17 Whatever the success of the profession to date, recent changes in the healthcare delivery  
18 and financing systems must also be considered. Such external marketplace forces compel  
19 us to take a proactive stance to allow our profession to continue to prosper in the next  
20 century. PAs, and in particular, PA educators, should not allow the difficulty of the task  
21 to discourage them from examining this issue and making specific recommendations  
22 about the appropriate entry-level credential for the profession. It is the profession’s  
23 prerogative and responsibility to establish its own educational standards and to thus affect  
24 its own future.

### 25 26 27 Current Situation

28  
29 Currently (September 2000) there are 123 accredited programs in the United States. This  
30 represents a 110 percent increase from 57 only six years ago. Of the 120 programs  
31 surveyed for the *APAP Sixteenth Annual Report on PA Educational Programs in the*  
32 *United States*, 35.8% offer a master’s degree (n=43), 47.5% offer a baccalaureate (n=57),  
33 5.8% an associate’s degree (n=7) and 10.8% a certificate (n=13) as the highest credential  
34 awarded.<sup>4</sup> Six of the institutions offering a certificate only program require a bachelor’s  
35 degree as an entrance requirement; and one community college–based program offers a  
36 certificate, bachelor’s, or master’s degree upon graduation.<sup>5</sup> There are numerous other  
37 optional tracks or arrangements allowing programs to award two or more different  
38 credentials.

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<sup>3</sup> Commission on Accreditation in Physical Therapy. *1997-1998 Accreditation Handbook*. Alexandria, VA: APTA; 1997.

<sup>4</sup> Simon A, Link M, Miko A. *Sixteenth Annual Report on Physician Assistant Educational Programs in the United States, 1999–2000*. Alexandria, VA: Association of Physician Assistant Programs; 2000.

<sup>5</sup> Association of Physician Assistant Programs. *1999 Physician Assistant Programs Directory*. 17th ed. Alexandria, VA: APAP; 1999.

1 A survey (see Appendix C) conducted by the Task Force in early 1999 revealed that 45 of  
2 96 (47%) programs responding intend to change the academic credential they award in  
3 the next five years. Of those intending to change, 62% indicated that the academic  
4 credential to be awarded would be a “master’s degree only” meaning that within five  
5 years it is conceivable that 60% of all PA programs would be at the master’s level.<sup>6</sup> This  
6 figure most likely is underestimated since it does not include programs that would offer a  
7 baccalaureate with a master’s option. It is apparent that even without a clear directive or  
8 mandate from the profession or any other “official” body, many academic institutions are  
9 already pursuing a graduate-level credential for their PA programs.

### 10 11 Equity with Other Professions

12  
13 The PA profession is following many other allied health professions in addressing the  
14 entry-level degree issue. At its August 1999 meeting, the Accreditation Council for  
15 Occupational Therapy Education (ACOTE) determined that it would accredit only post-  
16 baccalaureate programs as of January 1, 2007.<sup>7</sup> Physical therapy will accredit only entry-  
17 level educational programs at the post-baccalaureate level after January 1, 2002,<sup>8</sup> and the  
18 pharmacy profession has standardized its entry-level education at the doctoral degree.  
19 Many of the helping professions, including psychologists, social workers, and educators  
20 with similar levels of responsibility are credentialed at the master’s level.

21  
22 Because the PA profession is unique, it is difficult to make direct comparisons with other  
23 health care providers. However, PAs are frequently included under the rubric of “non-  
24 physician provider,” or an older term, “mid-level practitioner,” and are often compared to  
25 the nurse practitioner (NP) profession. Nurse practitioner programs have already  
26 standardized at the graduate level, and although quality of education and competency of  
27 graduates is not assured by standardization of the academic credential, the fact remains  
28 that NPs are the closest competitors for PA jobs. In a tight job market, when other factors  
29 are equal, it is reasonable to conclude that the graduate with an advanced degree will  
30 have a competitive edge, and graduates with lesser degrees may be disadvantaged.

31  
32 While it is not the goal of the PA profession to engage in a degree race with other health  
33 care providers for the sake of “one-upmanship,” there is a public perception that the  
34 academic credential should be commensurate with the level of responsibility for patient  
35 care. This perception can affect decisions by the public seeking medical care and by  
36 policy makers who shape the health care system and its associated economics. A single  
37 graduate professional degree would add clarity to the definition of the profession and  
38 make it easier for non-clinicians to understand the level of PA responsibility. In addition,  
39 there remains a longstanding hierarchy related to educational attainment in most  
40 professions, especially those involved in health care.

41  

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<sup>6</sup> APAP Degree Task Force. Academic credential survey. Unpublished. January 1999.

<sup>7</sup> Written communication: Stephen Heater, Chairperson, Accreditation Council for Occupational Therapy Education, August 25, 1999.

<sup>8</sup> Commission on Accreditation in Physical Therapy Education. *1997-1998 Accreditation Handbook*. (Article 3.9) Alexandria, Va: American Physical Therapy Association; 1997.

1 On the other hand, the profession should also be sensitive to perceptions of the medical  
2 establishment regarding any move to establish a higher-level academic credential for PA  
3 practice. There is concern among some PAs that if the PA profession establishes the  
4 master's degree as the standard for entry-level practice, some in the physician community  
5 may perceive this as a move toward independent practice, but this is speculative — there  
6 has been no statement to this effect from any physician organization.

### 7 8 Impact on Graduate Deployment

9  
10 Concerns have been raised about the effect a graduate degree requirement would have  
11 upon deployment to medically underserved communities in both rural and urban  
12 settings.<sup>9</sup> According to the AAPA report “The Differential Effects of Educational  
13 Degrees and Credentials from PA Schools” the proportion of PAs being awarded  
14 master's degrees has increased over time while the proportion of PAs who have never  
15 received at least a bachelor's degree has decreased. Currently, only 11% of PAs do not  
16 have at least a bachelor's degree.<sup>10</sup>

17  
18 However, the distribution of these graduates is enlightening: the AAPA report points out  
19 that a higher percentage of PAs working in the West and North Central regions never  
20 received a bachelor's degree, and that disproportionately more PAs without bachelor's  
21 degrees work in some type of community health center, or in areas with smaller  
22 populations. Master's-prepared PAs were more likely to work in areas with larger  
23 populations. Another key issue brought out in the report was the fact that 36% of all PAs  
24 and 28% of PAs who graduated after 1995 would not have qualified for enrollment in a  
25 PA program that offered only master's degrees, since they did not have bachelors degrees  
26 prior to enrolling in PA school. PAs without bachelor's degrees were also older,  
27 suggesting that these individuals were more experienced and likely to seek the least time  
28 consuming and expensive means for becoming a PA.<sup>11</sup>

29  
30 There are no current data that demonstrate a causal relationship between type of  
31 academic credential the PA graduate possesses and choice of practice type or location.  
32 Fowkes et al tackled this issue and showed that successful deployment of PAs and NPs  
33 from any given program to underserved areas was related to a number of factors,  
34 including a publicly stated mission, community orientation, the existence of data on the  
35 practice locations of graduates, being a Medex-type model, being a certificate program,  
36 and the use of comprehensive deployment strategies.<sup>12</sup> However, regression analyses

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<sup>9</sup> Fowkes V, Gamel N, Wilson S, Garcia R. Effectiveness of educational strategies preparing physician assistants, nurse practitioners, and certified nurse-midwives for underserved areas. *Public Health Reports*. September-October 1994; 109:673–682.

<sup>10</sup> American Academy of Physician Assistants. Strategic Planning, Trends Analysis. Alexandria, Va; February 2000.

<sup>11</sup> the differential effects of educational degrees and credentials from PA schools. AAPA Division of Research and Data Services, November 17, 1998. Alexandria, VA: AAPA.

<sup>12</sup> Fowkes V, Gamel N, Wilson S, Garcia R. Effectiveness of educational strategies preparing physician assistants, nurse practitioners, and certified nurse-midwives for underserved areas. *Public Health Reports*. September-October 1994; 109:673–682.

1 were not performed, thus the predictive value for each variable is unknown. A review of  
2 the literature on current admission practices in several allied health programs, in which  
3 occupational therapy and physical therapy were included, revealed that less priority was  
4 given to the need to increase student diversity and to the student's desire to work in  
5 underserved communities than to GPAs, letters of recommendation, or performance on  
6 admissions interviews.<sup>13</sup> However, market forces should also be acknowledged as another  
7 significant determinant of PA graduate deployment.

8  
9 Adoption of an entry-level graduate degree for PAs may negatively affect a large  
10 numbers of capable applicants who would be deprived of the opportunity to enter the  
11 profession. Many of these individuals are likely to be under-represented minorities or  
12 economically disadvantaged individuals whom studies have shown are more likely to  
13 practice in underserved areas<sup>14</sup> and more likely to enter generalist specialties than other  
14 groups.<sup>15</sup>

### 15 16 Effect on Policy

17  
18 The PA profession has enjoyed tremendous growth and acceptance since its inception in  
19 1965. This is evidenced in part by enabling legislation in all states and prescriptive  
20 privileges in forty-seven states, the District of Columbia, and Guam.<sup>16</sup> These gains have  
21 occurred without a standard entry-level credential. However, there are six states  
22 (Arkansas, Connecticut, Idaho, Massachusetts, New Mexico, and West Virginia) that,  
23 with various caveats, currently require a bachelor's degree (not necessarily earned at the  
24 PA program) to practice and one state that will eventually require PAs to possess a  
25 master's degree (Mississippi).

26  
27 Currently, a PA's academic credential is not a major issue in third party reimbursement,  
28 since most third party payers determine eligibility by state licensure. Recent Medicare  
29 regulations require NPs enrolling in the Medicare program after January 1, 2003, to be  
30 master's-level prepared in order to be eligible for reimbursement. While it is unlikely  
31 that the Medicare program will change its policy and require that PAs have a specific  
32 academic credential other than graduation from an accredited PA program, such  
33 challenges could emerge from third-party payers in the future.

34  
35 Some have argued that having a standard master's degree credential would assist the  
36 profession in optimizing state practice acts and federal policy.<sup>17</sup> Society, in general,  
37 relates a higher responsibility level to a higher academic credential; and is not very

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<sup>13</sup> Agho A, Mosely B, Williams A. A national survey of current admission practices in selected allied health educational programs. *Journal of Allied Health*. Spring 1999 (28);1:8-14.

<sup>14</sup> Association of American Medical Colleges. Fact Sheet: specialty choice, intended practice location, and ethnic identity: Career plans of the 1996 graduating medical school class. Available at <http://www.aamc.org/about/progemph/camcam/factsht/no.11.htm>. Accessed May 24, 1999.

<sup>15</sup> Ibid.

<sup>16</sup> American Academy of Physician Assistants. Facts at a Glance. Available at: [www.aapa.org](http://www.aapa.org). Accessed September 6, 1999.

<sup>17</sup> Blessing JD. Facing reality about a degree. *Physician Assistant*. February 1999;23:18, 21.

1 familiar with the competency-based education position. While patient satisfaction studies  
2 have been generally positive, some have noted that patients are confused about PA  
3 qualifications and roles.<sup>18,19</sup>

#### 4 Impact on Diversity

5  
6  
7 At the center of the debate regarding standardization of the entry-level degree for the PA  
8 profession is the potential impact this may have upon diversity and the inclusion of  
9 underrepresented minority populations in our profession. There is a concern that  
10 standardization of the entry-level academic credential will decrease access to the  
11 profession for minorities and disadvantaged candidates. Unfortunately, it is difficult to  
12 establish a causal relationship between degree requirement and access to the profession in  
13 this context, since there has not been an ongoing and systematic collection of data by the  
14 profession regarding students from disadvantaged backgrounds. In addition, there is no  
15 agreement as to which of the non-white populations are considered to be  
16 underrepresented in the PA profession.

17  
18 We do have some encouraging data on numbers of matriculating students: Enrollment of  
19 non-whites in PA programs has ranged from 13.8% in 1983–1984 to 22.1% in 1999–  
20 2000. During that time period, the number of programs offering master’s degrees  
21 increased, perhaps coincidentally, from 4.2% in 1987 (the first year for which this data  
22 was collected in the *Annual Report*) to 35.8% in 1998, and there was little change in the  
23 percentage of associate or certificate programs. The number of minority students enrolled  
24 in master’s programs (16%) is similar to that of other kinds of programs, and the attrition  
25 rate in master’s programs is lower than all other kinds of programs (3.2% vs. 5.0%)<sup>20</sup>.  
26 These findings are contrary to the inverse relationship one might expect; however, there  
27 may have been other factors contributing to the stability of minority enrollment during  
28 this period. Attrition in master’s-level programs may be affected by the fact that  
29 graduate-level programs do not typically admit “high-risk” (economically and  
30 academically disadvantaged) students and that the average class size is smaller (37  
31 students per class) than certificate (51) or bachelor’s (44) programs.<sup>21</sup>

32  
33 It is widely agreed that diversity within the physician assistant profession is a strength  
34 and a quality to be embraced. The existence of various entry points into the profession  
35 provides the opportunity for a greater number of individuals from diverse and  
36 disadvantaged backgrounds to enter the profession, which continues to embrace  
37 philosophically its historical mission of providing health care to underserved areas. In  
38 terms of the overall health care workforce, the PA profession has been an exception to the

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<sup>18</sup> Smith CW. Patient attitudes toward physician assistants. *Journal of Family Practice*. August 1981;13:201–204.

<sup>19</sup> Baldwin KS, Sisk RJ, Watts P, McCubbin J, Brockschmidt B, Marion LN. Acceptance of nurse practitioners and physician assistants in meeting the perceived needs of rural communities. *Public Health Nursing*. December 1998;15:389–397.

<sup>20</sup> Simon A. Demographic information on physician assistant programs prepared for the APAP Degree Task Force. Presented at: APAP Degree Task Force Meeting, August 28, 1999, Alexandria, VA.

<sup>21</sup> Ibid.

1 rule. Racial and ethnic minorities continue to be underrepresented in the health  
 2 professions workforce — African Americans, Hispanics, American Indians, and Alaska  
 3 Natives account for only 10 percent of the health professions workforce, even though  
 4 they make up nearly 25 percent of the U.S. population (see Table 1).<sup>22</sup>

5  
6

<b>Health Profession</b>	<b>% Black</b>	<b>% Hispanic</b>
Physicians	4.9	4.8
Physician Assistants	10.6	2.8
Occupational Therapists	6.5*	0.7*
Physical therapists	4.2*	5.4*
Registered Nurses	9.3	3.2
Social Workers	23.4	6.4
U.S. Population	12.1	11.4

7 *Source: Adapted from Kamat M. Black and Hispanic Employment in Health Occupations. In: Educating*  
 8 *Health Professions: Are We Failing Minorities? Closing the Gap, Office of Minority Health Newsletter,*  
 9 *May/June 1999:8.*

10  
11 \* This data includes all working therapists, which includes both pre- and post-master's.

12  
13 The data suggest that minority clinicians are two to five times more likely to care for  
 14 minority patients than their white counterparts<sup>23, 24</sup>. In view of this, it is reasonable to  
 15 conclude that the PA profession is having an important positive impact on access to  
 16 health care in underserved minority populations by educating a proportionally larger  
 17 percentage of people from those populations. Disadvantaged minority populations  
 18 already face obstacles to access — access to quality education, access to higher  
 19 education, and access to quality healthcare.

20  
21 Diversity within the PA profession has a direct relationship to access to care, and  
 22 diversity within the profession depends on diversity among the students moving into it.  
 23 There is concern among some PA faculty that standardization of the entry-level academic  
 24 credential may decrease access to the PA profession for some minority and disadvantaged  
 25 candidates. Blacks, Hispanics and American Indians still earn a disproportionately low  
 26 share of undergraduate degrees when compared with their representation in the  
 27 population. Collectively they earned only 13% of all science and engineering  
 28 baccalaureates in 1995, although they constituted 28% of college age students that year.  
 29 The number of degrees in the health professions awarded to blacks increased from a  
 30 baseline of 5.0% in academic year 1985-86 to 5.9% in 1993-94, well below the national  
 31 disease prevention and health promotion target of 8.0% set by the U.S. Department of

<sup>22</sup> Kamat M. Educating health professionals: Are we failing minorities? *Closing the Gap, Office of Minority Health Newsletter*. May/June 1999;8.

<sup>23</sup> Association of American Medical Colleges. AAMC Fact Sheet vol. 1, no. 11. Available at: [www.aamc.org/about/progemph/camcam/factshts/no11.htm](http://www.aamc.org/about/progemph/camcam/factshts/no11.htm). Accessed September 8, 2000.

<sup>24</sup> Komaromy et al. The role of black Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996;334:1305-10.

1 Health and Human Services' "Healthy People for the Year 2000" initiative. Hispanics  
2 progressed from a baseline of 3.0% of all health professions degrees in 1985-86, to 4.3%  
3 in 1993-94, again below the target of 6.4% for the year 2000. Finally, for America  
4 Indians/Alaska Natives, the baseline was 0.3% (1985-86); this proportion increased to  
5 0.4% in 1993-94, still below the target of 0.6% for the year 2000. Attrition is a big factor  
6 here: Attrition rates range from a high of 36% for blacks to a low of 8% for whites  
7 (contrasting 1991 and 1993 undergraduate cohort enrollment profiles).<sup>25</sup>

8  
9 We must continue to contemplate, investigate, and study the importance of diversity to  
10 the mission of our profession. While we cannot predict the exact impact that the  
11 standardization of the entry-level degree will have on the diversity of our profession, it  
12 likely will have a significant effect. The various potential effects must be given careful  
13 consideration prior to the implementation of a universal policy regarding a standardized  
14 entry-level degree for the profession. A recent Office of Minority Health lead off its  
15 cover article:

16  
17 "Recruitment, retention, training, and promotion of racial and ethnic  
18 minorities within the Nation's health professions workforce will not only  
19 help eliminate disparities in the health care received by minorities, it will  
20 improve the health of *all* Americans."<sup>26</sup>

### 21 22 Financial Impact for Students

23  
24 It is well known that higher education has become increasingly expensive and, according  
25 to some authorities, has outpaced inflation indices. During the period 1980-81 through  
26 1994-95, tuition at four-year public colleges and universities increased by 234 percent  
27 while the median household income only grew by 82 percent.<sup>27</sup> PA education is no  
28 exception. The average cost of PA education is estimated at \$26,653 for residents and  
29 \$32,147 for non-residents, with approximately 83% of the students in the country  
30 receiving some type of financial aid.<sup>28</sup> Data provided for the Task Force by Albert Simon,  
31 project director of the APAP annual reports on PA education, showed that the cost of PA  
32 education increased as the academic credential awarded at graduation increased.  
33 However, the same data showed little difference in cost associated with a bachelor's  
34 degree compared to a master's degree (\$29,495 vs. \$32,800).<sup>29</sup> Unfortunately, there are  
35 no data to demonstrate tuition differences with adjustments for public vs. private  
36 institutions. Based on the review of existing data, there appears to be no important

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<sup>25</sup> Kamat M. Educating health professionals: Are we failing minorities? *Closing the Gap, Office of Minority Health Newsletter*. May/June 1999:8.

<sup>26</sup> Lurie N. Putting the right people in the right places: Minority health professionals serve community needs. *Closing the Gap, Office of Minority Health Newsletter*. May/June 1999.

<sup>27</sup> U.S. General Accounting Office. Higher education: Tuition increasing faster than household income and public colleges' costs. Washington, DC: US General Accounting Office; 1996. Publication GAO/HEHS-96-154.

<sup>28</sup> Simon A. Demographic information on physician assistant programs prepared for the APAP Degree Task Force. Presented at: APAP Degree Task Force meeting; August 28, 1999; Alexandria, Va.

<sup>29</sup> Ibid.

1 difference in PA earning power related to the academic degree,<sup>30</sup> therefore the cost  
2 benefit ratio related to academic credential deserves consideration. For those students  
3 who attend a program granting a certificate of completion without first obtaining an  
4 undergraduate degree, conversion to a master's degree education may increase the overall  
5 education expenditures associated with entering the profession. On the other hand, since  
6 more than 80% of PA students are enrolled in either a master's or bachelor's degree  
7 program, conversions of all programs to master's programs would be unlikely to have an  
8 important effect on the total educational expenditures of a large majority of students.

9 Financial aid needs to be considered as well. The cost associated with six years of  
10 education for a master's, or four years for a bachelor's degree is likely to be greater than  
11 two years for an associate degree or certificate. However, 68.5% of the students enrolled  
12 in PA programs across the country already have at least a bachelor's degree at  
13 matriculation.<sup>31</sup> This limits financial aid opportunities for a student enrolling in programs  
14 offering other than a master's degree. Also, graduate students are generally eligible for  
15 higher levels of financial aid. For example, graduate students are eligible to borrow up to  
16 \$18,500 per year (\$8,500 subsidized) under the Stafford Loan Program while  
17 undergraduate students are eligible to borrow only \$5,500 per year during their junior and  
18 senior years.<sup>32</sup> In many cases, students seeking a second bachelor's degree are not  
19 eligible for subsidized financial aid. Since most of the financial aid awarded to students is  
20 in the form of loan programs, these students are encumbered by higher debt loads at  
21 graduation than they would be if graduating from master's programs. However, if current  
22 entry-level salaries for PA graduates remain stable or increase, then high educational debt  
23 loads may become less burdensome in the future.

#### 24 25 Impact on Existing PA Programs

26  
27 Any recommendation that deviates from the current status quo will have an impact on  
28 existing programs. If the entry-level degree were standardized at the baccalaureate level,  
29 then associate degree programs or certificate-only programs would need to seek  
30 affiliations with a bachelor's-degree granting institutions, make the transition inter-  
31 institutionally, or cease to exist. The same holds true for baccalaureate programs if the  
32 profession standardized at the master's level. Even programs that are already at the  
33 master's level may be affected — if all programs move to the graduate level, some  
34 master's programs might lose a market niche in their regions. These challenges are not  
35 insurmountable and have been dealt with by other professions. Even now we are seeing a  
36 variety of affiliation agreements and optional tracks allowing programs to award different  
37 credentials. The profession does need to recognize, however, that there will be significant  
38 challenges for individual PA programs associated with changes to the entry-level  
39 credential required for practice.

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<sup>30</sup> American Academy of Physician Assistants. Division of Research and Data Services. The differential effects of educational degrees and credentials from PA schools. Alexandria, Va: November 1998.

<sup>31</sup> Simon A, Link M, Miko A. *Sixteenth Annual Report on Physician Assistant Educational Programs in the United States, 1999–2000*. Alexandria, VA: Association of Physician Assistant Programs; 1999.

<sup>32</sup> FinAid Page. Student Loans. Available at: <http://www.finaid.org/loans/studentloan.phtml>. Accessed: September 6, 1999.

1

2 Notwithstanding any recommendation for changing the profession's entry-level  
3 credential for practice by the Task Force or any other group, there already is a strong  
4 movement in current and newly developing programs toward the master's degree. As  
5 noted earlier, 47% (n=45) of existing programs plan to change their academic credential  
6 within five years, the majority of these to a master's degree only.<sup>33</sup> If a majority of PA  
7 programs convert to the master's level in the near future without appropriate planning,  
8 there is a potential for de facto stratification of the profession, with master's-prepared  
9 PAs perhaps at an advantage in a tight job market.

10

### 11 Impact on PA Faculty

12

13 It is unclear what specific impact the standardization of the entry-level academic  
14 credential may have on the supply of qualified faculty for PA educational programs. PA  
15 faculty would be most significantly affected by converting to master's degree-granting  
16 programs. Assuming that a majority of sponsoring institutions would require faculty to  
17 have an earned academic degree equal to or exceeding the one awarded to graduates of  
18 the program, those faculty who do not currently possess a master's degree may be  
19 required to obtain one. Currently, only a little over half (55%) have a master's degree or  
20 higher (44% master's; 11% doctorate).<sup>34</sup>

21

22 Theoretically, standardization at the master's level could pressure as many as 44% of the  
23 current faculty to obtain a master's degree unless other creative options were identified  
24 by their academic institutions. As to new faculty, while many programs are now  
25 graduating PAs with master's degrees, these new graduates (a relatively large percentage  
26 of all PAs possessing master's degrees) may not possess the clinical experience necessary  
27 for faculty appointments. No studies currently exist which examine the long-range career  
28 objectives of those enrolled in master's completion programs.

29

30 Taking the long view, PA programs and faculty may benefit from association with a  
31 graduate-level program or department within their institutions. Fewer than one-third  
32 (31%) of PA program faculty are currently tenured or on a tenure track,<sup>35</sup> and it is likely  
33 that faculty of graduate-level programs would more likely be eligible for promotion and  
34 tenure. Although all academic institutions operate within their own political, economic  
35 and social contexts, PA faculty are more likely to be viewed as equals if their academic  
36 credentials equal or exceed those of their counterparts.

37

### 38 Impact on the Curriculum

39

40 No data in the current literature identify specific differences in depth or scope of  
41 curriculum related to the type of credential awarded on completion of a PA program. We  
42 can say with some degree of confidence that the profession is assured uniformity in

---

<sup>33</sup> APAP Degree Task Force. Academic credential survey. Unpublished. January 1999.

<sup>34</sup> Simon A, Link M, Miko A. *Sixteenth Annual Report on Physician Assistant Educational Programs in the United States, 1999-2000*. Alexandria, VA: Association of Physician Assistant Programs: 2000.

<sup>35</sup> Ibid.

1 substance, if not structure, of instruction as a result of the *Standards and Guidelines for*  
2 *an Accredited Educational Program for the Physician Assistant (the “Standards”)* — the  
3 guiding document of the profession’s current accrediting agency, the Commission on  
4 Accreditation of Allied Health Educational Programs (CAAHEP). However, many  
5 master’s degree programs do augment their curricula with courses such as research  
6 methodology and/or statistics, and typically require some type of research-related  
7 capstone experience — a thesis or scholarly project — making this portion of the  
8 curriculum unique to master’s programs.

9  
10 There are also no published data to suggest that the quality of patient care is related to the  
11 academic credential awarded to graduates upon completion of PA studies. PA education  
12 has nurtured a competency-based model of education that is not tied to a specific  
13 academic credential, and this model has served the profession well to date. Concern has  
14 also been expressed, though, that other health professionals may use fact of the various  
15 different degrees awarded by PA programs to further their own political agendas or  
16 employment opportunities<sup>36</sup>. It is important to note here that these are to a large extent  
17 unrelated issues — standardization of the entry-level degree could happily co-exist with  
18 the competency-based education model.

19  
20 Since the beginning of PA education in 1965, the depth and scope of PA education has  
21 increased dramatically with little change in the overall length of educational programs,  
22 which are typically two years in duration. The average PA program in 1986 was 23.7  
23 months in length,<sup>37</sup> rising to only 25.6 months 12 years later.<sup>38</sup> During that time, PA  
24 education has been asked to expand its curriculum to include PA professional issues,  
25 development of critical thinking skills, interpretation of the medical literature, and patient  
26 care concepts related to geriatric patients, all of which have appeared as requirements in  
27 revised editions of the *Standards*.<sup>39</sup> In addition, PA programs are being urged to provide  
28 education regarding the health care system, including insurance coding and managed  
29 care. This increasingly puts pressure on educational programs to do more in less time,  
30 increasing the rigor of the educational experience for PA students. Finally, as the  
31 professional component of PA education currently exists, it is consistent with graduate-  
32 level education, based on the intensity of the curriculum, number of contact hours and  
33 credit hours, and depth of instruction. Thus, standardization of PA education at the  
34 graduate level would provide more congruency between curricular content and the degree  
35 or academic credential awarded.

36 Jones E. From lexicon to praxis: Future characteristics of physician assistant education. In: *Proceedings of Defining the Future Characteristics of Physician Assistant Education*. Association of Physician Assistant Programs; August 16–17, 1996; Alexandria, Va.

37 Oliver D, Whitten P, Donahue W. *Third Annual Report on Physician Assistant Educational Programs in the United States, 1986–87*. Alexandria, Va: Association of Physician Assistant Programs: 1987.

38 Simon A, Link M, Miko A. *Fifteenth Annual Report on Physician Assistant Educational Programs in the United States, 1998–1999*. Alexandria, Va: Association of Physician Assistant Programs: 1999.

39 Commission on Accreditation of Allied Health Education Programs. *Standards and Guidelines for an Accredited Educational Program for the Physician Assistant*. CAAHEP: 1997.

## Impact on the PA Profession

The PA profession has grown fairly rapidly over its relatively short history. In a little over 30 years, the profession has gained recognition and acceptance by the lay public and medical professionals, created enabling practice legislation in all 50 states, and secured prescriptive privileges in 47 states and third-party reimbursement in nearly all settings.<sup>40</sup> In nearly every situation described above, the gains secured by the profession were accomplished through strategic initiatives resulting from conscientious policy planning and development.

In terms of the standard degree issue, the most serious potential consequence for the profession may be disenfranchisement of its members who lack the degree set as the standard, and who lack the resources or interest to seek a more advanced degree. Currently, it is estimated that 11.2% of the PA population have less than a bachelor's degree and 75.6% less than a master's.<sup>41</sup> However, if the profession were to move to a graduate-level entry credential, protection of the professional status of all physician assistants would have to be promoted by "grandfathering" and by realistic opportunities for continued education. This challenge can be addressed in part by the existing and developing "bridge" master's degrees, some of which can be accomplished primarily through distance learning or other non-residential options. Physician assistants may welcome graduate programs specifically designed to meet their professional and educational goals.

Potential positive consequences of standardization of the profession's entry-level credential include: parity of the academic degree with other health care professionals including nurse practitioners, better understanding of PA education (and perhaps the profession) by legislators and government policy makers, and graduate physician assistants with greater leadership and research skills. And PA program candidates may find the master's degree more attractive, particularly if they already have bachelor's degrees.

## Conclusions

The APAP Degree Task Force, through discussion and review of the literature, carefully examined the ramifications of standardization of the entry-level degree for the physician assistant profession. Consideration was given to a broad spectrum of options, including maintaining the status quo, recommending standardization at the baccalaureate degree, standardization at the master's level, and even the development of a new professional degree. Recognizing the serious impact on member programs and graduates, the Task Force weighed its recommendations based on the standard of what would be best for the PA profession at large. Although each PA program exists within a context of its sponsoring institution and geographic region, PA education must also acknowledge the

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<sup>40</sup> American Academy of Physician Assistants. Facts at a Glance. Available at: <http://www.aapa.org>. Accessed September 6, 1999.

<sup>41</sup> American Academy of Physician Assistants. 1998 AAPA Physician Assistant Census Report. Available at <http://www.aapa.org/members/981pacr.htm>. Accessed September 6, 1999.

1 broader socioeconomic and political realities of the nation's health care system as a  
2 whole. Difference of opinion on this issue is unavoidable; the Task Force  
3 recommendations reflect this fact and yet attempt to reflect the opinions of a majority of  
4 the group's members. After careful deliberation, the Task Force reached the following  
5 conclusions:

- 6
- 7 • A consensus statement regarding the appropriate entry-level degree is long overdue  
8 and would greatly benefit the profession.
- 9 • Standardization of the entry-level degree would engender a greater understanding of  
10 PA education and the profession by lay members of the community and policy  
11 makers.
- 12 • Standardization of the entry-level degree better defines the educational standard for  
13 PAs while continuing the competency-based model.
- 14 • Standardization at the master's level establishes degree equity with other professions  
15 with a similar level of responsibility in health care.
- 16 • A master's degree most accurately reflects the rigor of PA curriculum and the  
17 evolution of the profession.
- 18 • Graduate-level education provides additional avenues of career diversification for  
19 physician assistants.
- 20
- 21

## 22 Recommendations

23

24 Recognizing that policy development and strategic planning for any association is guided  
25 by careful analysis of the opportunities, threats, and constraints of the issues within the  
26 sociopolitical environment in which it exists; the Task Force presents this report to the  
27 APAP Board of Directors to use as a tool to help guide the discussions and decision-  
28 making of the Association's members and its appointed leaders. The APAP Degree Task  
29 Force requests that the APAP Board of Directors accept this report and the following  
30 recommendations:

- 31
- 32 1. The Association of Physician Assistant Programs (APAP) recognizes that PA  
33 education in accredited programs is conducted at the graduate level and recommends  
34 that PA programs grant students a credential\* reflective of this level of curriculum.
- 35
- 36 2. The credential granted should reflect the institutional mission and needs of the local  
37 and regional communities served by the program, and maintain the academic integrity  
38 of the curriculum and the competency of students. After careful study or reaffirmation  
39 of its mission, a program may determine that offering an alternative credential (non-  
40 master's degree) may better serve its institutional mission and the needs of the  
41 community.
- 42
- 43 3. The Association shall charge the Program Assistance and Technical Help (PATH)  
44 consultation service to assist programs with conversion to granting a graduate  
45 credential.
- 46

- 1 4. APAP shall work with the American Academy of Physician Assistants (AAPA or  
2 Academy) to develop further initiatives to encourage individuals from under-  
3 represented populations to seek careers as PAs, and to increase the representation of  
4 minorities and disadvantaged in the profession.  
5
- 6 5. APAP shall work with the Academy to develop strategies to ensure that the medical  
7 profession is aware that PA graduate-level education is not to be construed as a  
8 movement towards independent practice.  
9
- 10 6. The Association shall promote the intent of these recommendations to stakeholders.  
11
- 12 7. APAP shall communicate these recommendations to appropriate constituencies.  
13

14  
15 \*The Task Force elected not to specify traditional academic degree versus professional  
16 type degree at this time, allowing colleges and universities to determine the best fit in  
17 relationship to institutional mission. The development of specific strategies related to the  
18 implementation of the proposed recommendation were not considered to be part of the  
19 charges of the Task Force.  
20

**Appendix A**

**CHARGES**

The APAP Board of Directors charges the Degree Task Force with:

Exploration of entry-level credentials necessary for physician assistants including, but not limited to, the following:

1. background synthesis of information regarding the “degree issue”,
2. an assessment of current credentials awarded by the PA programs on the national level,
3. reporting of overall trends in entry-level credentials for PAs in the last 5 years,
4. comparable information regarding credential creep in other allied health professions,
5. reporting of the current market demands (employers) in terms of credentials for the entry-level PA, including what effect might be anticipated in this market if there were certain degree requirements in place,
6. identifiable trends on the part of regulatory agencies regarding PA entry-level credentials,
7. effects that might be anticipated on the part of regulatory bodies if there were certain degree requirements in place,
8. an assessment of the impact on graduates that a certain degree requirement would have,
9. an assessment of the impact on PA programs that a certain degree requirement would have, and
10. a recommendation to the BOD of APAP as to what the generally accepted entry-level credentials for PAs should be.

**Appendix B**

**TASK FORCE PAPER REVIEWERS**

1  
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3  
4  
5 Ruth Ballweg, PA-C, MPA – Program Director, University of Washington, Washington

6  
7 Sally Bauer, PhD – Program Director, Albany-Hudson Valley, New York

8  
9 Lynn Caton, PA-C – Battle Ground Clinic, Washington

10  
11 Libby Coyte, PA-C – Broadlawns Medical Center, Iowa

12  
13 Ronald Garcia, PhD – Associate Director, Stanford University, California

14  
15 Suzanne Greenberg, MS – Program Director, Northeastern University, Massachusetts

16  
17 Manuel Kaplan, MD – Medical Director, Augsburg College, Minnesota

18  
19 Terrence Kennon, PA-C – Co-Chair APAP Minority Affairs Committee; Tutor, Cook  
20 County Hospital/Malcolm X College, Illinois

21  
22 Alison Lauber, MD – Medical Director, Emory University, Georgia

23  
24 Jack Liskin, MA, PA-C – Faculty, University of Southern California, California

25  
26 Paul Lombardo, MPS, RPA-C – Program Director, SUNY Stony Brook, New York

27  
28 Sherry Stolberg, MGPGP, PA-C – Program Director, MCP Hahnemann, Pennsylvania

29  
30 Justine Strand, MPH, PA-C – Faculty, Duke University, North Carolina

31  
32 Carl Toney, PA – Program Director, University of New England, Maine

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34  
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36

## Appendix C

### DEGREE TASK FORCE SURVEY OF PROGRAMS

**Table 1. Distribution of Respondents by Academic Credential Currently Offered for Entry-level PA Program**

Respondents.....	96	100%
Associate Degree		
No.....	93	97%
Yes.....	3	3%
Certificate Only		
No.....	88	92%
Yes.....	8	8%
Bachelor's Degree Only		
No.....	70	73%
Yes.....	26	27%
Bachelor's and/or Certificate Options		
No.....	75	78%
Yes.....	21	22%
Master's Degree Only		
No.....	65	68%
Yes.....	31	32%
Other		
No.....	85	89%
Yes.....	11	11%

**Table 2. Distribution of Respondents by Type of Institution That Serves as Primary Sponsor of PA Program**

Respondents.....	96	100%
Two-Year or Community College		
No.....	92	96%
Yes.....	4	4%
Private College or University		
No.....	54	56%
Yes.....	42	44%
Public College or University		
No.....	72	75%
Yes.....	24	25%
Academic Health Center		
No.....	74	77%
Yes.....	22	23%
Hospital		
No.....	93	97%
Yes.....	3	3%
Military		
No.....	95	99%
Yes.....	1	1%
Other		
No.....	93	97%
Yes.....	3	3%

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**Table 3. Distribution of Respondents by Belief that APAP Should Endorse a Minimum Academic Credential for PA Programs**

Respondents.....	96	100%
Yes		
No.....	22	23%
Yes.....	74	77%

**Table 4. Distribution of Respondents Who Believe that APAP Should Endorse a Minimum Academic Credential for PA Programs by the Academic Credential that They Believe Should Be Considered the Minimum**

Respondents.....	74	100%
Bachelor's Degree Only		
No.....	50	68%
Yes.....	24	32%
Bachelor's and/or Certificate Options		
No.....	65	88%
Yes.....	9	12%
Master's Degree Only		
No.....	38	51%
Yes.....	36	49%
Other		
No.....	68	92%
Yes.....	6	8%

**Table 5. Distribution of Respondents by Whether Program Intends to Change Its Academic Credential Within the Next Five Years**

Respondents.....	96	100%
Yes		
No.....	51	53%
Yes.....	45	47%

**Table 6. Distribution of Respondents Whose Program Intends to Change Its Academic Credential Within the Next Five Years by When This Change Is Expected to Be Implemented**

Respondents.....	45	100%
Within 6 months to one year		
No.....	40	89%
Yes.....	5	11%
1 - 2 years		
No.....	32	71%
Yes.....	13	29%
2 - 3 years		

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No.....	35	78%
Yes.....	10	22%
3 - 5 years		
No.....	32	71%
Yes.....	13	29%
Greater than 5 years		
No.....	43	96%
Yes.....	2	4%

**Table 7. Distribution of Respondents Whose Program Intends to Change Its Academic Credential Within the Next Five Years by Stage of Program's Proposal for Change of Academic Credential**

Respondents.....	45	100%
Thinking Stage		
No.....	29	64%
Yes.....	16	36%
Proposal Development		
No.....	28	62%
Yes.....	17	38%
Proposal Developed and Routed for Internal Approval		
No.....	36	80%
Yes.....	9	20%
Proposal Developed and Routed for External Approval		
No.....	44	98%
Yes.....	1	2%
Proposal Approved and Awaiting Implementation		
No.....	44	98%
Yes.....	1	2%

**Table 8. Distribution of Respondents Whose Program Intends to Change Its Academic Credential Within the Next Five Years by Academic Credential Expected to Be Awarded After Proposal Is Approved**

Respondents.....	45	100%
Bachelor's Degree only		
No.....	45	100%
Post Bachelor's Certificate		
No.....	45	100%
Certificate or Bachelor's Option		
No.....	44	98%
Yes.....	1	2%
Master's Degree only		
No.....	17	38%
Yes.....	28	62%
Other		
No.....	28	62%

Yes.....	17	38%
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Table 9a. Distribution of Respondents Whose Program Does Not Intend to Change Its Academic Credential Within the Next Five Years by Rankings of Major Reasons for Not Electing to Initiate a Change in Academic Credential (Reasons were ranked 1, 2, and 3; 1=most important)

Respondents.....	51	100%
Already at Master's level		
First.....	34	67%
Not Ranked.....	17	33%
Lack of administrative support		
Second.....	1	2%
Third.....	1	2%
Not Ranked.....	49	96%
Institution not able to offer higher level degree		
First.....	5	10%
Third.....	2	4%
Not Ranked.....	44	86%
Lack of local community support		
Not Ranked.....	51	100%
Desire to maintain program history/culture		
Second.....	2	4%
Not Ranked.....	49	96%
Concern for negative impact on applicant pool		
First.....	3	6%
Second.....	3	6%
Third.....	2	4%
Not Ranked.....	43	84%
Concern for negative impact on graduate deployment		
Second.....	1	2%
Not Ranked.....	50	98%
No perceived benefit to the institution		
Second.....	2	4%
Third.....	2	4%
Not Ranked.....	47	92%
No perceived benefit to the profession		
First.....	3	6%
Second.....	2	4%
Third.....	3	6%
Not Ranked.....	43	84%
State legislation factors		
Second.....	1	2%
Not Ranked.....	50	98%
Other		
First.....	2	4%
Second.....	2	4%
Third.....	2	4%
Not Ranked.....	45	88%

Table 9b. Summary Measures of Rankings of Major Reasons for Not Electing to Initiate a Change in Academic Credential (Reasons were ranked 1, 2, and 3; 1=most important)

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Already at Master's level		
Respondents.....		34
Mean.....		1.0
Lack of administrative support		
Respondents.....		2
Mean.....		2.5
Institution not able to offer higher level degree		
Respondents.....		7
Mean.....		1.6
Lack of local community support		
Respondents.....		0
Mean.....		.
Desire to maintain program history/culture		
Respondents.....		2
Mean.....		2.0
Concern for negative impact on applicant pool		
Respondents.....		8
Mean.....		1.9
Concern for negative impact on graduate deployment		
Respondents.....		1
Mean.....		2.0
No perceived benefit to the institution		
Respondents.....		4
Mean.....		2.5
No perceived benefit to the profession		
Respondents.....		8
Mean.....		2.0
State legislation factors		
Respondents.....		1
Mean.....		2.0
Other		
Respondents.....		6
Mean.....		2.0

1 **Appendix D**

2  
3 **DEFINITIONS**

4  
5 **Disadvantaged:** An individual from a disadvantaged background is defined as “one who  
6 comes from an environment that has inhibited the individual from obtaining the  
7 knowledge, skill, and abilities required to enroll in and graduate from a health professions  
8 school, or from a program providing education or training in an allied health profession;  
9 or comes from a family with an annual income below a level based on low income  
10 thresholds according to family size published by the U.S. Bureau of Census . . . for use in  
11 health professions and nursing programs.”

12  
13 **Diversity:** “The representation of a wide variety of individuals from different  
14 backgrounds, according to gender, ethnicity, or socioeconomic status.”  
15