Physicians Assistants: Certification, Credentialing, Competencies and Case Studies

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Presenter: Tricia Marriott, PA-C, MPAS and Greg Thomas, PA, MPH
Physician Assistants:
Certification, Credentialing, Competencies & Case Studies

Speakers

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  National Commission on Certification of Physician Assistants (NCCPA)

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Disclosure

• Greg Thomas is a contractor with NCCPA. He has no other financial or industry disclosures to report.

• Tricia Marriott is an employee of the AAPA. She has no financial or industry disclosures to report. She is also currently licensed in the State of Connecticut, NCCPA certified, and is employed part-time by the Yale Medical Group in the Department of Orthopaedics.
Disclaimer

This presentation is provided for informational purposes only and does not constitute legal or payment advice.

• The ultimate responsibility for statutory and regulatory compliance, as well as the proper submission of claims, rests entirely upon the provider of services.
• Medicare policy changes frequently, so be sure to keep current by going to www.cms.gov and to your Medicare Administrative Contractor’s website.
• The American Medical Association has copyright and trademark protection of CPT ®.

PA DEFINITION & DEMOGRAPHICS

PA Definition/Role

Physician assistants (PAs) practice medicine, providing services a physician would otherwise have to provide.
What is a PA?
A physician assistant (PA) is a nationally certified and state licensed medical professional. PAs are educated in the medical model at the graduate level and practice in nearly every medical specialty and setting.

What do PAs do?
- Conduct physical exams
- Diagnose and treat illnesses
- Order and interpret tests
- Counsel on preventive healthcare, health and wellness
- Assist in surgery
- Write prescriptions
- Make rounds in nursing homes and hospitals
- Obtain medical histories
- Coordinate care
- Conduct research.

How One Becomes a PA
* There are 196 accredited PA educational programs in the United States.
* Most PA programs award a master's degree.
* PAs are required to complete:
  * More than 400 hours in basic sciences
  * More than 75 hours in pharmacology
  * 175 hours in behavioral sciences
  * Nearly 580 hours of clinical medicine
  * The average length of a PA program is 27 months (3 academic years).

About Certified PAs
Approximately 104,000 currently certified PAs*
Approximately 7,435 new PAs certified last year
PAs are a young profession; 52% are under the age of 40*

*Source: NCCPA July 2015
Certified PAs by Specialty*

- Family medicine/general internal medicine: 24.8%
- Surgical specialties: 19.5%
- Emergency medicine: 13.8%
- Internal medicine subspecialties: 7.6%
- Dermatology: 4.4%
- Hospital medicine: 3.1%
- Pediatrics (general and subspecialties): 2.8%
- General surgery: 2.1%
- OB/GYN: 1.4%
- Urology: 1.4%

* Based on NCCPA PA Profile data as of February 2015

Source: NCCPA 2014 Statistical Profile of Certified Physician Assistants. Used with permission. © NCCPA. 2015. All rights reserved.
PA Vital Statistics

**50 (+DC)**
Number of states authorizing PA prescribing privileges

**104,000**
Number of certified PAs as of July 2015, according to the National Commission on Certification of Physician Assistants

**$98,387**
Median annual income from primary employer for full-time clinically practicing PAs in 2014.


Projected Growth of PAs in Clinical Practice


Number of states authorizing PA prescribing privileges

**50 (+DC)**

Number of certified PAs as of July 2015, according to the National Commission on Certification of Physician Assistants

**104,000**

Median annual income from primary employer for full-time clinically practicing PAs in 2014.

**$98,387**


PA Profession Regulatory Changes

2014 State Legislation and Regulations

14 states and the District of Columbia enacted changes in laws and regulations in 2014...

...for a total of 184 law and regulation changes that improve PA practice.

Those changes have the potential to positively impact 99% of America’s 100,000 PAs...

...and up to 365 million patient encounters a year.

2015 State Legislation and Regulations

26 states have made 81 legislative changes.

21 states have made 44 regulatory changes

Source: NCCPA 2014 Statistical Profile of Certified Physician Assistants

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PA Profession Regulatory Changes

Federal PA Laws and Regulations

- Allow PAs to order portable x-rays and fecal occult blood tests for Medicare patients.
- Allow PAs to order DME under TRICARE.
- Allow PAs to care for Medicare patients with complex, chronic conditions.
- Allow PAs to document face-to-face encounters for DME under Medicare.
- Eliminate onsite supervision requirements for PAs working in RHCs.
- Allow RHCs to contract directly with PAs.
- Clarify that PAs can write hospital admission orders and conduct H&Ps.
- Include PAs in new value-based incentive program (MIPS) under Medicare.
- Avoid a 21% immediate decrease in Medicare payments for PA and physician services; establish .5% increase for 5 years.
- Include PAs in new value-based incentive program under Medicare.
- Allow PAs to order DME under TRICARE.
- Physicians Recognize the Value of PAs

- 76% of physicians say PAs and NPs contribute to the productivity of their medical practice.

Source: Jackson Healthcare, Physician Practice Trends, 2014

Patients Recognize the Value of PAs

- 93% Agree PAs are trusted healthcare providers.
- 91% Agree PAs improve health outcomes for patients.
- 91% Agree PAs improve the quality of healthcare.
Media Recognize the Value of PAs

PAs: #1 Most Promising Job of 2015

Forbes

Physician Assistant
Number of openings: 45,000
Average base salary: $111,000

PA CERTIFICATION

NCCPA's Board of Directors
10 PAs, 7 physicians and 2 public members, including
nominees from...

- American Medical Association
- American Osteopathic Association
- Association of American Medical Colleges
- Federation of State Medical Boards
- PA Education Association
- US Department of Veterans Affairs

- American Academies of:
  - Family Physicians
  - Pediatrics
  - Physician Assistants
- American Colleges of:
  - Emergency Physicians
  - Physicians

NCCPA Certification. Excellence.
PA CERTIFICATION
PA National Certifying Exam (PANCE)

Must be a graduate of an accredited PA program
(single accreditation body = ARC-PA)

International medical graduates and US medical
graduates who have not matched are not eligible
to sit for the exam

PANCE is required for initial licensure in all states
and DC

6 attempts to pass (within 6 years) and then lose
eligibility

Verification of PA Certification

Free, online primary source verification
https://www.nccpa.net/verify-pa

Immediate results:
– Generate a PDF
– Request email verification

Changes to the
Certification
Maintenance
Process
**New Certification Maintenance Process**

PA Recertifying Exam (PANRE) every 10 years

100 CME credits every two years

- Still 50 Category 1 credits

- 20 of the Category 1 credits must be designated as self-assessment and/or performance improvement

**Directed CME Defined**

100 Credit CME Requirement (every 2 years)

- Category 1 (50 credits)
- Category 1 or 2 (50 credits)
- 20 Category 1 CME credits designated as self-assessment and/or performance improvement

**Certification Maintenance Illustrated**

- **1st CME Cycle**: Earn 100 CME credits including 50 Category 1 credits with 20 earned through self-assessment and/or PI-CME activities.
- **2nd CME Cycle**: By the end of the 4th CME cycle, must have 40 Category 1 CME credits through SA activities and 40 Category 1 CME credits through PI activities.
- **4th CME Cycle**: Earn 100 CME credits including 50 Category 1 and pass PANRE
When Do PAs Start the New Process?

After passing PANCE or the next PANRE, the 10-year cycle will begin.

The new process began with the 2014 certification and recertification exams.

PAs can sign into their record at www.nccpa.net to find out where they are in the cycle and when they transition.

How a PA May Lose Certification

Administrative lapse
Fail recertification exam
Action by NCCPA following review triggered by
- Self-reports from PAs during certification maintenance process; must answer every two years
  - Adverse licensure actions
  - Misdemeanors and felonies
  - Adjudication of mental incompetence
- Reports on state board actions provided by the FSMB
- Individual state medical boards and/or federal entity reports
- Individual complaints
Potential Disciplinary Actions by NCCPA

- Take no action
- Issue a Letter of Concern (non reportable)
- Issue a Letter of Censure (reportable)
- Revocation (reportable)
  - of Certification
  - of Eligibility
- Other (e.g. extra CME credits, fees)

Regaining Certification

If certification lapsed for administrative reasons (failure to log CME credits, failure to pay fees, etc) or as a result of failing PANRE, a PA must meet 2 requirements:

1. Document 100 Cat 1 credits within past 2 years and 20 must be SA or PI
2. Pass PANRE or PANCE (can take twice a year, but not less than 90 days between attempts)
Key Principles of the Specialty CAQ Program

**PA-C** is still the primary credential for all PAs.

The CAQ program is voluntary.

The program has been developed to be as inclusive as possible, recognizing the individual differences among and within specialties.

The CAQ is an added credential that does not replace the PA-C, hence the name.

What Specialties?

Cardiovascular & Thoracic Surgery
Emergency Medicine
Hospital Medicine
Nephrology
Orthopaedic Surgery
Pediatrics
Psychiatry

Certified PAs by Specialty*

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* Based on NCCPA PA Profile data as of February 2015
Specialty CAQ Process

1. Prerequisite:
   • License
   • PA-C

2. CME Experience
   Cases and/or Procedures

3. Pass Specialty Exam

6 years to finish

CAQ Stats

# of CAQs awarded since 2011:
- 426 in emergency medicine
- 138 in psychiatry
- 78 in orthopaedic surgery
- 53 in hospital medicine
- 36 in CVT surgery
- 22 in pediatrics
- 16 in nephrology

Total of 769 CAQs issued -- eight PAs earned CAQs in two specialties

PA ROLES & RESPONSIBILITIES
PA Definition/Role

Physician assistants (PAs) practice medicine, providing services a physician would otherwise have to provide.

Physician Assistants

Licensed in all 50 states and DC.
National certification by the National Commission on the Certification of Physician Assistants (NCCPA) required for initial licensure; many states do not require certification maintenance for maintenance of licensure.
May prescribe medications in all 50 states/DC.
Physician not required to be on site; supervision via telecommunication allowed in all 50 states/DC.
Recognized by Medicare as enrolled ordering/referring providers.
Provide physician/Part B services.
Granted Medical Staff privileges in hospitals/ASCs
Can perform procedures, assist in surgery, perform visits in nursing and skilled nursing facilities.

Scope Defined by:

Education and experience: PAs are educated in the medical model. Programs average 26 months, with over 2000 hours of supervised clinical practice during training.
State Law and Regulations
Facility Policy/Privileging
Physician delegatory authority, practice and patient needs.
“Negotiated practice autonomy”

http://www.annalsofhealthlaw.com/annalsofhealthlaw/vol__24_issue_1/?pg=42&pm=1&u1=friend#p42
Interdependent Concepts

- Credentialing & Privileging PAs
- Reimbursement & Billing Policy
- Maximizing PA Utilization
- Regulatory Compliance & Scope of Practice

5th “Dimension” - Organizational Culture & Perceptions

Prior experience and/or preconceived notions of physicians, support staff and management.

- Generational and training experiences (or lack thereof)
- Lack of understanding of how the role has evolved and what the possibilities might be for change.
- Culture can completely derail even the best of business plans.
- Myths and misconceptions.
- The word “supervision”.

SUPERVISION
Supervision: Defined in State Law

Connecticut Statute
Ch 370: Medicine and Surgery
Sec 20-12 (a)(7)(a) “Supervision” in hospital settings…
(i) Continuous availability of direct communication either in person or by radio, telephone or telecommunications between the physician assistant and the supervising physician;…

Minnesota Statute
…Supervising physician’s physical presence not required so long as physician and PA can communicate via telecommunication. Scope and nature of supervision to be defined by individual physician-PA delegation agreement.
MINN. STAT. ANN. §147A.01 (24)

State Law Variations
PA practice oversight falls under the State Medical Board in most states; a few states have a separate “PA Board” or Committee.

Regulations can be promulgated through the Medical Board, PA Board, the Department of Public Health or other State Agencies.

***Many states require physicians to file applications, forms and/or registrations for delegatory authority.
Rules may vary by practice setting!

Supervision: Medicare Payment Policy

“The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise.”
Medicare Benefit Policy Manual Chapter 15, §190 Physician Assistant(PA) Services
**Supervision by an MD/DO**

Medicare Conditions of Payment as well as Medicare Conditions of Participation require that PAs are supervised by an MD/DO.

There are no provisions for any other type of physician under Medicare law. (DPM, Chiropractor, DDS, etc.)

There are a few state statutes that allow for PAs to work with podiatrists. HOWEVER, they would not be able to meet the requirements for Medicare payment or assisting in the OR under Medicare’s supervision rules (cropping up mostly in ortho practices and hospitals/ASCs). **Compliance risk!**

**DISPELLING MYTHS**

**Myths**

PAs cannot see new patients.

The physician must see every patient.

PAs cannot perform consultations.

PAs must have a first assistant certificate to be able to obtain first assist privileges.

A physician must be on site for a PA to see patients.

Patients want to see the physician/the “brand”.
PA CREDENTIALING & PRIVILEGING

Medical Staff Privileging

PAs must be credentialed and privileged through the Medical Staff process per Medicare ("providing a Medical Level of Care") and The Joint Commission.

No longer acceptable to use “equivalent process” through Human Resources.

Same process as for physicians.

References:
  - Joint Commission Comprehensive Accreditation Manual for Hospitals: Booster Pak published January 2011 specifies PAs and APRNs providing a “medical level of care” must obtain privileges via the med staff process.

Medical Staff Membership

PAs are allowed to be members of the Medical Staff by both Joint Commission Standards and Medicare’s Conditions of Participation if allowed by State Law.

The recently published “improved” Conditions of Participation really do not change anything, however do serve to clarify.

Privileges may be granted without granting membership.

As providers of a broad range of services that otherwise would be performed by physicians, medical staff membership allows PAs a voice in developing and implementing hospital and medical staff policies.
No. You already have the tools.

Using the MD/DO privilege list, redline the few privileges that would not be granted to the PA:

- in most cases, the PA will not serve as the admitting physician, but should be granted privileges to perform admission H&Ps (which is a core privilege for all PAs).
- in surgical specialties, the PA would not serve as the primary surgeon. Instead, insert first assisting privileges.

FAQ: Does AAPA have sample privileges for a PA in (insert specialty here)?

BEST PRACTICE:
PA Committees/Councils/Governance
Increasingly common and popular as hospitals take on more PAs. Often a parallel committee for the APRNs.

Can be stand alone or subcommittee of Credentialing Committee: review applications for appointment and re-appointment and provide peer review.

PAs should serve on Med Staff Committees (P+T, Quality, Ethics, etc.); consider MEC

Governance and Leadership positions are rapidly emerging, such as Chief PA for service lines/departments and Director of PA Services, mirroring physician governance.

“Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging Physician Assistants”

AAPA Position/Policy Paper

AAPA Professional Practice Commission presented to AAPA HOD: approved 2012. Written with input from PAs from multiple hospital systems.

Useful as a guide for updating your medical staff bylaws and credentialing processes.

Competency Assessment: What is Required?

**State laws** often have requirements for “chart review”, “review of the PA’s performance”, etc. Be sure to check regulations!

**CMS/Medicare Conditions of Participation for Hospitals:**
“The hospital’s Governing Body must ensure that all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital are individually evaluated by its Medical Staff and that those practitioners possess current qualifications and demonstrated competencies for the privileges granted.”

CMS S & C Letter 05-04

**DNV (Det Norske Veritas):** Requires a process to evaluate practitioners based on scope of responsibilities or delineation of privileges.

**HFAP:** Standards 03.15.01/03.15.02 in the Acute Care Hospital Manual/Standards 05.01.28/05.01.29 in the Critical Access Hospital Manual require practitioner performance evaluation and monitoring.

**The Joint Commission:** The Medical Staff Chapter, Standards MS.08.01.01 and MS.08.01.03 in the Hospital Manual a.k.a the FPPE/OPPE standards:
FPPE=Focused Professional Practice Evaluation
OPPE=Ongoing Professional Practice Evaluation
Four Organizations Serve the PA Profession:

Document: “Competencies for the PA Profession”

The four PA organizations (ARC-PA, AAPA, PAEA, and NCCPA) convened to define PA competencies in response to similar efforts by other health care professions and the growing demand for accountability and assessment in clinical practice.

As the document has been adopted by all four organizations representing the various facets of the PA profession, it serves as a valid foundation upon which to base a competency assessment policy for PAs in any setting.

Located in the AAPA Policy Manual:

Document: “PAs: Assessing Clinical Competence”

A corollary guidance document written to assist the various stakeholders as they write policy

Speaks to specialty privileges, and expansion of privileges

Addresses FPPE/OPPE

Contains citations

Link: http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2179
“Sample PA Competency Tool”

Based on the foundational document “Competencies for the Physician Assistant Profession”

Has been used in many settings.

First two pages are the core competencies for all PAs in all specialties:

- Medical knowledge
- Interpersonal and communication skills
- Patient care
- Professionalism
- Practice-based learning and improvement
- Systems-based practice

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Joint Commission’s definition of peer: “practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant”.

Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel can contribute to OPPE/PPPE data.

Q. Who can provide a peer reference for independent or non-independent allied health practitioners such as nurse practitioners, physician assistants, and psychologists, midwives, and social workers when there is no other similar practitioners on staff?
A. The definition of a peer is someone from the same discipline with essentially equal qualifications. To be able to provide a reference the peer would need to be familiar with the individual’s actual performance. For the nurse practitioner, physician assistant, ... ideally this should be another individual from the same discipline and the organization should attempt to obtain such references. This could be someone within the same organization or someone from outside the organization. However, in situations where there is no nurse practitioner, physician’s (sic) assistant, ... who could provide a peer reference it is acceptable for a physician or D.O with essentially equal qualifications, who is familiar with the allied health practitioner’s performance, to provide the reference. For example, an internist could provide a reference for a physician assistant; an anesthesiologist could provide a reference for a nurse anesthetist, and...

Source: http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=456&ProgramId=47

What already exists? What needs to be added?
Physicians must undergo FPPE/OPPE
Same metrics may apply to PAs; MANY WON’T
Use what you can that already is in place.
Make it relevant at the department level.
Data for PAs are often hidden under the attending of record, making extraction difficult and often requires manual chart review.

Take Home
There is no fixed time frame for the evaluations; can be extended or shortened. New grads may take longer.
There is no defined set of competencies to be evaluated, but it is based on privileges.
All defined at the department level and approved by the medical staff (not nursing, administration, or pharmacy).
Both Cognitive and Procedural Competencies; consider simulation.
Can be flexible; will look different in different departments and for different practitioners.
PAs Are Providers

PAs are recognized as enrolled “non-physician providers”, “ordering/referring” providers, and “eligible providers” in the Medicare program.

PA covered services are those that a physician would otherwise have to provide.

**Must** be enrolled in Medicare if ordering, referring and/or billing. (January 2014)

Reimbursement for services provided by PAs are reimbursed at 85% of the physician fee schedule.

There are provisions for 100%, such as *Incident-to* in the Office and *Shared Visits* in the hospital setting; specific rules apply.
PA Direct Billing/Payment

Medicare does allow PAs to submit claims under their own NPI.

Medicare does not allow PAs to direct bill/receive direct payment; while the claim is submitted under the PA’s NPI, the payment field is to the PA’s employer.

Medicare Manual Citations

The Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services §190 - Physician Assistant (PA) Services (Rev. 11/2001/99)
D. Employment Relationship
Payment for the services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories.


Medicare Program Integrity Manual, Pub 100-08, Chapter 10, §2.4.11
Payment for the PA’s services may only be made to the PA’s employer, not to the PA himself/herself. In other words, the PA cannot individually enroll in Medicare and receive direct payment for his or her services. This also means that the PA does not assign his or her benefits to the employer, since the employer must receive direct payment anyway. The PA’s employer can be either an individual or an organization.


PAs can bill all levels of E/M: Medicare

Medicare Benefit Policy Manual: Chapter 15, §190 Physician Assistant (PA) Services states:

“PAs may furnish services billed under all levels of CPT evaluation and management codes and diagnostic tests if furnished under the general supervision of a physician.”

New Patients/New Problems: Medicare

PAs may provide evaluation and management services to new patients and established patients with new problems in the Medicare program.

When they do, the encounter should be billed under the PA’s NPI for Medicare; reimbursement will be at 85% of the physician rate.

Note: It is ALWAYS appropriate/“legal” to bill Medicare for work provided by a PA under the PA’s NPI.

MYTH

What about the 15% left on the table?!

Let’s Compare

Physician Salary/Compensation  PA/NP Salary/Compensation
PA/Physician Salaries

PAs are paid approximately 1/3rd to 1/4th the salary of their physician counterpart. (This is a broad generalization, but supported by MGMA data.)

This is about math.

The **profit margin** is higher when the PA provides the service, even at 85% reimbursement.

Math: Same Service Provided

<table>
<thead>
<tr>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary $300,000 ($144/hr)</td>
<td>Salary $100,000 ($48/hr)</td>
</tr>
<tr>
<td>The service/office visit is reimbursed at 100% for $100.</td>
<td>The same service/office visit is reimbursed at 85% for $85.</td>
</tr>
<tr>
<td>First visit of the day: still <strong>$44</strong> in the RED. Recurs first visit every hour thereafter.</td>
<td>First visit of the day: profit <strong>$36</strong>.</td>
</tr>
</tbody>
</table>

Another View

Assumptions:
- 15 minute appointment slots= 4 visits per hour= 28 visits per day
- 8 hour days

<table>
<thead>
<tr>
<th></th>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts providing same level of service</td>
<td>$2800 ($100 x 28 visits)</td>
<td>$2380 ($85 x 28 visits)</td>
</tr>
<tr>
<td>Wage per day</td>
<td>$1152 ($144/hour x 8 hours)</td>
<td>$384 ($48/hour x 8 hours)</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td><strong>$1648</strong></td>
<td><strong>$1996</strong></td>
</tr>
</tbody>
</table>
All state Medicaid programs pay for services provided by PAs.

Many states do not enroll, although that is changing rapidly since PPACA (Section 6401)

For those states that do not enroll, the claim is submitted under an enrolled physician’s NPI.

Most do not require a physician’s presence on site.

A few will not pay for services provided in a hospital. Some won’t cover first assisting.
States that authorize Medicaid payment for PAs to provide first assist on Medicaid patients:

- RI
- DE
- DC

States that do not authorize Medicaid payment for PAs to provide first assist:

- Commercial Payers
  - Private payers may promulgate their own rules.
  - Many choose not to enroll PA/NPs. They DO however pay for services provided by PA/NPs.
  - Claim is typically submitted under the physician’s number when a payer does not enroll PAs.
  - Many do not discount; payment is at the physician rate.
Payer Policy Variability

The billing methodology must be clearly ascertained by every individual practice for every individual payer with whom they contract.

Enrollment does not necessarily equate with payment.

Many do not follow Medicare rules (such as Incident-to or Shared Visits) or use Medicare modifiers.

Many do not discount services provided by PAs.

Must not assume.

Example: Aetna

Aetna enrolls PAs (since June 2010) except in Alaska, Maine, Michigan.

Discounts PA services to 85%.

Aetna’s policy manual states that it follows Medicare’s Incident-to policy, allowing for 100% reimbursement if all rules are met.

It remains the responsibility of the practice to ascertain the payment policy and claims instructions for each payer with whom they contract.

CPT® Code Utilization

“Throughout the CPT code set the use of terms such as “physician”, “qualified health care professional”, or “individual” is not intended to indicate that other entities may not report the service.”

CPT ® 2015, Professional Edition p. xii

“A “physician or other qualified health care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

CPT ® 2015, Professional Edition p. xii
What’s in a name?
PA NOMENCLATURE

What’s in a Name?
Allied Health
Advanced Practice Professional/Clinician
Mid-level
Non-physician practitioner
Physician extender
Allied Health: Federal Definition

CITE: 42USC295p
TITLE 42--THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A--PUBLIC HEALTH SERVICE
SUBCHAPTER V--HEALTH PROFESSIONS EDUCATION
Part F--General Provisions Sec. 295p. Definitions

(5) The term “allied health professionals” means a health professional (other than a registered nurse or physician assistant)…

PA Definition

HP-3100.2.1 AAPA Policy Manual

Physician assistants (PAs) practice medicine with … licensed physicians. As members of the health care team, PAs provide a broad range of medical services that would otherwise be provided by physicians.


PA

HP-3100.1.3 AAPA Policy Manual

The AAPA believes that, whenever possible, PAs should be referred to as “physician assistants” and not combined with other providers in inclusive non-specific terms such as “midlevel practitioner”, “advanced practice clinician”, or “advanced practice provider”.

PAs should utilize, and encourage employers (e.g., hospitals, HMO’s, clinics), third party payers, educators, researchers, and the government, to utilize, the term “physician assistant” or “PA” to reflect the unique position of PAs in the healthcare system.


HOT TOPICS

Ordering Restraints
Medicare CoPs are problematic, with language that includes “as allowed by State law”.

Most State PA Practice legislation and regulations are not that specific. Some states have recently added specific language.

However, PAs may initiate, evaluate and monitor. Required to receive training on restraints and must contact the attending physician.

What does your policy say?
EMTALA Provisions

The following must be included in privileging/policy:

Medical Screening Exam
Certification of False Labor
On-Call Coverage
Transfers

Expanding Privileges/New Technology

Same approach as physicians.

If hospital acquires a daVinci robot, the surgeon needs training. The PA will also require training as the tables role is vital to the success of the case. The first assistant must be trained with the surgeons.

CASE STUDIES
Case Study

PA LOST NCCPA CERTIFICATION

The Problem: PA loses certification

NCCPA Certification expires December 31, 2014

State license expires June 30, 2015.

PA failed the final attempt at the PANRE in early December.

Facts

State does NOT require maintenance of certification for maintenance of licensure,

PA is employed by a “hospital-owned” surgical physician practice.

Hospital policy requires maintenance of certification for privileges.
Can I allow this PA to work?

It Depends

- Cannot provide care in hospital (rounds, OR first assist) after December 31, 2014.
- Physician practice is considered a hospital outpatient clinic; then the PA could not work there either.
- Physician practice is a separate physician office (POS 11); then the PA could personally see patients there.
- MUST CHECK WITH MALPRACTICE CARRIER for Conditions of Coverage.
- What about Medicare billing in the office? Medicare does not require certification maintenance; PA must have passed the initial NCCPA exam.

What are the options regarding this PA’s medical staff privileges?
- Revocation?
- LOA?
- Resignation?

Case Study

PAs and Conscious Sedation
Problem

PA contacted AAPA because a “surveyor” questioned a PA’s ability to “order” conscious sedation.

The initial reaction of the hospital administration was to change “policy”; told the PAs they could not “order” conscious sedation.

PAs in the interventional radiology suite were ordering procedural sedation administered by an RN while the PA performed procedures.

Proof Checklist

Policy
Policy needs to include PAs where appropriate. Citation to professional guidelines provide a rationale for key elements of policy.

Privileges
The privilege must be granted.

Performance
FPPE/OPPE=Documented Competency.

Regulatory Considerations

State Law and Regulation: is there anything to preclude a PA from ordering/performing/providing conscious sedation?

Joint Commission Standards:
Comprehensive Accreditation Manual for Hospitals. Note: Standards are RARELY practitioner specific, leaving it up to the facility to specify in policy.

Medicare Conditions of Participation for Hospitals: Interpretive Guidelines

However, in real time, this is RARELY the case.

Note: For the Joint Commission, if an assertion is made for which there is significant disagreement, the organization’s account representative (NOT THE PA) should call the Joint Commission WHILE THE SURVEYOR IS ON SITE to clarify the validity of such an assertion.

However, in real time, this is RARELY the case.

Note: For the Joint Commission, if an assertion is made for which there is significant disagreement, the organization’s account representative (NOT THE PA) should call the Joint Commission WHILE THE SURVEYOR IS ON SITE to clarify the validity of such an assertion.
Source Materials

Professional Guidelines
http://ftp.asahq.org/publications
AndServices/sedation1017.pdf

CMS transmittal R74SOMA

What is the Answer?

Medicare Conditions of Participation (CoP) define who may administer anesthesia. PAs are NOT included in that list. HOWEVER, the CoPs also clearly state that Conscious Sedation is NOT anesthesia:

- Moderate sedation/analgesia (“Conscious Sedation”): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. CMS, consistent with ASA guidelines, does not define moderate or conscious sedation as anesthesia (71 FR 68690-1).

- Minimal sedation: a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. This is also not anesthesia.

Further CMS Guidance

“We encourage hospitals to address whether the sedation typically provided in the emergency department or procedure rooms involves anesthesia or analgesia. In establishing such policies, the hospital is expected to take into account the characteristics of the patients cared for, the skill set of the clinical staff in providing the services, as well as the characteristics of the sedation medications used in the various clinical settings."

The regulation at 42 CFR 482.52(a) establishes the qualifications and, where applicable, supervision requirements for personnel who administer anesthesia. However, hospital anesthesia services policies and procedures are expected to also address the minimum qualifications and supervision requirements for each category of practitioner who is permitted to provide anesthesia services, particularly moderate sedation.

Joint Commission Standards

PC.03.01.01 The hospital plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia. Note: Equipment identified in the elements of performance is available to the operating room suites.

EP1 Individuals administering moderate or deep sedation and anesthesia are qualified and have credentials to manage and rescue patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally. (See also MS.06.01.03, EP 6)

Medical Staff Chapter

MS.03.01.01 The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

EP 2 Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

MS.06.01.03 The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege.

EP 6 The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:
- The applicant’s current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration
- The applicant’s relevant training
- The applicant’s current competence (See also PC.03.01.01, EP 1)

Conclusion

There is no state law, CMS regulation or Joint Commission Standard or Element of Performance to exclude PAs from being able to order or provide conscious sedation.

The facility must have policies in place as required by CMS and TJC, for the provision of anesthesia services as well as sedation and analgesia, the administration of medications, and the qualifications of personnel.
Conclusion

In the absence of anything to the contrary…

PA CAN order, administer/ provide conscious sedation…

AS LONG AS THE FACILITY POLICY ALLOWS &

PA HAS BEEN GRANTED THE PRIVILEGE

Case Outcome

The facility was able to refute the assertion, using the Medicare Conditions of Participation Interpretive Guidelines, Joint Commission standards and facility policies.

HOWEVER, their sedation policies did not reference PAs! They were unable to produce Policy/Proof.

Resources

Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs

EMTALA and PAs

Competencies for the PA Profession


FPPE and OPPE are more than Just Acronyms (article)

Sample Competency Assessment Tool

Issue Brief, PA Scope of Practice
Guidelines for Updating Medical Staff Bylaws:
Credentialing and Privileging Physician Assistants
(Adopted 2012)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information, and may lose nuance of policy.
You are highly encouraged to read the entire paper.

AAPA believes that

- Physician assistants must seek delineation of their clinical privileges and that the process must be outlined in medical staff bylaws.
- Physician assistants should be members of the medical staff.
- Medical staff bylaws should require that each physician assistant be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital.
- The criteria for delineating PA clinical privileges should be specified in the bylaws.
- AAPA opposes specialty certification examinations as a requirement for physician assistant credentialing or privileging.
- Duration of appointments and privileges should be the same for physicians and physician assistants.
- Bylaws should give physician assistants the right to due process when actions taken by the medical staff or governing board adversely affect his or her clinical privileges.
- The criteria and process for disciplining physician assistants should be spelled out in the bylaws. The process should involve PA peers and conform to the process applied to physicians.
- Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
- Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
- Bylaws should allow PA representation on medical staff committees, including the medical executive committee.
- Bylaws should include language enabling physician assistants to provide care during emergency or disaster situations.
Introduction

Physician assistants (PAs) are highly skilled professionals who practice in every medical and surgical specialty. They are employed by hospitals and healthcare systems, medical practices, hospital medicine groups, and emergency department staffing groups. PAs provide medical care almost anywhere in a hospital, including emergency departments, inpatient services, operating rooms, outpatient units and critical care/ intensive care units. Requirements for PA practice are defined by state law and hospital policy. All state laws allow the flexibility of physicians being off-site as long as they are available via telecommunication. Most hospitals develop policies and definitions based on the language used in their state's laws and regulations governing PA practice. Federal facilities and federally employed PAs, however, are governed by federal agency guidelines, not state law.

The criteria and process for granting clinical privileges to physician assistants is similar to the process for physicians and must be outlined in the medical staff bylaws. The organized medical staff is required to review and verify the credentials of practitioners to ensure that those who provide medical care are competent and qualified to provide specified levels of care. In order to provide patient care services in the hospital or other healthcare facilities, physician assistants must seek delineation of their clinical privileges, which are then granted by the medical staff, and ultimately, the governing body.

In most hospitals, the medical staff credentialing process involves simultaneous consideration of applications for medical staff membership and for clinical privileges. The following guidelines are intended to assist medical staffs in making appropriate changes to the bylaws that authorize the granting of membership and clinical privileges to physician assistants. They are intended to be a general guide that can be applied and adapted to suit the requirements of individual medical staffs. Where possible, sample language has been included.

Definition of Physician Assistant

Medical staff bylaws usually begin with a section that includes definitions of terms. This section should include a definition of physician assistant. It should generally conform to the definition used in state law and may reflect the definition used by the American Academy of Physician Assistants. In the case of federally employed PAs, the legal definition is found in federal regulations or policies, rather than state law.
All states require that a physician assistant be a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies and/or pass the initial exam given by the National Commission on Certification of Physician Assistants (NCCPA), be licensed to practice as a physician assistant.

Federally employed PAs must meet the first two criteria, but are typically not required to be licensed, as federal agencies are not governed by state laws. Many states and employers require current NCCPA certification.

The following definition serves as an example.

A physician assistant (PA) is an individual who is a graduate of a physician assistant program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants (NCCPA). The individual meets the necessary legal requirements for licensure to practice medicine as delegated by a licensed physician.

PAs as Members of the Medical Staff
AAPA believes that physician assistants should be members of the medical staff. Physician assistants are providers of a broad range of services that otherwise would be performed by physicians. They exercise a high level of decision-making and autonomy in providing patient care as members of medical and surgical teams. Medical staff privileges enable/authorize clinicians to diagnose illness and perform other functions in the hospital. Medical staff “membership” is not a pre-requisite for a hospital to grant physicians or PAs clinical privileges. However, medical staff membership allows PAs a voice in developing and implementing hospital and medical staff policies and ensures participation in programs to review the quality and appropriateness of patient care. It is important that PAs participate in the system in which medical care policies are made and communicated.

In the majority of states, medical staff and hospital governing boards decide which types of practitioners will be medical staff members. Both the Joint Commission Medical Staff standards and Medicare’s Conditions of Participation for Hospitals allow PA membership on medical staffs. The Joint Commission’s Comprehensive Accreditation Manual for Hospitals states: “The governing body and the medical staff define medical staff membership criteria, which…may include licensed independent practitioners and other practitioners.”
Medicare Conditions of Participation for Hospitals clearly state that, in addition to MD and DO members, the medical staff “may also be composed of other practitioners appointed by the governing body.” The Medicare surveyors’ manual further specifies that hospitals can appoint PAs to the medical staff. State law should be consulted; the makeup of medical staff membership is occasionally dictated there.

Sometimes PAs are erroneously categorized as allied health professionals or under nursing structures. PAs, by definition, are providers of medical care and, as such, are not part of the allied health field or nursing profession. The National Commission on Allied Health, convened by an act of Congress in 1992, defined an allied health professional as “a health professional (other than a registered nurse or physician assistant)....” The federal Bureau of Health Professions uses this same definition and classifies PAs as medical providers. [42USCS §295p; Title 42. The Public Health and Welfare, Chapter 6A – Public Health Services]

AAPA believes that PAs should be referred to as “physician assistants” and not combined with other providers in non-specific, inclusive terms such as “midlevel practitioner,” “advanced practice clinician,” or “advanced practice provider.” PAs should utilize, and encourage employers (e.g., hospitals, HMO’s, clinics), third party payers, educators, researchers, and the government to utilize, the term “physician assistant” or “PA” for clarity and accuracy.

Medical staff membership language might state:

Membership on the medical staff shall be extended to physicians, dentists, podiatrists, physician assistants, and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and who are appointed by the hospital Board of Directors.

**Credentialing Physician Assistants**

Medical staff bylaws specify professional criteria for medical staff membership and clinical privileges. The Joint Commission specifies four core criteria that should be met when credentialing licensed independent practitioners, including:

- current licensure
- relevant training or experience
- current competence and
- the ability to perform privileges requested.
This serves as a reasonable guideline. As applied to physician assistants, these criteria might include:

- evidence of national certification
- letters from previous employers, supervising physicians, physician assistant peers, or PA programs attesting to scope and level of performance
- verified logs of clinical procedures
- personal attestation as to physical and mental health status
- evidence of adequate professional liability insurance
- information on any past or pending professional liability or disciplinary actions
- a letter from a sponsoring physician (MD or DO) who is a member of the medical staff.

When credentialing a PA, a query should be made to the National Practitioner Data Bank (NPDB) regarding the individual's medical liability and disciplinary histories. Entities that make malpractice payments on behalf of PAs have been required to report that information to the NPDB since its inception in 1990. Since March 2010, employers and regulators have been required to report to the NPDB adverse professional review actions taken against PAs. Queries about licensure actions taken against PAs can be made to the Federation of State Medical Boards (FSMB). Though all state licensing boards are encouraged to report disciplinary actions to the FSMB, it is impossible to ascertain whether all actions are reported, so it is important that hospitals also query individual boards in all states where the PA has been licensed.

The American Medical Association’s (AMA) Physician Profile Service also offers PA credentials verification. Credentialing professionals can confirm a PA’s education program attendance and graduation dates, national certification number and status, current and historical state licensure information, and AAPA membership status. The Joint Commission has deemed that the information provided by the AMA Physician Profile service is equivalent to primary source information.

**Physician Assistant Privileges**

The fundamental premise of the physician assistant profession is a solid educational foundation in medicine and surgery that prepares PAs to work with physicians in any specialty or care setting. The medical staff bylaws should require that each PA be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital. Medical staff membership should not be a requirement for granting
of clinical privileges. This is in accordance with Joint Commission standards and the Medicare Conditions of Participation for Hospitals.

The medical staff bylaws should stipulate that all clinical privileges granted to a physician assistant should be consistent with all applicable state and federal laws and regulations and that a physician assistant may provide medical and surgical services as delegated by a physician. Typically, privileges for a physician assistant are delineated using a form and process identical to or very similar to that used for physicians. Because PAs provide medical services, the physician form and privileging system is a useful template for developing a system of granting PA privileges.

The process for granting clinical privileges is usually discussed in four places in the bylaws: the article concerned with clinical privileges, the article describing the structure of the credentials committee, the article describing the duties of department chairs, and the article describing hearing procedures. The process of granting clinical privileges may vary considerably from one hospital to another, but generally the process should include the following: 1) completion in a timely fashion; 2) department chairs, if they exist, should make specific recommendations for clinical privileges; 3) an appeal mechanism for adverse decisions; and 4) the governing board should have ultimate authority to grant clinical privileges. An application for renewal of clinical privileges should be processed in essentially the same manner as that for granting initial privileges.

The criteria for delineating clinical privileges should be specified in the bylaws. They are usually the same as those used for credentialing: evidence of current state licensure, relevant training and experience, national certification, letters or other verification from authoritative sources attesting to the individual’s ability to perform certain privileges, attestation as to physical and mental health status, evidence of adequate liability insurance, and information on any past or pending professional liability or disciplinary actions. Privilege determinations – at reappointment or other interim times – might also include observed clinical performance, quality improvement data, and other documented results of quality improvement activities required by the hospital and medical staff.

Other requirements of physician members of the medical staff also may apply to PAs. For example, if hospital policy requires that a department chair approves physician privilege requests before they are submitted to the medical staff credentials committee, then the same should apply to PAs. For Joint Commission-accredited hospitals, PAs, like physicians, are evaluated using a focused professional practice evaluation (FPPE) for
new privileges or performance improvement and ongoing professional practice evaluation OPPE) for bi-annual reappointment.

**Expanding Privileges**

PAs are educated in the medical model of evaluation, diagnosis, and treatment. They are committed to lifelong learning through clinical experience and continuing medical education. Recognition that new tasks and responsibilities can be taught and delegated to the PA by physicians as a PA gains experience, and as the physician and PA grow as a team, are key to effective utilization of PAs. As such, PAs may need to request additional privileges; this process should mirror that of the physicians requesting additional privileges.

**Specialty and Subspecialty Privileges**

When PAs request privileges for specialized procedures or other highly technical, specialty-related care, their qualifications should be assessed just as they would be for any other privilege – verification of specialized training in the clinical setting, previous privileges, relevant CME, a documented skills assessment, or performance of procedures under direct proctoring by a physician or physician assistant granted privileges to perform the procedure.

The AAPA is committed to lifelong learning and encourages advanced educational opportunities (such as Pediatric Advanced Life Support (PALS) or Advanced Trauma Life Support (ATLS)), as well as verification of specific course completion. However, AAPA does oppose specialty certification examinations as a requirement for physician assistant credentialing or privileging. The physician assistant profession currently does not have a system of specialty credentialing like the specialty boards system developed by physicians. Because there are other ways to assess PA competency, the AAPA believes imposing specialty boards or specialty exams is unnecessary and would undermine the basic construct of the profession, which is to be broadly educated medical providers with the versatility and adaptability to meet changing health care needs. Many PAs fulfill their national certification CME requirement by attending highly specialized courses specific to their area of practice.

**Duration and Renewal of Appointments**

Duration of appointments and privileges should be the same for physicians and physician assistants. The renewal/re-appointment process should also be aligned with that required of physicians.
Due Process
The bylaws should give the physician assistant the right to request the initiation of due process procedures when actions taken by the medical staff or the governing board adversely affect his or her clinical privileges. Hospital accreditation standards from the Joint Commission specifically state that medical staffs must establish a fair hearing and appeals process for addressing adverse decisions made against medical staff members and others holding clinical privileges. The process should include PA peer reviewers.

Corrective Action
The criteria and process for disciplining physician assistants should be spelled out in the bylaws. The process should involve PA peers and conform to the process applied to physicians.

Quality Assurance
The bylaws should provide for effective mechanisms to carry out quality assurance responsibilities with respect to physician assistants. Peer review of PA practice should be conducted by peers ideally other physician assistants in the same area of clinical specialty. If the staff does not include other PAs in the same or similar specialty, PA peers from outside the hospital should be called in.

Continuing Education
The medical staff bylaws should require participation by physician assistants in continuing medical education that relates, at least in part, to their regular practice and to their clinical privileges.

Committees
Bylaws should allow physician assistant representation on medical staff committees, including the medical executive committee.

Discrimination
The fundamental criteria for medical staff membership or clinical privileges should be directly related to the delivery of quality medical care, professional ability and judgment, and community need. Medical staff membership or particular clinical privileges should not be denied on the basis of gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, disability, socioeconomic status, or sexual orientation.
Participation in Disaster and Emergency Care

The bylaws should include language enabling physician assistants to provide care during emergency or disaster situations. The bylaws should state that the chief executive or his or her designee may grant temporary clinical privileges when appropriate and that emergency privileges may be granted when the hospital’s emergency management plan has been activated. The hospital’s emergency preparedness plan should include physician assistants in its identification of care providers authorized to respond in emergency or disaster situations.

Bylaws language might state:

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any physician assistant acting in an emergency or disaster situation shall be exempt from the hospital’s usual requirements of physician supervision to the extent allowed by state law in disaster or emergency situations. Any physician who supervises a physician assistant providing medical care in response to such an emergency or declared disaster does not have to meet the requirements set forth in these bylaws for a supervising physician.

Conclusion

- Physician assistants must seek delineation of their clinical privileges; the process must be outlined in medical staff bylaws.
- The AAPA believes that physician assistants should be members of the medical staff.
- Medical staff bylaws should require that each physician assistant be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital.
- The criteria for delineating PA clinical privileges should be specified in the bylaws.
- AAPA opposes specialty certification examinations as a requirement for physician assistant credentialing or privileging.
- Duration of appointments and privileges should be the same for physicians and physician assistants.
- Bylaws should give physician assistants the right to due process when actions taken by the medical staff or governing board adversely affect his or her clinical privileges.
The criteria and process for disciplining physician assistants should be spelled out in the bylaws. The process should involve PA peers and conform to the process applied to physicians.

Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.

Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.

Bylaws should allow PA representation on medical staff committees, including the medical executive committee.

Bylaws should include language enabling physician assistants to provide care during emergency or disaster situations.
Endnotes

1. Several states have no explicit educational requirement. However, because those states require national certification and because only graduates of accredited programs are eligible for the national certification exam, the certification requirements in the laws of those states are the functional equivalent of an educational requirement.

2. Upon graduation from a physician assistant program, PAs must pass the NCCPA’s initial certifying exam, the Physician Assistant National Certifying Examination (PANCE). To maintain current certification, PAs must complete 100 hours of continuing medical education every two years and pass the Physician Assistant National Recertification Examination (PANRE) every six years.

3. CMS -3244-P, October 24, 2011 Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation (proposed rule) states: “Alternatively, a hospital could establish categories within its medical staff to create distinctions between practitioners who have full membership, and a new category for those who could be classified as having an ‘associate’, ‘special’ or ‘limited’ membership. Such a structure is neither required nor suggested; we are providing it here as a possible way to align all of its practitioners under the ‘Medical Staff’ rules.”


Competencies for the Physician Assistant Profession
(Originally adopted 2005; revised 2012)

PREAMBLE

Between 2003-2004, the National Commission on Certification of Physician Assistants (NCCPA) led an effort with three other national PA organizations (Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), American Academy of Physician Assistants (AAPA), and Physician Assistant Education Association (PAEA) -- formerly Association of Physician Assistant Programs (APAP)) to define PA competencies in response to similar efforts conducted within other health care professions and the growing demand for accountability and assessment in clinical practice. The resultant document, Competencies for the Physician Assistant Profession, provided a foundation from which physician assistant organizations and individual physician assistants could chart a course for advancing the competencies of the PA profession.

In 2011, representatives from the same four national PA organizations convened to review and revise the document. The revised manuscript was then reviewed and approved by the leadership of the four organizations in 2012.

INTRODUCTION

This document serves as a map for the individual PA, the physician-PA team, and organizations committed to promoting the development and maintenance of professional competencies among physician assistants. While some competencies will be acquired during formal PA education, others will be developed and mastered as physician assistants progress through their careers. The PA profession defines the specific knowledge, skills, attitudes, and educational experiences requisite for physician assistants to acquire and demonstrate these competencies.

The clinical role of PAs includes primary and specialty care in medical and surgical practice settings. Professional competencies for physician assistants include the effective and appropriate application of medical knowledge, interpersonal and communication skills, patient care, professionalism, practice-based learning and improvement, and systems-based practice.

Patient-centered, physician assistant practice reflects a number of overarching themes. These include an unwavering commitment to patient safety, cultural competence, quality health care, lifelong learning, and professional growth. Furthermore, the profession’s dedication to the physician-physician assistant team benefits patients and the larger community.
**PHYSICIAN ASSISTANT COMPETENCIES**

**Medical Knowledge**

Medical knowledge includes the synthesis of pathophysiology, patient presentation, differential diagnosis, patient management, surgical principles, health promotion, and disease prevention. Physician assistants must demonstrate core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care in their area of practice. In addition, physician assistants are expected to demonstrate an investigative and analytic thinking approach to clinical situations. Physician assistants are expected to understand, evaluate, and apply the following to clinical scenarios:

- evidence-based medicine
- scientific principles related to patient care
- etiologies, risk factors, underlying pathologic process, and epidemiology for medical conditions
- signs and symptoms of medical and surgical conditions
- appropriate diagnostic studies
- management of general medical and surgical conditions to include pharmacologic and other treatment modalities
- interventions for prevention of disease and health promotion/maintenance
- screening methods to detect conditions in an asymptomatic individual
- history and physical findings and diagnostic studies to formulate differential diagnoses

**Interpersonal & Communications Skills**

Interpersonal and communication skills encompass the verbal, nonverbal, written, and electronic exchange of information. Physician assistants must demonstrate interpersonal and communication skills that result in effective information exchange with patients, patients’ families, physicians, professional associates, and other individuals within the health care system. Physician assistants are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective communication skills to elicit and provide information
- adapt communication style and messages to the context of the interaction
- work effectively with physicians and other health care professionals as a member or leader of a health care team or other professional group
- demonstrate emotional resilience and stability, adaptability, flexibility, and tolerance of ambiguity and anxiety
- accurately and adequately document information regarding care for medical, legal, quality, and financial purposes
Patient Care

Patient care includes patient- and setting-specific assessment, evaluation, and management. Physician assistants must demonstrate care that is effective, safe, high quality, and equitable. Physician assistants are expected to:

- work effectively with physicians and other health care professionals to provide patient-centered care
- demonstrate compassionate and respectful behaviors when interacting with patients and their families
- obtain essential and accurate information about their patients
- make decisions about diagnostic and therapeutic interventions based on patient information and preferences, current scientific evidence, and informed clinical judgment
- develop and implement patient management plans
- counsel and educate patients and their families
- perform medical and surgical procedures essential to their area of practice
- provide health care services and education aimed at disease prevention and health maintenance
- use information technology to support patient care decisions and patient education

Professionalism

Professionalism is the expression of positive values and ideals as care is delivered. Foremost, it involves prioritizing the interests of those being served above one’s own. Physician assistants must acknowledge their professional and personal limitations. Professionalism also requires that PAs practice without impairment from substance abuse, cognitive deficiency or mental illness. Physician assistants must demonstrate a high level of responsibility, ethical practice, sensitivity to a diverse patient population, and adherence to legal and regulatory requirements. Physician assistants are expected to demonstrate:

- understanding of legal and regulatory requirements, as well as the appropriate role of the physician assistant
- professional relationships with physician supervisors and other health care providers
- respect, compassion, and integrity
- accountability to patients, society, and the profession
- commitment to excellence and on-going professional development
- commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- sensitivity and responsiveness to patients’ culture, age, gender, and abilities
- self-reflection, critical curiosity, and initiative
- healthy behaviors and life balance
- commitment to the education of students and other health care professionals

Practice-based Learning & Improvement

Practice-based learning and improvement includes the processes through which physician assistants engage in critical analysis of their own practice experience, the medical literature, and
other information resources for the purposes of self- and practice-improvement. Physician assistants must be able to assess, evaluate, and improve their patient care practices. Physician assistants are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology in concert with other members of the health care delivery team
- locate, appraise, and integrate evidence from scientific studies related to their patients’ health
- apply knowledge of study designs and statistical methods to the appraisal of clinical literature and other information on diagnostic and therapeutic effectiveness
- utilize information technology to manage information, access medical information, and support their own education
- recognize and appropriately address personal biases, gaps in medical knowledge, and physical limitations in themselves and others

**Systems-based Practice**

Systems-based practice encompasses the societal, organizational, and economic environments in which health care is delivered. Physician assistants must demonstrate an awareness of and responsiveness to the larger system of health care to provide patient care that balances quality and cost, while maintaining the primacy of the individual patient. PAs should work to improve the health care system of which their practices are a part. Physician assistants are expected to:

- effectively interact with different types of medical practice and delivery systems
- understand the funding sources and payment systems that provide coverage for patient care and use the systems effectively
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- partner with supervising physicians, health care managers, and other health care providers to assess, coordinate, and improve the delivery and effectiveness of health care and patient outcomes
- accept responsibility for promoting a safe environment for patient care and recognizing and correcting systems-based factors that negatively impact patient care
- apply medical information and clinical data systems to provide effective, efficient patient care
- recognize and appropriately address system biases that contribute to health care disparities
- apply the concepts of population health to patient care

*Adopted 2012 by AAPA, ARC-PA, NCCPA, and PAEA*
EMTALA and Physician Assistants

EMTALA is the "Emergency Medical Treatment and Labor Act," a law that took effect in 1986 intended to ensure that all individuals have access to emergency care and that they are not inappropriately transferred to another facility. The regulations for EMTALA fall under the Centers for Medicare and Medicaid Services (CMS).

The law requires that hospitals provide an appropriate medical screening examination (MSE) to any individual who comes to the facility requesting emergency care.

The purpose of the MSE is to determine whether an emergency medical condition exists.

If the clinical staff determines that an emergency medical condition does exist, they must either provide the treatment necessary to stabilize the individual or, if the facility and staff are unable to provide the care needed, the individual may be transferred. The law includes specific criteria that must be met regarding transfers.

EMTALA affects PA practice specifically in four areas:

- Medical Screening Exam
- Certifying False Labor
- Emergency Call
- Transferring patients

Medical Screening Exam

Summary: The EMTALA law and regulations allow physician assistants (PAs) to conduct MSEs. A hospital’s written policies must specify that PAs are among the providers qualified to conduct them. Individual PAs must have privileges to perform the exams.

EMTALA regulations state:

“In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) ‘comes to the emergency department,’ as defined in paragraph (b) of this section, the hospital must provide an appropriate medical screening examination (MSE) within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations ...” [42 CFR §489.24(a)(1)(i)]

CMS Guidance/Interpretation

The CMS State Operations Manual (SOM) (also called “interpretive guidelines”) is written by CMS national staff to guide surveyors who are inspecting hospitals for Medicare and Medicaid participation. The public can access the guidelines online. The EMTALA guidelines are found in SOM Appendix V.

The interpretive guidelines state, "The MSE must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations ..."
EMTALA and Physician Assistants

bylaws or rules and regulations and who meets the requirements of §482.55 concerning emergency services personnel and direction. The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform the medical screening examinations may be set forth in the rules and regulations, or the hospital bylaws. It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.* SOM Appendix V, page 41.

Certifying False Labor

Summary: Physicians assistants can certify false labor if they are acting within their scope of practice as defined by the hospital and their individual privileges.

EMTALA regulations state:
“Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.” 42 CFR §489.24(b) Definitions

CMS Guidance/Interpretation
CMS guidance to surveyors quotes the regulation and provides no additional interpretation. SOM Appendix V, page 37.

Emergency Room Call

Summary: Physician assistants can take emergency room call under EMTALA.

EMTALA regulations state:
The hospital agrees to provide “An on-call list of physicians who are on the hospital’s medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services under §489.24 in accordance with the resources available to the hospital;”  §489.20(r)(2)

Section 489.24(j) – Availability of On-call Physicians – requires hospital to have written policies and procedures in place to address how they will respond when a particular specialty is not available or the on-call physician cannot respond, how it will meet on-call needs if physicians schedule elective surgery during their on-call hours, if physicians have simultaneous on-call duties, or participate in a formal community call plan. §489.24(j)

CMS Guidance/Interpretation Regarding PAs and Call
In its guidance about on-call duties, CMS provides some specifics about PAs taking call:

“If it is permitted under the hospital’s policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual’s medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations. There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. It is important to note, however, that the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the DED, regardless of who makes the in-person appearance. Furthermore, in the event that the treating physician disagrees with the on-call physician’s decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person. Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.” SOM Appendix V, page 31.

CMS also provides extensive guidance about the on-call list and scenarios of possible on-call coverage plans, SOM Appendix V, pages 25-32.
Transferring Patients

Summary: The EMTALA regulations allow “qualified medical personnel” other than physicians to order the transfer of emergency patients. If a physician assistant is going to certify transfer of an unstable patient to another emergency department, the law requires that the PA first consult with a physician before ordering the transfer. Subsequently, the physician must co-sign the order within a timeframe specified in hospital policy.

EMTALA regulations state:
*If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—*

*****

“(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based;*

*****

“(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.” [CFR Title 42, Section 489.24(e)(ii)(C)]

CMS Guidance/Interpretation

CMS interpretive guidelines state:
“Section 1861(r)(i) of the Act defines physicians as: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State’s regulatory mechanism).” [SOM Appendix V, pages 60-61.]

“Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer or if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for transfer.” [SOM Appendix V, page 61.]

"Under certain circumstances qualified medical personnel other than a physician may sign the certification. A qualified medical person (QMP) may sign the certification of benefits versus risks of a transfer only after consultation with a physician who agrees with the transfer. The physician must subsequently countersign the certification. The physician’s countersignature must be obtained within the established timeframe according to hospital policies and procedures. Hospital by-laws or rules or regulations must specify the criteria and process for granting medical staff privileges to QMPs, and, in accordance with the hospital or CAH Conditions of Participation, each individual QMP must be appropriately privileged.” [SOM Appendix V, page 60.]

References

United States Code at Title 42 USC §1867, Chapter 7 (Social Security), subchapter XXVIII, Part D, Sec.1395cc, Medicare Provider Agreements, and Sec.1395dd, Examination and treatment for emergency medical conditions and women in labor.

Code of Federal Regulations, Title 42,§489.20, Provider Agreements: Basic Commitments and §489.24, et seq., EMTALA on-call responsibilities

CMS State Operations Manual, Interpretive Guidelines, Appendix A, Conditions of Participation for Hospitals

CMS State Operations Manual, Interpretive Guidelines, Appendix V, Responsibilities of Medicare Participating Hospitals in Emergency Cases (EMTALA)
Additional Resources

Federal Department of Health and Human Services
EMTALA site

American College of Emergency Physicians
EMTALA reference page
EMTALA: Medical-Legal Issues
Sample Competency Assessment Tool

Introduction

This Sample Competency Tool serves as a corollary to the foundational document, *Competencies for the PA Profession*. Of note, there are significant similarities to the competencies required of physicians, as the education training of a PA mirrors that of the physician. Therefore, the competency assessment (FPPE/OPPE in Joint Commission accredited facilities) policy for PAs will often mirror that of the physicians in the same specialty.

Professional competencies for PAs include:

- the effective and appropriate application of medical knowledge,
- interpersonal and communication skills,
- patient care, professionalism,
- practice-based learning and improvement, and
- systems-based practice.

The first two pages of the attached Sample Tool can be considered "core competencies” for the profession, and will apply to all PAs regardless of specialty. The third page is drawn from the specialty/department specific privileges granted; these vary widely by specialty and setting. The competencies selected are determined by the department/department chair and approved by the Medical staff.

Additional Resources

[Physician Assistants: Assessing Clinical Competence](#) (PDF)
This is a useful guide for regulators, hospitals, employers and third-party payers.

[FPPP and OPPE Are More than Just Acronyms](#) (PDF)
This article, published in AAPA’s magazine PA Professional, speaks to the Joint Commission requirements (and challenges) for Focused Professional Performance Evaluation and Ongoing Professional Performance Evaluation.
## Physician Assistant Competency Measures

<table>
<thead>
<tr>
<th>Competency Measure</th>
<th>Unacceptable</th>
<th>Poor</th>
<th>Satisfactory</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> A score of 1 or 2 requires comment in the space provided.</td>
<td>Clearly inadequate; requires remediation</td>
<td>Many deficiencies</td>
<td>Adequate</td>
<td>Exceeds in many areas- top 20%</td>
<td>Superior in every way- top 10%</td>
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<tr>
<td><strong>Patient Care (and Procedures)</strong></td>
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<tr>
<td>• History taking: accurate and complete</td>
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<tr>
<td>• Physical exam: required components present</td>
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<tr>
<td>• Complete assessment and plans</td>
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<tr>
<td>• Provides quality patient education</td>
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<tr>
<td>• Competently performs medical and surgical procedures delineated by medical staff privileges-overall evaluation (See page 3 for department specific privilege, focused evaluations.)</td>
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<tr>
<td><strong>Medical Knowledge</strong></td>
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<td>• Appropriate selection of diagnostic tests</td>
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<tr>
<td>• Appropriate interpretation/analysis of test results</td>
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<td>2</td>
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<tr>
<td>• Appropriate integration of history and physical findings and diagnostic studies to formulate a differential diagnosis.</td>
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<tr>
<td>• Overall integration of clinical information into treatment planning</td>
<td>1</td>
<td>2</td>
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<tr>
<td>• Pharmacological knowledge/ appropriate ordering of therapeutics</td>
<td>1</td>
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<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
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<tr>
<td>• Applies evidence-based medicine to clinical decisions</td>
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<tr>
<td>• Awareness of quality improvement measures and application to clinical practice</td>
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<tr>
<td>• Facilitates the learning of students and other health care professionals</td>
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</table>
# Physician Assistant Competency Measures

<table>
<thead>
<tr>
<th>Competency Measure</th>
<th>Unacceptable</th>
<th>Poor</th>
<th>Satisfactory</th>
<th>Very Good</th>
<th>Excellent</th>
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<tbody>
<tr>
<td><strong>Professionalism</strong></td>
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<td>◦ Displays sensitivity and responsiveness to patients’ culture, age, gender, and disabilities</td>
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<tr>
<td>◦ Understanding of the legal and regulatory requirements governing PA practice and the role of the PA.</td>
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<td>◦ Commitment to personal excellence and ongoing professional development.</td>
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<tr>
<td><strong>Interpersonal &amp; Communication Skills</strong></td>
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<td>◦ Communications and behaviors with patients are effective and appropriate.</td>
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<tr>
<td>◦ Communications and behaviors with physician supervisors are effective and appropriate.</td>
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<td>◦ Demonstrates emotional resilience and stability, adaptability, flexibility and tolerance of ambiguity and anxiety</td>
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<td>◦ Uses effective listening, nonverbal, explanatory, interviewing and writing skills to elicit and provide information.</td>
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<td><strong>Systems Based Practice</strong></td>
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<td>◦ Uses information technology resources to support patient care decisions and patient education.</td>
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<td>◦ Practices cost-effective health care and resources allocation that does not compromise quality of care.</td>
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<tr>
<td>◦ Applies medical information and clinical data systems to provide more effective, efficient patient care.</td>
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Note: A score of 1 or 2 requires comment in the space provided.

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# Physician Assistant Competency Measures

## Competency Measure—Orthopaedics

Note: A score of 1 or 2 requires comment in the space provided.

<table>
<thead>
<tr>
<th>Competency Measure—Orthopaedics</th>
<th>Unacceptable</th>
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<th>Satisfactory</th>
<th>Very Good</th>
<th>Excellent</th>
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<tr>
<td><strong>X-ray Interpretation:</strong></td>
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<tr>
<td>• Demonstrates accurate interpretation of findings</td>
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<tr>
<td>• Provides complete documentation</td>
<td>1</td>
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<td><strong>Fracture/dislocation reduction:</strong></td>
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<td>• Demonstrates appropriate technique</td>
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<td>• Achieves acceptable alignment</td>
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<tr>
<td>• Provides appropriate post-reduction management/immobilization</td>
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<td><strong>Cast/Splint Application</strong></td>
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<td>• Demonstrates appropriate technique</td>
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<tr>
<td>• Applies appropriate splint type and selects appropriate materials</td>
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<td><strong>Assistant at Surgery</strong></td>
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<td>• Maintains sterile technique</td>
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<td>5</td>
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<tr>
<td>• Demonstrates appropriate patient positioning/draping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>• Provides effective retraction/exposure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>• Demonstrates acceptable wound closure techniques, including approximation of layers, selection of closure material, and dressing application</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Medical Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antibiotics ordered appropriately (1 hour prior to surgery, stopped in 24 hours post-op, appropriate drug selected)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>• DVT prophylaxis ordered appropriately</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>• Pain management appropriate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Physician Assistant Competency Measures

Evaluator Level of Interaction:

- ☐ Minimum-occasional encounters
- ☐ Moderate-weekly encounters
- ☐ Extensive-daily encounters

Evaluator

- ☐ Physician (MD/DO)
- ☐ Peer (PA)

Comments: (Required for any Rating of “1” or “2”)

Evaluator Name: ________________________________  Evaluator Signature: ________________________________

PA Name: ________________________________  Date of Evaluation: ________________________________
PAs: Assessing Clinical Competence
Guide for regulators, hospitals, employers and third-party payers

Physician assistants (PAs) are versatile members of the medical team, with broad, yet rigorous medical training. PAs practice in every medical and surgical specialty and every practice setting, providing a broad range of services that would otherwise be provided by physicians. They are graduates of accredited PA programs, licensed and nationally certified.

PA education is a masters-level program modeled on physician education. Applicants must complete at least two years of college courses in basic and behavioral sciences as prerequisites.

PA education programs average 26 months in length. The first year of PA school provides a broad grounding in medical principles and instruction in the classroom and lab. Year one consists of basic medical science courses, including anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory sciences, behavioral sciences and medical ethics. In the second year, PA students receive hands-on clinical training through rotations that include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine and psychiatry. PA students complete on average more than 2,000 hours of supervised clinical practice prior to graduation. There are more than 187 PA programs accredited by the Accreditation Review Commission on Education for the Physician Assistant.

Upon graduation from a physician assistant program, PAs must pass the Physician Assistant National Certifying Examination (PANCE), the initial certifying exam administered by National Commission on Certification of Physician Assistants. Starting in 2014, NCCPA’s Certification Maintenance requirements changed, with enhanced CME requirements and re-examination extended to a 10-year cycle, to mirror the Maintenance of Certification® requirements for physicians. PAs will transition from a 6-year cycle to the 10-year cycle at their next recertification due date. While all states require initial certification for initial licensure, not all states require maintenance of current certification for licensure renewal.

Credentialing PAs
Organizations credential healthcare professionals to assure that patients receive high quality medical care. Hospitals, healthcare organizations, practices and third-party payers use varied systems for doing this. Many organizations adapt physician forms and criteria to create a parallel process for PAs.

For PAs, primary sources include:
- State licensing board to confirm that the applicant is properly licensed
- Accredited PA program for graduation information
- National Commission on Certification of Physician Assistants (NCCPA) to confirm initial and ongoing national certification. Go to www.nccpa.net.
- National Practitioner Data Bank (NPDB) for malpractice and adverse actions history

Unlike physicians, PAs do not have specialty board exams. They specialize by virtue of the physicians with whom they work.
PAs: Assessing Clinical Competence

The American Medical Association’s (AMA) Physician Profile Service offers PA credentials verification. For a nominal fee, credentialing professionals can confirm a PA’s education program attendance and graduation dates, national certification number and status, current and historical state licensure information, and AAPA membership status. The Joint Commission has deemed that the information provided by the AMA service is equivalent to primary source information.

Similarly, the Federation of State Medical Boards offers its Federation Credential Verification Service to PAs.

Privileging PAs in Hospitals
Because of the breadth and rigor of PA education programs, students graduate with skills that are fundamental and essential to every specialty – a fund of medical knowledge, interpersonal and communication skills, patient care-including the ability to provide age appropriate patient assessment, evaluation and management, professionalism, practice-based learning and improvement, and systems-based practice. PAs providing care in the hospital must be privileged through the Medical Staff process whether they are employed by the hospital or by an outside practice.

Core Privileges
Some organizations identify core privileges that may be granted to any PA who meets the organization’s criteria. Core privileges may vary depending upon the clinical department. They include, but are not limited to such things as performing histories and physicals; developing and implementing treatment plans; performing rounds; recording operative and procedure notes; recording progress notes; ordering and interpreting diagnostic laboratory tests and diagnostic imaging studies; ordering medications and writing prescriptions; managing fractures; suturing lacerations; performing corneal fluorescein exams and foreign body removal; providing anterior nasal packing for epistaxis; administering trigger point injections; incising and draining abscesses; and performing discharge summaries. This listing of PA core privileges is not meant to be exhaustive. There could be other core privileges, depending on the institution and department.

Specialty Privileges
PA medical education is broad. PA students master clinical fundamentals that prepare them to practice with physicians in virtually every area of medicine and surgery. However, unlike physicians, PAs do not have specialty board exams. They specialize by virtue of the physicians with whom they work.

When PAs are evaluated for specialty privileges, hospitals can verify their competence through a number of means.

- Attestation to the PA’s competence by physicians and PA peers
- Hospital systems that track clinical activity
- Data collected for initiatives such as the Surgical Care Improvement Project (SCIP) or the Physician Quality Reporting System (PQRS)
- Requiring a certain percentage of continuing medical education credits specific to the specialty
PAs: Assessing Clinical Competence

- Requiring maintenance of pertinent certifications such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Life Support, etc.
- Certificates of completion from relevant clinical courses
- Use of simulation labs to assess cognitive and procedural competence
- Professional portfolio in which the PA documents procedures and patient care provided

When a PA is a recent graduate or is changing specialties, it may be necessary to facilitate proctoring by a physician or senior PA until the PA requesting privileges can demonstrate competence.

FPPE and OPPE
Joint Commission accredited hospitals are required to include PAs in their focused professional practice evaluations (FPPE) and ongoing professional practice evaluations (OPPE), which are intended to help ensure the competence of providers. Data for the ongoing evaluation is acquired from periodic chart review, direct observation, procedures logs, peer review, monitoring of diagnostic and treatment techniques, and input from other individuals involved in the care of the same patients, including clinicians and administrators.

Regulatory Agencies and Insurers
State regulatory agencies and third-party insurance companies typically leave the determination of an individual PA’s specialty and scope of practice up to the physicians with whom the PA works. This ranges from solo physicians, through large multi-specialty practices, to major health care systems. A PA working in a particular specialty has oversight and guidance by a physician in that specialty. Because the physicians and PAs work closely together, they are the individuals most able to determine the appropriate specifics of a PA’s day-to-day practice, based on the PA’s training and experience, patient needs and the needs of the particular practice.

References
5. Competencies for the Physician Assistant Profession (Originally adopted 2005; revised 2012) http://www.nccpa.net/App/PDFs/Definition%20of%20PA%20Competencies%203.5%20for%20Publication.pdf

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