PAs: Certification, Credentialing, and Competencies

Session Code: TU09

Date: Tuesday, September 20, 2016

Time: 10:00am - 11:30am

Total CE Credits: 1.5

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Physician Assistants:
Certification, Credentialing & Competencies

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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 other 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.

PA DEFINITION & DEMOGRAPHICS

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 210 accredited PA educational programs in the United States.
- 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 111,000 currently certified PAs*
- 7,776 new PAs certified in 2015
- PAs are a young profession; 55% are under the age of 40*

*Source: NCCPA July 2016

Certified PAs by Specialty*

- Family medicine/general internal medicine: 26%
- Surgical specialties: 19%
- Emergency medicine: 13%
- Internal medicine subspecialities: 9%
- Dermatology: 4%
- Hospital medicine: 3%
- Pediatrics (general and subspecialties): 3%
- General surgery: 3%

* Based on NCCPA PA Profile data as of December 2015
Projected Growth of PAs in Clinical Practice


PA CERTIFICATION

NCCPA’s Board of Directors

10 PAs, 6 physicians and 2 public members, including nominees from...

- American Academy of Family Physicians
- American Academy of Pediatrics
- American Academy of Physician Assistants
- American College of Physicians
- American Medical Association
- American Osteopathic Association
- Association of American Medical Colleges
- Federation of State Medical Boards
- PA Education Association
- US Department of Veterans Affairs

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
Certification Maintenance Process

PA Recertifying Exam (PANRE) every 10 years
100 CME credits every two years
   - At least of those must be 50 Category 1 credits
   - 20 of the Category 1 credits must be designated as self-assessment and/or performance improvement

Competencies for the PA Profession

Rationale for changing certification maintenance process was to incorporate more of these competencies into the process.

1. Medical knowledge
2. Patient care
3. Interpersonal & communication skills
4. Professionalism
5. System-based practice
6. Practice-based learning and 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

During each cycle, earn 100 CME credits including 50 Category 1 credits with 20 earned through self-assessment and/or PI-CME activities.

By the end of the 4th CME cycle, must have 40 Category I CME credits through SA activities and 40 Category I CME credits through PI activities.

Earn 100 CME credits including 50 Category I and pass PANRE.

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 FSBMB
- 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)

Specialty CAQ Program

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

**Current Practice Area of Principal Clinical Position**

**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:
- 553 in emergency medicine
- 167 in psychiatry
- 105 in orthopaedic surgery
- 79 in hospital medicine
- 40 in CVT surgery
- 37 in pediatrics
- 17 in nephrology

Total of 998 CAQs issued -- PAs may earn CAQs in more than one specialty

PA ROLES & RESPONSIBILITIES

PA Definition/Role

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

See Medicare Benefit Policy Manual, Chapter 15, §103 PA Services:
B. Covered Services
"They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (M.D./D.O.)."
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.

2015 State Legislation and Regulations

49 states and the District of Columbia enacted PA positive changes to their laws and regulations in 2015…

…for a total of 201 law and regulation changes that improve PA practice.

These changes have the potential to positively impact 99% of America’s 111,000 PAs…

…and more than 400 million patient encounters a year.

PA Profession Regulatory Changes

Recent Federal PA Laws and Regulations

Allow PAs to order portable x-rays and fecal occult blood tests for Medicare patients.

Eliminate onsite supervision requirements for PAs working in RHCs.

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.

NEW! Proposed Rule to eliminate “LIP” from “restraint” Medicare CoPs.

Allow RHCs to contract directly with PAs.

Avoid a 21% immediate decrease in Medicare payments for PA and physician services; establish 5% increase for 5 years.

Clarify that PAs can write hospital admission orders and conduct H&Ps.

Include PAs in new value-based incentive program (MIPS) under Medicare.

NEW! Proposed Rule to eliminate “LIP” from “restraint” Medicare CoPs.
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”

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”.

http://www.annalsofhealthlaw.com/annalsofhealthlaw/vol__24_issue_1/?pg=42&pm=1&u1=friend#pg42
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!

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.

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

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.
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.

Resource: AAPA Policy Manual (see page 102)

CLINICAL COMPETENCY ASSESSMENT
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

Competency Assessment

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”

Document first adopted in 2005 and revised in 2012

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: (See Page 257)


Document: “PAs: Assessing Clinical Competence”

Guide for regulators, hospitals, employers and third-party payers

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

Document: “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

Located online at:

### Physician Assistant Competency Measures

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<th>Competency Measure</th>
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<th>Fair</th>
<th>Satisfactory</th>
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<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>Medical Knowledge</strong></td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td><strong>System Based Evaluations</strong></td>
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<td><strong>Surgical Skills</strong></td>
<td>1</td>
<td>2</td>
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**Note:** A score of 3 or less in any category indicates unsatisfactory performance.
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.

Thank You!

Contact:

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http://www.chlm.org/contact-us/

Come see us at the AAPA/NCCPA Exhibit Hall Booth #127!