Medical Staff Briefing

A Primer in PA Certification

With over 100,000 physician assistants (PA) in practice and predictions that the number will continue to grow, healthcare organizations are increasingly relying on these practitioners to fill patient-care needs. This means that like with physicians, it is up to the medical staff to monitor and ensure the quality of care being provided by PAs, and medical staff leaders and professionals must familiarize themselves with the profession, including ways to assess competence, state laws regarding licensure, and the certification process.

Certification

Upon completing an accredited PA program, PAs must pass a certification examination in order to become licensed to practice. Those who pass the Physician Assistant National Certifying Examination (PANCE) are issued the Physician Assistant—Certified (PA-C) credential by the National Commission on Certification of Physician Assistants (NCCPA). All states require PAs to be initially certified by NCCPA in order to practice. However, like physicians, recertification is a gray area—not all states/healthcare organizations require maintenance of certification.

PAs who have never been certified are eligible to take PANCE for up to six years after completing their educational program. During that six-year period, PANCE may be taken a total of six times. When either the six attempts or six years are up, the individual loses eligibility to take the exam. At that point, the PA must complete a full-length, accredited PA educational program again.

“For students who have sat through 2.5–3 years’ program of education, that certification exam is like a culminating event. It brings together their entire curriculum and entire clinical training,” says **Dawn Morton-Rias, Ed.D, PA-C,** president & CEO of NCCPA.

“In a way it serves the same purpose as physician certification. Back in the day, there were general practitioners. Now when people say they are board-certified physicians, it puts another layer on their expertise. I think the same is true for PAs,” says **Ann Davis, MS, PA-C,** vice president of constituent organization outreach and advocacy for the American Academy of Physician Assistants (AAPA).

The PANCE certification is not specialty-specific; instead it assesses basic medical and surgical knowledge. **Daniel Pace,** chief strategy officer/vice president of education and research for AAPA, says that this generalist certification has allowed PAs to be adaptable to the changing needs of the healthcare system. “The fact that a PA can be certified and work in one specialty and then move to another specialty where there may be a shortage has always been an asset to individual PAs and the healthcare system.”

However, the general and all-encompassing nature of the recertification exam concerns Pace. As PAs become specialized, they may then be tested on areas of competence they no longer practice. This is one of AAPA’s issues with the current recertification offered by NCCPA.

Recertification

As of 2014, recertification is required every 10 years, which aligns with most physician recertification exams. Before this, it was required every six years. This cycle is broken into five, two-year periods in which PAs must earn a minimum of 100 credits of CME, including at least 50 Category 1 CME credits. At the 10-year mark, PAs sit for a recertification exam—the Physician Assistant National Recertifying Exam (PANRE). The multiple-choice exam tests general medical and surgical knowledge.

“I think the 10-year mark is a good mark. You don’t want to be burdensome; you don’t want to make the profession inaccessible. A 10-year interval is consistent with our physician colleagues in terms of their recertification period,” says Morton-Rias.

As previously mentioned, recertification is not required in all states to maintain PA licensure. Twenty-two states currently require it, including three states that only require it for osteopathic or prescribing PAs. To see a list of state-by-state requirements regarding PAs, click here.

“What I think is interesting is the number of PAs who maintain certification regardless of what the law is in their state,” says Morton-Rias. “I think they do that because employers, insurers, and payers require it. They want to

know that the PAs they are hiring have obtained the highest credential possible in their profession and they have demonstrated that baseline competency. The recertification process is rigorous and credible and is required by many employers, and I think that is quite appropriate."

The recertification process has been met with some opposition, including from the AAPA.

"Just as in the physician world, several groups have questioned whether high-stakes testing is the best option, as opposed to other education and assessment requirements. There is more understanding of the options available and high-stakes testing is just one option, and perhaps not the best," says Davis.

"The goal of certification is to assess and demonstrate competence," says Pace. "There are ways you can assess that the competence is being maintained that are not quite as punitive and provide more opportunity for development."

Morton-Rias describes the goal of certification differently. "Certification ensures that PAs are staying up-to-date on medical knowledge and serves as an objective measure to patients, employers, and others that those who maintain certification are keeping up with changes in treatment options and standards."

Morton-Rias knows that most people don't like taking tests. "We all go back to our third grade experience of sitting in our seats and panicking and our palms sweaty at the concept of taking a test." The argument over highstakes testing is also being debated among the physician community, most notably among the American Board of Internal Medicine. Detractors of the internal medicine recertification process argue that the test covers areas of internal medicine that a physician may no longer practice. A similar argument has been posed in the PA community, since the recertification exam is based on general clinical knowledge and PAs have the ability to practice in a variety of specialty areas. According to Morton-Rias, more than half of PAs have reported changing disciplines during their career. However, she sees this as a reason for general recertification.

"There is a body of literature that supports the notion that we lose it over time and if you don't use it, you lose it. Nobody wants to admit that. Our fund of knowledge degrades as time goes by and that is compounded by some of our practice areas; if you are not practicing in certain areas, that information may become even more remote to you.

"There is also literature that points to the benefit of recertification processes that are active, that involve assessment, and the outcomes that are achieved from those activities. If I have to study for a test, and spend three months of fairly consistent review, that matters. That makes a difference in what I have readily available in my mind as I see patients, and that translates to good care."

Pace disagrees, saying that there is no evidence that indicates mandatory recertification testing has a positive impact on patient care or patient safety. "While studying for a recertification exam may increase what a PA has in their mind when seeing patients, the content they must study to do well on these recertification exams is often 18-36 months out of date. Compare that approach to the now common clinical activity of simply looking up the most current information at the point of care via EMR or smartphone apps."

Morton-Rias, who is a certified PA, has gone through the recertification process. She is the first president and CEO of NCCPA who is also a PA. She admits she has a unique view of the recertification process: She is responsible for the NCCPA organization and PA profession on a macro level, but she also understands the perspective of the busy PA who does not want to, after a day of working, go home and study while trying to take care of a family or have a personal life.

"We know people are busy. We don't want to give them busy work or assessment strategies that are burdensome and irrelevant. We work to minimize that. Our average age of PAs is 38, so they are raising children, and dealing with aging parents, and just the complexities of life; I get it," says Morton-Rias. "The NCCPA works hard to make sure our assessment and recertification processes are relevant, that we are minimizing extraneous content. We do a practice analysis to understand how the healthcare landscape continues to change, and we receive feedback from thousands and thousands of PAs, employers, medical boards, and physician groups so we can ensure our recertification strategies make sense."

NCCPA is working to transition PANRE from a broad-based, generalist exam to a core knowledge exam, narrowing content to that which all PAs should be expected to maintain in any area of practice.

Specialty certification

For PAs practicing in specialty medicine, NCCPA offers specialty certificates of added qualifications (CAQ). These specialty certificates do not replace general certification but rather are offered in addition for PAs who want to show their expertise in a specialty area. The specialty certificates are currently offered in: cardiovascular and thoracic surgery, emergency medicine, hospital medicine, nephrology, orthopedic surgery, pediatrics, and

psychiatry.

“We heard from PAs that they wanted a credential in addition to basic certification to illustrate additional experience and knowledge in those practice areas. We are proud to have developed those programs and continue to offer them,” says Morton-Rias.

This raises the question that if PAs are concerned about the general and broad scope of the recertification exam, should recertification become specialty specific?

“That is a great question and one we have wrestled with as a profession,” says Davis. “I think right now what we believe is that PAs are sort of the utility infielder of the healthcare workforce. We maintain a generalist fund of knowledge throughout our career that is important. That allows for PAs to move into specialties that are high need. That unique attribute would be lost if PAs take specialty exams and are required to stay in the specialty they are certified in.”

The NCCPA agrees. "Specialty-specific recertification would impede PAs’ ability to change specialties, which is a hallmark of the profession—a reason many choose the PA career over other health professions.”

Credentialing, privileging, and peer review

Organizations must decide how they will use certification/recertification when assessing the competence of PAs.

Pace suggests looking beyond certification for credentialing and privileging. “One option is portfolios or other demonstrations of expertise and experience in the actual practice setting. That is something that the AAPA would support instead of or in adjunct to certification as a way of demonstrating experience and competence.”

Davis adds that this is not unlike what hospitals do when they grant privileges to physicians. “They look for a certain number of procedures performed and observation of those procedures.”

In fact, CMS states in its Conditions of Participation that “the medical staff may not make its recommendation solely on the basis of the presence or absence of board certification but must consider evidence of current licensure, evidence of training and professional education, documented experience, and supporting references of competence.”

The AAPA suggests when credentialing a PA, using the following primary sources:

- State licensing board to confirm that the applicant is properly licensed
- Accredited PA program for graduation information
- NCCPA to confirm initial/ongoing certification
- NPDB for malpractice and adverse actions history

When it comes to privileging PAs, the AAPA suggests medical staffs use the following to assess PAs’ competence to perform the privilege:

- Attestations 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 or the Physician Quality Reporting System
- Requiring a certain percentage of CME credits specific to the specialty
- Requiring maintenance of pertinent certifications such as basic life support, advanced cardiac life support, etc.
- Completion of 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

One way to ensure PAs’ competence is being measured correctly is to get their input—instead of physicians when it comes to peer review and privileging.

“People can say they know best how to utilize PAs, but it helps when you have PAs at the table; it adds to the effectiveness of the planning,” says Davis.

Extending PAs’ membership on the medical staff is one way to accomplish this. For organizations who are hesitant or restricted by law to grant membership, a committee may be the answer. St. Jude Medical Center in Fullerton, California recently did this by creating a committee for PAs and nurse practitioners.

According to **Cindy Radcliffe, CPMSM,** director of medical staff services, the committee was created with a few goals in mind. The first was to provide a similar forum physicians have for coming together as a group to discuss

general information about the hospital. “They are at the bedside, they are in the trenches, and we had no way for them to get information on things they should know in general like policy changes. We have a lot going on with EMR—we had a huge upgrade a year ago—and they are accessing it. They need to know these things, need to know about order sets. They also need to know how we are doing as an organization with our infection prevention data, they are part of that.”

Another goal of the committee is to conduct peer review that is specific and relevant to the 60 APPs at St. Jude’s.

“The problem is, we credential them, and then they are kind of out there on their own,” says Radcliffe. “We hope that their supervising physician is taking them under their arms and helping them do things appropriately, but we have no assurance that is happening. It is also extremely difficult to monitor them. We have proctoring if they are new on staff, but we really haven’t had a robust peer review process for them. The medical staff felt we needed to develop something close to the medical staff peer review process.”

A core group of the committee is responsible for conducting peer review through chart review. They use a combination of random chart reviews and charts that come through via the incident reporting system. Like the peer review process for medical staff members, the charts are prescreened by a quality nurse. The core group will review it and decide whether the standard of care was met. They can then decide whether they want to discuss the case as a larger group at the committee meeting.

Radcliffe says the goal is to review two to three charts per APP at each meeting. The core group then reports its findings/recommendations to its respective medical staff department, and the information is included in the APP’s OPPE report.

The core group is the liaison between APPs and physicians, and is able to provide a level of review that physicians might not be able to. The four core members receive a stipend for their peer review work. The medical staff members who helped construct the committee felt it was important to acknowledge the additional work and time away from patients.

One way St. Jude’s is hoping to increase attribution of APPs on patient records is by having PAs in the emergency department put stickers with their names on their case charts. The hospital is also considering having the OR team complete 360-degree evaluations on surgical PAs, who do not document in their charts.

The goal is to get the group to talk about opportunities for improvement or what could have been done differently. If the case is subjective, i.e., not something black and white like a rule violation, the core group extends a special invitation to the NP or PA involved in the case to make sure he or she is at the meeting to explain the case.

“We want them to be engaged, at the table, involved, and informed,” says Radcliffe. “And we want to find a way that we can do ongoing monitoring of the care they provide.”

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