Report of Reference Committee B

Friday, May 20, 2022

THIS REPORT IS NOT POLICY. THESE RESOLUTIONS WILL NOT BECOME ACADEMY POLICY UNTIL FORMALLY ACTED UPON BY THE HOUSE OF DELEGATES.

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| **Number:** | **Title:** | **Committee****Recommendation:** | **Line:** |
|  | 2022-B-01 | Initial Education | Adopt | 7 |
|  | 2022-B-02 | Specialty Certification, Clinical Flexibility, and Adaptability | Adopt | 34 |
|  | 2022-B-03 | Increased CME Credit for Precepting | Amend | 490 |
|  | 2022-B-04 | PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers | Adopted onConsent Agenda |  |
|  | 2022-B-05 | Identifying and Cultivating CORE Leadership Skills for PAs | Amend | 520 |
|  | 2022-B-06 | Replacement Policy for the Importance of PAs in Executive Leadership Policy Paper | Adopted onConsent Agenda |  |
|  | 2022-B-07 | Development of Transition to Practice Programs/Onboarding Templates | Amend | 534 |
|  | 2022-B-08 | Reproductive Healthcare Restrictions  | Amend | 563 |
|  | 2022-B-09 | Breastfeeding | Amend | 589 |
|  | 2022-B-10a | Button Battery Safety Legislation | Adopt | 650 |
|  | 2022-B-10b | Button Battery Safety Education | Amend | 664 |
|  | 2022-B-11 | Cannabinoids | Amend | 686 |
|  | 2022-B-12 | False or Deceptive Healthcare Advertising | Adopted onConsent Agenda |  |
|  | 2022-B-13 | Hepatitis | Adopted onConsent Agenda |  |
|  | 2022-B-14 | Interprofessional Medical Education to Incorporate the PAs Role | Amend | 711 |
|  | 2022-B-15 | Health Equity for Students Pursuing PA Education  | Amend | 750 |
|  | 2022-B-16 | Recruitment and Retention - Amendment to Include Disabilities and Application Barriers | Amend | 784 |

\*Shaded resolutions were Adopted on the General Consent Agenda and will not appear in this document.

Madam Speaker, Reference Committee B has considered each of the resolutions referred to it and wishes to present the following report. The committee's recommendations on each extracted resolution will be submitted separately, and I respectfully suggest that each extracted item be dealt with before going on to the next. Madam Speaker, please proceed with the extraction process.

The Committee considered testimony on 2022-B-01, the resolved portion of which reads:

Amend policy HP-3200.1.3 as follows:

AAPA recognizes that PA education is conducted at the graduate level and supports awarding the master’s degree AS THE TERMINAL DEGREE. ~~for new PA graduates.~~

Con testimony included

* + Concern that this would put the profession at a disadvantage compared to other professions in similar roles.
	+ PA students already complete doctoral level credit hour requirements and the type of degree should be determined at the degree-conferring institution.

Pro testimony included

* + This provides a definition of the terminal degree for the PA profession and reflects the current terminal degree.
	+ Concern that if the terminal degree was not a master’s this would lead to:
		- Increased cost passed on to current and future students
		- Increased barriers for underrepresented populations in the PA profession
		- Limit faculty ability to earn tenure
		- Limit PAs entering and staying in education
		- Limit PA programs' ability to recruit faculty

Of note, PAEA will be conducting further investigation through a doctoral summit next year.

**Madam Speaker, the committee recommends adoption of Resolution 2022-B-01**

The Committee next considered testimony on 2022-B-02, the resolved portion of which reads:

Amend the policy paper entitled *Specialty Certification, Clinical Flexibility, and Adaptability*.

**Specialty Certification, Clinical Flexibility, and Adaptability**

[Adopted 2017]

**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 recognizes that flexibility to adapt to the needs of the healthcare system is a unique attribute of the PA profession that creates value to the health system by allowing PAs to be deployed and redeployed within the health-care system to address critical workforce shortages and increase patient access to care.
* AAPA recognizes that the flexibility and adaptability of the PA profession is closely associated with the broad generalist training that PAs receive, coupled with an orientation toward lifelong learning that allows them to adapt to many practice settings.
* AAPA recognizes that changes in PA practice have resulted in the majority of PAs practicing in specialty areas, creating desire among PAs to be recognized for their expertise, and for employers to distinguish more qualified from less qualified applicants.
* AAPA is opposed to the use of specialty certification as a criterion for the following: 1) entry into specialty practice, 2) licensure, 3) credentialing, 4) third-party reimbursement.
* AAPA recognizes that specialty certification may have a useful role in the career development and promotional path of a PA within a health system, but this must be carefully balanced against the potential barriers that it may represent to clinical flexibility and adaptability.
* AAPA endorses approaches to specialty training that emphasize formative development of the knowledge and competencies that a PA will need to practice in the specialty rather than a summative evaluation of knowledge.
* AAPA recommends consideration of a portfolio approach that incorporates external validation of relevant Entrustable Professional Activities (EPAs) OR SIMILAR COMPETENCY-BASED ASSESSMENTS as a more comprehensive and textured approach for evaluating the qualifications of a PA.
* Research should be conducted to determine if there is a link between specialty certification and improved quality of care, and whether or not any such improvement would offset the potential losses to the system of the flexibility and adaptability inherent in the current model.

#  Background

The PA profession was created in the late 1960s as a response to a shortage of primary care physicians and a need to extend the availability of medical services for patients beyond what physicians alone were able to provide. The initial idea was that physicians would be able to delegate many routine tasks to this new medical professional. The training pattern that emerged and was eventually formalized through accreditation of PA programs was a curriculum averaging 26 months that combined a didactic grounding in the basic sciences with a clinical apprenticeship model emphasizing general medical knowledge and its application in a primary care setting. (1) The profession was originally designed to be physician-dependent. Once in practice, PAs would form dyadic collaborative relationships with physicians, who would take moral and legal responsibility for the PA’s work and extend the PA’s scope of practice as the PA demonstrated competency related to specific tasks. (2) This model has changed over time. In particular, the role of PA-physician collaboration has been redefined in a way that has tended toward increasing levels of PA autonomy. Regardless, the PA model has produced a remarkably flexible medical professional who can be trained fairly quickly and readily availableto address unmet needs of patients and the healthcare system in general.

The flexibility of the PA to function in multiple venues is an attribute that is highly prized among physicians, the healthcare system, and PAs. PAs regularly take advantage of this flexibility. An analysis of PA cohorts between 1969 and 2008 found that 49% of PAs had changed specialties at least once in their careers, 24% made specialty switches to another specialty class (i.e., primary care to a surgical specialty), and 11% reported practicing in at least three specialties during their career. (3) ~~In a 2015 survey, 8.3% of PAs indicated that they had changed their specialty during 2014.~~ IN SURVEYS CONDUCTED BY AAPA BETWEEN 2015 AND 2018 PAS REPORT CHANGING SPECIALITES AT RATES RANGING FROM 5.5% AND 6.5% EACH YEAR (4) The generalist training, coupled with a culture that emphasizes lifelong learning, has been seen as the keys to this adaptability and, as a result, specialty certification has been viewed by many members of the profession as a specific threat to flexibility and adaptability. AAPA has had policy opposing specialty certification since 2002. (5)

At its founding, the PA model rested on two assumptions. The first assumption was that most PAs would enter the primary care workforce, and the second was that physicians would be the primary employers of PAs. (1) Both of these assumptions are challenged by the realities of contemporary PA practice. Health systems have emerged as direct employers of PAs, altering the paradigm of the PA working with their supervising physician in a mentor role that was initially designed for the profession. (6) This has resulted in a fundamental change to the dyadic PA-physician model and the assumed apprenticeship-mentor relationship that was intended to regulate PA practice.

There has also been a longstanding trend of PAs moving away from primary care toward specialty practice. In 1974, 68.8% of PAs were in primary care practice. (1) According to ~~2015~~ 2020 NCCPA data, ~~just over 70% of PAs report that they practice in a medical specialty~~ 24,4% OF CERTIFIED PAS REPORT PRACTICING IN PRIMARY CARE SPECIALIES (FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, PEDIATRICS) INDICATING THAT THREE OUT OF FOUR PAS ARE INVOLVED IN SPECIALTY PRACTICE. (7) This has created an anomaly whereby a profession with a generalist training model and an assumed primary care trajectory is now dominated by specialty practice.

NCCPA introduced Certificates of Added Qualifications (CAQs) in 2011. (8) In 2016, NCCPA proposed a change to the recertification process whereby at the time of recertification PAs would choose a specialty exam relevant to their practice and, if an exceptional level of performance was achieved, examinees would be eligible to be awarded a CAQ, in addition to the renewal of the PA-C credential should they desire to pursue CAQ and were willing to meet the additional requirements. After a spirited debate, this proposal was withdrawn. NCCPA ~~has announced plans to focus the revision of~~ REDESIGNED PANRE ~~on~~ AROUND WHAT IT HAS IDENTIFIED AS “core knowledge~~,~~” ~~and efforts are underway to define more specifically what “core knowledge” represents for PA practice~~ IN AN EFFORT TO ENSURE THAT IT IS FOCUSED ON KNOWLDEGE RELEVANT TO PRACTICING PAS IN ALL SPECIALTIES. (9) Participation in the CAQ has SHOWN MODEST GROWTH BUT REMAINS ~~been~~ low.

Health systems have responded to the need to prepare PAs for specialty practice by developing postgraduate programs. From 2007-2014, ARC-PA offered voluntary accreditation for these programs. (8) The process was then held in abeyance, so only eight clinical postgraduate training programs received accreditation. ARC-PA ACCREDITATION OF POSTGRADUATE PROGRAMS HAS RESUMED IN JANUARY OF 2020 WITH NINE ORGANIZATIONS ACHIEVING ACCREDITATION AS OF MARCH OF 2021. THE NUMBER OF NON-ACCREDITED POSTGRADUATE PROGRAMS HAS CONTINUED TO GROW. AS OF 2022 THE ASSOCIATION OF POSTGRADUATE PA PROGRAMS LISTS 143 PROGRAMS IN 35 SPECIALTIES. IT IS REASONABLE TO ASSUME THAT THE NUMBER OF PROGRAMS THAT SEEK ARC-PA ACCREDITATION WILL ALSO INCREASE NOW THAT ACCREDITATION HAS RESUMED. Overall, postgraduate fellowship programs range from well-structured and accredited to those with more informal curricula that may be regarded as “onboarding” programs that train PAs for their roles within a specific health system. The capacity of these programs is low, with most capable of accommodating one to four trainees per cohort. A recent review concluded that if these postgraduate programs are to continue to exist, they should adhere to more consistent standards. (10)(11)

Given the current nature of PA practice, what is the role of specialty certification? How does the profession preserve the flexibility that has created so much value for the healthcare system and the patients they serve, while addressing the needs of health systems in assessing the competencies and experience of PAs? How does the profession accommodate the understandable desire of specialized PAs to be formally recognized for their expertise, or to gain a credential that would facilitate their promotion within an established healthcare system’s defined structure for career advancement?

To address these questions, AAPA’s Commission on Continuing Professional Development ~~convened a task force of members representing a broad range of specialties, employment, and educational settings to review the issue~~ BUILT UPON THE WORK OF A TASKFORCE IT HAD CONVENED IN 2017, REVIEWED NEW DEVELOPMENTS, UPDATED DATA, AND CONDUCTED SURVEYS WITH STAKEHOLDERS TO UNDERSTAND CURRENT PERSPECTIVES ON SPECIALTY CERTIFICATION.

#  Stakeholder Input

A member of the 2017 task force conducted a review of literature related to PA specialty certification, PA roles and professional responsibility, PA workforce distribution among specialties, and factors influencing specialty choice. A summary of each relevant article was prepared for task force members, and the full text was made available to all members upon request. The literature about PA specialty certification is sparse, making it difficult to draw conclusions from existing scholarly research. For this reason, the ~~task force~~ COMMISSION utilized a series of ~~mini~~ surveys that were administered to various stakeholders in order to obtain information about PA specialty certification.

A survey was sent to ~~35~~ 6 PA specialty organizations ~~and special interest groups~~ affiliated with AAPA ~~that focus on specialty practice. Responses were received from 24 organizations, resulting in a 69% response rate. All organizations with a corresponding CAQ responded.~~ THAT CURRENTLY HAVE A CAQ ASSOCIATED WITH THEIR SPECIALTY AND 2 ADDITIONAL ORGANIZATIONS FOR WHICH A NEW CAQ RELEVANT TO THEIR SPECIALTY HAS BEEN ANNOUNCED. RESPONSES WERE RECEIVED FROM 7 ORGANIZATIONS. PAS IN CARDIOTHORACIC AND VASCULAR SURGERY DECLINED TO PARTICIPATE STATING THAT THEY WERE DEBATING THEIR POSITION INTERNALLY AND PLANNED TO PUBLISH AN OFFICIAL STATEMENT IN THE NEAR FUTURE. To gain an employer perspective, a survey was sent to the PAs who participate in the PAs in Administration, Management, and Supervision (PAAMS) group in AAPA’s social networking site known as “Huddle.” ~~Twenty~~ SEVENTEEN responses were received. Of these, ~~four held titles indicating that they supervised a specialty service that included PAs either alone or combined with NPs. The remaining 16 respondents held titles such as “director, PA Services” or “director, Advanced Practice Providers.” Additional stakeholder feedback was sought from physicians who work with PAs. A survey link was sent by members of the task force to physicians they knew. As a result, the sampling was neither complete nor systematic. Twenty-seven responses were received from physicians in seven specialties, five of which had some form of specialty certification available to PAs. While insufficient to draw conclusions, the physician data nevertheless gives some indication of physician awareness of and attitudes toward PA specialty certification.~~ 6 REPORTED HOLDING A DIRECTOR TITLE, 5 HELD A “LEAD” TITLE, 1 REPORTED A TITLE OF “CHIEF PA,” OTHER TITLES INCLUDED “SUPERVISOR” AND “TRANSITION TO PRACTICE MANAGER” OR SIMPLY “PA.” ALL BUT 3 RESPONDENTS HAD TITLES INDICATING THAT THEY HAD RESPONSIBILITY FOR MANAGING PAS AND NPS.

Questions posed to the specialty organizations focused on whether or not the organization had a formal position related to specialty certification and, if so, what that position was.

Additional questions explored whether or not there were specialty certifications available to PAs, of which the task force may not have been aware. Additionally, they were asked when specialty certification might be important to ensuring patient safety, and under what circumstances consideration of specialty certification might not be appropriate. PAs involved in supervision and management were asked how specialty certification is used within their institutions for hiring and promotion. ~~Questions for physicians focused on their relationship with the PA with whom they interact (PAs employed directly by physician practices or through an affiliated organization), their awareness of specialty certification, and whether or not specialty certification was a consideration or requirement in hiring or promotion.~~

## Interprofessional Certifications Open to PAs

The seven specialties for which NCCPA offers a CAQ AND THE TWO SPECIALTIES FOR WHICH A CAQ HAS BEEN ANNOUNCED BUT NOT YET AVAILABLE were determined to be the most relevant to this discussion (Table 1). However, the ~~task force~~ COMMISSION was able to identify many interprofessional certifications administered by other organizations that are open to PAs and other medical professionals. There are numerous life support certifications open to PAs that may not be related to a specific specialty, but may be required for a PA to function in a specific role, such as the “code team” in a medical facility. These non-NCCPA certifications are summarized in Table 2. For the purposes of this analysis, the task force considered information from each of these certifications; however, there is currently no global definition for PA specialty certification.

Table 1

|  |  |  |  |
| --- | --- | --- | --- |
| Specialty CAQs | Number Held\* | Number of PAs in Specialty\*\* | Estimated Percent of PAs in Specialty with CAQ \*\*\* |
| Cardiovascular and thoracic surgery | ~~41~~ 67 | ~~2738~~ 2,729 | ~~1.5~~ 2.4 |
| Emergency medicine | ~~519~~ 1124 | ~~10,876~~ 13,219 | ~~4.8~~ 8.5 |
| Hospital medicine | ~~84~~ 199 | ~~2,654~~ 3,859 | ~~3.2~~ 5.1 |
| Nephrology | ~~19~~ 36 | ~~Not reported~~ 397 |  |
| Orthopaedic surgery | ~~122~~ 258 | ~~9,071~~ 11,597 | ~~1.3~~ 2.2 |
| Pediatrics | ~~46~~ 78 | ~~1,631~~ 2,000 | ~~2.8~~ 3.9 |
| Psychiatry | ~~205~~ 588 | ~~1,033~~ 1,887 | ~~19.8~~ 31.2 |
| DERMATOLOGY | N/A | 4,350 | N/A |
| HOSPICE & PALLIATIVE N/A | 3,859 | N/A |  |

\*NCCPA as of ~~December 2016~~ NOVEMBER 2021 from a data set with a reported denominator of ~~~115,500~~ 148,560.
~~Specialty-specific data not yet published~~

\*\* NCCPA ~~2015~~ 2021 Statistical Report with an overall denominator of ~~108,717~~ 148,560

\*\*\* Calculated using different data sets so valid only as a rough estimate

# Table 2: Interprofessional PA-eligible Specialty Certifications\*

|  |  |
| --- | --- |
| Credential | Sponsor |
| Advanced Cardiac Life Support (ACLS) | Various |
| Advanced Trauma Life Support (ATLS) | Various |
| ~~Basic Life Support (BLS)~~ | ~~Various~~ |
| Pediatric Advanced Life Support (PALS) | Various |
| Approved Clinical Supervisor (ACS) | Center for Credentialing & Education |
| Registered Diagnostic Medical Sonographer (RDMS) | American Registry for Medical Diagnostic Sonography |
| Board Certified Advanced Diabetes Management (BC-ADM) | American Association of Diabetes Educators |
| Certified Clinical Densitometrist (CCD) | International Society for Clinical Densitometry |
| Certified Diabetes ~~Educator~~ CARE AND EDUCATION SPECIALIST ~~(CDE) (~~CDCES) | ~~National~~ Certification Board ~~of~~ FOR Diabetes ~~Educators~~ CARE AND EDUCATION |
| Certified Menopause Practitioner (NCMP) | North American Menopause Society |
| HIV Specialist™ (AAHIVS) | American Academy of HIV Medicine |
| Fellow of the American College of Critical Care Medicine (FCCM) | American College of Critical Care Medicine |
| Master of the American College of Critical Care Medicine (MCCM) | American College of Critical Care Medicine |
| Multiple Sclerosis Clinical Specialist (MSCS) | The Consortium of Multiple Sclerosis Centers |
| Board Certified Specialist in Obesity and Weight Management | Commission on Dietetic Registration |

\*These certifications were uncovered during our environmental scan, but the list is not intended to be exhaustive

# Results

Of the ~~24~~ 6 specialty organizations ~~and special interest groups~~ responding to the questionnaire, ~~only 10~~ 2 organizations had official positions ~~on specialty certification, and of these organizations, eight were officially opposed~~ ENDORSING THE CAQ IN THEIR SPECIALTY. ~~The task force received responses from all constituent organizations with a corresponding CAQ.~~ The Society of Emergency Medicine Physician Assistants ~~and the Association of PAs in Psychiatry~~, AND THE SOCIETY OF DERMATOLOGY PAS are the only AAPA-affiliated specialty organizations with a position endorsing the CAQ in their specialty. THE ASSOCIATION OF PAS IN PSYCHIATRY HAD PREVIOUSLY INDICATED THAT THEY ENDORSED THE CAQ. HOWEVER, CURRENT LEADERSHIP IS UNAWARE OF A PREVIOUS ENDORSEMENT AND FEELS THAT THE TOPIC MERITS PERIODIC REASSESSMENT. When asked about ~~the role of voluntary certification in their specialty for ensuring quality of care and patient safety, constituent organization respondents expressed considerable skepticism, with many stating bluntly that they saw no relationship between certification and ensuring quality or patient safety. Others stated that holding a certification did not demonstrate clinical competence. When asked about inappropriate use of specialty certification, respondents expressed similar concerns.~~ USING THE CREDENTIAL AS A MARKER FOR PATIENT SAFETY AND QUALITY, THREE ORGANIZATIONS INDICATED THAT THEY FELT THAT THIS USE OF THE CAQ WAS INAPPROPRIATE,TWO FELT IT WAS APPROPRIATE AND ANOTHER ORGANIZATION WAS UNSURE. WHILE THERE WAS A GREATER RANGE OF OPINIONS THAN IN 2017, RESPONDING organizations are generally opposed to specialty certification in situations where it is used as a criterion for the following:

* Licensure
* Credentialing
* Entry into specialty practice
* Third-party reimbursement

~~Respondents expressed considerable skepticism for any additional requirements that would require additional study time and expense, unless it was accompanied by evidence that it would improve patient care and safety.~~

Those PA specialty organizations that saw a role for specialty certification indicated that added qualifications could allow PAs to identify a level of specialty knowledge beyond generalist training. Others commented that it might be helpful in defining core competencies for a specialty, and to enhance ability of PAs to compete for jobs with other providers such as NPs, who do have specialty training.

Based on the responses received from the PAAMS group, it appears that specialty certification is not routinely required when hiring a PA; however, it may facilitate promotion within a healthcare system.

~~Responses were received from physicians in seven specialties, five of which had corresponding CAQs. The majority of responding physicians reported working in settings where PAs are employed directly by the practice. While awareness of specialty certification was low among these physicians, those who were aware of it indicated that holding a relevant specialty certification might be considered along with experience in hiring decisions. Physicians were less likely than health systems to use specialty certification as a factor in promoting a PA.~~

## Alternative Model

~~Two organizations provide a structured curriculum of learning modules intended to prepare PAs who are entering the field. The Society of Dermatology Physician Assistants bills their program as a “diplomate fellowship” program. It does not rely on testing or award a certification. Rather, it relies on documentation that a PA has completed a structured curriculum of CME activities addressing PA practice in dermatology.~~ The Association of Rheumatology Health ~~Professions~~ PROFESSIONALS, which includes PA members, has worked with the American College of Rheumatology to produce a modular curriculum for PAs and NPs entering rheumatology practice. This program ~~will award~~ CONFERS CME/CE CREDITS ANDAWARDS a certificate upon completion.

# Discussion

## Potential Advantages of Specialty Certification

Specialty certification has a number of potential advantages for PAs and other stakeholders within the healthcare system. First, it provides external validation of a PA’s expertise. Second, specialty certification may be helpful to a PA who is seeking promotion within an established “clinical ladder” program in a health system. Often, these promotion structures have been established within a nursing structure that has long recognized the role of specialty certification as a means of promotion. Discouraging PAs from taking advantage of this pathway for promotion may disadvantage PAs who are seeking to advance into leadership positions. Third, holding a specialty certification may enable a PA to compete more effectively for jobs within a specialty by giving employers a criterion for distinguishing one applicant from another. Finally, specialty certification may provide patients with assurance that the PA providing care for them is qualified to do so.

## Concerns about Specialty Certification

The main concern about specialty certification is that its adoption will limit both entry into specialty practice and movement among specialties. The CAQ model requires ~~3000~~ 2,000 TO 4,000 hours of experience in the field DEPENDING ON THE SPECIALTY, including procedures and patient care activities that are considered to be core to the field, in order to establish eligibility to take the exam. While this is generally compatible with the PA model where one is trained as a generalist and gains experience through work-related experience, if holding a specialty certification becomes an entry criterion, it will favor those already in the field while barring entry to other PAs. This could create shortages of PAs who are able to engage in the field if not enough PAs holding the certification are available, and increasing costs to the system through higher salary requirements.

If specialty certification were to become a mandatory requirement for entry into PA practice in a specialty, a likely consequence would be the establishment of formal training programs; this would further reduce flexibility and adaptability by restricting PA practice to areas where one is trained and certified. PAs could find themselves working within the same rigid structures as physicians and nurse practitioners. Not only would PAs lose the ability to move from specialty to specialty, but healthcare systems would lose the ability forPAsto be available in areas where there are workforce gaps. This could result in higher costs for the system and reduced access for patients.

## When Might Specialty Certification be Appropriate?

The most compelling case for requiring specialty certification would be if a clear relationship between specialty certification and patient outcomes, including quality of care, could be demonstrated. Currently, there is a paucity of such evidence. This link has been difficult to demonstrate in physician literature. In a review of 33 findings by Sharp and colleagues, 16 demonstrated a positive relationship between certification status and desirable clinical outcomes. Fourteen showed no association, and an additional three showed a negative relationship, although the studies showing a negative relationship suffered from insufficient case mix. (12) Research should be conducted to determine if any relationship between specialty certification and patient outcomes exists in the context of PA specialty practice.

While AAPA remains opposed to using specialty certification as a criterion for hiring IN A SPECIALTY POSITION, one specific circumstance where specialty certification might play a helpful role in PA practice is within the promotion structures of a health system. In this context, gaining specialty certification may allow a PA to meet a requirement to be promoted with the system’s defined “clinical ladder” program. This seems appropriate because its use is not to deny access to the “ladder,” but merely to meet a criterion for moving from one rung to a higher rung of the ladder.

## What Uses of Specialty Certification Would be Inappropriate?

We conclude that any use of specialty certification is inappropriate if its use results in 1) reduced flexibility for PAs to move among care settings, 2) reduced ability of healthcare systems to address critical workforce needs, 3) higher costs to the system, and 4) REDUCED ACCESS TO PROMOTION FOR PAS WITHOUT THE CREDENTIAL WHO ARE OTHERWISE DESERVING OF PROMOTION, 5) reduced access to care, unless this is balanced by compelling evidence that specialty certification results in higher quality care. Until this evidence is available, we oppose the consideration of specialty certification in the following situations:

* As a criterion for entry into specialty practice employment settings
* As a criterion for licensure
* As a criterion for credentialing
* As a criterion for reimbursement

## An Alternative Proposal

A clinical “portfolio” approach that allows PAs to provide a more rounded portrait of their clinical experiences and competencies might meet the needs of stakeholders who are currently looking to specialty certification as a marker of competence. Portfolios have been used in the U.K. for trainees in the health professions and for periodic revalidation. (13)(14)(15)(16) They are in current use among U.S. medical students, residents, and fellows, and their potential for the PA profession is being explored. (17) Unlike current specialty certifications that document that an individual has passed a knowledge test, a portfolio SUCH AS AAPA’S “PA PORTFOLIO” maintained by the PA with certain portions subject to external validation could allow a PA to display information related to formal and informal training, relevant CME, procedures performed with associated proficiency documentation, and relevant certificates or certifications to prospective employers, credentialing authorities, insurance companies, and other stakeholders. Of particular interest would be the ability to document assessed proficiency with Entrustable Professional Activities (EPAs) important within a field. (18) EPAs are comprised of activities that a medical professional can be trusted to perform without supervision after verification of competency. U.S. medical students, residents, and fellows use this model. Standardized lists of EPAs are being developed, along with methods for assessing them. (19) This would allow stakeholders to make informed decisions about individual PAs based on a broad understanding of the PA’s professional standing and experience, rather than relying on a solitary marker such as specialty credentialing. MICROCREDENTIALLING AND DIGITAL BADGING ARE AN EMERGING TECHNOLOGY THAT ALLOWS THE HOLDER OF THE CREDENTIAL TO SHARE IT IN ELECTRONIC FORMATS IN A WAY THAT ALLOWS AN ASSESSOR TO AUDIT IT BACK TO THE ISSUER AND MAY ENHANCE THE CREDIBILITY OF FORMALLY ASSESSED COMPETENCIES COMMUNICATED IN AN ELECTRONIC PORTFOLIO.

#  Conclusions

The PA model adds value to the healthcare system by supplying a medical professional who can be educated and trained rapidly and deployed throughout the system to address unmet needs. This flexibility and adaptability should be fiercely protected in order to avoid losing this unique advantage. As the model of PA practice evolves, employers and other stakeholders are looking for ways to assess the qualifications and competencies of PAs. The profession should respond to these legitimate concerns in a way that demonstrates the expertise of PAs, but does not inhibit the flexibility of the profession.

Specialty certification could be problematic in that it may restrict the ability of PAs to move throughout the healthcare system as needs arise. Some of the concerns about specialty certification are already being realized, since employers in some areas are already using it as a criterion for hiring.

There may be an appropriate role for specialty certification in facilitating a PA’s advancement within a healthcare system’s promotion pathway or enhancing the ability of PAs to compete for jobs with other providers. However, this must be balanced against the ability of PAs to move within the healthcare system to meet gaps in patient care, thereby diminishing the value of the profession to the healthcare system and to patients. As the relationship between specialty certification and quality of care is unknown, research should be conducted to determine if such a relationship exists. In addition, further research on PA specialty certifications overall should be conducted. The profession should take steps to allow PAs to provide stakeholders with rich and nuanced information about a PA’s background and experience, rather than credentials that rely primarily on knowledge testing.

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Con testimony included

* + Desire for more specialty organization involvement.
	+ Concern about the potential issues that the CAQ has on PAs including, but not limited to, transition to practice, specialty transition, competition, cost, and limiting practice scope.

Pro testimony included

* + The importance of updating data to make the paper current.
	+ Stakeholder input was solicited from organizations including PAAMS, fellowship program directors, and presidents of specialty organizations that have a CAQ or a CAQ in development.
	+ The paper maintains AAPA policy that specialty certifications should not be a criteria for entry into practice, licensure, credentialing, or third party reimbursement.
	+ This paper was part of the 5 year review and has already been referred to the Commission on Continuing Professional Development and Education (CCPDE) for review and recommendation.

**Madam Speaker, the committee recommends adoption of Resolution 2022-B-02**

The Committee considered testimony on 2022-B-03, the resolved portion of which reads:

Amend policy HP-3200.3.3.1 as follows:

The preceptors of entry-level accredited PA programs may earn two Category 1 credits per week for each PA student they precept. The preceptor may earn a maximum of ~~20~~ 30 Category 1 credits during any single calendar year.

Con testimony included

* + Preceptors could obtain the vast majority or all of their category 1 CME through precepting.

Pro testimony included

* + Granting CME assists in recruitment and retention of preceptors since it is increasingly difficult to obtain preceptors.
	+ The act of precepting ensures that the preceptor stays up to date on evidence-based medicine and the current literature in their field.
	+ Preponderance that supported the intent of the resolution to expand CME allotment.
	+ Current language does not limit which type of preceptors can receive CME.

A friendly amendment was provided to remove “entry-level” to include all types of accredited PA programs.

**Madam Speaker, I move that Resolution 2022-B-03 be amended as follows:**

The preceptors of ~~entry-level~~ accredited PA programs may earn two Category 1 credits per week for each PA student they precept WITH NO MAXIMUM. ~~The preceptor may earn a maximum of 20 30 Category 1 credits during any single calendar year~~

The Committee considered testimony on 2022-B-05, the resolved portion of which reads:

AAPA strongly encourages PAs to become active leaders in administrative roles of their practice. To enhance the preparation of future PA Administrators, AAPA shall create a task force to identify CORE leadership skills and competencies required for entering an administrative role and develop learning modules containing such skills to be available as part of PA’s continual leadership development.

There was a question about why “core” was capitalized and if it was an acronym. Clarification from the author was that this was an error and should not be capitalized. There was no additional testimony on this resolution.

**Madam Speaker, the committee recommends adoption of Resolution 2022-B-05.**

The Committee considered testimony on 2022-B-07, the resolved portion of which reads:

AAPA should create a task force to develop a model Transition to Practice program template to assist healthcare systems and practices to successfully onboard their newly hired graduate PAs and to assist with existing PA staff who want to change specialties and may require some additional onboarding and training.

Con testimony included

* + Concern about optics of creating a task force and that it may imply current education is not sufficient.
	+ The action should be about creating resources for transition to practice.

Pro testimony included

* + Structured onboarding supports the success of new graduates and PAs transitioning specialties or to new employers.
	+ The need for the AAPA to provide an example or foundation for PAs to bring to their employers.
	+ Preponderance that supports the need for resources for transition to practice.

**Madam Speaker, I move that Resolution 2022-B-07 be amended as follows:**

AAPA should INVESTIGATE AND DEVELOP RESOURCES FOR TRANSITION TO PRACTICE MODELS AND HAVE THEM AVAILABLE TO ASSIST INSTITUTIONS WITH SUCCESSFUL ONBOARDING OF PAS. ~~create a task force to develop a model Transition to Practice program template to assist healthcare systems and practices to successfully onboard their newly hired graduate PAs and to assist with existing PA staff who want to change specialties and may require some additional onboarding and training.~~

The Committee considered testimony on 2022-B-08, the resolved portion of which reads:

Amend policy HX-4600.6.1 as follows:

AAPA opposes RESTRICTIONS OR attempts to restrict the availability of reproductive healthcare.

Con testimony included

* + Concern that AAPA would appear to be a taking a stance instead of remaining neutral.
	+ Concern of potential repercussions such as loss of membership and legislative hurdles.

Pro testimony included

* + That access to reproductive care and family planning is essential.
	+ Medical decisions should be between the PA and the patient.
	+ Optimal practice conditions should not be interfered with by legislation.
	+ That medical ethics states that patients should have access to the care they need.
	+ Strong national policy allows PAs to advocate for continued access to reproductive healthcare.
	+ This is in alignment with other PA organization policies.
	+ Amendments for clarity were provided and the author was in agreement.

**Madam Speaker, I move that Resolution 2022-B-08 be amended as follows:**

AAPA opposes RESTRICTIONS AND attempts to restrict the availability of AND ACCESS TO reproductive healthcare.

The Committee considered testimony on 2022-B-09, the resolved portion of which reads:

Amend policy HX-4200.1.5 as follows:

AAPA endorses exclusive breast OR CHEST feeding ~~when possible,~~ for about the first 6 months of life. CONTINUED BREAST/CHEST FEEDING (ALONG WITH COMPLEMENTARY FOOD INTRODUCTION) UNLESS MEDICALLY CONTRAINDICATED, IS RECOMMENDED FOR AT LEAST THE FIRST YEAR OF THE INFANT’S LIFE AND THEN AS MUTUALLY DESIRED BY THE PARENT AND INFANT. ~~followed by breastfeeding with complementary food introduction until at least 12 months of age.~~

Con testimony included

* + Concern that the language was not inclusive enough and not encompassing all ways to deliver human milk.

Pro testimony included

* + The definition of chest feeding is inclusive of all forms of human milk delivery.
	+ This follows the recommendations of the American Academy of Pediatrics, American Academy of Family Physicians, the Academy of Breastfeeding Medicine, and the World Health Organization.

There was a proposed amendment that would align language with other organizations.

**Madam Speaker, I move that Resolution 2022-B-09 be amended as follows:**

AAPA endorses exclusive breast OR CHEST feeding ~~when possible,~~ for about the first 6 months of life, UNLESS MEDICALLY CONTRAINDICATED. CONTINUED BREAST/CHEST FEEDING (ALONG WITH COMPLEMENTARY FOOD INTRODUCTION) ~~UNLESS MEDICALLY CONTRAINDICATED,~~ IS RECOMMENDED FOR AT LEAST THE FIRST YEAR OF THE INFANT’S LIFE AND THEN AS MUTUALLY DESIRED BY THE PARENT AND INFANT. ~~followed by breastfeeding with complementary food introduction until at least 12 months of age.~~

The Committee considered testimony on 2022-B-10, the resolved portion of which reads:

AAPA supports the legislation and the use of safety-related labeling for button/coin batteries and more secure closure of compartments of products containing a button/coin battery.

Furthermore, AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines to current didactic curriculum of PA programs and continuing medical education for practicing PAs.

**The Reference Committee requested and was granted permission from the Speaker to divide 2022-B-10 into two parts:**

2022-B-10a

AAPA supports the legislation and the use of safety-related labeling for button/coin batteries and more secure closure of compartments of products containing a button/coin battery.

and

2022-B-10b

Furthermore, AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines to current didactic curriculum of PA programs and continuing medical education for practicing PAs.

The Committee next considered testimony on 2022-B-10a, the resolved portion of which reads:

AAPA supports the legislation and the use of safety-related labeling for button/coin batteries and more secure closure of compartments of products containing a button/coin battery.

 There was no testimony given for this resolution.

**Madam Speaker, I move that Resolution 2022-B-10a be adopted as follows:**

AAPA supports the legislation and the use of safety-related labeling for button/coin batteries and more secure closure of compartments of products containing a button/coin battery

The Committee next considered testimony on 2022-B-10b, the resolved portion of which reads:

Furthermore, AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines to current didactic curriculum of PA programs and continuing medical education for practicing PAs.

Con testimony included

* + That AAPA should not make policy that dictates PA educational requirements.
	+ Concern for burden on PA programs to incorporate into curriculum.

Pro testimony included

* + The need to teach this at a deeper level due to the vague presentation and potential catastrophic end point.
	+ The preponderance was in support of educating PAs and PA students about this topic.

**Madam Speaker, I move that Resolution 2022-B-10B be amended as follows:**

~~Furthermore,~~ AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines OF BUTTON BATTERY/COIN INGESTION to current ~~didactic~~ curriculum of PA programs and continuing medical education for practicing PAs.

The Committee considered testimony on 2022-B-11, the resolved portion of which reads:

Amend policy HX-4600.7.3 as follows:

AAPA supports continued education programs and public health based strategies relating to the abuse of ~~marijuana~~ CANNABINOIDS and addressing and reducing the use of ~~marijuana~~ cANNABINOIDS.

AAPA supports public health-based strategies~~,~~ AND LOCAL LEGISLATION, ~~instead~~ IN LIEU of incarceration, when dealing with persons in possession of ~~marijuana~~ NON-MEDICAL USE CANNABINOIDS.

Testimony included a proposed amendment to bring the language in line with states that have legalized cannabinoid use and FDA-approved cannabinoid use. There was no additional testimony.

**Madam Speaker, I move that Resolution 2022-B-11 be amended as follows:**

AAPA supports continued education programs and public health based strategies ADDRESSING AND REDUCING ~~relating to~~ the ~~abuse~~ NON-MEDICAL USE of ~~marijuana~~ CANNABINOIDS. ~~and addressing and reducing the use of marijuana~~.

AAPA supports public health-based strategies~~,~~ AND LOCAL LEGISLATION, ~~instead~~ IN LIEU of incarceration, when dealing with persons in possession of ~~marijuana~~ NON-MEDICAL USE CANNABINOIDS.

The Committee considered testimony on 2022-B-14, the resolved portion of which reads:

Amend policy HP-3200.1.7 as follows:

AAPA acknowledges the importance of interprofessional curricula that includes PA practice and the PA’s role in the seamless delivery of high-quality patient care. AAPA SUPPORTS COMMUNICATION WITH RESIDENCY AND FELLOWSHIP ORGANIZATIONS (ALLOPATHIC AND OSTEOPATHIC, PHARMACY PROGRAMS) TO SUPPORT EDUCATION REGARDING THE PA’S ROLE ON THE HEALTHCARE TEAM.

Con testimony included

* + Original policy was sufficient.

Pro testimony included

* + The need to educate other healthcare professions to help them understand the PA role.
	+ Empower AAPA to engage in the work of interprofessional education regarding the role of PAs.

There were multiple amendments provided and considered.

It was also noted that a specified list of professions would be potentially limiting in the future as the make-up of the interprofessional team evolves.

There was a question about the use of specific language to invoke an action by the BOD; it was noted that the House cannot direct AAPA staff through policy.

**Madam Speaker, I move that Resolution 2022-B-14 be amended as follows:**

AAPA acknowledges the importance, AND SUPPORTS THE DELIVERY of interprofessional curricula that includes PA practice and the PA’s role in the seamless delivery of high-quality patient care. AAPA SHOULD PROVIDE EDUCATION TO OTHER HEALTH PROFESSIONS REGARDING THE PA’S ROLE ON THE HEALTHCARE TEAM. ~~AAPA SUPPORTS COMMUNICATION WITH RESIDENCY AND FELLOWSHIP ORGANIZATIONS (ALLOPATHIC AND OSTEOPATHIC, PHARMACY PROGRAMS) TO SUPPORT EDUCATION REGARDING THE PA’S ROLE ON THE HEALTHCARE TEAM.~~

The Committee considered testimony on 2022-B-15, the resolved portion of which reads:

 AAPA believes that PA students should have access to cost-free or low-cost healthcare services or coverage while pursuing PA education.

Con testimony included

* + Concern for possible downstream effects on the cost of PA school.
	+ AAPA policy should not dictate what PA programs do.
	+ Students should retain individual choice.
	+ AAPA policy HX-4600.1.8 already states we believe in equitable access to healthcare for all people.

Pro testimony included

* + The increased access and reduction of financial burden to students as they pursue their PA education.
	+ That PA students being able to care for themselves improves their learning and ability to care for others in the future.
	+ Future PA students should not be deterred from pursuing PA education due to healthcare costs, risk of bias, or making life decisions prematurely.
	+ ARC-PA Standard A1.04 states that PA students should have equivalent access to services as comparable students on campus, thus this would increase access to healthcare.
	+ This resolution is a philosophical statement and does not require any institution to pay for or provide healthcare coverage.
	+ A suggestion was made to include mental health.

**Madam Speaker, I move that Resolution 2022-B-15 be amended as follows:**

AAPA believes that PA students should have access to cost-free or low-cost healthcare AND MENTAL HEALTH services or coverage ~~while pursuing PA education.~~

The Committee considered testimony on 2022-B-16, the resolved portion of which reads:

Amend policy HP-3200.6.1 as follows:

In order to ensure ~~the~~ DIVERSITY OF age, gender, racial, cultural, ~~and~~ economic AND DISABILITY STATUS WITHIN ~~diversity~~ ~~of~~ the profession; AAPA strongly endorses the efforts of PA educational programs to develop partnerships aimed at broadening diversity among qualified applicants for PA program admission. Furthermore, AAPA supports ongoing, systematic and focused efforts to REDUCE UNDUE BARRIERS TO ENTRY FOR APPLICANTS AND attract and retain students, faculty, staff and others from demographically diverse backgrounds.

Testimony included an amendment to increase the inclusivity of the resolution, and this was supported by the authors. No further testimony was given.

**Madam Speaker, I move that Resolution 2022-B-16 be amended as follows:**

In order to ensure ~~the~~ DIVERSITY OF age, gender, racial, cultural, ~~and~~ SEXUAL ORIENTATION, RELIGION, SEX, EDUCATIONAL BACKGROUND, economic AND DISABILITY STATUS WITHIN ~~diversity~~ ~~of~~ the profession; AAPA strongly endorses the efforts of PA educational programs to develop partnerships aimed at broadening diversity among qualified applicants for PA program admission. Furthermore, AAPA supports ongoing, systematic and focused efforts to REDUCE UNDUE BARRIERS TO ENTRY FOR APPLICANTS AND attract and retain students, faculty, staff and others from demographically diverse backgrounds.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank the House Officers Todd Pickard, Leslie Clayton, and Peggy Walsh for their support and guidance. I would like to thank the committee members for their hard work and being well prepared for this committee.

SIGNATURES ON FILE

Respectfully submitted,

Rachel Weinzimmer, Chair

Saje Davis-Risen

Greg Selasky

Jared Wiebel

Charles Sun, Student Representative