AAPA Response to NCCPA Document Release

In NCCPA's May 10, 2016, release of additional information regarding its recertification proposal, NCCPA has unfortunately distorted the AAPA Board's position, as well as the results and conclusions of research studies and literature reviews, and released an inadequate report on results of its highly flawed survey.

NCCPA's Commentary on the Board Resolution:

- NCCPA states that the Board's "resolution refers to CME as a single entity" and "implies that CME is valuable generally".

  FACT: The Board's resolution does not include any reference to CME. The discussion paper accompanying the resolution includes a reference to literature cited by NCCPA regarding CME. The discussion paper clearly states that study authors conclude that "*interactive CME sessions that enhance participant activity and provide the opportunity to practice skills"* can change professional practice and, on occasion, health outcomes. The Board document does not suggest that all CME is structured in this manner. Nevertheless, this finding does support the resolution's call for "the use of evidence-based alternatives to testing for maintenance of certification" by showing that such alternatives do exist. As noted elsewhere in the document, other alternatives are identified in literature cited by NCCPA, including "qualifying competency evaluation programs at hospitals and other institutions that credential, privilege, and/or employ health care professionals." Contrary to NCCPA's assertion, such programs also include "periodic demonstrations of continuing competencies" and therefore can meet the definition of what is "acceptable" for certification/recertification programs.

- NCCPA states that the Board's resolution "excludes assessments and relies on the practitioner's ability to self-assess and direct CME to their learning needs".

  FACT: The Board's resolution opposes only two specific requirements: (1) "a closed-book, proctored exam in a specialty area for maintenance of certification"; and (2) "any requirement that PAs take multiple examinations during a 10-year recertification cycle". The resolution does not speak in opposition to assessments of medical knowledge, which could include, for example, required knowledge assessments that are used by PAs to identify areas in which CME must or should be taken, without the threat of losing one's license or certification standing because of the assessment results per se.

- NCCPA dismisses, as small studies with various limitations (including the fact that one utilizes Medicare recipient data), the studies cited in the supporting documentation for the Board's resolution. Those studies find no statistically significant difference in the clinical performance or quality of care provided between physicians required to participate in MOC versus physicians who were not required to participate in MOC.

  FACT: NCCPA has not identified any studies that found a statistically significant difference in patient care or patient outcomes between physicians who have been required to take an MOC test and those who have not. There is only one study cited by NCCPA that specifically looks at MOC testing and patient effects. That study found a relationship between patients obtaining two of four *processes of care* (hemoglobin A1C testing, mammography, lipid testing and retinal screening) and physician scores on maintenance of certification exams. Like the studies dismissed by NCCPA, this study is based on data for Medicare patients. Further, the study authors do not attribute the higher rates of medical processes to taking the MOC test, but rather to the cognitive skills of the individual physicians. This paper was also discussed in the AAPA review of the 11 studies identified by NCCPA in February 2016 as the basis for their proposal to modify the recertification exam process.

NCCPA's Literature Review

AAPA appreciates that NCCPA has provided a comprehensive overview of the literature it has relied on to develop its new recertification exam proposal, though we are at a loss to understand why these studies could not be made available months ago. Like the eleven studies it previously cited as the basis for the proposal, it is our view that, in its totality, the evidence does not support the proposed change, which includes at least two open-book exams on general medical knowledge and a closed-book proctored exam in a specialty area during every 10-year recertification cycle.

With regard to the document itself, NCCPA misleads the reader by identifying its own interpretation of study results as "Key Messages", implying incorrectly at times that the study authors drew those conclusions. As a result, the reader cannot rely on the summary provided by NCCPA as support for the PANRE changes it has proposed. Below are some examples:

- NCCPA states that one of the "Key Messages" of the Alper, et al, (2012) paper[1] is that "Much medical knowledge is in flux, and a great deal can change in a short time. As a responsible certifying body, NCCPA should move to more frequent assessments of changes in core medical knowledge."

  FACT: The paper does not address the issue of the appropriate frequency of certification assessments. According to the abstract included in NCCPA's document, the paper is focused on measuring the proportion of core medical knowledge that changes in one year. It concludes that 20% of core information guiding clinical practice is changed within one year, and concludes that using textbooks as a marker of standard practice is no longer warranted.

- NCCPA states that the "Key Message" of the Day, et al, (1987) paper[2] is that "The longer physicians are away from formal training the worse they perform on tests of medical knowledge; this is especially true for knowledge that changes."

  FACT: The study does not support the NCCPA statement with regard to stable medical knowledge. According to the abstract included in NCCPA's document, the finding applies only to items related to new or changing knowledge, and that "performance on items testing stable knowledge was relatively constant across age groups".

- NCCPA states that the "Key Message" of the Lipner, et al, (2011) paper[3] is that "Increased activity in CME is associated with increased scores on MOC examinations. A finding such as this emphasizes the value of MOC examinations as indicative of the types of change that CME is designed to bring about. In other words, MOC examinations are also a valuable indicator of knowledge."

  FACT: The study makes no claim about the value of MOC exam. According to the abstract included in NCCPA's document, the paper does not evaluate whether assessment exams appropriately measure physician performance with respect to patient outcomes or patient safety. Instead, the underlying premise of the study is that the MOC exam is a reliable indicator of performance, and the authors suggest that *improvement programs* be targeted to physicians who practice in isolation, are older, are international medical graduates, and who performed poorly on their initial certification exam. CME is identified as one way to improve physician performance on assessment exams. More importantly, with regard to NCCPA's "key message", NCCPA recertification exams are not, in fact, used to measure the effectiveness of CME, but, rather, to determine whether or not a PA may continue to practice as a certified, and in some states, licensed medical provider.

[1] "The Evidence Base: A Compendium of the Data and Research Informing the Proposed Two-Part Recertification Model Under Consideration by NCCPA", May 10, 2016, p 8

[2] Ibid, p. 20

[3] Ibid, p 35

NCCPA Survey Results:

On February 12, AAPA released an assessment of the NCCPA survey conducted by an independent researcher with a PhD in survey design. That assessment concluded that the instrument itself was biased. It was designed to arrive at one of two conclusions: support for the proposed recertification exam process or support for the current recertification exam process. It asked only about the benefits of each, and did not give the respondent an opportunity to answer questions about the negative aspects of either alternative. Nor did it give the respondent the opportunity to consider or offer, including: alternatives with regard to the proposed timing, content, or nature of the exams; alternatives to the proposed use of exams (such as identifying necessary CME focus areas); and alternatives to the use of exams at all. It is not surprising, therefore, that the NCCPA survey results found that the survey found that respondents said they favored either the new exam model or the old exam model, or had no preference between the two. No other answer – or finding - was possible.

Even NCCPA's presentation of the results of its survey is suspect. While claiming that the survey was "completed" by 30,492 PAs, the report does not disclose the number of respondents who answered each question. AAPA has heard from a number of PAs that they skipped the survey's multiple choice questions but "completed" the survey in order to express their opinions in the one open-ended response opportunity at the very end of the survey. We are compelled to ask why NCCPA did not follow standard practice in presenting survey results by showing the number of respondents to each question.

NCCPA has promised that it will eventually release a summary of the open-ended responses. It would have been helpful to have this summary presented in this release or, at least, a verbatim list of the comments provided in response to the single open-ended question in the survey instrument. Given the flawed nature of the survey itself, these comments are likely to represent the most informative results of the survey, and it is disappointing that the AAPA House of Delegates will not have the benefit of that information prior to its deliberations this weekend.

Finally, AAPA has been asked why, particularly if the NCCPA survey was flawed, it did not conduct its own survey on this topic. AAPA believes that the decision regarding the appropriate requirements for recertification should be based on evidence, not an opinion poll, and this evidence should be considered through a broad, deliberative process. While an appropriately structured opinion survey could also contribute to understanding potential implications of the proposal and identifying a wider range of potential alternatives, AAPA believes that the conversations that have taken place in AAPA constituent organizations, on Huddle, and in other forums have contributed more effectively to a richer understanding of these issues than could be achieved through a poll. AAPA now confidently puts this matter in the hands of the 274 PA leaders, representing 94 constituent organizations that comprise the AAPA House of Delegates, to deliberate and to establish AAPA policy with regard to these important issues facing the PA profession.