PA Recertification Proposal: Reform or Reaction?

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Above all, in my more than seven years of writing editorials for *Clinician Reviews*, I have endeavored to engage thought and stir emotion in my PA and NP colleagues. You may not always have agreed with me, but I hope you were inspired to consider your own opinions on various topics—some controversial. This month, I must apologize to my NP readers for focusing on what is (at least, in terms of specifics) a PA-centric issue.

The big buzz in the PA world at the moment is the proposed changes in the recertification process by the National Commission on the Certification of Physician Assistants (NCCPA). Having been certified through the first board exams in 1974 and served in various leadership roles with NCCPA and the American Academy of Physician Assistants (AAPA), I admittedly have a personal stake in this process. But then, this is personal for every certified PA.

The PA profession has spent its first 50 years undergoing extensive entry-level, post-professional, and continuing education reform. Although this is an ongoing process, we are at the point when we, as a profession, must begin to critically review the means of professional entry: certification and licensure.

It is important to understand that the responsibility of a national professional certification agency is first and foremost patient safety through assurance of medical knowledge and then second, a reliable system of certification (or in this case recertification) congruent with the practice setting. Therein lies the contradiction: when a recertification examination no longer assesses the body of knowledge needed for those it certifies. Let's face the facts: Sorting out core knowledge is a very difficult task. We must begin by defining what core knowledge is and how we identify the commonality we all share despite our individual specialty areas of practice.

The NCCPA instituted professional certification of PAs in 1974. In the 40+ years since the inception of certification, the process has undergone several significant transformations, most notably in the 1980s, when maintenance of certification through a recertification exam was instituted, and in 2014, when recertification moved from a six-year to a 10-year cycle. The Commission has dutifully served the public by assuring quality through establishment of a certification process for entry-level PAs and maintaining quality assurance by requiring ongoing continuing education and regular re-examination of its certificants. In 2014, the NCCPA certified its 100,000th PA.

The objective of the first PA programs in the mid-1960s was to equip new practitioners to fill the void in primary care.[1] Through the 1990s, most PAs worked in primary care, so it stands to reason that the entry-level PA certification exam (PANCE) and the recertification exam (PANRE) have been primary care oriented. Yet today,

more than 73% of certified PAs practice *outside* primary care specialties.[2] While the recertification exam maintains a broad-based focus, many complain that it has minimal relationship to their day-to-day clinical practice. This relevance issue is at the heart of today's debate and triggers the most controversy.

Within health care and medicine, certifications are most commonly used to delineate advanced areas of training, such as a physician who is board certified in endocrinology or in other specialties. Rarely in clinical health care or medicine is certification used as the *entry-level* benchmark. The NCCPA credential is an exception to that rule. What is disingenuous is that we use the "C" for both entry-level and ongoing certification.

Before we make any significant changes in the current process, we must stop and ask ourselves some very fundamental questions about the professional practice of PAs today and in the future.

- Does the current recertification process (or any future one) serve the public and other stakeholders? After all, shouldn't this discussion be first and foremost about the quality of patient care and the patients we serve?
- Does the PA profession benefit from the PA-C®—a single, widely recognized benchmark of professional endorsement? Is it possible for a single credential to meet the needs of all PAs?
- Should the PA be considered a generalist first and a specialist second? This speaks to the issue of mobility/flexibility between specialties. Is this still an important concept for us in 2016 and into the future?

As the debate about impending changes to the recertification exam model simmers, some PAs are questioning the value of recertification at all. While we can debate that amongst ourselves and grouse about the time and cost of recertifying, the fact is that patient advocates, state medical boards, and third-party payers—when asked about the value of ongoing "certification"—continue to promote an objective assessment process, which meets industry standards and is a reliable measure of PA knowledge and cognitive skills. *This matters to them and should matter to us as well.*

If you are a PA working in a specialty practice, do you consider yourself a specialty PA or a generalist PA working in a specialty practice? There is a huge difference between the two. I worked for more than two decades in asthma, allergy, and immunology and considered myself a specialty PA. As a specialty PA, do I not owe it to the patient to demonstrate the knowledge and skills to practice in that specialty?

> *"We need an objective assessment process that is a reliable measure of PA knowledge and cognitive skills."*

Some believe that once you have demonstrated a grasp of general medical knowledge on an entry-level exam (PANCE) into the profession (much like our physician colleagues), you should then recertify periodically in your specialty, thus demonstrating competence in your chosen field of clinical practice in an up-to-date fashion. Do we not need to decide the difference between core (general) knowledge and advanced (specialty) knowledge—and then who should assess it? Or should we have a process that gives the PA a choice?

On the other hand, to support the flexibility of PAs to change specialties during their careers and to work in multiple specialties concurrently, the AAPA and many individual PAs believe it is important to maintain the generalist nature of the PA-C credential as a core philosophical tenet of the current recertification process. I contend that it is difficult to be all things to all people, especially to a diverse PA profession that is more than 100,000 strong.

In an effort to do due diligence to this issue, the NCCPA conducted a PA practice study last year. According to the Commission, the data suggested that there are appreciable (and measurable) differences in the nature of practice from one specialty to another.[3] This should not be a surprise to anyone but raises the question of the need for a greater degree of assessment focused on specialty practice. Faced with this dilemma, the NCCPA is attempting to implement a specialty assessment component that will help address the wide diversity in PA specialty practice.

So, in an attempt to meet the needs (and demands) of multiple stakeholders, the NCCPA has proposed a two-component recertification model whereby (1) core medical knowledge would be as-

sessed during every 10-year certification maintenance cycle using periodic take-at-home exams that provide individual assessment across a broad range of organ systems and task and skill areas and (2) remediation through continuing medical education (CME) or other means for those whose performance falls below the passing standard. These untimed exams completed over an extended period of time would allow the individual PA the opportunity to use reference materials while answering questions, if needed.

Practice specialty knowledge would then be assessed using a secure, proctored, timed exam during the final years of each 10-year cycle. These exams would be shorter than the current PANRE and would assess core knowledge PAs need to practice safely and effectively. Within a relatively short period of time, 10 to 12 specialty exam options would be available, including family medicine and general surgery. According to this proposal, PAs would be able to select the exam of their choice, with the family medicine exam an option for those preferring to continue to take a generalist exam irrespective of their practice specialty. Those scoring high enough might also be eligible for a Certificate of Added Qualification (CAQ) in that specialty if they also meet related CME and experience requirements. Each performance level would be determined for each exam through proven scientific methods by PAs selected as representative of those taking that exam.[3]

The AAPA remains unconvinced that this new model will make a difference, citing concerns over unnecessary burdens on PAs, employers, and the health care system overall. Many feel that competency is best judged at the practice level.[4] Also, there continues to be some concern about the CAQ. Just as the General Practitioner (GP) vanished or evolved into the Family Practitioner (FP) over time, will the PA-C vanish to become the PA-CAQ? Will specialty postgraduate training become required to hold a generalist CAQ? According to the NCCPA, the CAQ will continue to be optional. The current PA model is, however, unique in that the PANCE allows entry into the PA profession for state licensure. There is nothing wrong with that model until one decides to go into specialty practice—which encompasses 73% of our profession.

Leaders at the NCCPA contend that this new model addresses the significant shift in practice that has taken place throughout the spectrum of health care as well as the changes that have come about with advanced professional development of the PA/physician concept.

Frankly, at face value, the NCCPA proposal seems to be a practical option to meet the needs of a majority of the PAs in this country, improving the relevance of the proctored exam while maintaining the generalist credential and keeping the flexibility of PAs to change specialties during their career. What do you think?

Your opinions on the current or proposed PA recertification process are important. I strongly encourage you to take advantage of the NCCPA's request to share your comments and questions with them (through March 2016) via email (newpanre@nccpa.net) or via a survey that the NCCPA will be conducting this month. The value of open and competent dialogue in the profession will assist all of us in determining the correct path to ensuring we provide the best possible care to our patients.

I, of course, would also like to hear your thoughts; feel free to email me at PAeditor@frontlinemedcom.com. Your opinion and comments are invaluable as we sort out the best and most reliable method to recertify PAs for the future. **CR**

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