



# In Response to “Unraveling the recertification conundrum”

**Denni Woodmansee, MS, PA-C**

**Board Chair, NCCPA**

The past few months have seen considerable debate and discussion regarding potential changes to PANRE under consideration by the NCCPA Board of Directors. The Board welcomes and encourages thoughtful and constructive perspectives and ideas on the potential changes.

Given that almost 75% of PAs practice outside of primary care, what is the optimal PANRE recertification model to ensure we meet our obligations to patients, to employers and to the PA profession of today as well as tomorrow? The current PANRE exam model does not optimally assess current PA practice. We believe the model under consideration would be a significant, evidence-based improvement in that direction. There are those that may disagree. If so, we welcome alternative models that would better meet the objectives we are trying to accomplish. For those that agree, we would like to hear your thoughts as well.

This is the discussion we are trying to cultivate and inform. However, this is a complex topic, and we have seen some misunderstandings and misinformation circulate about it. The March issue of JAAPA contains an [editorial](#) that includes some misstatements and some opinions that I will address in this response [1].

## **NCCPA Information Gathering Efforts**

NCCPA has engaged in a significant effort to gather information and data to inform our consideration of a new approach to recertification. In 2015, NCCPA conducted *two* profession-wide surveys, a three-day focus group of certified PAs, and a survey of state medical boards *before* opening up a six-month public comment period. We also evaluated current assessment methodologies and trends in certification and assessment; looked at what other organizations are doing in this area; considered capabilities offered by recent technological developments; and analyzed recent and historical exam performance data and PA feedback. These efforts substantiate NCCPA’s commitment to well-informed decision making. We are working to balance a wide range of perspectives among stakeholder groups and even (perhaps especially) *within* the increasingly heterogeneous PA profession.

Despite those considerable efforts, the authors of the JAAPA editorial criticized the 17% response rate to the 2015 practice analysis study. While we hoped for and worked hard to attain a higher response rate, statistical validity would have been satisfied with even a much lower sample size. Also, when compared to the demographics collected through NCCPA's PA Professional Profile that has been completed by approximately 92% of certified PAs, the survey respondents were representative of the PA population in areas like principal specialty, years of experience, gender, geographic region, and race. (You can read more about methodology and data in the [white paper](#) NCCPA published on this issue.)

The JAAPA writers also seemed to dismiss the input NCCPA gathered through the PA focus group, saying its participants were "handpicked." In fact, those 29 participants *were* handpicked as representative of the profession in terms of practice areas, experience and demographics. They were also selected because they were individuals with *no prior involvement* with NCCPA in any volunteer or exam development role. These were not handpicked fans of NCCPA or supporters of the certification process; there was a significant diversity of perspectives represented in that group.

### **The Value of the Take-at-Home Component of this Model**

The JAAPA editors dismissed the take-at-home component of this model as devoid of any real value in terms of "quality assurance." I would agree *if* we were talking about the old Pathway II recertification exam. However, the take-at-home component of this exam model is very different. From the perspective of the test-taker, the most notable difference would be the nature of the questions themselves. The new take-at-home exam would cover core medical knowledge. That means its content would cover diseases, disorders and conditions that are relatively common across the landscape of health care and in their typical presentation. It would assess things that most PAs should easily recognize, not questions that would require extensive research to find answers. That content would address core knowledge that any medical practitioner should have for safe and effective practice. Also, thanks to today's technology, these take-at-home exams could be more solidly based on psychometrically sound principles than the paper-based exams of years past.

With the take-at-home component of this exam model, PAs would receive feedback that clarifies where their knowledge gaps are and would be equipped with resources or information to bring them up to date. For some, there would be the opportunity to remediate through directed CME rather than retesting. The take-at-home tests would be conducted periodically during the 10-year certification maintenance cycle, enabling PAs to have more frequent exposure to essential core medical knowledge.

The take-at-home element in the proposed model is based on integration of key findings from the educational and assessment literature that illustrates new approaches to testing that enhance knowledge retention and support continuous professional development. The very nature of medical practice requires commitment to lifelong learning, and this model provides a process that enables PAs to stay up-to-date.

### **The Mobility Issue**

As long as there has been a recertification exam for PAs, there has been discussion and debate about whether that exam should be a generalist exam or whether it should reflect what PAs are doing in the various areas in which they practice. This model does both, preserving the generalist nature of the PA-C credential with the core medical knowledge component while also assessing PAs on what they do in practice.

The JAAPA writers and others have postulated that merely adding a specialty-related component to the PA recertification process would encumber professional mobility. This is a possibility we are exploring during the public comment period and have invited anyone with evidence to support this position to share this data with us. The inclusion of specialty related items within PANRE is not new. NCCPA has offered the “practice-focused” PANRE in its current form since 2009, giving PAs the opportunity to focus 40% of their exam in the areas of adult medicine, surgery or primary care. Since the practice-focused PANRE was initiated, we have yet to see PAs forced into a particular exam option by employers or others. The proposed changes to the PANRE model separates out the core and practice focused components into two assessment elements.

JAPAA writers characterize the new PANRE as “a wholesale swap of the current proctored generalist examination for the proposed specialty-specific examination” or “creating mandatory specialization.” NCCPA strongly disagrees. We maintain that the proposed PANRE model includes the necessary elements to continue the generalist PAC credential by including a core knowledge component and providing the PA the option to select the proctored examination that best aligns with their area of practice or experience.

We have received comments from PAs who want to demonstrate their abilities and retain the generalist PA-C credential but who are also concerned over the challenges of time and expense associated with preparing for the generalist PANRE. We believe that offering PAs the opportunity to focus their exam preparation and study on content more closely aligned to the care they provide patients is beneficial to the PA and the patient as well. During this public comment period, we are gathering input from all of our stakeholders: PAs, patients, employers, and others who depend on the PA-C as a marker of ongoing professional development and competencies.

### **NCCPA’s Motivation**

NCCPA has the responsibility of providing certification and recertification programs that reflect standards for clinical knowledge, clinical reasoning and other medical skills and professional behaviors required upon entry into practice and throughout the careers of PAs. We do that to serve the interest of the public, guided by our passionate belief in the essential role and significant contributions of certified PAs. NCCPA is a not-for-profit organization. Enhancing profitability has never even been a point of discussion during the eight years I have served on this Board. Fees are set to cover the cost of development and administration of those activities. NCCPA Board members are all volunteers and receive no compensation for their service. Revenue is only used for the purpose of fulfilling the mission of the organization.

### **NCCPA’s Mandate**

As an organization accredited by the National Commission for Certifying Agencies (NCCA), we are required to provide high quality examinations and to periodically review them for relevance based on a scientific analysis of the current state of PA practice. NCCPA has the responsibility of ensuring the overall integrity of relevant, meaningful, and reliable certification and certification maintenance processes for over 108,000 PAs, patients, state licensing boards, employers, and other stakeholders.

With more than 350 years of collective clinical experience, members on the NCCPA Board are attuned to the breadth of issues facing this profession and are committed to engage the PA community to provide a better-informed decision making process. We are not conducting a referendum on whether or not the PA profession should have a recertification exam or how the PA profession’s recertification process

compares with that of others who practice medicine. Rather, we are looking for thoughtful comments and ideas that will better inform the Board in their decision making process.

We continue to invite the submission of your ideas and suggestions to [newpanre@nccpa.net](mailto:newpanre@nccpa.net) until the public comment period ends on June 15.

[1] JAAPA invited us to submit this response for review and potential publication in a future issue. While we appreciate that invitation, due to the months-long delay that would have resulted from that approach given JAAPA's publication schedule, we have opted instead to publish this timelier rejoinder here.