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University of Rochester Medical Center
Physician Assistant Executive Committee
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To the NCCPA Board of Directors:

We read with great interest the recent NCCPA white paper, "Re-examining Recertification for the PA Profession".

The University of Rochester Medical Center (URMC) Physician Assistant Executive Committee (PAEC) is the advisory committee for all matters pertaining to physician assistant practice, and is the central body for reviewing credentials and recommending privileges for all PAs practicing at URMC. Almost three hundred PAs are employed throughout the four hospitals and other facilities in our health system.

PAEC has discussed in detail the proposed changes to the PANRE, and would like to offer our thoughts on each of the proposed elements. We understand that our perspective is from that of a large academic health system, (URMC is a University Health System Consortium member). However, we also represent a number of PAs who work in small community practices that are part of our health system. We have attempted to frame our responses to the proposed changes with all of the PAs we represent in mind.

We will respond to each of the model attributes in turn. In evaluating these proposed changes, we would like to comment that many larger regional health centers, both academic and non academic, are imposing increasing numbers of mandatory training requirements for providers, both across the health system, and additionally at the departmental level. For those that are in procedure intensive fields, there are education requirements to maintain procedural competency, through education, simulation, and number of procedures performed. This ongoing training and education makes up a substantial portion of the PA's maintenance of competency in their respective field of practice, and we hope that the proposed changes will allow PAs to focus their time on content more relevant to their practice.

At-home, remote administration:
Although the paper states that scheduling and traveling to a test is burdensome, we suggest that mandating a portion that would be done at home would also be seen by many as burdensome, as some may prefer to complete the test at a facility, rather than spend significant amounts of time

at home completing portions of the test. We note that 71% of PAs prefer to test in one sitting instead of spreading the exam over multiple sessions. We therefore recommend that if at-home, remote administration is adopted, it should be an option, not a mandatory change.

More frequent assessments:
We believe that this may be beneficial, but heavily depends on implementation, the average length of time required to complete, and difficulty of the content, as well as its relevance to clinical practice.

More meaningful feedback on exam performance:
We are generally supportive of this change, provided that the feedback is brief, targeted, and can guide the PA on selection of CME activity.

Specialty-focused assessment:
We agree that specialty focused assessment may be beneficial, as this should require less preparation than the general exam. Our primary concern about specialty focus is that, unlike physicians, there is no national standard on what specialty PAs should do. Although PAs have significant autonomy, their utilization in any particular specialty varies significantly, and the expected knowledge base is not uniform. In addition, many PAs work in subspecialties, such as critical care or nephrology, which cross multiple specialties, and may not fit into a particular category.

In conclusion, we recommend caution in proceeding with yet another significant change in PA certification requirements. Many PAs are just now entering the 10 year cycle, and many are still adjusting to the new requirements, including meeting PI CME requirements, which is already increasingly onerous. Thank you for the opportunity to participate in the discussion regarding these potential changes.

Regards,

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