March 18, 2016

Mr. Denni J. Woodmansee, MS, PA-C
Chair, NCCPA Board of Directors
National Commission on the Certification of Physician Assistants
12000 Findley Road, Suite 100
Johns Creek, GA 30097

Dear NCCPA Board of Directors,

On behalf of the Illinois Academy of PA's (IAPA) Board of Directors and its constituents, I respectfully wish to express our concerns of the newly proposed NCCPA PANRE testing model. The IAPA represents over 3700 practicing PAs and PA faculty and over 500 students in the State of Illinois. After soliciting feedback from our members and holding an in-person board of directors meeting, the IAPA wishes to express its concerns and opposition to the new model for reasons outlined below:

1. **Flexibility:** *The new model will cause a loss of flexibility in the PA profession.*
   Whether you wish to believe it or not, this model creates specialization. Employers will begin to require specialty exams and PAs will not be able to move across disciplines. This will cause the profession to lose diversity, and therefore will decrease access to patient care. One of the greatest assets of our profession is the ability to change disciplines. If you implement this new model, it will change the face of the profession entirely.

2. **Research:** *The cited research is outdated and does not support the proposed model.*
   The NCCPA drew several inappropriate and biased conclusions from the cited research. Several studies examined data that was outdated and collected over 20 years ago. These studies compared student classroom testing models not provider board exam models. Not one of the studies cited indicated that frequent test taking improved provider competency or patient outcomes such as quality and safety. The current NCCPA testing model has been in place for almost 30 years. At no time has it ever been indicated or demonstrated that a PA's competency, quality or safety practices by the current model have been compromised and/or questioned. In fact, current literature shows that PAs, under the current testing model, improve quality outcomes and safety of patients. After a thorough review the research, there are no definitive results that support the NCCPA's claims. Thus it is clear that the research does NOT support the proposed model.

3. **Competency:** *Frequent standardized exams do not determine competency.*
   Competency is multifactorial and is determined at the practice or hospital level. More than 30% of PAs are hospital based PAs and of the other 60% in private practice, many hold

hospital privileges. Currently, in the hospital setting, there are several competency measures already in place including Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) requirements. Also of note, the NCCPA just began its new, robust PI and SA-CME model in 2014. Several PAs have still not even moved to the ten-year cycle yet. Before the entire testing and CME system is changed, it would be prudent to gather data on the new CME process, including outcomes.

4. **Time Commitment, Cost, Decreased Access to Care:**
   The proposed new structure would create an undue and unnecessary time commitment and cost to practicing PAs. PAs, their employers, and their patients would also be subject to increased costs and time off work due to exam preparation, and testing demands. This not only decreases PA, patient, and employer satisfaction, but also decreases access to patient's access to care.

5. **Physicians:** *The current physician-PA testing models and CME requirements are similar.*
   We are a profession that maintains alignment with our physician colleagues. PA education is based on the medical model. Most state's providers are boarded by the same medical board. PAs are often held to the same accountability as our physician counterparts in terms of patient care, quality, and safety. We also follow similar CME structures with PAs always having a more demanding structure than physicians.

6. **Nurse Practitioners:** *The current nurse practitioner testing model and CME requirements are much less demanding, practical and cost effective.*
   PAs and NPs often hold similar roles throughout a private or hospital practice. In fact, NPs have much fewer requirements that PAs do, but often have more job and leadership opportunities than we do. Increasing testing demands to practicing PAs widens this gap and we fear that PAs will be left behind. We often see areas such as critical care, psychiatry, pediatrics, neonatology, and anesthesia preferring NPs to PAs because they are "specialized" by their exam. Adding "specialized" exams to the PA profession would likely create this "syndrome" for all medical and surgical specialties and we fear that specialty exams will become a requirement of our profession.

We hope that the NCCPA will take our suggestions seriously and listen to clinically practicing PAs, PA faculty, and students. We have grave concerns about the way data behind this proposal has been gathered (example: One focus group with only 29 individuals purported to represent over 100,000 PAs which helped create the proposed model.) The NCCPA needs to consider not only academic justification for the new model, but also consider the practicality of the proposed model and the undue burden it will place upon PAs and the PA profession.

Sincerely,

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