AANPA

AMERICAN ACADEMY OF NEPHROLOGY PAs

Attn: NCCPA Board of Directors
c/o Chair Denni J. Woodmansee, MS, PA-C
12000 Findley Road, Suite 100
Johns Creek, GA 30097-1409

To the NCCPA BOD:

In response to the NCCPA's proposed model for a new PANRE, AANPA respectfully submits the following official response:

1) In a survey of our membership, they overwhelmingly responded against the new changes. Our membership saw, and many filled out, the NCCPA survey although many members noted that there was little 'wiggle room' in the survey. AANPA membership felt the survey was biased and set up to only allow one way of responding/thinking. One member suggested it was in the same vein as the question *'Do you still beat your wife'* which presupposes that one already beats his wife and is thus impossible to answer. Our membership felt that if NCCPA wishes to actually **ask** our opinion, the survey needs to allow actual dialogue.

2) The AANPA BOD feels that shortening a proctored test is putting more PAs at risk of failing the PANRE. PANRE test questions fall into 3 categories: known, able to narrow down to 2 answers and unknown. We all accept that there will be questions we are unable to answer. However, by decreasing the number of questions (the denominator), then the unknowns will increase in percentage importance and thus, a PA is more likely to fail a PANRE. The length of the test is not the *'stress factor'*; it is the actual test itself that stresses many PAs. By shortening the test, NCCPA increases the fail rate and thus increases the number of PAs who may lose their certification.

3) Too many changes at one time are confusing PAs. AANPA has been on the forefront of the PI and SA CME programs. Our *Kidneys in a Box* PI-CME program has been completed by 200+ PAs in the last 2 years. AANPA members have done workshops on PI-CME and lectured throughout the US for the last 2.5 years. Our members teach PI and SA at the *Board Review* classes. The common theme in all these workshops has been the utter confusion of the PAs regarding PI....SA seems a bit easier to comprehend. By adding another change, when the introduction of PI and SA is only 2/3 done, NCCPA runs the risk of driving out the older PA and decreasing new PA students at a time when PAs are desperately needed and shortages continue in many areas of the US. It also means more confusion with PAs not completing what was required and thus losing their certification, simply due to a misunderstanding.

4) PI-CME is a game changer in altering the behavior of practicing PAs and we need to see it through. The studies cited by NCCPA for changing testing for PAs all state that continued learning through practicum on an annual or biannual basis is best for retention of material. At the present time, PI-CME fits this description exactly. *Kidneys in a Box* is now 2 years old and the analysis of the data we have collected is

showing huge changes in PA behavior. By simply asking all PAs, no matter the specialty, to consider kidney disease in their patient population, we have shown an increase in implementation of national guidelines. Many PAs now consider kidney disease as they select medications for their patients, thus decreasing the incidence of iatrogenic error. AANPA has shown that significant changes in practices is possible with a simple PI project. *(manuscript in preparation)* PI projects are now rolling out throughout the US and data on these changes is just starting to be published. PI projects have the ability to positively impact patient health and we must allow this process to fully mature.

5) AANPA members note that nephrology is a CAQ but is not one of the choices for the specialty exam. One of the arguments NCCPA puts forward in favor of the changes is that PAs can use the exams towards their CAQ. Nephrology is a small specialty but we have a CAQ. However, nephrology is not one of the choices, and we have been told by Ragan Cohn that nephrology is unlikely to be a choice in the future and thus, this argument is invalid for us. Nephrology has always felt that increased education in any and all specialties is important but it is more important to allow PAs to cross-walk across specialties. Nephrology PAs are found across many disciplines: cardiology, hospitalist, ICU/CCU, critical care, orthopedics, cardiac surgery, urgent care/ED, transplant and of course, nephrology. We feel it is vital to allow PAs to continue to practice to their highest level of ability and throughout many disciplines. The CAQ is helpful for educational purposes but must NOT become a requirement for PAs to practice in a specialty. Note: adding nephrology to the IM choices will not change our opinion.

AANPA strongly opposes the new changes NCCPA has offered and wishes to register their opposition to the manner in which members feel that their voices have not been allowed to be heard via the poorly constructed and worded *'survey'* put out by NCCPA.

Sincerely, the AANPA BOD speaking for the AANPA membership:

Peter Juergensen, PAC	*AANPA President*
Martha Versprille, PAC	*AANPA Vice President*
Donna Anderson, PAC	*Treasurer*
Kim Zuber, PAC	*Secretary*
Karen Burchell, PAC	*AANPA/AAPA renal liaison*
Denise Link, PAC	*CME chair*
Ashlie Burns, PAS	*Student member*
Molly Lenahan, PAC	*Founding treasurer*
Ray Cord, PAC	*Past President*