Proposal to Establish a

NATIONAL DATA CENTER FOR PHYSICIAN ASSISTANTS (NDCPA)

As a Joint Effort of the AAPA, APAP and NCCPA

The National Data Center for Physician Assistants (NDCPA) will be the principle information gathering agency of the American Academy of Physician Assistants, the Association of Physician Assistant Programs and the National Commission for Certification of Physician Assistants. Its purpose is to serve the research needs of the PA profession, Federal and State health agencies, private foundations, institutions and other health-related organizations. The NDCPA will collect information - at the national level - on the following: 1) Applicants, 2) Students, 3) Entry-level graduates, 4) Academy members and 5) Non-Academy members certified by NCCPA. Once collected, the data will be analyzed and reported as statistical summaries in the form of descriptive, longitudinal and profile studies.

As the most current and comprehensive repository of information on physician assistants, the NDCPA and its sponsoring organizations will be in a favorable position to foster and facilitate research on physician assistants. The NDCPA will carry-out only research sanctioned by the three parent organizations. It will operate under direction of a Research Advisory Committee appointed by the Board of Directors of AAPA, APAP and NCCPA. The Advisory Committee will establish guidelines, policies and lines-of-authority for NDCPA. These will be reviewed and approved annually by the Board of Directors.

Problem

"Times, they are a changing"...says the lyricist of a recent ballad. If you've tried to secure funds for a "pet" project lately, you know what he's talking about. Resources are scarce; a movement is underway to get rid of government and private agencies who can't justify their socio-economic worth. As PAs, we've grown accustomed to being asked to "prove" that we are needed. As a spokesman for the GMENAC report puts it..."We (i.e., PAs) are a public dilemma; a viable option that works but one that may not be needed". To justify our worth to society, we will have to continue describing who we are and what we do. Our information must be current, accurate and useful.

To date our research activities can, at best, be described as inconsistant and redundant. Things are a little better than when I joined the Research and Review Committee in 1975. At that time, nobody sought our advice about research. Federal bureaucrats and independent researchers made most decisions. Our graduates were flooded with questionnaires; there was much duplication of effort. First we got our graduates and program directors to stop responding to questionnaires that weren't approved by AAPA and APAP. Then we established a mechanism to review research proposals. Finally, we decided to establish our own data base. We felt this was necessary since Federal and private researchers were destroying their raw data tapes to assure confidentiality. Valuable information was being lost. We couldn't get access to it. Also graduates were tired of answering the same background questions over and over. The response rate to

surveys dropped off appreciably.

Funds to establish the data base came from the Robert Wood Johnson Foundation. We conducted the first National Survey of Physician Assistants in 1976. The information helped secure a new wave of Federal funding for PA programs in 1977. The mailing list generated from the '76 survey strengthen the Association and Academy's position. We now held the "keys" for those wanting access to the PA profession. No longer could we be ignored or left out of research decisions.

We hired a full-time Director of Research and Development. However, this person was given very little guidance and spent alot of time completing administrative tasks. Once the '76 data was collected, analyzed and reported, that was it. There was no follow through to validate and to keep the data base useful. No secondary or follow-up studies were done. No Master index was compiled. Things bogged down. As chairman of the Research and Review Committee at that time, I assume much of the blame. The '78 National Survey was a disaster; not in terms of collecting and analyzing data, but in terms of "reporting-the-data-out".

Here we are in '81 doing another survey. The information will be collected, analyzed and reported - but then what? Do we let the data base stagnate or do we keep it dynamic and useful? Given the current economic and political climate, can we afford not to develop a mutual plan-of-action.

Need

The reasons for establishing a National Data Center are not new; nor are they unique. They are: 1) to reduce duplication and repetition, 2) to use resources more effectively, 3) to cut cost, 4) to centralize control, give direction and meaning to research activities, 5) to identify priorities and funding sources, 6) to expand our information services, and 7) to enhance our decision-making capability.

Most health organizations have some type of research data center. The AMA, AAMC, ANA, AHA have theirs. We're all familar with the National Research Council of the National Academy of Sciences. These organizations understand how important it is to gather and use information to advance their socio-economic and political position. Nobody is going to do it for us; it's going to cost money - but it's vital to our survival.

I'm not overly concerned about confidentiality or protecting our data files from one another. We're mature and honest individuals. The computer experts can tell us how to protect our files and data from outside individuals. This is nothing new for them. Banks do it all the time. In fact, our data might turn out to be better protected than it is now. At least some formal guidelines would exist for doing research and releasing information. That's more than we have now.

Data Sources

As stated earlier, the NDCPA would be responsible for collecting, analyzing and reporting information on a regular basis.

Applicant Data: No national data exist on applicants. Most member programs of APAP would like to see this information collected (see attachment 1). Information on applicants and acceptees to medical schools is retrieved from the Medical Student Information Service (MSIS) maintained by the AAMC. Data is gathered from two sources: 1) the AAMC's Application Service (AMCAS) application form and 2) the questionnaire accompaning the Medical College Admissions Test (MCAT). Although AAPA has considered establishing an Applicant Information Service, this has not been done. Nor do we have a single admissions test required by all programs. The best source for this information is the programs themselves. They would have to submit to the NDCPA a listing (preferably data tape) of applicants and acceptees containing: name, address, social security number and other demographic information including education, health experience and socio-economic data. The benefits of collecting applicant information are obvious and will not be discussed at this time.

Student Data: This is being collected as a part of the RWJ National Survey. However, there is no plan for doing this on an annual basis. Each student enrolled in U.S. Medical Schools is reported to the AAMC on a Matriculation Blank containing relevant information. In addition, the status of each student is reported to the AAMC on a Change of Status form indicating transfers, dismissals, leave of absence, readmission, etc. The AAMC receives a list of entire class of graduates each year. I see no reason why member programs of APAP could not provide similar information by having students complete Fall enrollment questionnaires and by informing APAP of changes in student status.

Entry-level Graduates: We should make every attempt to determine where new graduates are going to work and how hard it was for them to get jobs. This information could be collected by NCCPA when new grads sit for their Board Exams. AAPA could get information from those who don't take Boards after graduation. Timing is important.

Academy Members: This information is being collected as part of the RWJ Survey. AAPA membership application forms are another source of information which could be used to create a Master index listing the entire population of PAs working in the United States. The Master index will classify PAs as active or inactive, as civilian or government employed, as office-based or hospital-based, as involved in patient care or in some other professional activity such as medical education, administration or research. Validation of the Master index needs to be an ongoing process involving all three organizations and NDCPA. The Master index will be used to identify subpopulation of PAs to study. For example, we should conduct a practice profile survey of office-based PAs each year. Other subpopulations would include hospital-based PAs, military PAs or PAs who worked in subspecialties such as pediatrics, mental health, geriatrics, and industrial clinics. The possibilities are endless once the Master index has been established and is kept current.

Nationally Certified PAs: The NCCPA is the best source of information on informally trained PAs and non-Academy members who are certified. These individuals should be listed on the Master index. They shouldn't be excluded from studies. Comparative studies would be interesting. We should make every effort to get non-Academy members to join the Academy and Academy members who are not certified to take the Boards.

Location and Cost

I believe the National Data Center should be based within the Division of Biometry, Department of Community and Family Medicine, Duke University Medical Center. The computer facilities at the Triangle Universities Computation Center (TUCC) are outstanding (see attachment 2) and the Division has capable personnel and resources to accomplish many tasks "in house". As a non-profit institution, the University can provide computer services cheaper than commercial outfits. A large number of statistical packages are available; software is shared to hold down expenses. Duke University is conveniently located between Washington, D.C. and Atlanta, GA. There shouldn't be any travel or communication problems. Finally, the Division exist within an academic environment where the PA concept is understood and supported; a Medical Center recognized for its research and innovations. This environment is conducive to good research. There is a built-in incentive to publish results and to seek funding. Much has already been learned from the '81 National PA Survey. We need to build upon this experience.

By sharing the expense and responsibility for collecting information, the cost might not be so bad. It's hard however, to estimate cost. If we move fast enough - some of the software might be developed under the current RWJ contract in conjunction with the '81 Survey. Let me give you some estimates for the sake of discussion:

STUDY	NUMBERS	COST
Applicants	3,000	$3,000
Students	1,500	3,000
New Grads	1,500	3,000
Master index	5,000	7,500
Profiles	3,000	4,500

I would guess that the Data Center could operate on $20,000 to $25,000 a year. This would include coding, data entry, validation, analysis and to some extent developing new software to meet the growing demands for research and information sharing. The above estimate does not include any "start-up" or planning costs. It would support only an offline database (i.e., not directly accessible to AAPA or NCCPA offices). It would also allow only for conventional analysis of pre-specified, routine (not special) studies. It might however, allow for small analysis for use in substantiating grant and contract proposals.

First we need to decide what information we want to collect and what kind of communications capabilities we want. Then we can get a better idea of how much it's going to costs. We could buy part or all of it.

What about sources of revenue? Other Data Centers generate money by selling: 1) mailing lists, 2) data tapes and 3) publications (e.g., the AMA's annual PROFILE

MEDICAL PRACTICE). Most depend upon grants, subcontracts and financial assistance from sponsoring organizations. We need to explore all possible avenues. I can already tell you that RWJ is not interested. Mrs. Shuster says..."a National Data Base is essential to the PA profession. Consequently, the 'profession' should be willing to pay for it".

Issue

Should the Board of Directors endorse the establishment of a National Data Center for Physicians Assistants? If so, a person(s) needs to be appointed to join with other designated individuals to draft a detailed proposal including projected budget. This should be completed by January, 1982.

WORKSHOP NOTES

APAP APPLICANT, STUDENT, AND GRADUATE DATA

APRIL 12, 1981

SAN DIEGO, CALIFORNIA

Representatives from twenty-one member programs attended this workshop. Prior to the workshop, twenty-two programs had sent application forms, student profile data sheets, and/or graduate survey forms to the conveners. This data was reviewed, and handouts were prepared for the workshop participants to indicate points of commonality and unique features of the data from various programs.

Those in attendance agreed that it would be desirable to have a national applicant pool. Among the items mentioned as desirable to include on a common applicant data sheet were the following: number of programs applied to and the names of those programs, sex, age, educational background, previous health experience, previous helping professions experience, military experience (both veteran and corpsman), source of interest in the profession, and need for financial aid. In discussing a mechanism to collect this data, it seemed that programs would be willing to enclose a supplemental data sheet with their applications if the problems of data analysis could be handled.

In discussing the desirability of a common student profile form, it was suggested that APAP request samples from various programs before deciding on a common format. Again, there were several suggestions made for inclusion in a common form. They include the following; re-application status, number of programs aplied to, choice factors in program selection (money, geography, spouse preference, and degree options), attrition data, geographic origins patterns and regional concentration, reason for choosing the physician assistant profession, and stress factors within the physician assistant program as as correlated with curriculum.

Dr. Carter described his efforts with respect to the longitudinal survey for 1981, and again asked for program suggestions regarding data collection and analysis. The following suggestions were offered; professional attrition, reasons and patterns for job changes, correlation between number of hours worked and salary earned, type of job by year of graduation, how to deal with boredom and burnout, correlation between background and type of job, and difficulty in dealing with physician dependency when the employing physician retires, moves or dies.

In summary, this was a productive workshop, which offered member programs an opportunity for input into common data collection and analysis tools. The task of developing and implementing these tools now rests with the conveners of the workshop and/or various APAP Committees.

PHYSICIAN ASSISTANT APPLICANT DATA FORM (Draft)

NAME:

DATE OF BIRTH:

RACE:

SEX:

HIGHEST DEGREE ATTAINED AT TIME OF APPLICATION:

If you do not have a baccalaureate degree, how many semester hours of college work have you completed:

Are you licensed or certified in a health or helping professions field?
What field?

How many months of full-time patient care experience have you had?
In what capacity or capacities?

Please list other health care or helping professions experience:

Have you had military experience?
If so, please list dates and function:

How did you become interested in the physician assistant profession?

What do you anticipate your financial assistance needs to be?

C. TUCC - THE TRIANGLE UNIVERSITIES COMPUTATION CENTER

The Triangle Universities Computation Center was formed on May 24, 1965 by Duke University, North Carolina State University at Raleigh, and the University of North Carolina at Chapel Hill, with initial support being given by the National Science Foundation. By combining to share one large computer the three universities were able to obtain much more computing power than they would have separately. TUCC obtained its first computer, an IBM 360 Model 40 in March, 1966. This was replaced in October of the same year with an IBM 360 Model 75. The Model 75 was TUCC's computer for five years, until August of 1971, when it was replaced with an IBM 370 Model 165. A second 165 was installed in December, 1976. In August, 1979, an Amdahl 470/V7 was added to the twin 165's system. In May, 1980 the Amdahl was upgraded from a V7 to a V8.

TUCC is located in the Research Triangle Park and is a non-profit corporation separate and distinct from the three universities but controlled by them to ensure that its activities are in full conformity with their objectives of teaching and research. Its president, who is also Director of TUCC, reports to the Board of Directors consisting of three members from each of the three sponsoring universities.

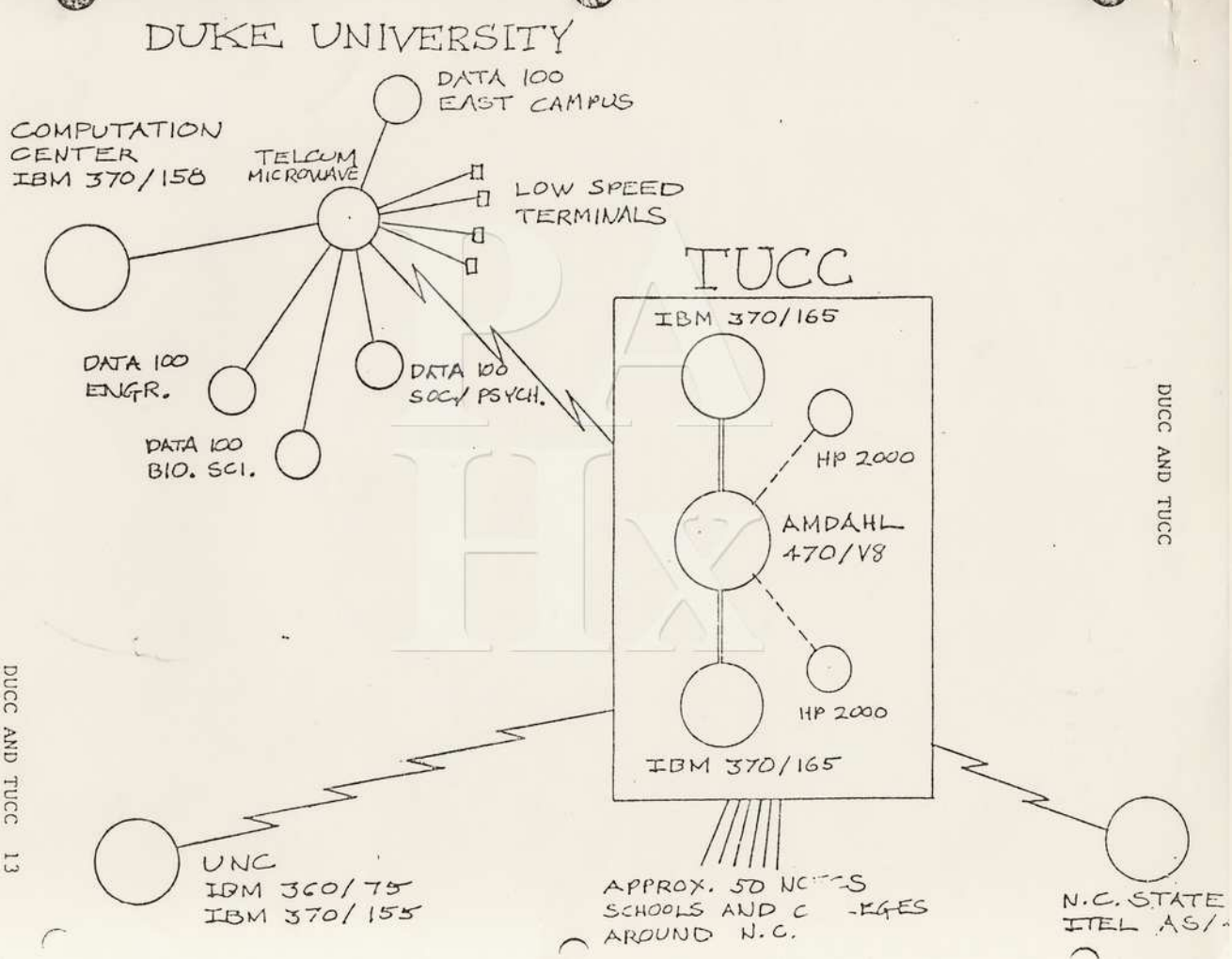
In addition to the three major universities, TUCC serves over fifty smaller colleges and institutions through the NCECS organization (North Carolina Educational Computing Services).

Scheduled meetings between TUCC staff and staff members from the three universities are held at various levels.

On the informal level, certain staff members at the Computation Center serve as liaison between the user and TUCC. Users having questions are requested to inquire at the Computation Center and not to contact TUCC directly. Most questions can be answered locally without consulting TUCC.

The TUCC Operating System is described in Section III-B. TUCC's daily operating schedule is given in Appendix A.

A map of TUCC and DUCC is shown on the following page. Almost all Duke research and instructional computing is done at TUCC. Card decks may be entered at the Comp Center or at one of the four DATA-100 medium speed terminals. As is shown on the map these jobs are teleprocessed through the Duke Telcom (Telephone Department) facilities and are sent to TUCC via microwave. Users may also access TUCC from any low speed terminal through the same Telcom and microwave facilities. Jobs are processed at TUCC and (normally) sent back to the originating terminal.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