Baylor College of Medicine
CENTER FOR ALLIED HEALTH MANPOWER DEVELOPMENT • 713 790-4611

August 17, 1979

David Glasser, Executive Director
National Commission on Certification of Physician Assistants
3384 Peachtree Road, N.E., Suite 560
Atlanta, GA 30326

Dear Dave:

I have asked a number of questions in the attached letter seeking answers to be provided our membership on points of concern as expressed to me.

I have tried my best to phrase the questions allowing NCCPA to respond on a positive note.

Best wishes,

C. Emil Fasser
Education Coordinator
Physician Assistant Program

CEF:dc

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August 20, 1979

David Glaser, Executive Director
National Commission on Certification of Physician Assistants
3384 Peachtree Road, N.E., Suite 560
Atlanta, GA 30326

Dear Dave:

It was good to see you in Washington, to hear of the decision not to buy the plane and receive input into our deliberations concerning the future of the PA profession.

As we have discussed on several occasions over the last few months, there exist in the minds of my colleagues many questions covering the Commission and its role in relationship to the PA profession. Your recent letter responding to the questions raised by David Mittman, RPA, President-Elect to the New York State Society of Physician Assistants touched on but a few of their concerns.

To give you the idea of the magnitude of their questions, I have attempted to state them as asked of me during phone conversations and in letters. Though they are many, I would appreciate greatly your taking the time to address them so that I may share the replys with our membership.

1. How did the NCCPA come about?
2. Historically, who was involved?
3. Has that involvement changed and, if so, how?
4. Has the focus of financial support changed and, if so, how?
5. Who were originally involved in designing the initial exam for the Primary Care Physician's Assistant?
6. How has that involvement changed, if at all?
7. What factors lead to establishment of original eligibility criteria?
8. What data, if any, supports the notion that the current eligibility criteria should remain unchanged?
9. What benefits, if any, are to be gained by maintaining status quo in terms of exam eligibility?

Some Questions?

10. Has there been any major shift in focus for the financial support of exam development, etc.? ✓

11. In what way were these changes, if any, involved in determining current certification and registration fees? ✓

12. What fees patterns are projected over the next five years in view of "soft dollars" and double digit inflation? —

13. In what way, if any, has NCCPA impacted on the stability and credibility of the PA profession? ok

14. Does NCCPA view itself as having a continuing impact on the PA profession over the next five years? Yes

15. In what way are the goals of NCCPA at odds with those of the PA profession and why? ?

16. Are these differences and/or similarities mirrored within other professions and registration bodies? Yes to some extent

17. Has the NCCPA addressed the issue of recertification and, if so, in what way? —

18. Can the PA profession anticipate requests from NCCPA to participate in experimental efforts or otherwise over the months ahead in regard to recertification? Yes, sort of

19. What factors may be involved in NCCP's decisions to proceed along a particular approach to recertification? ok

20. To date, how effective has the process of re-registration been in terms of numbers complying? stay tuned

21. If the process has not operated appropriately, Why is this so? ?

22. In what way, if any, has the changing of a non-member logging fee by the Academy impacted on the process of re-registration? A

23. Has, or is the NCCPA considering movement of the CME logging process "in-house" to offset such problems if they exist? — No?

24. Were NCCPA to assume the process of CME logging, What, if any, fee(s) would be charged for the service, and would such a service charge be borne by all certified PA's? — ?

25. While eliminating the current non-member fee would an NCCPA logging mechanism not, in fact, cost every PA more in the long run? — don't know

26. Does NCCPA see there to be any difference in how state medical boards will view initial certification versus re-certification? Yes

27. Based upon NCCPA's interactions with credentialing bodies, how do you view state medical boards reacting to self-assessment as the process used to document continued competency and maintain certification?

28. Does NCCPA view itself as having a role, if any, in the development and/or implementation of a program self-assessment aimed at documenting continued competency based upon Academy interest learning in that direction?

As you can see, the questions are many with the issues differsed from the emotional components. Needless to say, each one is important. When coupled with the data provided in letter to Dennis Oliver, Ph.D., I feel I can adequately reply to my colleagues.

Best wishes,

C. Emil Fasser
Education Coordinator
Physician Assistant Program

CEF:dc
cc: Ron Ross, PA-C
Donald Fisher, Ph.D.

National Commission on Certification of Physician's Assistants, Inc.

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Executive Director
David L. Glazer

September 27, 1979

C. Emil Fasser
Education Coordinator
Physician Assistant Program
Baylor College of Medicine
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Houston, Texas 77030

Dear Carl:

Thank you for your letter of August 20, 1979. I have not responded sooner because it has taken a great deal of time to assemble the extensive material you have requested.

I am extremely pleased to provide this information, not only for the communicative reason that you suggested in your letter, but also to provide input for subsequent publication of a document that would provide a sense of history to incoming NCCPA Directors. As you may recall, you and I discussed this some time ago and I think some of the questions you have posed are pertinent enough for me to respond in extremely detailed fashion. In fact, I have even included appendices referencing some of the answers. I thank you for your thoughtfulness in developing your questions.

One other point. As you are aware, I corresponded with each of the PA program faculty and staff in the country asking for precisely these kinds of questions so we could assemble some sort of compendium of information. The program personnel were largely unresponsive to that request. That is why such a compendium has never been assembled.

Once again, thank you for your thoughtful development of these questions. I hope you find the answers sufficiently detailed. If you have any other questions, please do not hesitate to contact me.

Sincerely,

David L. Glazer

DLG/cpa

1. Question: How did NCCPA come about?

   Answer: Appendix A provides a history and description of NCCPA, including a brief summary of its original formation. Specifically, with the proliferation of PA training programs, the National Board of Medical Examiners (NBME), the American Medical Association (AMA), the American Academy of PA's (AAPA), the Association of PA Programs (APAP), and the Department of Health, Education, and Welfare, Division of Associated Health Professions (DAHP) agreed to the need to develop a comprehensive certifying examination for PA's. The examination was ultimately developed by NBME with support provided by DAHP and the Kellogg Foundation.

   The charge of NBME had traditionally been the development, administration, and scoring of examinations for sponsoring health professional organizations. The responsibility to establish and enforce eligibility requirements and to certify successful candidates was an unfamiliar and uncomfortable role for NBME.

   After much deliberation by the original fourteen organizations involved (see Question #2), it was decided, with the endorsement of the profession, to form an independent, free-standing Commission to certify the entry level and continued competence of Primary Care Physician Assistants.

2. Question: Historically, who was involved?

   Answer: The following fifteen (15) organizations were originally invited to participate in the consideration to form the National Commission on Certification of Physician's Assistants. The original meeting was sponsored by AMA and NBME, and was held in 1973 in Chicago.

   American Academy of Family Physicians
   American Academy of Pediatrics
   American Academy of Physician Assistants
   American College of Obstetrics and Gynecology
   American College of Physicians
   American College of Surgeons
   American Hospital Association
   American Medical Association
   American Nurses' Association
   American Society of Internal Medicine
   Association of American Medical Colleges
   Association of Physician Assistant Programs
   Federation of State Medical Boards of the U.S.
   National Board of Medical Examiners
   U.S. Department of Defense

   Of the above organizations, only the American College of Obstetrics and Gynecology elected not to particiapte because there were no schools training OB/GYN Assistants and OB/GYN was not considered primary care. The remaining organizations constituted charter membership on the NCCPA Board of Directors.

3. Question: Has that involvement changed, and if so, how?

   Answer: The fourteen organizations listed in item #2 have continued to participate actively on the NCCPA Board of Directors. The AAPA provides five Directors to NCCPA; each of the remaining organizations provide one Director. Additionally, there are three Directors-at-Large, two of whom represent the public, and one of whom must be a physician.

From time to time, NCCPA has received inquiries from organizations interested in being added to the Board. Any organization representing users, employers, trainees, or PA's (as defined by NCCPA) is eligible for membership on the NCCPA Board. Only one of these organizations has pursued interest to the point of formal application. The organization was not admitted to the Board since it was a society which represented a population other than that currently or expected to be examined by NCCPA.

4. Question: Has the focus of financial support changed and, if so, how?

Answer: NCCPA began its operations formally early in 1975, just after completion of the 1974 Certifying Examination. The original budget for NCCPA was developed by a Budget Committee, which first convened in early 1973, and completed their planning in early 1974. That budget indicated that NCCPA would receive five basic types of fees from Physician's Assistants: application fees, examination fees, certification fees, reregistration fees, and recertification fees. After developing an operating budget, this committee determined the extent to which outside support would be necessary. All of this was predicated upon the fact that the DAHP was also supporting, independently, the NBME activity involved in the development, analysis, and scoring of the National Certifying Examination for Assistants to the Primary Care Physician.

As a result of the proposal efforts, NCCPA was funded through a contract from DAHP and a grant from the Robert Wood Johnson Foundation (RWJ) for a three-year period. These funds represented approximately % of the total NCCPA budget in the first three years of operation. As indicated in the newsletter shown in Appendix B, ("Considerations for the 1976 Examination") full support of the examination terminated with the 1976 exam. At that point, it was believed that the examination had been proven to be a reliable and valid competency assessment tool for PA's. Also, a sufficient number of pool test items had been developed to substantially reduce the annual cost of examination development. NCCPA, through test candidate fees, assumed the responsibility of total support for examination development, analysis, and scoring beginning with the 1976 examination. As indicated in the analysis in the newsletter article, use of the item test pool and subsequent economies in test development reduced the total cost of the examination development from $288,000, to approximately $163,500, a savings of approximately $125,000 in the first year. NBME effort has remained relatively constant since 1976. The total examination cost has been elevated as a function of inflation and investigations, as required, of reported irregularities in the examination process.

The initial three-year support provided by DAHP and RWJ terminated in 1978. NCCPA successfully proposed additional support from DAHP for the subsequent three-year period. The amount of support provided by DAHP amounts to approximately 30% of the personnel budget of NCCPA and 18% of its total budget. One of the major fiscal goals of NCCPA since its inception has been to be self-supporting within six years of initial funding.

Because DAHP supported the development of the examination in its early years the per capita examination fee originally was $55.00. In 1975, when NCCPA assumed total responsibility for examination development, administration, and scoring, the fee went to $165.00, which included a $50.00 non-refundable application fee, and a $115.00 examination fee. In 1979, inflation forced an increase in fees to $200.00 per capita; $65.00 for the application fee, and $135.00 for the examination fee.

The schedule for reregistration fees was originally developed in 1973. That schedule called for a $30.00 fee for the first three years, a $40.00 fee for the next two years, and ultimately, a $50.00 fee. That schedule has been adhered to.

5. Question: Who were originally involved in designing the initial examination for the Primary Care Physician's Assistant?

Answer: As part of the DAHP contract, NBME spendt considerable time and effort in developing a task analysis to describe the PA role. The task analysis was developed on the basis of a survey of all known PA graduates and their employers. Originally, there were nearly 3,000 task statements which were ultimately combined into a list of approximately 650 tasks. The task analysis served as the basis for the examination matrix developed by NBME.

Original test item development was accomplished by four separate test committees. Those committees were:

1. Multiple Choice Questions (MCQ); pictorials;
2. Multiple Choice Questions, written;
3. Patient Management Problems (PMP), data gathering;
4. Patient Management Problems, management and therapy.

Each of the test committees were composed of practicing and academic PA's, practicing and academic physicians, and practicing and academic nurse practitioners. Test writing expertise was also represented on the examination committees.

The original test committee membership was selected through a solicitation of names from each of the PA training programs that had been accredited to date. The total number of original test committee members was approximately 35 people.

6. Question: How has that involvement changed?

Answer: As indicated in the newsletter in Appendix B, it was necessary to substantially reduce the cost of examination development in order to avoid prohibitively high examination fees. In addition to developing current year examinations, the four original test committees began developing a pool of test items. Moreover, the development of the first three examinations provided a pool of reuseable test items for consideration on future examinations.

Consequently, test committee members developing items for examinations subsequent to the first three administrations were, and are, required to write fewer new items, and are able to devote some of their energy to reviewing older items for inclusion in the examination. Thus, the utilization of pool items reduced the requisite activity of the committee and also the number of new pictorials that might be developed for any given examination. The reproduction of glossy photographs for examination use is one of the single most expensive aspects of examination development.

These factors allowed NCCPA, in conjunction with NBME, to reduce the size and number of test committees. Beginning with the 1976 examination, the four test committees were reduced to two; the MCQ and PMP Committees. Each committee consists of eight to ten members representing a spectrum of specialty and sub-specialty interests and includes academic and practicing physicians, academic and practicing PA's, and academic and practicing nurse practitioner input. This structure has continued.

With the change in the practical portion of the examination, a new committee, the Clinical Skills Problems (CSP) Test Committee was convened in 1978.

Test committee members generally cycle off the committees every three years. There are staggered terms to assure continuity on the committee. On occasion, because of test committee turnover, NCCPA has requested a few committee chairmen or members to continue beyond their three-year term.

7. Question: The first administration of the National Certifying Examination occured in December, 1973. Eligibility criteria for the initial adminstration were developed by NBME. It was determined, since there was no appropriate examination measuring the competence of mid-level health practitioners who assist primary care physicians, that PA's, Medex, and Nurse Practitioners would be eligible to sit for the examination.

For the 1974 examination administration, NBME was required by federal contract to establish informal training eligibility criteria. Subsequent to its formation, but before its actual formal organization, the NCCPA reviewed and approved those eligibility criteria.

The award of a contract to NCCPA for the first three years of support by DAHP included a stipulation that "....eligibility criteria shall not be solely based on an individual completing and graduating from a recognized educational program. The criteria must accomodate those individuals who may have become qualified through unconventional ways, such as on-the-job training or experience". This stipulation was included was included in the subsequent three-year follow-on contract.

Initially, one could become eligible to sit for the NCCPA exam if he/she met one of the following eligibility categories:

1. Be a graduate of an accredited PA program;
2. Be a graduate of a nurse practitioner program, either family or pediatric in orientation, at least four months in duration, and affiliated with either an accredited school of nursing or accredited school of medicine;
3. Have been employed as a PA for four out of the past five years (as verified by current and previous employers) in the U.S. or in the uniformed services of the U.S.;
4. Be a graduate of a PA program supported by the Bureau of Health Manpower, DHEW.

The last category was established to allow graduates of programs which had not yet received accreditation to sit for the examination. This category was established in the formative years of the accreditation process and was dropped in 1977. The other three eligibility criteria have remained substantively unchanged.

8. Question: What data, if any, supports the notion that the current eligibility criteria should remain unchanged?

Answer: Nearly 90% of the annual candidates for the examination are graduates of accredited PA programs (including Medex). A very small number of nurse practitioners take the examination annually, and nearly 50% of that population are nurse practitioners trained in two programs which are indeed accredited as PA programs. To date, NCCPA has certified approximately 160 informally trained PA's. In order to become eligible to sit for the examination, informally trained candidates must meet very stringent training criteria as attested to

by both current and previous physician employers. The examination clearly distinguishes competencies. Historically, graduates of formal PA programs have performed at approximately a 84% pass rate, whereas informally trained candidates have passed at a rate of about 40%.

NCCPA has received no indication from employers or state boards of medical examiners that indicate that any of our eligibility criteria should be changed. We have no indication that informally trained candidates or nurse practitioners certified by NCCPA perform at any different level or in any different role than do graduates of formal PA training programs.

The National Commission on Health Certifying Agencies is an organization designed to establish standards for certifying agencies. It numbers sixty-five health related organizations among its members. One of the criteria for membership is to demonstrate that the certifying activity allows people with other than traditional training to become certified in the health profession. If that is not possible, the certifying agency must justify why only formally trained candidates are admitted to their certifying process. Because NCCPA has historically administered the examination to informally trained candidates, and because there is no data to indicate that these people function any differently than formally trained PA-C's, it would seem difficult for NCCPA to justify closing the examination to informally trained candidates.

9. Question: What benefits, if any, are to be gained by maintaining status quo in terms of exam eligibility?

Answer: Beyond the benefits listed in the previous answer, the PA profession is one of the few with the unique ability to indicate publicly that entry into the profession is based on demonstrations of competence, rather than acquisition of specific educational requirements. This is not to say that informal training is not critiqued. On the contrary, the NCCPA exam is not a challenge exam, and eligibility criteria for informally trained candidates are very stringent. What the PA profession in general, and NCCPA specifically, can say publicly is that, while formal training is the rule rather than the exception for the large majority of candidates for the national certifying examination, it is recognized that one can become a professional without undergoing the more traditional form of training. This in no way denegrates the professionalism or professional identity of the PA.

The concept of a PA is not new, only formal training is. The informal training eligibility category permits the small number of informally trained people to legitimize their role through an objective demonstration of competence. Without such eligibility, many states would admit these people to practice with no required exam. Admitting people to take the exam with appropriate informal training is as important to the formally trained PA as to the informally trained PA.

10. Question: Has there been any major shift in focus for the financial support of exam development, etc?

Answer: See the answer to Question #4.

11. Question: In what way were these changes, if any, involved in determining current certification and registration fees?

Answer: The determination of application, examination, and reregistration fees was discussed in the answer to Question #4. Recertification fees have not as yet been determined. None of the current NCCPA support is, or has been, earmarked

for the activity of recertifying PA competence. It has been understood that outside funds, obtained either through fee assessment or grant/contract award will be necessary to develop a recertification program. Obviously, the intent of the NCCPA Board is to keep any candidate fees to the minimum.

12. Question: What fee patterns are projected over the next five years in view of "soft dollars" and double digit inflation?

Answer: NCCPA approves its annual budget at the Spring meeting each year. The Finance Committee meets at least twice annually to develop and review budget line items. NCCPA has historically worked on a very close budget. In fact, NCCPA has historically utilized current fees to pay a portion of previous year examination costs billed by the NBME. In 1978/79, NCCPA went from a cash-based budget to an accrual budget. In so doing, the ramifications of cash flow became obvious.

NCCPA reregistration fees have remained as originally programmed in 1973; examination fees have remained unchanged since NCCPA initially assumed total responsibility for the examination. Inflation, of course, has become a fact of life for everyone, including NCCPA vendors, suppliers, and sub-contractors. There are also occasional, unanticipated cost which can be relatively high. For example, in 1978, NCCPA received reports of possible irregularities at a test site. In order to investigate these irregularities, a series of detailed, involved, and costly statistical studies were necessary. Incidentally, the statistical data did not support the reported irregularities.

As result of the inflation and the unanticipated costs over the years, as well as the cash flow problems engendered by "post-payment" of examination activities, the NCCPA Board of Directors, on the advice of the Finance Committee, voted to raise the total examination and application fee from $165.00 to $200.00 in 1979. The current five-year plan calls for no anticipated increase in these fees. Our ability to obtain this goal is naturally contingent upon the nation's economic posture and the continued stability of the number of program graduates each year. NCCPA fees and annual budgets will continue to be reviewed on a regular basis.

13. Question: In what way, if any, has NCCPA impacted on the stability and credibility of the PA profession?

Answer: The most obvious benefit to the stability and credibility of the profession rests in NCCPA's interaction with state enabling bodies. Over the past four years, NCCPA has had contact with virtually all fifty states. Materials have been provided to nearly all those states, and NCCPA representatives have testified at a number of hearings of state legislative committees, state legislatures, and state medical boards.

State enabling agencies are quite accustomed to being confronted by advocates of given professional groups. The posture is almost adversarial. The professional group presents to the state board what it thinks is appropriate for enabling legislation, rules and regulations for the profession, and members of the board respond by indicating they are the best judges of what is appropriate for their given jurisdiction. NCCPA has approached state medical boards from the position of being an independent, free-standing commission, which deals in the public's, rather than the profession's, interest. As soon as the NCCPA representative outlines the structure of NCCPA, the credibility of the certifying process, as viewed by the state medical board, becomes enhanced.

The net effect has been that NCCPA has been quite instrumental in assisting states in developing legislation, rules and regulations that benefit the PA-C. NCCPA has made a strong impact on who may practice in given states and what they may be allowed to do.

The most effective presentations have often been in concert with representatives from AAPA; the NCCPA representative speaks to certification and the process of assuring competence within the profession, and the AAPA representative speaks to the activities of individual PA's.

A measure of NCCPA's success in this arena is the acceptance of the examination by states. It took state medical boards over fifteen years to accept their own examination for physicians, the Federation Licensure Examination. In four short years, the NCCPA examination is recognized, at least in some form, in over thirty states. The existence of an independent certifying body with strong input from organized medicine has greatly enhanced the professional identity of PA's at the state level.

While not so obvious, the activity of NCCPA representatives and Directors with other health professions, its visibility within the federal government, and participation on such organizations as the National Commission on Health Certifying Agencies has gone a long way to publicize and legitimize the role of a physician's assistant.

14. Question: Does NCCPA view itself as having a continuing impact on the PA profession over the next five years?

Answer: Yes. NCCPA continues to be called upon by state boards and by federal agencies for input. We anticipate that we will continue to provide such information and serve as a resource to any bonafide agency requesting it.

As state boards become more involved in the process of assuring continued competence, it is expected that NCCPA will serve as a major resource for not only continued competence measurement for physician's assistants, but as a model for other professions as well.

15. Question: In what way are the goals of NCCPA at odds with those of the PA profession and why?

Answer: It is doubtful that the goals of NCCPA and AAPA are at odds at all. The single charge of NCCPA is to assure entry level and continued competence of PA's and to present attainment of appropriate certification to appropriate parties and groups, including state enabling bodies, employers, etc. This activity surely is not at odds with any goal of the AAPA.

The frustration, I believe, comes largely from a paradox. The greatest single benefit to the PA of the NCCPA organization it its structure. It is that independence that may frustrate the PA.

NCCPA operates in the public domain. A charge of NCCPA is to assure the public of the competence of PA's. To that end, NCCPA operates in the public's interest, and not necessarily the profession's. This apparent lack of control of the certifying process may be the major source of frustration to PA's. As an example, PA's may feel that the practical portion of the examination is an unnecessary expense and a threat to their entry level examination scores. On the other hand, NCCPA, having reviewed the data very carefully, has decided that the practical portion of the examination provides a very useful way to separate out those people who don't possess the most rudimentary of skills.

Thus, NCCPA might decide to continue the use of the practical exam, even though the PA profession is opposed to it.

This is not to say the NCCPA Board of Directors is inattentive or unresponsive to the position of PA's. Quite the contrary is so. In fact, NCCPA has often reversed or tabled decisions that have passed, on the basis of unified opposition of the five PA's on the NCCPA Board. Clearly, the NCCPA Board of Directors is concerned when the PA Directors present unanimous expressions of support or doubt and is responsive to those expressions.

16. Question: Are these differences and/or similarities mirrored within other professions and registration bodies?

Answer: The structure of the PA professional organization has tailored itself after the parent profession, medicine. Since there is no supervising or employing profession for medicine, the structure of NCCPA as a certifying body is unique. Medical specialty boards are composed of members of that medical specialty. Medical specialty boards have come under fire from various federal agencies, including the Federal Trade Commission, because of the concern about possible restraint of trade. NCCPA is less likely to fall under similar critical umbrellas because of its unique structure.

Within the other allied health professions, there are some organizations with similar construction. Most of those deal with medical lab personnel, and there seems to be such a schism between various levels and types of laboratory personnel, that internecine battles seem to take precedence over the certifying/professional society interface.

Because of its unique organization, there are few similarities mirrored in other professions that can be isolated. Based on the correpsondence that NCCPA has received, and our contact at state level, NCCPA seems to enjoy a great deal of credibility among a large percentage of working PA's.

Where you have an agency representing the profession and another one credentialing that profession, it seems likely that there will continue to be philosophical differences. These differences are not necessarily bad; in fact, they may be healthy. It is the responsibility of the profession to continually advise NCCPA concerning membership response to NCCPA decisions and deliberations. It is up to NCCPA to assist the profession in demonstrating that PA's are indeed competent and professional and in understanding the requirements of public accountability in the certifying process.

17. Question: Has the NCCPA addressed the issue of recertification and, if so, in what way?

Answer: NCCPA has developed a proposal to investigate different methods of assuring continued competence of health professionals, utilizing physician's assistants as a model population. The proposal has been developed and is currently being circulated among various potential funding sources.

The fact of the matter is that NCCPA, like all other organizations, is not convinced of the best method for assuring continued competence. Consequently, NCCPA has proposed to implement a series of different methods, then compare them, in order to arrive at the best means for ultimately assuring continued competence. A draft of the technical proposal is shown in Appendix C.

18. Question: Can the PA profession anticipate requests from NCCPA to participate in experimental efforts or otherwise over the months ahead in regard to recertification?

Answer: Experimentation is perhaps the wrong word. NCCPA would like to adminster the multiple choice question section of a previous examination to a group of attendees at the annual conference. The purpose in administering this examination is to try to get some feel for the direction that recertification studies should take.

19. Question: What factors may be involved in NCCPA's decisions to proceed along a particular approach to recertification?

Answer: See Appendix C

20. Question: To date, how effective has the process of reregistration been in terms of numbers complying?

Answer: NCCPA has undergone three reregistration cycles to date. The first year of reregistration (1977) NCCPA captured 86% of those eligible for reregistration. In the second year, approximately 84% of those eligible reregistered. In 1979, 75% of those people eligible for "current" reregistration have reregistered to date. NCCPA is obviously concerned about the steady downward trend and the dramatic percentile decreases between 1978 and 1979.

21. Question: If the process has not operated appropriately, why is this so?

Answer: There are a number of possible answers to this question. NCCPA is currently researching the question to determine why people may decide not to reregister. We don't know what the attrition rate of the profession is. Since most states do not require a currently valid certificate, there is no legal mandate for people to reregister.

Obviously, there is a question as to what impact the Academy's raising of fees for logging CME has had on NCCPA's reregistration capture rate. The answer to this is currently unknown.

NCCPA will continue to research this question and take action to recover those people who have elected to leave the system.

22. Question: In what way, if any, has the charging of a non-member logging fee by the Academy impacted on the process of reregistration?

Answer: As indicated in the previous answer, the answer to this question is unknown. NCCPA has certified 6,700 PA's. Of that group, approximately 2,500 are not current members of the AAPA. Of the approximately 1,100 people who have failed to reregister in the past three years, most are not current members of the AAPA or have ever been members. How many of those people dropped their membership in the current year, presumably as a result of the increase in AAPA member fees is not known. NCCPA will continue to research this question.

We have received over one hundred letters from non-members and an equal amount from Academy members questioning Academy fees and inquiring as to whether NCCPA could not log and accredit CME independent of the professional organization.

23. Question: Has, or is, the NCCPA considering movement of the CME logging process "in-house" to offset such problems if they exist?

Answer: NCCPA currently has no intentions of assuming the CME logging responsibility. This is clearly the responsibility of the profession. Moreover, the accreditation process is best done by a panel of peers rather than a group assembled by an outside agency, such as NCCPA. NCCPA is currently investigating what other groups do in CME and what appropriate acitvities and charges are involved. It is hoped that NCCPA can work closely with the Academy to either reduce fees or provide a strong justification to the constituency for the fee level.

NCCPA has a difficult problem in this area. While the Board of Directors feel strongly that it should not involve itself in AAPA fiscal policies, NCCPA does mandate that AAPA serve as the agency for assuring the meeting of requirements for reregistration. Because of this mandate, NCCPA feels an obligation to its PA-C constituency to assure that fees are reasonable and that no profit is being derived from an NCCPA manated activity.

24. Question: Were NCCPA to assume the process of CME logging, what, if any, fee(s) would be charged for the service and would such a service by borne by all certified PA's.?

25. Question: While eliminating the current non-member fee would an NCCPA logging mechanism not, in fact, cost every PA more in the long run?

Answers: As indicated in the previous answer, NCCPA has no current intentions for assuming responsibility for logging CME. Rather, recognizing the possibility that the AAPA charges may be higher than comparable organizations, NCCPA hopes to work closely with AAPA through the Liaison Committee to find mechanisms to reduce costs for accrediting and logging CME to the constituent member and to the non-member. As stated previously, it is not NCCPA's intention to involve itself in the fiscal policies of the AAPA, but merely to assure that that service mandated by NCCPA is of reasonable cost to the PA-C.

26. Question: Does NCCPA see there to be any difference in how state medical boards will view initial certification versus recertification?

Answer: Current correspondence indicates that many state boards are actively engaged in researching methods for assuring the public of the continued competence of a broad range of health professionals. A number of states have already altered their legislation, rules and regulations to require a "currently valid NCCPA certificate", rather than merely passage of the examination.

NCCPA anticipates a strong move in this direction by the majority of the states. It is clear that states feel an incumbent responsibility to assure continued competence. It is equally clear that states are reluctant to implement policies which may have the net effect of alienating the professional hierarchy.

The NCCPA reregistration and recertification process, as it evolces, will be a well thought our and well researched approach. NCCPA is committed to developing a reregistration/recertification porcess that is married to original certification and the CME activities of the AAPA to provide a career-long process of assuring competence. It is obviously to the advantage

of the PA to have its professional society and its certifying body establish a rational and viable method for assuring continued competence than to have one imposed on the profession by a state medical board. To this end, we are working very closely with state boards to get them to recognize NCCPA's requirements as fulfilling state requirements as well.

27. Question: Based on NCCPA's interactions with credentialing bodies, how do you view state medical boards reacting to self-assessment as the process used to document continued competency and maintain certification?

Answer: As indicated by the previous answer, state medical boards are as much in the dark as anyone else about the best way to assure continued competence. Moreover, state boards are faced with austere budgets and disciplinary requirements that preclude the implementation of expensive programs. If state boards were to generate requirements for continued competence, it is most likely that such requirements would take the form of documentation of CME. This is the least expensive and least threatening approach to state medical boards. It is the most expeditious route, but certainly not the best for assuring continued competence.

It is for this reason that NCCPA feels that state medical boards will be more and more willing to look at independent certifying body activities in the recertification arena as a resource for continued licensure/certification of professionals within the political boundries of the state.

We have heard no specific comments vis-a-vis self-assessment as a means for recertification.

28. Question: Does NCCPA view itself as having a role, it any, in the development and/or implementation of a program of self-assessment aimed at documenting continued competency based upon Academy interest learning in that direction?

Answer: The processes of training, entry level competency measurement, competencey maintenance, and competency assurance are all entertwined. They cannot be separated. It seems an extremely likely role for NCCPA to be involved in measuring, in the public interest, the entry level and continued competence of physician's assistants. It seems an equally responsible role for the profession to provide opportunities for relevant continuing medical education and self-assessment that measures the extent to which one has learned from exposure to that CME. I do not believe however, that these are separate activities. I believe that eventually, the NCCPA and the AAPA can work together to develop a career-long activity that meshes all of these learning and measurement functions. The recertification process can function no more in a vacuum than can the CME activity. All of these activities must be intergrated. I do not think it is appropriate to consider self-assessment as developed by AAPA as a means for recertification at this time. I think it is more important that NCCPA research, on its own, what is the best method of recertifying physician's assistants, comparing the self-assessment approach as one of the potential measurement tools for this purpose. In fact, reference to the NCCPA technical portion of its recertification proposal (Appendix C) indicates that NCCPA has indeed considered the self-assessment device and will compare it to other recertification approaches under study. If it is determined that self-assessment is as good a measure of continued competence as any other measure, and is less expensive, obviously NCCPA would endorse the self-assessment device developed by AAPA as the recertification tool and work closely with AAPA in its development and use.