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

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July 12, 1979

Richard Rosen, M.D.
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Montefiore Hospital
Bronx, New York 10467

Dear Richard:

Enclosed is a draft of the SA Proposal incorporating all final recommendations. This proposal has been sent to the National Board of Medical Examiners for their review and inclusion of cost estimates. As soon as these estimates are provided we will submit this proposal to appropriate funding agencies.

I will keep you abreast of our progress.

Sincerely,

Henry R. Datelle, Ed.D.
Assistant Director

HRD:cc

Enclosure

Study to Determine Necessity for Competency
Assurance Examination for Surgical Physician's Assistants

I. INTRODUCTION

Cost containment has become a major goal throughout the health industry. The disproportionate relationship between overall consumer cost increases and increases in the consumer cost for health services has been well documented in both trade and lay national publications. Health care has become a right rather than a privilege; American society places great value on health maintenance; society demands ready access to health care; society demands continued technological breakthrough in the treatment and prevention of disease; society demands sophisticated training and proof of competency of practitioners. Attendant with each of these demands are significant costs which continue to rise dramatically.

The Physician's assistant (PA) concept was initially developed to help alleviate the shortage and/or maldistribution of physicians, but has also proven to be one viable method of containing cost increases with no apparent decrease in the quality of health care if PA's are utilized to maximum effectiveness (1). Data indicate that the employment of a PA in a practice setting generally increases the patient load by 30-60% (2) (3). The physician-supervisor is free to make more economical use of his sophisticated training because the PA is capable of dealing with the more routine presentations previously seen by the M.D. Quality care is therefore more readily available to a larger population of patients without the need for highly trained, expensive additional physician manpower.

The majority of PA's have been trained and employed in primary care (defined as general or family practice, general internal medicine or general pediatrics) (4). The success of the PA profession in ambulatory care settings has led to the employment of PA's in increasing numbers in institutional and specialty settings, most notably in the surgical specialties. With the recent limitations placed on the number of entering foreign medical graduates, it is likely that there will be an expanding role for PA's trained in surgery in the hospital setting, and that the trend of hiring PA's for hospital-based positions will continue.

The competence of entry-level primary care PA's is assessed by the National Commission on Certification of Physician's Assistants (NCCPA). This national certifying process is currently recognized in 37 states in the primary care specialty. The process includes a primary care examination, developed under subcontract by the National Board of Medical Examiners (NBME) and administered annually in 56 separate locations. The examination is composed of three parts: multiple choice questions (MCQ), patient management problems (PMP), and clinical skills problems (CSP), a practical portion designed to assess the psychomotor skills involved in performing a physical examination.

There is currently no comparable process for measuring the competence of PA's trained and/or working in surgery. As the numbers of these specialty PA's increase, it is incumbent upon the health certifying system to assure competence, and to do so in the most economical fashion to help contain costs.

For a number of years, NCCPA has wrestled with the dilemma of how to certify the competence of SA's. A number of choices are available:

1. develop a new examination
2. require the primary care examination
3. develop core and specialty examinations
4. require the primary care examination plus specialty add-ons.

Historically, the choice would be alternative number 1: to develop an entirely new examination. This may, however, not be the most cost-effective approach. Examination development is costly and the decision to develop a new examination does not consider the possibility that elements of the existing examination may be relevant to surgical PA practice.

Conversely, administration of the primary care examination alternative may not consider those functions that may be peculiar to surgical practice, if such functions exist.

The separation of the current examination into "Core" and "Primary Care" sections has proven to be a difficult task (but perhaps, ultimately a necessary one), since primary care is a specialty characterized by breadth as well as depth of information and skills. The final alternative appears to be the least costly in terms of examination development, but there is some question as to both the relevance of the primary care portion and the ability to develop a relatively inexpensive add-on examination that is broad enough in scope to assure competence in surgery.

In order to assure public protection, and simultaneously to contain cost of development of quality control measurement devises, it is necessary to define the differences in the roles of primary care and surgical PA's.

The essentials for accreditation of surgical and primary care PA programs are significantly different. Surgical assistant (SA) program directors have informed NCCPA that the training received by SA's is very different than that obtained in primary care programs.

On the other hand, surveys conducted by the American Academy of Physician Assistants suggest that PA's may perform similar roles irrespective of the specialty setting in which they are employed (5). Given the necessity to assure the public of specialty PA competence, the specific questions from a certification viewpoint are clear:

1. Is a separate examination (either related to or divorced from the primary care examination) necessary for SA's and, perhaps, other specialty PA's?
2. If so, can an addition to the primary care examination be utilized for this purpose in order to eliminate costly development of an entirely separate examination?

This study proposes to answer the above questions and at the same time identify appropriate test specifications, if warranted, in order to develop measurement devices that assure the public of SA competence, while containing developmental costs.

II. METHOD

In addition to the SA programs (four are currently accredited), there are primary care programs with surgical "tracks". The SA and primary care PA programs are generically accredited by the same agency in accordance with two separate sets of program training essentials. NCCPA has identified the following classes of SA training/utilization:

-those trained as primary care PA's, but working for surgeons;
-those trained in surgical tracks within accredited primary care PA programs;
-those trained in accredited SA programs;

-those trained in unaccredited SA programs;
-those trained on-the-job.

There are currently over 250 known SA program graduates working in surgical practices in the U.S. The number of PA's working in surgery who received training through other means is not known, but is believed to be substantial.

In an effort to solve the dilemma of SA competence measurement, NCCPA has made the following decisions over the past four years:

1. attempted to separate "Primary Care" and "Core" functions;
2. opened the primary care examination to graduates of accredited SA programs;
3. attempted to determine the number of practicing SA's;
4. surveyed SA's and employers to identify specific SA generic functions not normally performed by primary care PA's (Appendix 1).
5. based on the above survey, developed, with the NBME, a preliminary MCQ examination to evaluate surgical competence in conjunction with the primary care examination;
6. identified specific items in the primary care examination which SA's should be able to answer correctly;
7. submitted a proposal to the American College of Surgeons to administer the primary care examination and the surgical add-on to eligible SA's as a part of the 1979 certification process (not funded).

The current proposal calls for a final preparation of the add-on examination (Item 5) and a pilot administration to a sample of SA's and selected primary care PA's. The results will provide a basis on which to compare performance on the new examination across a variety of populations, using the primary care examination performance as a benchmark.

In order to minimize the cost of the study, the surgical add-on, which includes no pictorials, will be finalized, reproduced, and mailed to cooperating programs for administration between project go-ahead and the primary care examination scheduled for October, 1979. The specific groups earmarked for administration of the surgical add-on are:

1. accredited SA program seniors due to graduate;
2. seniors due to graduate in selected primary care programs;
3. seniors in selected primary care programs who are enrolled in a surgical track;
4. students in post-graduate SA programs;
5. other SA's identified by the above programs who are available to sit.

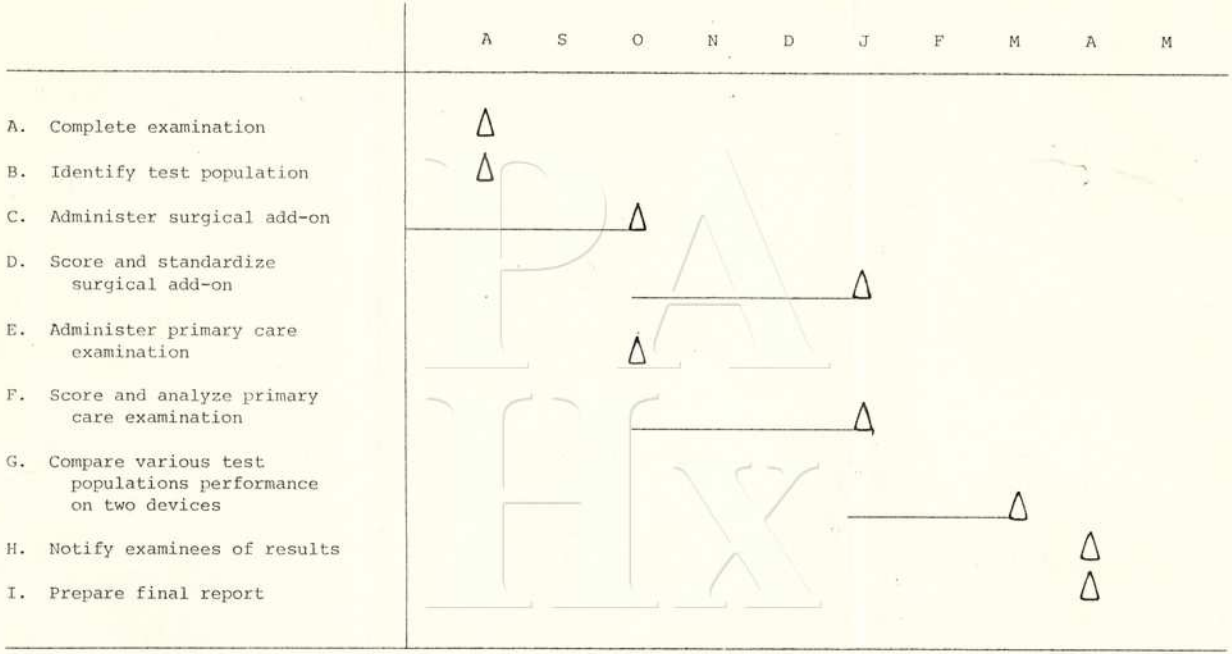
Exhibit 1 provides a time-line for the proposed project. The remainder of this section will detail the specific items shown in the time-line.

A. The preliminary examination must be reviewed for editorial changes and final preparation. As soon as the total test population is identified, the test booklets will be reproduced in the most economical manner. Since there are no pictorial or graphic presentations, quality paper and printing is not required.

B. Most of the test population has already been identified. Appendix 1 provides letters of cooperation from the programs contacted to date. It is anticipated that 150-200 SA's will be administered the surgical add-on.

C. The surgical add-on will be administered by faculty at each of the training programs identified. The schedule will be at the convenience of each program, but must begin in August in order to assure that seniors in the two originally accredited

EXHIBIT 1


A S O N D J F M A M
A. Complete examination
B. Identify test population
C. Administer surgical add-on
D. Score and standardize surgical add-on
E. Administer primary care examination
F. Score and analyze primary care examination
G. Compare various test populations performance on two devices
H. Notify examinees of results
I. Prepare final report

SA programs (Cornell and Alabama) are included in the test population.

D. The surgical add-on will undergo the same statistical analyses as the primary care examination including the calculation of reliability, discrimination, and difficulty indices. Inappropriate test items will be discarded.

E. The primary care examination is scheduled for administration in early October, 1979. Some of the surgical add-on test population will have taken the primary care examination in prior years. Primary care examination scores for each year in which it was given to the surgical test population will be grouped and ranked by examination section.

F. The scoring and analysis of the 1979 primary care examination will be completed by mid-January, 1980.

G. In order to determine the necessity for implementing a surgical examination, it will be necessary to determine if those people trained in surgery perform differently on the primary care examination than on the surgical add-on and if their performance differs from that of people with no special training in surgery. Anyone who does not take the primary care examination will be dropped from the test population. At a minimum, the following comparisons will be made:

1. SA performance on the primary care examination compared to SA performance on the surgical add-on;
2. primary care PA performance on the primary care examination compared to performance on the surgical add-on;
3. comparison of SA and primary care PA performance on the surgical add-on;
4. comparison of SA and primary care PA performance on the primary care examination.

H. Examinees taking the primary care examination will be notified in the usual manner. Surgical add-on performance results will be presented to the examinees by showing the mean and standard deviation of all weighted scores, the examinee's score, and rank.

If NCCPA determines that the study results indicate that an additional examination in the surgical specialty is necessary, a mechanism for certifying surgical competence will be determined. Pass/fail levels for SA's which may or may not require a different scoring pattern on the primary care examination and/or a different norm group for setting standards. Those candidates passing will receive certification of their competency as PA's with some notation referencing surgical competence. NCCPA is committed to the concept of generic certification and will avoid any certification process that establishes PA specialty certification, whether real or implied.

I. A project final report will be prepared which will summarize the study, present statistical findings and conclusions concerning the future of PA competence assurance in specialty areas.

III. PROJECT ADMINISTRATION

A. Financial: The total cost of this study project will be
The project will be accomplished in 10 months. The major cost of a study such as

this rests with the development, mailing, and anaylsis of the surveys and the initial examination development. NCCPA has already accomplished these activities using in-house funds. The item cost breakdown for accomplishing the current study is shown in Exhibit 2. The final examination preparation, administration, scoring and analysis will be done by the National Board of Medical Examiners (NBME). The NBME proposal is shown in Appendix 2.

B. Organization: The NCCPA Board of Directors is composed of twenty-one individuals representing fourteen different organizations. In addition to three directors-at-large representing the public, AAPA provides five directors to NCCPA. The remaining thirteen organizations each provide one director to the Board. Participation by each director and representative organization is voluntary. Attendance at the semi-annual Board meeting is always nearly 100%, even though directors receive no renumeration for expenses.

NCCPA policy is derived from Board consideration of Committee recommendations. NCCPA committees address issues, alternatives, and potential solutions which are then provided as recommendations for NCCPA Board action. The NCCPA Board meets twice annually.

The Executive Committee, composed of the President, Past President, Vice President, Secretary, and Treasurer is empowered to act on behalf of the Board of Directors during intervals between Board meetings and also reviews and evaluates policy issues prior to presentation to the NCCPA Board of Directors. The Executive Committee is responsible for direct staff implementation of Board derived policies.

Besides the Executive Committee, there are an additional eight committees. The NCCPA functional organization is block diagrammed in Exhibit 3. One of the eight committees, the Specialty PA Committee (SPAC), will serve as the Advisory Committee for the current project. Composed of physicians and PA's from a variety of medical specialty areas, this committee has been the major architect of NCCPA Specialty PA policy and direction and is extremely well informed about both examinations and the dilemma confronting specialty PA's.

c. Staff Personnel: The NCCPA staff is composed of the Executive Director, Assistant Director, Registrar, Business Manager, Assistant Registrars, and clerical staff. The Curricula Vitae of the appropriate key NCCPA professional staff are presented in Appendix 3.

1. David L. Glazer has been Executive Director since the beginning of NCCPA operation, and will serve as Technical Advisor for the proposed activity. Mr. Glazer will devote 15% of his time at no cost to the project. Mr. Glazer will assist the Project Director in the development of technical activities pursuant to the proposed study. Mr. Glazer has substantial experience in administration and management, PA education and utilization, human performance research, and testing. He has had extensive training in Experimental Psychology and Business Management.

2. Henry R. Datelle has been the Assistant Director since NCCPA began formal operation and will serve as the Project Director for the proposed activity. He provides administrative and technical management in the absence of the Executive Director and is responsible specifically for NCCPA research, registration, and state legislation activities. Dr. Datelle possesses an Ed.D. in Educational Administration. His experience includes extensive independent research and administrative responsibilities in both the health and education fields. Dr. Datelle will devote 10% of his time to the proposed activity.