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# Implementing Continuing Competency Requirements for Health Care Practitioners

**by**
**David Swankin, Citizen Advocacy Center**
**Rebecca Arnold LeBuhn, Citizen Advocacy Center**
**Richard Morrison, Consultant**

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.


AARP, 601 E Street, N.W., Washington, DC 20049
http://www.aarp.org/ppi

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## FOREWORD

Consumers rely on their personal physicians to ensure that they get good care. Regrettably, abundant evidence demonstrates that such confidence often may be misplaced. The Institute of Medicine explains that quality problems occur for many reasons, including (1) the growing complexity of science and knowledge; (2) an increase in chronic conditions; (3) poorly organized health delivery systems; and (4) not adopting health information technologies that could foster quality improvement.

In addition to the need for system redesign, experts also advise that "training and ongoing licensure and certification reflect the need for lifelong learning and evaluation of competencies."[1] In the current environment, responsibility for assessment and assurance of continuing competency is scattered and inconsistent and, in the minds of many, ineffective. AARP commissioned this study from the Citizen Advocacy Center, an organization that has studied clinical licensure and competence extensively, to recommend how to address regular assessment of clinicians to ensure continuing competency. Although the authors identify state licensure boards as the logical entity to shoulder this responsibility, they do acknowledge the challenges of implementing valid and reliable programs to accomplish this objective and offer numerous recommendations on how to reach the goal of state-based programs that assure the public of the ongoing competency of their clinicians and other health professionals.

Public and private purchasers have begun to recognize the importance of assessing physician performance to improve quality. It is also important to recognize that several professional organizations have already begun to address ways to advance programs to ensure continuing competency. The 24-member boards of the American Board of Medical Specialties (a private, nonprofit organization whose members issue 37 general and 92 subspecialty certificates) have all agreed to issue time-limited certificates that require recertification within specified time frames and to maintain certification programs that involve continuous processes of assessing competence.[2] These efforts may help to accelerate progress and should certainly inform the actions and activities of state licensure boards as the boards move to strengthen and improve licensing requirements.

Joyce Dubow
AARP Public Policy Institute
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[1] Committee on Quality of Health Care in America, *Crossing the Quality Chasm* (Washington, DC: Institute of Medicine, 2001), 12.

[2] R. Steinbrook, "Renewing Board Certification," *New England Journal of Medicine* 353 (November 10, 2005): 1994–1997.

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# EXECUTIVE SUMMARY

## I. BACKGROUND

Over the past half-century, authorities on health professional education, licensing, and accreditation have consistently recommended that state professional licensing boards address the continuing competence of health care practitioners with as much vigor and integrity as they exercise in examining the qualifications of candidates for initial licensure. During the past decade, these calls for rigorous assessment and demonstration of continued professional competence have come in response to evidence of widespread preventable medical errors and other problems with health care quality. Authoritative public policy experts have joined earlier critiques of health professional licensure in advocating that state boards institute programs for assuring the current competence of all health care professions. In this study, three experts affiliated with the Citizen Advocacy Center (CAC) present their recommendations for implementing state-based requirements for continuing competency assessment and assurance as a prerequisite for licensure renewal. These recommendations stem from several key assumptions: problems exist with both patient safety and health care quality; practitioner competence is as important as system safety; regulators and certifiers do not currently assure the continuing competence of health care professionals; and state licensure boards are the logical entity to be charged with assuring continuing professional competence.

**(1) Problems exist with both patient safety and health care quality.** Among the institutions focusing on the need to improve health care quality and to address serious problems affecting patient safety is the Institute of Medicine (IOM), which estimated in its 1999 report, *To Err Is Human: Building a Safer Health System*, that "between 44,000 and 98,000 hospital patients die each year from preventable medical errors." Two years later, the IOM issued a sweeping critique of the U.S. health care system in its report, *Crossing the Quality Chasm—A New Health System for the 21st Century*.

**(2) Practitioner competence is as important as system safety.** Systems for periodic assessment and verification of the continuing competence of all health care professionals are needed as well. Individual competence—which includes technical knowledge, practical skills, clinical performance, proper attitude, judgment, and ethics—is as much a systems issue as is error prevention.

**(3) Regulators and certifiers do not currently assure continuing competence.** The public cannot be assured that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent throughout their careers. With very few exceptions, state statutes do not empower boards to require demonstration of continuing competence as a condition of licensure renewal.

**(4) State licensure boards are the logical entity to assure continuing professional competence.** To address the global concerns of safety and quality of care, tested and feasible requirements for continuing competency assessment and assurance must be compulsory for all health care practitioners. The logical agent to impose requirements for universal competency assessment and assurance is the health professional licensing board in each state. These entities are the only ones with legal authority over all practitioners within a profession and with the power to give and to take away the privilege to practice

## II. PURPOSE

The purpose of this study is to explore the hypothesis that state legislatures would enhance patient safety and the quality of care by mandating that health professional licensing boards implement procedures requiring all health care professionals to demonstrate their continuing competence as a condition of relicensure.

The study addresses the following questions and makes recommendations related to many of them:

- What current methodologies and techniques assess and document continuing professional competence?

- Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?

- How frequently should licensees be required to demonstrate their competence?

- Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?

- How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of private specialty certification boards? Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?

- How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?

- Who should pay the costs of continuing competency assurance? Licensees? The state?

- What should be the legal status of a licensee who cannot meet relicensure or recertification standards? What rules of confidentiality, if any, should apply to this information? What information should be given to the public concerning a health care provider's continuing competence?

## III. METHODOLOGY

This study and the policy recommendations in it are anchored in CAC publications and projects related to continued professional competence over the past decade. They are also based on the extensive expertise of the authors and a project advisory committee comprised of current or former CAC board members whose names appear in Appendix I.

That foundation is supplemented with:

- a review of the literature on assessing and assuring the continued competence of health professionals;

- a critical analysis of information provided by licensing boards and their national associations, accrediting agencies, and specialty certification boards, some of which is publicly available from Internet Web sites; and

- conversations with key stakeholders from interested communities, including professional associations, certifying agencies, specialty boards, licensing boards and their associations, hospital staff, researchers, consumer advocates, and testing organizations.

## IV. FINDINGS

The principal finding of this study is that new laws are needed to require health professionals to demonstrate that they continue to be competent. Voluntary continuing competence or professional development programs have not done the job in the past and cannot be relied on to do so in the future. Even if they were to become more substantive and dependable, voluntary programs do not reach all members of a profession. Thus, a mandate is required, and the logical enforcers of that mandate are state professional licensing boards, the only entities poised to impose valid and reliable requirements for universal competency assessment and assurance

**A new regulatory model is needed**. A new regulatory model must go beyond imposing mandatory continuing education (CE) to require some form of the five-step model that includes periodic *assessment* of knowledge, skills, and clinical performance; development, execution, and documentation of an *improvement* plan based on the assessment; and periodic *demonstration* of current competence.

***A) What current methodologies and techniques assess and document continuing professional competence?***

A wide variety of methods and techniques have been used in the United States and abroad to evaluate and then document current professional competence. Among these methods are:

- written or oral examinations,
- peer review,
- consumer satisfaction surveys,
- records review,
- self-reflection leading to self-directed learning program portfolios,
- evaluation by "standardized patients,"
- on-site practice review,
- performance evaluations, and
- continuing education based on needs assessment and followed by a test or other verification that the course material has been absorbed.

Thus, one must first establish what is to be assessed and verified: Does reaffirming *entry-level* competence equate with demonstrating *current* competence? Or is it more appropriate to assess a professional's competence in the clinical setting or specialized area in which he or she practices? Is it important to assess core competency, cognitive knowledge, clinical performance, or a combination of these variables?

**Both cognitive knowledge and clinical skills need to be assessed.** There are psychometrically sound and legally defensible examinations for measuring *cognitive skills* for each licensed health profession; state boards now require applicants for initial licensure to perform acceptably on these examinations. Some professions have openly resisted objective assessment of *clinical performance*, and progress toward valid and reliable assessment has been difficult and expensive.

**Are self-assessment and third-party assessment equivalent**? A major policy issue for regulators is whether competency assessment must be delegated to independent third parties or self-assessment is sufficient. There is not enough evidence at this time to answer the question definitively. Many voluntary credentialing organizations and some regulatory agencies have adopted self-assessment as part of their emerging continuing competency or professional development programs. This approach is likely to be more acceptable to many professionals than is third-party assessment, as it appears to be a comparatively painless and potentially more cost-effective way to introduce periodic assessment into the routine of professional careers, at least until there is hard evidence that independent, third-party assessment is more reliable and valid.

**A five-step competency assessment and demonstration model is most promising.** After evaluating many of the existing competence-maintaining models, CAC recommended a five-step framework for assessing and demonstrating continuing professional competence:

1. Routine Periodic Assessment
2. Development of a Personal Improvement Plan
3. Implementation of the Improvement Plan
4. Documentation
5. Demonstration of Competence, based on steps 1 through 4 above

Steps 1 through 4 constitute *quality improvement*; step 5 is the *quality assurance* component, without which the process is incomplete. The critical first step is routine periodic assessment, the key to pinpointing knowledge deficiencies needing correction and to tailoring lifelong learning choices to the needs of individual health care professionals Assessment also reveals whether a practitioner *applies* his or her knowledge and skills competently in clinical situations.

***B) Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?***

There is little convincing evidence that any one method or technique for demonstrating continuing competence is more valid and reliable than another, nor is there evidence clearly indicating that the use of any one method leads to better outcomes in patient safety or health care quality. However, what does *not* work is better documented, and there is continuing and widespread interest in finding a better way than traditional continuing education mandates to ensure continuing competence. It is precisely this current condition of uncertainty that provides a rich opportunity to test and compare a variety of techniques and creative innovations.

Among the questions pilot programs must answer are: (1) what is the impact of continuing competency assurance on patient outcomes; (2) is there value-added for practitioners and health care organizations that participate; (3) what is the comparative reliability of various methodologies and techniques for assessing continuing competence; and (4) on what bases should boards give deemed status to the competency assurance procedures of voluntary credentialing agencies, professional associations, employers, and other institutions?

***C) How frequently should licensees be required to demonstrate their competence?***

There is as yet no basis for determining how frequently health care practitioners should be required to demonstrate their continued competence. Licensing boards have varied time periods for license renewal, usually ranging from one to three years. Hospitals generally recredential their health care staff every two years.

A powerful rationale for requiring periodic demonstrations of continued competence is that health care technology, treatment protocols, practice guidelines, prescription medicines, medical devices, and other aspects of health care delivery change constantly. By demonstrating continued competence, health care professionals show that they have kept up with new developments related to their particular profession and specialty. The pace of change in health care delivery argues for a shorter time lag between demonstrations of competence, to the extent that such demonstrations are economically feasible.

***D) Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?***

A decade ago, there was considerable disagreement over whether *all* health care professionals should demonstrate their continuing competence periodically or only those whose competence has been called into question. The prevailing view is that continuing competency assessment and assurance should not be confined to "incompetent" practitioners or the few "bad apples." Rather, maintaining competence underpins any effort to assure patient safety and improve the quality of care, so it must apply to all practitioners.

***E) How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of specialty certification boards? Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?***

State legislatures need to provide guidance to licensing boards on implementing a continuing competency mandate. Within certain parameters, legislatures should empower boards to issue rules and regulations specifying acceptable *methods* for assessing and demonstrating competence. Legislatures should also empower boards to recognize a variety of acceptable *pathways* via which licensees can demonstrate their continuing competence. For example, boards might be authorized to recognize (deem) outside organizations as the board's *agents* in enforcing the new continuing competency requirements because few, if any, licensing boards have the resources to implement universal competency requirements. Moreover, such an effort by boards could unnecessarily duplicate sound assessment and demonstration programs already administered by other organizations.

Legislatures and boards have to identify the criteria that outside organizations will be required to meet to earn deemed status. Several acceptable approaches are possible. Legislatures could choose to legislate some or all of the criteria that govern granting deemed status to private organizations; they could direct licensing boards to establish the deeming criteria by rules and regulations; or the legislature could establish criteria in broad policy terms and allow the boards

to fill in the specifics. Whatever the approach, it is essential that any program for evaluating current competence be equivalent, in terms of public protection, to the program the licensing board establishes on its own for periodically evaluating and verifying the continued competence of its licensees.

***F) How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?***

In addition to specialty certification bodies, licensing boards need to consider awarding deemed status to qualifying competency evaluation programs at hospitals and other institutions that credential, privilege, and/or employ health care professionals. An example of the kind of program that might satisfy board requirements is the third-party assessment program at Pitt County (North Carolina) Memorial Hospital, an academic medical center with 745 beds and 4,500 employees, including 1,200 nurses. This hospital revisited its employee orientation program in the wake of the IOM's *Errors* report and the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) growing interest in ongoing competence and the nursing shortage. The hospital decided to administer to all new-hire nurses the performance-based development system (PBDS) created by Dr. Dorothy del Bueno of Performance Management Services Inc.

***G) Who should pay the costs of recertification? Licensees? The state?***

There are two types of costs associated with assessing and assuring continuing professional competence. First, there are the costs to health care professionals to assess and maintain their competence throughout their careers and to demonstrate periodically that they have done so. CAC has recommended that these costs should be borne by the licensed professionals.

The second category includes costs incurred by licensing boards in establishing and administering continuing competency requirements. There will be costs to establish the programs (including the cost of developing rules and regulations) and to administer them (preparing exams, evaluating "deemed status" applications, monitoring compliance). Each state will have to estimate expenditures and then decide whether to raise the funds by increasing licensing fees, seeking funding from general revenues, or some combination of both.

***H) What should be the legal status of a licensee who cannot meet relicensure or recertification standards? What rules of confidentiality, if any, should apply to this information? What information should be given to the public concerning a health care provider's continuing competence?***

Resolution of practitioner confidentiality issues may depend on whether the new continuing competency programs are considered (1) quality improvement/quality assurance under the boards' *licensing* responsibility (which is to issue licenses only to those who demonstrate minimal competence), or (2) part of the boards' *disciplinary* responsibility under which it removes or restricts the licenses of individuals who have violated the state practice act. In either case, the legal rationale for giving licensing boards responsibility in this area is the same—to protect and promote the public health and safety.

## RECOMMENDATIONS

The agenda for reform presented in this study focuses on state government, since it is the states that license health care practitioners and, when necessary, discipline them. The authors propose the framework below for state legislative action, which forms the basis for the recommendations that follow:

- Eliminate continuing education requirements.

- Mandate that as a condition of relicensure, licensees participate in continuing professional development programs approved by their respective health care boards.

- Mandate that continuing professional development programs include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence.

- Provide licensure boards with the flexibility to try different approaches to foster continued competence.

- Ensure that the boards' assessments of continuing competence address the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure.

- Require that boards evaluate their approaches to gathering evidence on the effectiveness of methods used for periodic assessment.

- Authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards.

Significant challenges must be overcome to implement effective systems for continuing competency assessment and assurance. Progress is likely to be incremental and may be frustratingly slow. This is justification for moving expeditiously to enact the appropriate legislation and initiate pilot programs to generate the evidence on which to promulgate broad-based continuing competency programs that enhance patient safety and health care quality. To further that goal, we propose the following recommendations:

**RECOMMENDATION 1: State laws and implementing rules and regulations should require that, as a condition of relicensure, licensees participate in continuing professional development (CPD) programs approved by their respective boards. CPD programs must include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence. Licensees should be permitted to demonstrate continuing competence through a variety of legally defensible, psychometrically sound, evidence-based methods.**

**RECOMMENDATION 2: Demonstrations of continuing competence should cover the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure**.

**RECOMMENDATION 3: State licensing boards should conduct pilots to test a variety of methods and techniques for periodic assessment and assurance of continued competence. The boards should designate an objective, third-party institution to assist in the design and evaluation of these programs.**

**RECOMMENDATION 4: Professions should endeavor to codify standards and definitions of clinical competence that are relevant to them and incorporate those cross-cutting competencies identified by the IOM as being relevant to all health care professions: patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics.**

**RECOMMENDATION 5: Licensing boards should grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards. Boards must require organizations to meet or exceed the standards applicable to licensees who choose to demonstrate their continued competence through board-administered continuing competence programs.**

**RECOMMENDATION 6: Licensees who choose to fulfill licensing board continuing competence requirements by meeting the parallel requirements of a certifying body, employer, professional association, or other organization to which the board has given deemed status, shall waive the deemed organization's confidentiality provisions to give the board access to information pertinent to competency assessment and demonstration.**

**RECOMMENDATION 7: Licensees should bear the costs of assessing and demonstrating their continuing competence, either individually or though private sources of funding, such as professional associations, insurance carriers, employers, and the like.**

**RECOMMENDATION 8: The board should inform the public whether a licensee has been successful in demonstrating his or her continuing competence.**

# I. BACKGROUND

Over the past half-century, authorities on health professional education, licensing, and accreditation have consistently recommended that state professional licensing boards address the continuing competence of health care practitioners with as much vigor and integrity as they exercise in examining the qualifications of candidates for initial licensure. During the past decade, these calls for rigorous assessment and demonstration of continued professional competence have come in response to evidence of widespread preventable medical errors and other problems with health care quality. Authoritative public policy experts have joined earlier critiques of health professional licensure in advocating that state boards institute programs for assuring the current competence of all health care professions. In this study, three experts affiliated with the Citizen Advocacy Center (CAC)[3] present their recommendations for implementing state-based requirements for continuing competency assessment and assurance as a prerequisite for licensure renewal. These recommendations stem from several key assumptions: problems exist with both patient safety and health care quality; practitioner competence is as important as system safety; regulators and certifiers do not currently assure the continuing competence of health care professionals and state licensure boards are the logical entity to be charged with assuring continuing professional competence.

**(1) Problems exist with both patient safety and health care quality.** Among the institutions focusing on the need to improve health care quality and to address serious problems affecting patient safety is the Institute of Medicine (IOM), which estimated in its 1999 report, *To Err Is Human: Building a Safer Health System*, that "between 44,000 and 98,000 hospital patients die each year from preventable medical errors."[4] Two years later, the IOM issued a sweeping critique of the U.S. health care system in its report, *Crossing the Quality Chasm—A New Health System for the 21st Century*.[5]

Other research also documents that quality deficiencies and safety problems are not confined to hospitals, but also occur in outpatient settings, where more and more patients receive care. A 2003 study concluded that, on average, Americans receive only about one-half of the health care

[3] The study's authors are David Swankin, A.B, M.S., J.D.,CAC president and CEO; Rebecca Arnold LeBuhn, B.A., M.A., chair of CAC's Board of Directors; and Richard Morrison, B.A., M.A., Ph.D., former CAC board member and executive director, Virginia Board of Health Professions, 1984–1994. The Citizen Advocacy Center (CAC) is a unique, not-for-profit 501(c)(3) organization whose primary mission is to provide resources and networking opportunities for public members serving on health care regulatory and oversight bodies. Details about CAC's programs can be found at www.cacenter.org.

[4] Institute of Medicine, *To Err Is Human, Building a Safer Health System* (Washington, DC: National Academy Press, 1999).

[5] Institute of Medicine, *Crossing the Quality Chasm—A New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001).

recommended by evidence-based guidelines. "The gap between what we know works and what is actually done is substantial enough to warrant attention," the researchers write. "These deficits, which pose serious threats to the health and well-being of the U.S. public, persist despite initiatives by both the federal government and private health care delivery systems to improve care."[6]

In its "chasm" report, the IOM asserted, "(t)he American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."[7] Accordingly, several public and private initiatives have concentrated primarily on reforming the *systems* and *processes* of health care delivery. Many positive changes are occurring as a result of the focus on system safety, such as requiring multiple sign-offs to prevent wrong site or wrong patient surgeries and incorporating information technology into clinical routines. Other positive system changes include helping to expose errors, identify their causes via meaningful root cause analyses, and institute fail-safe procedures to prevent their recurrence.

**(2) Practitioner competence is as important as system safety.** Systems for periodic assessment and verification of the continuing competence of all health care professionals are needed as well. Individual competence—which includes technical knowledge, practical skills, clinical performance, proper attitude, judgment, and ethics—is as much a systems issue as it is error prevention. Dr. Lucian Leape of the Harvard School of Public Health, a member the IOM's Committee on Quality of Healthcare in America and a well-known proponent of *system safety*, puts it this way: "I don't see safety failures overall as a dichotomy—either as systems problems or as performance problems. Performance problems are systems problems, too. We have totally inadequate systems for identifying potentially unsafe practitioners **before** (emphasis crucial) they cause harm."[8]

Dr. R. Salvata of the University of Washington argues that concentrating exclusively on the *system* is an "initial over-reaction" to the data on medical errors. He goes on to say: "There has been an unintentional ignoring of the actual error that the surgeon commits. It is time to put the approach to errors into perspective and redefine errors within the context of the surgical community, which can result in a balance of the surgeon's position in regard to systemic and personal responsibility."[9]

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[6]E. A. McGlynn et al., "The Quality of Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (June 26, 2003): 2635–2645.

[7]Institute of Medicine, *Crossing the Quality Chasm*.

[8]Letter from Dr. Lucian Leape to David Swankin, president, CAC, April 2000.

[9]R. M. Salvata, *The Nature of Surgical Error: A Cautionary Tale and Call to Reason* (New York: Springer-Verlag LLC, 2005). Published online (PubMed 16027984).

A 2004 survey of nurses, physicians, clinical care staff, and administrators found that 81 percent of physicians and 53 percent of nurses and other clinical care providers have concerns about the competence of a (particular) nurse or other clinical care co-worker. In addition, 68 percent of physicians and 34 percent of nurses and other clinical care providers have concerns about the competence of at least one physician with whom they work.[10]

A retrospective review of closed OB/GYN claims for the years 1999–2001 by MedStar Health, a nonprofit community health care organization serving the Baltimore/Washington, D.C., area, found that more than 70 percent of such claims involved a problem with the clinical judgment of the involved physicians, nearly 20 percent involved a problem with these physicians' technical skills, and in nearly 20 percent of the cases, a communications problem was involved.[11] Similar findings were reported in a study analyzing risk management files from an urban hospital OB/GYN department, where poor clinical performance contributed to an adverse event in 31 percent of 90 cases. Incomplete or incorrect diagnosis contributed to an adverse event in 18 percent of these same 90 cases.[12]

**(3) Regulators and certifiers do not currently assure continuing competence.** The public cannot be assured that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent throughout their careers. With very few exceptions, state statutes do not empower boards to require demonstration of continuing competence as a condition of licensure renewal.

Although most boards do require licensees to document participation in continuing education programs to maintain their licenses, with rare exceptions, these requirements ask only that a licensee show that he or she has *attended* approved courses or other activities. Whether these are relevant to the licensee's specific practice or the information presented has been understood is not subject to regulatory review. Only in the case of the small proportion of licensees (2 or 3 percent and often less) who are subjected to disciplinary action do boards require specified remedial educational courses that address the practice deficiencies that led to discipline.

Traditionally licensure has been concerned with ensuring the minimum competence required for safe practice within a broad scope of practice specified in state statutes, while specialty certification concentrates on competencies required for specialty practice. Private specialty certification boards devote more attention to continuing competence than do state legislatures

[10] Survey conducted by VitalSmarts for the American Association of Critical Care Nurses, 2004, www.vitalsmarts.com.

[11] Speech by Larry Smith, vice president, Risk Management Services, MedStar Health, at a conference on medical malpractice sponsored by the Commonwealth Fund, Washington, D.C., July 11, 2005.

[12] Andrew White, M.D., et al. "Cause and Effect Analysis of Closed Claims in Obstetrics and Gynecology," *Obstetrics and Gynecology* (May 2005): 1031–1038.

and professional licensing boards, but a majority of certification boards continue to rely heavily on continuing education hours as a basis for recertification.[13]

In lieu of requiring valid evidence of continuing competence, licensing boards and certifying bodies have relied on the assumption that prolonged clinical experience leads to improved safety and better outcomes. This assumption is challenged by a systematic literature review published in 2005 analyzing 62 studies of the relationship between a physician's years of experience and the quality of his or her performance.[14] Fifty-two percent of the studies reported decreasing performance on some outcomes, but no association between better performance and increased experience on others. One of the studies found that performance increased initially with length of experience, then decreased as experience increased. Only one study reported increased performance on all measures with increasing years of practice. The studies included in this literature review used knowledge and conformity with evidence-based practice standards known to improve health care outcomes as a surrogate measure of the complex concept of quality.

Other research on the epidemiology of medical error and discipline in nursing and of competent performance among pharmacists reports similar findings related to age or experience. As the age and experience of nurses increase, so do the risk of error and the likelihood of disciplinary action.[15] A study by the North Carolina Board of Pharmacy found that the likelihood of a pharmacist providing consultation—a critical new role for the profession—decreases with the number of years since the pharmacist's graduation from pharmacy school. The reason is straightforward: older pharmacists were not trained to consult, nor were they graduates of six-year education programs that lead to the Pharm.D., now a prerequisite for initial licensure in every state.[16] The remedy many policy experts recommend is to require periodic assessment and assurance of continuing competence as a condition of license renewal.

**(4) State licensure boards are the logical entity to assure continuing professional competence.** To address the global concerns of safety and quality of care, tested and feasible requirements for continuing competency assessment and assurance must be compulsory for all

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[13] Institute of Medicine, *Health Professions Education: A Bridge to Quality* (Washington, DC: National Academy Press, 2003), 109.

[14] N. K. Choudry, R. H. Fletcher, and S. B. Soumerai, "Systematic Review: The Relationship Between Clinical Experience and Quality of Health Care, *Annals of Internal Medicine* 142 (February 15, 2005): 260–273.

[15] Personal conversations with Vickie Sheets, director of practice and regulation, National Council of State Boards of Nursing, spring and summer, 2005.

[16] Personal conversation with David Work, then executive director, North Carolina Board of Pharmacy. The research conducted by Stephen Mitchener and David Work, *The Role of Patient Counseling in Preventing Medication Error*, is available at the North Carolina Board of Pharmacy Web site, www.ncbop.org.

health care practitioners. The logical agent to impose requirements for universal competency assessment and assurance is the health professional licensing board in each state. These entities are the only ones with legal authority over all practitioners within a profession and with the power to give and to take away the privilege to practice.[17]

A number of policy experts have weighed in on the subject. In 1998 the Pew Health Professions Commission recommended that "(s)tates should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers."[18]

While emphasizing the need for systems reform, the IOM's *Errors* report called on professional licensing boards to "implement periodic reexaminations and re-licensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices."[19] In still another major report in 2004 dealing with reforming health care professionals' education, the IOM recommended that:

> All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care...through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods.
>
> Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies (provide patient centered care; work in interdisciplinary teams; employ evidence-based practice; apply quality improvement; utilize informatics), among other requirements.[20]

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[17]"Sir Graeme Catto, MD, president of the General Medical Council, which regulates doctors in the United Kingdom, said the GMC wants to start a program to enhance patient safety and create public confidence that licensed doctors are fit to practice. The plan calls for a new registration system with compulsory revalidation. Doctors would be issued a license when they register with the GMC, and would keep their licenses by revalidating them periodically." From Damon Adams, "Medical Leaders Emphasize Safety Over Punishment," *American Medical News* 48 (October 10, 2005).

[18]*Recreating Health Professional Practice for a New Century*, Fourth Report of the Pew Health Professions Commission (San Francisco: Center for the Health Professions, University of California, San Francisco, December 1998).

[19] Institute of Medicine, *To Err Is Human*, Recommendation 7.2 (1).

[20]Institute of Medicine, *Health Professions Education: A Bridge to Quality* (Washington, DC: National Academy Press, 2004), Recommendations 4 and 5.

In support of these two recommendations, the IOM stated:

> Currently, there is no mechanism for ensuring that practitioners remain up to date with current best practices. Responsibility for assessing competence is dispersed among multiple authorities. For example, a licensing board may question competence only if it receives a complaint, but most boards do not routinely assess competency after initial licensure. Professional societies and organizations may require examination for certification and are now beginning to assess competence in addition to knowledge, but such practices are at an early stage and [are] inconsistent among the professions. Some institutional accreditors require competence to be measured for all individual practitioners, but such requirements remain highly task-specific and subject to great variability in terms of implementation in hospitals, health plans, and other health care organizations.[21]

In framing this issue, it is important to acknowledge that many health care professionals resist the notion of having to redemonstrate their competence. The push-back from the professions—with little countervailing public demand—goes a long way toward explaining why long-standing efforts to introduce meaningful continuing competency programs have borne little fruit.

Clearly, a stronger system will result if all stakeholders are willing to participate in the development and implementation of mechanisms for competency assessment and demonstration. In recent years, there has been a change in atmosphere and greater willingness to recognize that it is not enough to test the credentials of health care practitioners only once at the beginning of their careers. The newly developing positive attitude allows some optimism that it may be possible to obtain professional buy-in, but much work remains to reach the tipping point. Seven years ago, one commentator described the landscape this way:

> Discussions related to the demonstration of continuing competence as a requirement for licensure and/or certification and/or continued employment are extraordinarily controversial and generate a wide span of reactions and opinions. They have resulted in considerable anxiety and conflict, as well as a coming together in many instances, between and among individual nurses and various agencies, organizations, and regulators. Clearly substantive reforms in academic and continuing education and in credentialing requirements are needed to accommodate consumer protection, technological innovations, sociodemographic and market forces and the rising incidence of litigation related to health care. The question is how to accomplish this goal most effectively while minimizing unacceptable and damaging consequences.[22]

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[21]Ibid, 111.

[22]C. B. Lenberg, "Redesigning Expectations for Initial and Continuing Competence for Contemporary Nursing Practice," *Online Journal of Issues in Nursing* (September 30, 1999), www.nursingworld.org.

More recently, a study of physicians by the American Board of Internal Medicine and the American College of Physicians found that more than half of those general internists and subspecialists take part in competence activities to maintain their professional image and/or update their knowledge. Fewer than half (42 percent of generalists, 20 percent of specialists) maintain their certification because it is required for work.[23]

## II. PURPOSE

The purpose of this study is to explore the hypothesis that state legislatures would enhance patient safety and the quality of care by mandating that health professional licensing boards implement procedures requiring all health care professionals to demonstrate their continuing competence as a condition of relicensure.

The study addresses the following questions and makes recommendations related to many of them:

- What current methodologies and techniques assess and document continuing professional competence?

- Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?

- How frequently should licensees be required to demonstrate their competence?

- Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?

- How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of private specialty certification boards? Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?

- How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?

- Who should pay the costs of continuing competency assurance? Licensees? The state?

[23] B. S. Lioner, W. H. Bylama, G. K. Arnold et al., "Who Is Maintaining Certification in Internal Medicine—and Why? A National Survey 10 Years after Initial Certification," *Annals of Internal Medicine* 144 (2006); 29–36.

- What should be the legal status of a licensee who cannot meet relicensure or recertification standards? What rules of confidentiality, if any, should apply to this information? What information should be given to the public concerning a health care provider's continuing competence?

# III. METHODOLOGY

## Overview

This study and the policy recommendations in it are anchored in CAC publications and projects related to continued professional competence over the past decade. They are also based on the extensive expertise of the authors and a project advisory committee comprised of current and former CAC board members whose names appear in Appendix I.

That foundation is supplemented with:

- a review of the literature on assessing and assuring the continued competence of licensing health professionals;

- a critical analysis of information provided by licensing boards and their national associations, accrediting agencies, and specialty certification boards, some of which is publicly available from Internet Web sites; and

- conversations with key stakeholders from interested communities, including professional associations, certifying agencies, specialty boards, licensing boards and their associations, hospital staff, researchers, consumer advocates, and testing organizations.

## Literature Review

CAC has published extensive reviews of the literature, including an annotated bibliography of research and policy resources through 2003. CAC's publications and projects related to continued competence are listed in Appendix II. For this study, we also reviewed published research and policy literature from 2003 to 2005.

## Personal Communications, Internet Web Sites, and Sponsored Sources

The literature search included visiting Web sites, which virtually every state licensing board now maintains. National associations of these boards also post publicly available information on their Web sites. Individual state boards are instruments of state government and can be found on state Web sites or through Web searches of individual state boards of interest. National associations

of state boards, such as the Federation of State Medical Boards, the National Council of State Boards of Nursing, and the National Association of Boards of Pharmacy, are useful sources of information specific to regulation of individual professions. In addition, specialty certification boards maintain Web sites, and their national associations collect and publish information of pubic interest.

Finally, personal communications through a combination of telephone contact, correspondence, e-mails, meetings, and conferences informed this study.

## IV. FINDINGS

The principal finding of this study is that new laws are needed to require health professionals to demonstrate that they continue to be competent. Voluntary continuing competence or professional development programs have not done the job in the past and cannot be relied on to do so in the future. Even if they were to become more substantive and dependable, voluntary programs do not reach all members of a profession. Thus, a mandate is required, and the logical enforcers of that mandate are state professional licensing boards, the only entities poised to impose valid and reliable requirements for universal competency assessment and assurance.[24]

**A new regulatory model is needed.** Licensing boards in most professions have implemented programs intended to address continuing competence issues, but in virtually every case, these programs consist of requirements for continuing education (CE), attending conferences, workshops, etc., that use didactic teaching mechanisms, as a condition of license renewal. Some early reviews concluded that broadly defined CE using practice-enabling or reinforcing strategies consistently improved physician performance and, in some instances, better outcomes. Later studies by these same authors conclude that widely used CE methods—especially those using didactic teaching techniques—have little impact on practice performance. CE providers seldom use methods that are more effective, such as systematic practice-based interventions and outreach.[25]

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[24] In 1978, Michigan's Public Health Code was amended to include section 333.16205 (2), which reads: "A board may promulgate rules to establish a system of assessing the continued competence of licensees as a condition of periodic license renewal." Replacing the word "may" with the word "shall" and adding the words "and verifying" after the word "assessing" would create a mandate to regulate the *continuing* as well as the *initial* competence of health care professionals. Virginia statutes specify that "[Boards] may promulgate regulations specifying additional training for candidates seeking certification or licensure, or for the renewal of certificates and licenses." Code of Virginia $ 54.1-103.A.

[25] D. A. Davis, M. A. Thompson, A. D. Oxman, and R. B. Haynes, "Evidence for the Effectiveness of CME: A Review of 50 Randomized Controlled Trials," *Journal of the American Medical Association* 268 (September 2, 1991); also see D. A. Davis et al., "Changing Physician Performance: A Systematic Review of the Effect of Continuing Education Strategies," *Journal of the American Medical Association* 274 (September 8, 1995); D. A. Davis et al., "Impact of

A new regulatory model must go beyond imposing mandatory CE to require some form of the five-step model (discussed in detail below) that includes periodic *assessment* of knowledge, skills, and clinical performance; development, execution, and documentation of an *improvement* plan based on the assessment; and periodic *demonstration* of current competence.[26]

Such a regulatory model is conceptually consistent with the established mandate of state licensing boards to impose requirements for licensure to practice within a legally protected scope of practice. The U.S. Supreme Court upheld the authority of state boards to require specific entry requirements for licensure over a century ago (*Dent v. West Virginia*, 1888). Pursuing their mandate to protect public health and safety, boards have deemed that graduation from accredited educational programs and successful performance on psychometrically sound and legally defensible examinations meet the requirements for initial licensure. Boards are statutorily mandated to enforce professional practice acts by (1) denying a license to persons who do not meet the competency standards for initial licensure, and (2) revoking a license when professional competence has fallen below minimum standards. Where state statutes so require, boards have imposed requirements as a condition of license renewal (most often, mandatory CE, despite a consensus that exposure to traditional CE has little demonstrable public health or safety benefit).

It is premature to draft model state legislation specifying precisely how licensees must go about demonstrating their continuing competence because there is not yet enough evidence to endorse any particular method. Thus, the first set of state laws should direct licensing authorities to initiate pilot projects that would develop an evidence base to inform subsequent legislation. Legislation enacted in Washington State in 1991 did exactly that. RCW 18.130.270 reads in part:

> Continuing Competence Pilot Projects. The disciplinary authorities are authorized to develop and require licensees' participation in continuing competency pilot projects for

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Formal Continuing Medical Education, *Journal of the American Medical Association* 282 (September 1, 1999): 867–874.

[26] Calling something a *continuing competence* program does not make it so if the substance of the program remains mandatory continuing education. The danger of this is illustrated by the "continuing competence" program announced in 2005 by the Kentucky Board of Physical Therapy. This new program requires licensees to complete a "minimum" of 18 hours of Category One activities and a maximum of 10 hours of Category Two activities. Category One lists 11 types of activities that are acceptable, the first of which is completion of approved continuing education courses, with no requirement that these hours be based on any type of needs assessment. Category Two lists six acceptable activities, including self-study, participation in community service, attending scientific poster sessions at meetings, participation in study groups, etc. Taken as a whole, the "new" program in reality is the "old" program with a new name; see http://pt.ky.gov and the board's May 2005 newsletter.

> the purpose of developing flexible, cost-efficient, effective, and geographically accessible competency assurance methods. The Secretary shall establish criteria for development of pilot projects… . The department shall report to the legislature in January of each odd-numbered year concerning the progress and findings of the projects… . Each disciplinary authority shall establish its pilot project in rule and may support the projects from a surcharge on each of the affected profession's license renewal in an amount established by the Secretary.

A legislative mandate is only the first, albeit the most important, step. Indeed, while the Washington State regulation reads well, it has encountered implementation difficulties. Boards need to incorporate in their rules and regulations a *regulatory model* for implementing a continuing competency assessment and assurance mandate. The remaining sections discuss a number of specific issues that must be addressed in fleshing out such a regulatory model.[27]

## A) *What current methodologies and techniques assess and document continuing professional competence?*

**What are the parameters of competence?** Many health professions have defined the terms, "competence" and "continued competence," for their own professions. The National Board for Certification in Occupational Therapy (NBCOT) defines continued competence in this way: "Continuing competence is the ongoing application and integration of knowledge, critical thinking, and interpersonal and psychomotor skills essential to the safe and effective delivery of occupational therapy services within the context of a practitioner's role and the environment."[28]

The National Council of State Boards of Nursing (NCSBN) defines competence as "the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health."[29]

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[27] The National Council of State Boards of Nursing's (NCSBN) Nursing Practice and Education Continued Competence Subcommittee evaluates regulatory proposals according to the following criteria (the APPLE acronym):

A = Administratively feasible
P = Publicly credible
P = Professionally acceptable
L = Legally defensible
E = Economically affordable

[28] National Board for Certification in Occupational Therapy, Inc., *Self-Assessment Resource Tool* (Gaithersburg, MD: Author, 2005).

[29] National Council of State Boards of Nursing, "Assuring Competence: A Regulatory Responsibility" (position paper), Chicago, IL, 1996).

The Federation of State Medical Boards (FSMB) defines competence as: "Possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards."[30]

The Saskatchewan Registered Nurses' Association, the regulatory body for nurses in that province, adopted the following definition of *continuing* competence in 2000: "Continuing competence is the ongoing ability of a registered nurse to integrate and apply the knowledge, skills, judgment, and personal attributes to practice safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs."[31]

Each of these definitions addresses a complex mix of academic learning, mental and physical acuity, the application of knowledge in clinical situations, and adherence to standards related to professional values, such as public health, ethics, or professional roles.

While each profession defines competencies specific to its scope of practice, the IOM, in both its 2001 *Chasm* report and its 2004 *Health Professions Education* report, identified five "core" competencies all health care professionals should possess throughout their careers:

- **Provide patient-centered care**—identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

- **Work in interdisciplinary teams**—cooperate, collaborate, communicate, and integrate care in teams to ensure continuous and reliable care.

- **Employ evidence-based practice**—integrate best research with clinical expertise and patient values for optimum care and participate in learning and research activities to the extent feasible.

- **Apply quality improvement**—identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the goal of improving quality.

[30]Federation of State Medical Boards, Report of the Special Committee on Evaluation of Quality of Care and Maintenance of Competence, approved as policy in May 1998.

[31]See www.srna.org/registration/ccp.php.

- **Use informatics**—communicate, manage knowledge, mitigate error, and support decision making using information technology.

A wide variety of methods and techniques have been used in the United States and abroad to evaluate and then document current professional competence. Among these methods are:

- written or oral examinations,
- peer review,
- consumer satisfaction surveys,
- records review,
- self-reflection leading to self-directed learning program portfolios,
- evaluation by "standardized patients,"
- on-site practice review,
- performance evaluations, and
- continuing education based on needs assessment and followed by a test or other verification that the course material has been absorbed.

Thus, one must first establish what is to be assessed and verified: Does reaffirming *entry-level* competence equate with demonstrating *current* competence? Or is it more appropriate to assess a professional's competence in the clinical setting or specialized area in which he or she practices? Is it important to assess core competency, cognitive knowledge, clinical performance, or a combination of these variables?

Selection of measures of continuing competence must take into consideration the evolution of health care practitioners as they pursue their careers. The IOM recognized six stages of lifelong learning: novice, advanced beginner, competent, proficient, expert, and master.[32] There appears to be a growing consensus that measurement of continuing competence should target a health care professional's current practice and should measure both cognitive knowledge and clinical skills.

During the past decade, many health professional organizations have developed and implemented "Maintenance of Competence" or "Continuing Professional Competence" programs for their respective professions. In medicine, The American Board of Medical Specialties (ABMS), an umbrella organization for 24 medical specialty boards, has mandated that all 24 member boards develop maintenance of competence (MOC) programs and require demonstration of both cognitive knowledge and clinical competence as a condition of recertification. Cognitive knowledge is measured by a closed-book examination covering the core competencies all physicians should have throughout their careers. Clinical skills, on the other hand, are measured by a variety of other techniques, including peer review, performance evaluations, consumer satisfaction surveys, and additional methods that take into account the

[32] Institute of Medicine, *Health Professions Education*, 113–114.

differences between novices and more seasoned practitioners. The MOC program requires all physicians who wish to be recertified to provide evidence of (1) professional standing, (2) lifelong learning and periodic self-assessment, (3) cognitive expertise as demonstrated by a secure examination, and (4) performance in practice.[33]

A supporter of the MOC program, Troyen A. Brennan, M.D., a board member of the American Board of Internal Medicine (ABIM), wrote:

> Each ABMS member board has agreed to design methods to meet these requirements by instituting maintenance of certification programs that will be continuous in nature and include periodic cognitive examinations, as well as components focused on clinical practice assessment and quality improvement. Although each board can design its own methods for compliance with this mandate, an ABMS Oversight and Monitoring Committee has been established to ensure adherence to the principles.[34]

**Both cognitive knowledge and clinical skills need to be assessed.** The PEW Health Professions Commission, among others, was sensitive to the need to assess both a practitioner's knowledge and his or her clinical performance: "Most continuing education programs," the Commission wrote, "do not consider whether the health professionals enrolled know how to apply their new knowledge in appropriate situations." Pew cited studies showing that less than 10 percent of all inadequate medical practice is due to a lack of practitioner knowledge, and that only 6 percent of hospital-based physician deficiencies resulted from a lack of knowledge. The Commission went on to say, "some studies have even questioned the correlation of superior knowledge retention to professional performance, suggesting that an individual's ability to 'bring order to the informational chaos that characterizes one's everyday environment' determines whether that professional continues to perform competently."[35]

There are psychometrically sound and legally defensible examinations for measuring *cognitive skills* for each licensed health profession; state boards now require applicants for initial licensure to perform acceptably on these examinations. Some professions have openly resisted objective assessment of *clinical performance*, and progress toward valid and reliable assessment has been difficult and expensive. Still, the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB) have developed an evidence-based clinical

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[33]S. D. Horowitz, S. H. Miller, and P. V. Miles, "Board Certification and Physician Quality," *Medical Education* 38 (2004):10–11.

[34]Troyen A. Brennan et al., "The Role of Physician Specialty Board Certification Status in the Quality Movement," *Journal of the American Medical Association* 292 (September 1, 2004): 1038–1043.

[35] Pew Health Professions Commission, "Report of the Task Force on Health Workforce Regulation," Center for the Health Professions, University of California, December 1955, p.p. 25-26.

assessment examination that medical students must pass after completing formal course work and before entering a residency program. This examination of clinical skills proficiency has also become part of the United States Medical Licensing Examination (USMLE) and has withstood legal challenge by organized medicine. The examination uses standardized patients, a teaching tool accredited medical schools successfully employ.

Efforts to develop evidence-based clinical performance assessment date back to at least 1997 when the American Medical Association (AMA) launched the American Medical Accreditation Program, intended to be a definitive measure of the performance of individual physicians and to supersede duplicative requirements for hospital privileges, specialty certification, and participation in multiple health plans. That initiative was aborted in 2000, but work has continued nevertheless through a parallel initiative, the AMA Practice Guidelines Partnership established in 1998. The partnership, including representatives of the AMA, state and county medical societies, and physician specialty societies, was augmented in 1999 to include representatives of the National Committee on Quality Assurance and the American Association of Health Plans as observers. Simultaneously, the American Board of Medical Specialties and the Council of Medical Specialties have been working to assess the maintenance of competence of clinical specialists, with help from the Institute for Health Policy at Massachusetts General Hospital/Partners HealthCare System In 2002 the Institute reported its results in a comprehensive document, which begins with a definition:

> Physician clinical assessment demonstrates that an individual physician provides care consistent with the best evidence available that establishes an evidence-based clinical process and the relationship between the process of care and patient health status outcomes. [It] measures an individual physician's practice behavior and adherence to evidence-based process and outcomes of care.

The report then identifies four ways clinical assessments may be used:

- continuous improvement of clinical practice and the care delivery microsystems that support clinical practice,
- assessing performance of an individual physician in comparison to his or her peers,
- promoting patient choice based on objective clinical measures of "best practice," and
- rewarding physicians for excellent quality of care.

The report concludes that state of the art best supports the use of the physician clinical performance assessments for promoting continuous quality improvement *within* a physician's practice environment. As for the use of assessments for the three other purposes, the report was less sanguine:

> Although measurement of physician clinical performance is *possible,* the use of this information for reporting external to the physician's practice environment for

> purposes of physician competence assessment, patient choice and rewarding physician excellence is limited by the concerns cited above. [Ed. note: these concerns were methodological and statistical, among others.] [36]

A more concise version of the report [37] uses a definition of professional competence first proffered by Epstein and Hundert as: "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served."[38] This report offers six characteristics of a performance measure that might be used for competency assessment; it cites the considerable impact that such a measure could have on practicing physicians, such as sanctions for poor performance, which might include loss of board certification, suspension or loss of hospital privileges, decredentialing by health plans, or in the most extreme case loss of licensure. The six characteristics are:

- evidence based,
- agreed-upon standards for satisfactory performance,
- standardized specifications,
- adequate sample size for reliable evidence of individual performance,
- care attributable to individual physicians, and
- representative of the activities of the specialty.

Although the report concludes that a broadly based mandatory clinical performance assessment for individual physicians appears to be infeasible, competency assessment is a worthwhile goal that can be approached through careful, incremental steps.[39] These reviews of clinical competency assessment all have common problems (e.g., the identification of substantial methodological and statistical obstacles), yet each concludes these can be overcome.

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[36] J. Daly, C. Vogell, D. Blumenthal et al. *Physician Clinical Performance Assessment: The State of the Art. Issues, Possibilities and Challenges for the Future* (Boston, MA: Institute of Health Policy, Massachusetts Hospital and Partners HealthCare System, 2002).

[37] B. E. Landon, S. T. Normand, D. Blumenthal, and J. Daley, "Physician Clinical Performance Assessment: Prospects and Barriers," *Journal of the American Medical Association* 2290 (2003): 1183–1189.

[38] R. M. Epstein and E. M. Hundert, "Defining and Assessing Professional Competence," *Journal of the American Medical Association* 287 (2002) 226–236.

[39] "Performance assessment has seldom been tried and found difficult; rather, it has been found difficult and seldom tried." R. Kirkwood, R., "Process or Outcome: A False Dichotomy," in T. M. Stauffer (Ed.), *Quality: Higher Education's Principal Challenge* (Washington, DC: American Council on Education, 1981).

**Are self-assessment and third-party assessment equivalent**? A major policy issue for regulators is whether competency assessment must be delegated to independent third parties or is self-assessment sufficient? There is not enough evidence at this time to answer the question definitively. Many voluntary credentialing organizations and some regulatory agencies have adopted self-assessment as part of their emerging continuing competency or professional development programs. This approach is likely to be more acceptable to many professionals than is third-party assessment, as it appears to be a comparatively painless and potentially more cost-effective way to introduce periodic assessment into the routine of professional careers, at least until there is hard evidence that independent, third- party assessment is more reliable and valid.

Critics point out that self-assessment is inevitably subjective, so it does not provide the same degree of public accountability third-party assessment affords. Evidence suggests that professionals' judgments about their own strengths and weaknesses are of questionable reliability.[40]

While third-party assessment seems to be both more objective and more accountable, it is also more expensive than self-assessment and potentially more disruptive to practice. Moreover, there are too few third-party assessment programs available to provide the service for all health care practitioners. Hybrid approaches have potential appeal; these include methodologies combining self-assessment with independent evaluation and consultation at the workplace and random review by a certification or regulatory agency. CAC's *Road Map to Continuing Competence Assurance* accepts self-assessment in the short run, but sets as a goal moving to independent, third-party assessment or hybrid approaches over a period of time.[41]

[40] Presentation by Betsy White-Williams, then associate director, University of California at San Diego, PACE Program, proceedings of a CAC conference, *Demonstrating Continuing Professional Competence: A National Summit to Develop Strategies for Assuring that Health Care Practitioners Remain Competent Throughout Their Careers*, July 2003, 9.

[41] Citizen Advocacy Center, *Maintaining and Improving Health Professional Competence: Road Map to Continuing Competence Assurance* (Elmhurst, IL: Author, April 2004), 9–12.

**Professions Develop Self-Assessment Tools**

In 1989, the Commission on Dietetic Registration began work on a comprehensive self-assessment module using case studies based on an experienced dietician's scope of practice. Dieticians can tailor the self-assessment process to their individual situation. Feedback provides individualized commentary on the practitioner's performance.[42]

In 1991, the National Council of State Boards of Nursing (NCSBN) published a *Conceptual Framework for Continued Competence* stressing the importance of assessment for determining learning needs and, in 1993, acknowledged the licensee's responsibility for self-assessment in collaboration with boards and employers. Around the same time, the Ontario College of Nurses instituted a reflective practice and portfolio model for continuing competence that eventually became a mandatory part of the province's licensure renewal process.[43]

In 2005, the National Association of Boards of Pharmacy (NABP) introduced an online "Pharmacist Self-Assessment Mechanism" (PSAM) to assist pharmacists in obtaining "non-punitive" feedback on their knowledge base. The PSAM consists of 100 multiple choice questions applicable to general pharmacy practitioners in all practice settings. A feedback loop displays each question, the answer selected, the correct answer, a brief rationale, and a reference where more information relating to the topic is available.[44]

In medicine, most if not all of the ABMS's boards are developing self-assessment tools as part of their maintenance of competence programs. For example, the American Board of Internal Medicine's (ABIM) self-evaluation process (SEP) can be completed at home on paper, online, or via CD. Diplomates may choose from a range of self-assessment options, including open-book exams that test clinical and practical knowledge in a particular field and practice-based improvement modules. These two categories—knowledge and clinical practice—correspond to the "Maintenance of Certification" framework adopted by all 24 ABMS member boards.

[42] Presentation by Grady Barnhill, director of recertification, Commission on Dietetic Registration, proceedings of a CAC conference, *Demonstrating Continuing Professional Competence: A National Summit to Develop Strategies for Assuring that Health Care Practitioners Remain Competent Throughout Their Careers,* July 2003; follow-up conversation with Mr. Barnhill.

[43] National Council of State Boards of Nursing, *Meeting the Ongoing Challenge of Continued Competence*, www.ncsbn.org.

[44] *NABP Launches PSAM, Non-Punitive, Knowledge Evaluation Tool for Pharmacists*, May 2, 2005, www.nabp.net.

**A five-step competency assessment and demonstration model is most promising.** After evaluating many of the existing competence maintaining models, CAC recommended a five-step framework for assessing and demonstrating continuing professional competence:

1. Routine Periodic Assessment
2. Development of a Personal Improvement Plan
3. Implementation of the Improvement Plan
4. Documentation
5. Demonstration of Competence based on steps 1 through 4 above[45]

Steps 1 through 4 constitute *quality improvement*; step 5 is the *quality assurance* component, without which the process is incomplete. The critical first step is routine periodic assessment, the key to pinpointing knowledge deficiencies needing correction and to tailoring lifelong learning choices to the needs of individual health care professionals Assessment also reveals whether a practitioner *applies* his or her knowledge and skills competently in clinical situations.

The Royal Pharmaceutical Society of Great Britain asserted in a 2004 study:

> It is widely recognized that a commitment to CPD [continuing professional development] cannot on its own guarantee continued professional competence. Without regular appraisal neither the NHS [National Health Service] nor other employers have a means of monitoring an individual's professional performance and assisting with professional development in a systematic way.

Examination and analysis of maintenance of competence programs in different health professions shows that many, if not most, professions have adopted steps 1 through 4 of the five-step model for assessing and demonstrating continuing competence. These are the steps that have to do with quality improvement. As far as we know, only the ABMS boards currently require step 5, periodic *demonstration* of competence, the quality assurance requirement.

The NABP's Continuing Professional Development (CPD) program includes these five steps: (1) reflecting upon one's practice, (2) conducting a learning needs assessment, (3) developing a learning plan, (4) implementing the learning plan, and (5) *evaluating the learning plan outcomes* (emphasis added).[46] However, the NABP's step 5 is in reality a self-evaluation and does not have the rigor ABMS requires.

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[45]Citizen Advocacy Center, *Maintaining and Improving Health Professional Competence: Road Map to Continuing Competence Assurance* (Elmhurst, IL: Author, April 2004), 9–12.

[46]www.nabp.org.

In nursing, the NCSBN is developing a regulatory model for periodically assessing the continued competence of nurses.[47] To date, most boards of nursing and nursing specialty credentialing bodies do not have rigorous maintenance of competence programs, nor do they require demonstrations of competence as a condition of relicensure or recertification. They generally require mandatory continuing education, but not based on assessment. In 2005, the North Carolina state legislature passed a law specifically empowering that state's board of nursing to require demonstrations of continued competence as a condition of relicensure. The board's implementing rules are rather lenient, however, because "that is all this state is ready for at this time," according to the board's executive director.[48] The new program, called "reflective practice," is described as follows:

> …a process for the assessment of one's own practice to identify and seek learning opportunities to promote continued competence. Inherent in this process is the evaluation and incorporation of this learning into one's practice.
>
> Using a reflective practice approach, the licensed nurse will carry out a self assessment of her/his practice, and develop a plan for maintaining competence. This assessment will be individualized to the licensed nurse's area of practice. There will be a wide variety of choices/methods from which the nurse could select in maintaining continued competence. The committee and Board want to assure licensed nurses that they *will not have to take or pass an exam*. Assessment tools will be made available by the Board of Nursing for use by the licensee.

In July 2005 the American Board of Nursing Specialties (ABNS) conducted an informal survey of its member boards to determine whether their recertification requirements include continued competence provisions. According to ABNS, of the 10 responding boards, all but one reported that their recertification requirements can be met by taking a specified number of CE credits and, in some cases, by logging a specified number of practice hours. Only one reported going beyond mandatory CE and requiring certificants to retake the examination required for initial certification *or* to develop a professional portfolio. According to the ABNS executive director, many member boards are considering requiring portfolios (discussed on page 27) based on self-reflection and/or self-assessment in the near future.[49]

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[47]Conversation with Kathy Apple, executive director, NCSBN.

[48]Conversation with Mary Polly Johnson, executive director, North Carolina Board of Nursing; see www.ncbon.com.

[49] Conversation with Bonnie Niebuhr, executive director, ABNS. The survey was distributed to ABNS members only and not published.

**B)** ***Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?***

There is little convincing evidence that one method or technique for demonstrating continuing competence is more valid and reliable than another, nor is there evidence clearly indicating that the use of any one method leads to better outcomes in the form of patient safety or health care quality. However, what does *not* work is better documented, and there is continuing and widespread interest in finding a better way than traditional continuing education mandates to ensure continuing competence. The rationale for mandating that health professional licensing boards require periodic assessment and demonstration of continuing competence is based on the assumption that patient safety and quality outcomes will improve as a result. As with requirements for *initial* licensure to practice, this assumption ultimately must meet the legal challenge that the requirement enhances the public health, safety, and welfare and that the public is not effectively protected by any other means.

That more evidence needs to be gathered is clear from these observations by researchers at the Institute for Health Policy about the state of the art in physician performance assessment:

> Ideally, for each medical specialty, there would exist evidence-based measures of either outcomes of care or clinical processes that have been linked definitively to improved outcomes for patients and that are representative of the most important clinical activities of that specialty. These measures would serve as the basis of an objective, evidence-based performance assessment system. In fact, few medical specialties have an evidence base that is robust and comprehensive enough to support physician clinical performance assessment.[50]

Fellow researchers at the Institute for Health Policy agree about the shortage of tested and reliable tools for assessing and documenting clinical performance, but they believe it worthwhile nevertheless to continue with periodic assessment initiatives:

> At the same time, purchasers, payers, regulators and patients are appropriately demanding increased accountability from the medical profession. Voluntary, internal, non-transparent quality improvement efforts have yet to demonstrate that they can succeed in meeting expectations for a higher level of performance on the part of medical professionals. The requirement by specialty certifying boards for

[50] Landon, Normand, Blumenthal, and Daley, "Physician Clinical Performance Assessment," 1187.

> evidence of ongoing physician participation in individual physician clinical performance assessment as one of many strategies to improve health care processes and patient outcomes in our healthcare system supports and promotes efforts to improve care.[51]

Pilot or demonstration programs are essential to generate the kind of compelling research data that many feel are needed to justify a shift from the status quo of licensure "in perpetuity" to an era of continuing competency assessment and assurance fully integrated into the licensure process and clinical practice. Ultimately, it will be desirable to have consistent national requirements. Some data will become available from ongoing professional development and nascent continuing competence activities in medicine, nursing, dietetics, pharmacy, physical therapy, and other professions, most of which offer multiple pathways that can be compared and contrasted. Experimentation at the state level will generate evidence on which to base national standards.

Among the questions that pilot programs must answer are: (1) what is the impact of continuing competency assurance on patient outcomes? (2) is there value-added for practitioners and health care organizations that participate? (3) what is the comparative reliability of various methodologies and techniques for assessing continuing competence? and (4) on what bases should boards give deemed status to the competency assurance procedures of voluntary credentialing agencies, professional associations, employers, and other institutions?

Many of the regulatory boards and certifying agencies that have implemented continuing competence programs permit use of alternative methods to demonstrate such competence.[52] This approach seems sensible, not only because there is no consensus on the most *reliable* (consistently accurate when used by numerous assessors) and *valid* (accurately measures what it is intended to measure) technique or combination of techniques for demonstrating competence in a given profession. In addition, the availability of multiple methods provides richer research opportunities for identifying optimal competency assessment and demonstration methods and techniques. Even in the long run, recognition of multiple, evidence-based methods should remain the formula of choice, because it gives flexibility to licensees, regulators, employers, certifiers, and others.

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[51]Daly, Vogell, Blumenthal et al. *Physician Clinical Assessment*, 12.

[52]A 2005 literature review conducted for the American Nurses Association summarizes current thinking about several methods used to evaluate continuing competence. The literature review focuses methodologies, including, Testing, Performance-based evaluations, Case Studies, and Portfolios; A. H. Cary and M. C. Smolensky, "Overview of Competency and the Methods for Evaluating Continued Competence," in Rita Black Monsen (Ed.), *Genetics Nursing Portfolios: A New Model for Credentialing* (Silver Spring, MD: American Nurses Association, 2005), 1010 (see www.nursebooks.org).

In its 2004 report, "Health Professions Education," the IOM summarized the current situation regarding measurement of competence:

> Computerized or written multiple-choice examinations are the main method by which professionals are initially licensed or certified. Questions remain about the validity of this approach. Some licensure and certification exams do not encompass the range of complexity and degree of uncertainty encountered in practice, or the psychosocial behaviors need for practice...
>
> A variety of other mechanisms—peer review, professional portfolio, objective structured clinical examination, patient survey, record review, and patient simulation—also are being explored by certification bodies, and to some extent by licensing boards, as means of assessment. These have been shown to be valid measures of professional performance, and the consensus is that a combination of such approaches is the best strategy.[53]

Regulatory agencies are accustomed to looking at the legal defensibility of examinations—reliability, accuracy, validity, fairness, and nondiscrimination. These standards can also guide the evaluation of methods for assessing and assuring continuing competence.

Continuing competence assessments must assure nondiscrimination and fairness. *Fairness* is guaranteed by the Fourteenth Amendment, which forbids states from depriving an individual of life, liberty, or property without due process of law. Elements of procedural due process include the right to notice, to a fair hearing, to be represented by counsel, to have an objective adjudicator, to present and challenge evidence, to have a record, and to be given a written decision. Substantive due process requires that there be a rational relationship between the action taken and a legitimate end of government.

The Fourteenth Amendment also guarantees *nondiscrimination*. By forbidding states to deny equal protection of the law, it guarantees that similarly situated individuals will be treated by the government in a similar manner. Questions of nondiscrimination would have to be addressed if regulators were to adopt rules and regulations declaring only certain methods for demonstrating continuing competence to be acceptable, or if regulators were to award deemed status to some but not all private certification boards or hospital credentialing programs, assuming they were all following the same procedures.

[53] Institute of Medicine, *Health Professions Education*, 112–113.

Evidence-based standards for assessing and assuring continuing competence will go a long way toward assuring that licensing boards meet the legal standards mentioned above when they promulgate implementing rules and regulations. State pilots should be designed to help inform the formulation of:

- profession-specific, nationally applicable definitions of competence;
- effective, nonburdensome, cost-efficient assessment methods;
- scope of assessment (i.e., comprehensive assessment for everyone versus screening assessment for everyone and comprehensive assessment only for practitioners found to warrant it);
- effective approaches to remediate practice deficiencies;
- satisfactory ways to ensure due process and balanced confidentiality protections;
- viable alternatives for paying for continuing competency assessment and demonstration;
- provisions that should appear in protocols for board recognition of third-party "deemed status" organizations;
- components that should be included in professional portfolios to make them meaningful indicators of continuing competence; and
- improvements in continuing education structure and administration consistent with the needs of a continuing competency program.

**Tests:** Many professionals resist having to pass a test as part of a demonstration of continuing competence. Every profession has its initial licensure examination, which is accepted because the tests are almost universally psychometrically sound, reliable, and valid. But there is no agreement that passing an entry-level examination a second time is the most meaningful way to demonstrate continuing competence in the test-taker's current practice situation. One advocate of repeating the entry-level examination is Gary Smith, executive director of the National Board for Respiratory Care and former official of both the National Organization for Competency Assurance (NOCA) and the National Commission for Certifying Agencies (NCCA). He calls upon each professional specialty to periodically update its job analysis and subsequently its entry-level test to reflect current practice. Therefore, Smith contends, an experienced practitioner who can pass the current entry-level exam demonstrates that he or she is at least minimally competent in the currently accepted scope of practice for the profession.[54]

[54] Gary Smith, "Proceedings, Citizen Advocacy Center 2004 Annual Meeting, Orlando,

The ABMS has decided to require its 24 member boards to administer a closed-book examination on core competencies as one part of its certificants' demonstration of ongoing competence. Paper and pencil tests are best at measuring knowledge but are of little use in measuring actual clinical performance; therefore, the ABMS also requires each member board to require performance-based evaluations.

**Performance-based evaluations**: These may be self- or third-party evaluation based on a standardized evaluation tool. Third-party performance evaluations could be conducted by an employer or supervisor and could involve patient satisfaction surveys, on-site observation, records review, and peer review (formal or informal), among other options. Various ABMS boards have different requirements for their diplomates to demonstrate performance-based competence. For example, the American Board of Pathology requires its diplomates to document:

- accreditation status of lab;
- satisfactory performance of lab in interlab improvement and QA programs;
- satisfactory performance in both interlab and intralab improvement and QA processes every two years; and
- use of appropriate protocols, outcome measures, and practice guidelines.

Diplomates whose performance does not meet board expectations must submit an implementation plan to improve performance.[55]

The American Board of Neurological Surgery requires its diplomates to submit data on 10 consecutive key cases (from a list of 10 procedures) every three years over a 10-year maintenance of competence cycle. Review of the key cases yields feedback on practice performance as well as outcomes. The process also includes a consumer satisfaction survey and a chief of staff questionnaire about the diplomate's performance.[56]

**Case studies:** Case studies are used to evaluate an individual's ability to think critically, to make decisions based on a set of data or a presentation, and to work with specific situations or patients. Case studies may be presented in a paper and pencil format, or in a computer simulation that takes the case study down different paths, depending on the individual's responses to questions. Real or simulated patients may also present case studies or clinical scenarios, and the interaction can be observed and evaluated, thus combining performance evaluation with case study analysis.[57]

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Florida," *Citizen Advocacy Center News & Views* 16 (2004), 26–27.

[55] www.abpath.org.

[56] www.abns.org.

[57] Cary and Smolensky, "Overview of Competency**"?,** 4.

**Portfolios:** Nursing, physical therapy, and a variety of other allied health professions are exploring portfolios as a viable method of demonstrating continued competence. Portfolios are a collection of documents that provide evidence of a practitioner's accomplishments. They can be as minimal as a collection of letters of reference, documentation of continuing education courses completed, or a list of awards. Portfolios can also be comprehensive self-assessments of knowledge and skill strengths and weaknesses, performance reviews, learning plans, and more. The American Nurses Association (ANA) supports portfolios documenting five areas of activity:

- professional credentials, including license, certifications, and academic credentials;
- workplace evaluations by peers and colleagues and any institution-initiated skills testing;
- continuing education, including academic or contact hours related to the candidate's practice;
- leadership activities in professional associations and publications and research; and,
- narrative self-reflection, in which the nurse identifies strengths, weaknesses, and goals.[58]

Recognizing continued competence based on portfolio review is subjective unless there are specific criteria for both the portfolio's content and its evaluation. The Genetic Nursing Credentialing Commission (GNCC) intends to rely on portfolios rather than examination for both initial and recertification, so it has developed a rigorous portfolio structure that includes assessment and extensive case studies. Trained evaluators score the case studies according to how well they demonstrate the candidate's comprehension and application of evidence-based practice guidelines established for the profession.[59]

**Continuing education:** Logging continuing education hours ("seat time") does not equate to maintaining competence. Thus, there is a danger that, by permitting licensees to use one of a number of alternative methods to demonstrate their competence, licensing boards will permit licensees to choose traditional CE to the exclusion of other more meaningful alternatives. Nevertheless, CE is likely to—and should—continue to play an important role in a continuing competency assessment and assurance system. CE can become a more valuable part of the process if course selection is dictated by an assessment of an individual's strengths and weaknesses, if courses are given by accredited providers, and if attendees are required to take a test or otherwise demonstrate they had mastered the course material.

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[58]Presentation by Mary Smolensky, director, Certification Service, American Nurses Credentialing Center, proceedings of a CAC conference, *Measuring Continuing Competence of Health Care Practitioners: Where Are We Now—Where Are We Headed?*, 27.

[59] A compete description of the GNCC portfolio requirement can be found in Monsen, *Genetics Nursing Portfolios*; see especially Chapter 5, Developing a Credential Based on Portfolio Evidence, 55–68.

## C) *How frequently should licensees be required to demonstrate their competence?*

There is as yet no basis for determining how frequently health care practitioners should be required to demonstrate their continued competence. Licensing boards have varied time periods for license renewal, usually ranging from one to three years. Hospitals generally recredential their health care staff every two years.

Specialty certifying agencies also vary in their renewal periods, often timing recertification requirements to coincide with updated job analyses, which, in turn, lead to updated certifying examinations. The 24 ABMS member boards require diplomates to recertify (by demonstrating their continuing competence) at intervals of six to 10 years, with the great majority of them specifying every 10 years.[60] Other certifying bodies require recertification at intervals as short as two or three years.

It is important to keep in mind that many emerging continuing competency programs are based on lifelong learning or CPD programs. These programs are ongoing, so while actual demonstration of continued competence is at set intervals, learning and self-improvement activities are continuous.

A powerful rationale for requiring periodic demonstrations of continued competence is that health care technology, treatment protocols, practice guidelines, prescription medicines, medical devices, and other aspects of health care delivery change constantly. By demonstrating continued competence, health care professionals show that they have kept up with new developments related to their particular profession and specialty. The pace of change in health care delivery argues for a shorter interval between demonstrations of competence, to the extent that such demonstrations are economically feasible.

## D) *Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?*

A decade ago, there was considerable disagreement over whether *all* health care professionals should demonstrate their continuing competence periodically, or only those whose competence has been called into question. At a 1996 CAC Conference in Washington, D.C., James R. Winn, MD, then-executive vice president of the Federation of State Medical Boards (FSMB), suggested that incompetent individuals—those who either do not know or do not perform adequately—are

[60]Conversations with Stephen Miller, M.D., executive director, ABMS. Three have a seven-year cycle; the shortest cycle (six years) is required by the American Board of Obstetrics and Gynecology.

frequently identified early on and eliminated from practice. It is harder, he said, to identify those who may lack the knowledge and ability to perform in certain areas or may overstep their area of competence. Winn referred to these individuals as "incompetent," and he recommended using "markers" to determine which practitioners' continuing competence should be assessed. He suggested these markers for consideration:

- action against a licensee in another jurisdiction;
- changes in hospital privileges;
- practice gaps longer than two years;
- limitations on a drug registration certificate;
- malpractice information;
- changes in a specialty certification or failure to recertify;
- changes in health status;
- advanced age; and,
- absence of continuing medical education.[61]

The prevailing view is that continuing competency assessment and assurance should not be confined to "incompetent" practitioners or the few "bad apples." Rather, maintaining competence underpins any effort to assure patient safety and improve the quality of care, so it must apply to all practitioners.

Writing in the FSMB's quarterly journal in 2003, Stephen Miller, M.D., executive vice president of ABMS, explained the rationale behind ABMS's maintenance of competence requirements for *all* board certified physicians, not just those where a "marker" suggests a potential problem. He wrote:

> The ABMS and the member boards now believe that if certification of physician specialists is to remain credible as a credential signifying quality medical care, the organizations involved must be accountable to a variety of interested

[61]Citizen Advocacy Center, conference proceedings, *Continuing Professional Competence: Can We Assure It?*, Washington, D.C., December 16–17, 1996. The obverse of the "markers" theory is a school of thought propounded by some in the health care professions who would rather not see systematic continuing competency assurance take hold. They contend that the absence of state board disciplinary actions or malpractice lawsuits on one's record is itself proof of continuing competence. This view ignores the across-the-board quality improvement, or "raise all boats" impact likely to result from systematic continuing competency assurance programs. It also places undue faith in the ability of both regulatory boards and malpractice systems to weed out *all* practitioners of questionable competence.

> stakeholders. That accountability must be not only for initial certification, but for an ongoing and continuing affirmation that certified specialists are maintaining the necessary capability to provide patients with quality medical care based on the most up-to-date scientific evidence."[62]

Harvey W. Meislin, M.D., then president of ABMS, and Bonnie Niebuhr, executive director of ABNS, told CAC's July 2003 continuing competency summit that introducing a competency assessment and assurance program by targeting only people known or suspected to have problems would undercut the idea that competency assessment is a positive strategy of benefit to all professionals. To be perceived as an affirmative responsibility borne by all practitioners, rather than as a punitive program, continuing competency assessment and assurance must apply to everyone.[63]

### E) *How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of specialty certification boards? Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?*

State legislatures need to provide guidance to licensing boards on implementing a continuing competency mandate. Within certain parameters, legislatures should empower boards to issue rules and regulations specifying acceptable *methods* for assessing and demonstrating competence. Legislatures should also empower boards to recognize a variety of acceptable *pathways* via which licensees can demonstrate their continuing competence. For example, boards might be authorized to recognize (deem) outside organizations as the board's *agents* in enforcing the new continuing competency requirements because few, if any, licensing boards have the resources to implement universal competency requirements. Moreover, such an effort by boards could unnecessarily duplicate sound assessment and demonstration programs already administered by other organizations.

It would be consistent with current regulatory practice for a licensing board to recognize a credential awarded by a private entity (e.g., a specialty certification board, professional association, or hospital credentialing committee) as evidence that a licensee has demonstrated continuing competence. Many boards already deem that individuals meet education and

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[62]Stephen H. Miller, "Maintenance of Certification: Relationship to Competence," *Journal of Medical Licensure and Discipline*, FSMB 89 (November 1, 2003): 8.

[63] Bonnie Niebuhr and Harvey Meislin, M.D., proceedings of a CAC conference, *Demonstrating Continuing Professional Competence: A National Summit to Develop Strategies for Assuring that Health Care Practitioners Remain Competent Throughout Their Careers*, July 2003.

examination requirements for initial licensure by successfully completing programs recognized by the board or accredited by an independent agency recognized by the board as well as CE programs in which a mandated requirement may be satisfied by completing courses that meet the standards of an independent accrediting agency in the field.

Legislatures and boards will have to identify the criteria that outside organizations will be required to meet to earn deemed status. Several acceptable approaches are possible. Legislatures could choose to legislate some or all of the criteria that govern granting deemed status to private organizations; they could direct licensing boards to establish the deeming criteria by rules and regulations; or the legislature could establish criteria in broad policy terms and allow the boards to fill in the specifics. Whatever the approach, it is essential that any program for evaluating current competence be equivalent, in terms of public protection, to the program the licensing board establishes on its own for periodically evaluating and verifying the continued competence of its licensees.

Private voluntary specialty certification bodies will likely seek deemed status from their professions' licensing boards. In some professions states already accept board certification as evidence of qualification for initial licensure. In many professions, specialty certification indicates that the practitioner has met a higher standard, as opposed to maintaining *minimum* acceptable competence, which is the most that a regulatory body traditionally can require. Therefore, regulatory boards may not be empowered to *require* specialty certification as evidence of continuing competence, but they could offer it as an option for meeting the legal continuing competence requirement to those licensees who choose to earn a specialty certification. However, no licensees should be put in danger of having their licenses taken away or legally restricted unless they fall below statutory minimum competency standards.

The number of specialty certification organizations varies widely by profession. Medical specialty boards are numerous and, by some estimates, about 90 percent of all licensed physicians are certified by a specialty board as well.[64] There are no firm data on the proportion of nurses who hold specialty certification, although some estimate that the number is approximately 20 percent of RNs.[65] ABMS has 26 member boards in the United States,[66] one of which is the American Nurses Credentialing Center (ANCC), an ANA-sponsored organization

[64]Conversation with Stephen Miller, executive vice president, ABMS, which has 24 specialty boards. The American Osteopathic Association (AOA) Bureau of Osteopathic Specialists recognizes 18 specialty boards. *Medical Economics* identifies 75 additional medical certification boards not affiliated with ABMS or AOA (see *Medical Economics* 72 (1995): 26–36.

[65]Conversations with Bonnie Niebuhr, executive director, ABNS; see also American Board of Nursing Specialties, *A Position Statement on the Value of Specialty Nursing Certification* (March 5, 2005). www.abns.org.

[66] www.abns.org.

that certifies 145,000 nurses in more than 50 specialties.[67] It is estimated that only about 4 percent of pharmacists are board certified by one of the five specialty boards recognized by the Board of Pharmaceutical Specialties.[68] In other health professions, there are no specialty certification boards at all.

Some specialty certification boards have developed recertification programs requiring maintenance of competence, ongoing lifelong learning based on assessment, and periodic demonstrations of continuing competence. The most developed of these is the ABMS program described earlier. In addition, all certification programs accredited by the National Commission for Certifying Agencies (NCCA) must require periodic recertification, although for many, the requirement can be satisfied by documenting CE credits.

In 2002 CAC surveyed certification bodies from a variety of health professions and found that while 95 percent of 44 responding certification boards require practicing board members to demonstrate their competence periodically, 86 percent of them allowed their certificants to meet their continued competence requirements by taking approved continuing education courses not based on assessment.[69]

Before granting deemed status, licensing boards need to evaluate and assess the specific requirements of each voluntary certification board and compare these to the licensing board's own requirements to ensure reasonable equivalence. Certification bodies that allow their certificants to fulfill recertification requirements simply by taking continuing education courses should be found inadequate. Likewise, voluntary programs that call for portfolios based solely on self-reflection, and continuing professional development programs that contain only competency *improvement* steps (steps 1–4 in the conceptual framework described earlier), but stop short of competency *assurance* (step 5 in the framework), also would not meet the level of rigor recommended in this study.

AARP has articulated principles for according deemed status, including the following seven criteria:

- State boards retain full authority to enforce all regulatory requirements.

- Reliance on deemed status is subject to full and open public comment.

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[67] www.nursecredentialing.org.

[68] Conversations with Carmen Catizone, executive director, National Association of Board of Pharmacy, and Lucinda Maine, executive vice president, American Association of Colleges of Pharmacy; see also www.bpsweb.org.

[69] The unpublished *Report from a Survey of Continuing Competence Activity by Regulatory Boards, Voluntary Certification Bodies, and Specialty Boards* is available from the Citizen Advocacy Center.

- The public has ready access, at nominal or no cost, to deemed status organizations' standards and measures.

- Information about individuals, including their qualifications and affiliations, who conduct reviews on behalf of the deemed status organization is made public.

- Surveys conducted by deemed status organizations are validated periodically.

- Results of deemed status organizations' review process are public.

- Deemed status organizations have no conflicts of interests with and are independent from those entities they approve or accredit.[70]

Perhaps the Federation of State Medical Boards (FSMB), which is currently developing a new policy position on maintenance of competence for member licensing boards, will break new ground. While it is too early to know what the new FSMB model will specify, some believe it might recommend to state medical boards that holding current certification from an ABMS member board should satisfy a future licensing board continuing competence requirement for relicensure, thereby granting deemed status to ABMS member programs.[71]

### F) *How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?*

In addition to specialty certification bodies, licensing boards need to consider awarding deemed status to qualifying competency evaluation programs at hospitals and other institutions that credential, privilege, and/or employ health care professionals. Drs. Lucian Leape and John Fromson have recommended that hospitals adopt programs to monitor physician performance and identify problem doctors more systematically. "The challenge is clear," they write,

> We need to identify problem doctors early and address the problems in a timely fashion. To do this, we require better measures for identifying physicians who need help and better programs for providing help to those who need it. Although performance problems are widespread, we suggest that the place to start is in hospitals, where a credentialing process is already in place.[72]

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[70]AARP, *The Policy Book: AARP Public Policies* (Washington, DC: Author, 2005), 6–22, 6–79.

[71]Conversations with FSMB staff.

[72] L. Leape and J. Fromson, "Problem Doctors: Is There a System-Level Solution?, *Annals of Internal Medicine* 144 (2006): 107–115.

An example of the kind of program that might satisfy board requirements is the third-party assessment program at Pitt County (North Carolina) Memorial Hospital, an academic medical center with 745 beds and 4,500 hundred employees, including 1,200 nurses. This hospital revisited its employee orientation program in the wake of the IOM's *Errors* report and the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) growing interest in ongoing competence and the nursing shortage. The hospital decided to administer to all new-hire nurses the performance-based professional development system (PBDS) created by Dr. Dorothy del Bueno of Performance Management Services Inc.

The four-hour PBDS assessment asks participants to respond in writing to questions based on vignettes describing specific clinical situations. The answers enable the hospital to assess the strengths and limitations of new-hires' critical thinking as well as their interpersonal and technical skills. Using the assessment results, the hospital develops individualized two- to 15-week orientation plans. Each nurse's performance is evaluated during the orientation period, and some may be reassessed.[73] Pitt Hospital's PBDS manager, Diane Marshburn, believes the program may soon be extended to include incoming pharmacists and respiratory care professionals and could easily be adapted to measure current competence of existing staff as well as new-hires.[74]

More than one hundred hospitals use the PBDS system, making it a potential candidate for recognition by licensing boards if the boards determine PBDS offers consumer protection equivalent to competency demonstration programs offered directly by the boards. It would be more difficult for licensing boards to evaluate hospital competency assurance programs developed in-house. Although there is no reason a licensing board could not do this theoretically, the resources required to evaluate individual programs on a case-by-case basis could be prohibitive. Monitoring the administration of hospital- or other institution-based continuing competence programs will also take resources–and may require licensing boards to work more closely with state departments of health with jurisdiction over health care provider organizations.[75]

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[73]Presentation by Diane Marshburn, R.N., administrator, Patient Care Service, Pitt County Memorial Hospital, Greenville, N.C., at a CAC conference, *Demonstrating Continuing Professional Competence*, July 2003. Proceedings from this conference are available at www.cacenter.org.

[74]Conversation with Diane Marshburn.

[75]A recent issue of the online newsletter, *Credentialing Connection*, demonstrates that credentialing rules are not always followed. In *Darling v. Charleston*, a hospital was found negligent because when it permitted an unqualified on-call physician to set a leg fracture, it violated its own credentialing rules, according to which (1) surgeons should be called in for orthopedic cases, (2) privileges should be extended based on current clinical competence, and (3) nurses should report to supervisors when they have concerns about a patient's care. In a second case, one hospital sued another for sending only a form letter of recommendation for a

Eventually, boards may be able to look to JCAHO accreditation as a basis for giving deemed status to a hospital or other accredited institution. However, JCAHO's current standards applicable to credentialing and privileging are not explicit enough for licensing boards to rely on. A number of JCAHO standards address *initial* credentialing of physicians and other health care practitioners.[76] Recently JCAHO set in motion a process (including field testing) to address recredentialing and reprivileging. In January 2006 JCAHO's Credentialing & Privileging Task Force proposed revised standards that, if adopted, will put in place beginning in 2007 new process standards for hospital physician privileging. Hospitals would be required to show that they have a process to address the ongoing competence of physicians every two years when they reconsider their individual privileges. Over time, JCAHO could strengthen the requirements by requiring hospitals to follow specific substantive (as opposed to process) standards. Until this happens, JCAHO's proposed standards, even if adopted for 2007, probably are not rigorous enough to qualify for deemed status recognition. It is unlikely in the near term that other delivery settings, such as freestanding, outpatient surgical centers and nursing homes, will have continuing competency assessment and assurance programs that could qualify for deemed status recognition by state licensing boards. A review of the literature showed no such programs currently in existence.

### G) *Who should pay the costs of recertification? Licensees? The state?*

There are two types of costs associated with assessing and assuring continuing professional competence. First, there are the costs to health care professionals to assess and maintain their competence throughout their careers and to demonstrate periodically that they have done so. CAC has recommended that these costs should be borne by the licensed professionals.[77] This is consistent with current practice; professionals already bear the costs of preparing for initial licensure, license renewal fees, and mandatory CE courses. These costs vary greatly. The National Association of Boards of Pharmacy's PSAM program costs $75.[78] The fee to enroll in the American Board of Internal Medicine's recertification program was $1,045 as of September 2005.[79]

The second category includes costs incurred by licensing boards in establishing and administering continuing competency requirements. There will be costs to establish the programs (including the cost of developing rules and regulations) and to administer them

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transferring physician, rather than reporting detailed information about the physician's actual performance; *Credentialing Connection* 7 (October 7, 2005).

[76]See, for example, current standards LD.3. 80; MS. 4:10 and MS.4.20.

[77]Citizen Advocacy Center, *Maintaining and Improving Health Professional Competence*, 8.

[78]See www.NABP.net.

[79]See www.ABIM.org.

(preparing exams, evaluating "deemed status" applications, monitoring compliance). Each state will have to estimate expenditures and then decide whether to raise the funds by increasing licensing fees, seeking funding from general revenues, or some combination of both.

An expert task force at a CAC conference identified six action steps to begin to address the cost issues:

- Develop cost/benefit projections.
- Discuss alternatives, such as creating a fund to which all licensees pay a small fee (as with some diversion programs for chemically dependent practitioners).
- Document the value-added to individual practitioners of continuing competency verification (and even specific continuing education classes); conceptualize this as positive practice-enhancement, rather than a way of treating problems.
- Encourage liability insurance carriers to fund the program as a risk-reduction effort.
- Examine industry assessment centers and the value-added to the employees.
- Estimate the costs regulatory boards would avoid by reducing their disciplinary caseloads.[80]

Public funding of continuing competency programs may be appropriate, since practitioner competence is in the public interest. However, public funding is politically unlikely in the immediate future and attempting to obtain it could jeopardize forward movement. Furthermore, there is already a precedent for funding licensure through user fees.

### H) *What should be the legal status of a licensee who cannot meet relicensure or recertification standards? What rules of confidentiality, if any, should apply to this information? What information should be given to the public concerning a health care provider's continuing competence?*

Resolution of practitioner confidentiality issues may depend on whether new continuing competency programs are considered (1) quality improvement/quality assurance under the boards' *licensing* responsibility (which is to issue licenses only to those who demonstrate minimal competence), or (2) part of the boards' *disciplinary* responsibility under which it

[80] *Measuring Continuing Competence of Health Care Practitioners: Where Are We Now–where Are We Headed?* proceedings of a Citizen Advocacy Center conference, June 2000, 36–37.

removes or restricts the licenses of individuals who have violated the state practice act. In either case, the legal rationale for giving licensing boards responsibility in this area is the same—to protect and promote the public health and safety.

There are reasons for preferring that continuing competence programs fall under a board's licensing rather than disciplinary responsibilities. Disciplinary programs are punitive. They deal with that small percentage of licensees whose actions or inactions are below the minimal acceptable standard of practice. In exercising their disciplinary functions, licensing boards are perceived as "cops," looking for and dealing with "bad actors." The overwhelming majority of licensed health professionals never interact with their licensing boards on disciplinary matters, nor do they wish to.

The board's licensure responsibilities, in contrast, apply to all licensees and touch directly on questions of competence. There is a more comfortable fit between the licensure aspects of a board's work and continuing competency assurance, which has elements of quality assurance and quality improvement.

Another difference between licensure and discipline functions involves information disclosure. Disciplinary information is made public. In fact, in recent years, laws, regulations, and court decisions have all tended to open the disciplinary process to public scrutiny, making public the names of licensees who have been disciplined, the nature of the disciplinary action, and the reasons the discipline was imposed. Names of disciplined licensees appear on board web sites, in board newsletters, in general circulation newspapers, and other media.[81]

The same disclosure rules do not apply in licensing matters other than to publish the names of everyone who is licensed to practice. Individual exam scores and other information associated with initial licensure generally are not made public. If board-mandated competency assessment and assurance were to become part of a board's licensure responsibilities, it follows that such details as the results of periodic assessments, the contents of learning plans flowing from the assessments, documentation related to the implementation and outcomes of learning plans, test results, and performance evaluations would be available to the licensing board, but not to the general public. However, the public would be informed when a licensing board restricts or revokes a license because the licensee is unable to demonstrate at least minimally acceptable continued competence.

As a condition for receiving deemed status, credentialing boards, hospitals, and other institutions would have to agree to share with licensing boards any case-specific information these private organizations have. Many of these credentialing programs assure their certificants that all

[81] A major exception applies to chemically dependent practitioners who enter board-approved treatment programs in lieu of discipline. In virtually all states, the names of these individuals are not made public, as long as they abide by the substance abuse program's terms and conditions.

information they give to the credentialing board to demonstrate their continuing competence is confidential, and they are unlikely to change their confidentiality rules. However, should a licensee choose to fulfill his or her continuing competence legal requirement by offering evidence of successfully completing the requirements of a voluntary credentialing body that has deemed status, these individuals will have to waive the certification body's confidentiality protection and authorize the licensing board—but not the general public—to have access to pertinent information. This is critical because licensing boards must have access to relevant supporting data to protect the public adequately.

Two related public protection issues must be considered as well. First, what should licensing boards be authorized to do when licensees fail to complete their learning plans? Boards should be able to take the same remedial actions they take now when licensees fail to fulfill any mandatory continuing education requirements: licensure suspension or imposition of some other sanction for failure to comply, and, perhaps, another chance to complete the learning plan under more rigorous supervision.

Second, what actions should licensing boards be empowered to take when health care professionals seeking to renew their licenses fail to demonstrate *minimally* acceptable levels of knowledge and/or performance? For this process to be credible, boards need to be empowered to intervene in instances where licensees fail to establish their continuing competence and restrict or suspend the license until the practitioner brings his or her practice up to at least a minimal level of competence. In egregious cases, the board should have the authority to suspend or revoke licenses. Statutory language empowering boards to do so will need to specify a standard of evidence. *Clear and convincing* is too rigid a standard because it would require the board to establish gross negligence or patient harm. The more appropriate legal standard is *preponderance of evidence* that the licensee has failed to demonstrate his or her current competence.

## RECOMMENDATIONS

The agenda for reform presented in this study focuses on state government, since it is the states that license health care practitioners and, when necessary, discipline them. The authors propose the framework below for state legislative action, which forms the basis for the recommendations that follow:

- Eliminate continuing education requirements.

- Mandate that as a condition of relicensure, licensees participate in continuing professional development programs approved by their respective health care boards.

- Mandate that continuing professional development programs include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence.

- Provide licensure boards with the flexibility to try different approaches to foster continued competence.

- Ensure that the boards' assessments of continuing competence address the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure.

- Require that boards evaluate their approaches to gathering evidence on the effectiveness of methods used for periodic assessment.

- Authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board- established standards.

Significant challenges must be overcome to implement effective systems for continuing competency assessment and assurance. Progress is likely to be incremental and may be frustratingly slow. This is justification for moving expeditiously to enact the appropriate legislation and initiate pilot programs to generate the evidence on which to promulgate broad-based continuing competency programs that enhance patient safety and health care quality. To further that goal, we propose the following recommendations:

**RECOMMENDATION 1: State laws and implementing rules and regulations should require that, as a condition of relicensure, licensees participate in continuing professional development (CPD) programs approved by their respective boards. CPD programs must include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence. Licensees should be permitted to demonstrate continuing competence through a variety of legally defensible, psychometrically sound, evidence-based methods.**

**RECOMMENDATION 2: Demonstrations of continuing competence should cover the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure**.

**RECOMMENDATION 3: State licensing boards should conduct pilots to test a variety of methods and techniques for periodic assessment and assurance of continued competence. The boards should designate an objective, third-party institution to assist in the design and evaluation of these pilot programs.**

**RECOMMENDATION 4: Professions should endeavor to codify standards and definitions of clinical competence that are relevant to them and incorporate the cross-cutting competencies identified by the IOM: patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics.**

**RECOMMENDATION 5: Licensing boards should grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards. Boards must require organizations to meet or exceed the standards applicable to licensees who choose to demonstrate their continued competence through board-administered continuing competence programs.**

**RECOMMENDATION 6: Licensees who choose to fulfill licensing board continuing competence requirements by meeting the parallel requirements of a certifying body, employer, professional association, or other organization to which the board has given deemed status, shall waive the deemed organization's confidentiality provisions to give the board access to information pertinent to competency assessment and demonstration.**

**RECOMMENDATION 7: Licensees should bear the costs of assessing and demonstrating their continuing competence, either individually or though private sources of funding, such as professional associations, insurance carriers, employers, and the like.**

**RECOMMENDATION 8: The board should inform the public whether a licensee has been successful in demonstrating his or her continuing competence.**

# APPENDIX I

CAC empanelled a project advisory committee composed of six current or former CAC board members with significant experience relevant to the subject of this policy paper. Their expertise was instrumental in developing the recommendations set forth.

The expert panel comprised the following individuals:

***Len Finocchio, Ph.D.***, is a health care consultant who served as staff director for the Pew Health Professions Commission Task Force on Regulatory Reform.

***Ruth Horowitz, Ph.D.***, is a public member on the New York medical board and previously served as a public member of the Delaware medical board. She is a professor of sociology at New York University and is writing a book on the role of public members in making health licensing boards more accountable to the public.

***Andy Hyams, B.A., M.P.H., J.D.***, is deputy general counsel of the Boston Public Health Commission and served for a number of years as general counsel to the Massachusetts medical board. He is also an adjunct lecturer in law and health at the Harvard School of Public Health.

***Arthur Levin, B.A., M.P.H.***, served on the IOM committee that produced *To Err Is Human* and *Crossing the Quality Chasm: A New Health System for the 21st Century*. He is the director of the New York-based Center for Medical Consumers.

***Mark Speicher, B.A., M.H.A.***, was formerly executive director of the Arizona Board of Medical Examiners and now serves as a consultant to the Office of the Inspector General, U.S. Department of Health and Human Services on issues relating to credentialing health care providers.

***Mark Yessian, Ph.D.***, recently retired as director, regional operations, Office of Evaluations and Inspections, Office of the Inspector General, U.S. Department of Health and Human Services.

# APPENDIX II

## ANNOTATED BIBLIOGRAPHY
## CITIZEN ADVOCACY CENTER PUBLICATIONS
## CONTINUED COMPETENCY ASSESSMENT AND ASSURANCE

The publications listed here can be accessed through the CAC Web site, www.cacenter.org, or obtained from Citizen Advocacy Center, 1400 Sixteenth Street, N.W., Washington, DC 20036. Telephone: (202) 462-1174. Fax (202) 265-6564. The bibliography is organized chronologically beginning with the most recent publications.

**Maintaining and Improving Health Professional Competence: The Citizen Advocacy Center Road Map to Continuing Competency Assurance. April 2004.** This publication documents the challenge and urgency of a plan to mandate state licensure boards to require periodic continuing competency assessment and assurance as a condition of license renewal. CAC presents six goals and assigns responsibility for accomplishing them over the next decade: (1) conduct research; (2) seek enabling legislation; (3) develop evidence-based standards; (4) change expectations during initial education; (5) use fees to pay for competency assessment; and (6) reform continuing education. This plan was presented to an audience of leaders in health professional education, licensure boards and other credentialing agencies on September 13, 2004 (available on the CAC Web site).

**Demonstrating Continued Professional Competence: A National Summit to Develop Strategies for Assuring that Health Care Professional Remain Competent Throughout Their Careers.**

**A. Meeting Report.** In July 2003 CAC collaborated with 12 national organizations to convene this summit attended by more than 75 stakeholders representing the health professions, licensure boards, certifying agencies, and health policy consultants. The purpose of the summit was to (1) reexamine the legal, cultural, administrative, political, and financial barriers to a universal system of competency assurance, and (2) propose a plan of action to be taken by stakeholder groups, individually or in concert to address these barriers. The collaborating organizations were:

American Association for Respiratory Care
American Association of State Social Work Boards
American Occupational Therapy Association
American Physical Therapy Association
Association of Regulatory Boards in Optometry
Commission on Dietetic Registration
National Board for Certification in Occupational Therapy
National Board for Respiratory Care
Federation of State Boards of Physical Therapy
National Board of Examiners of Long -term Care Administrators
National Association of Boards of Pharmacy
National Council of State Boards of Nursing

**B. Background Readings.** These readings were collected and published for attendees at the July 2003 Summit (see above). The compendium is in five parts: (1) executive summary of a June 2000 forum convened by CAC; (2) a report of a 2002 CAC-conducted survey to determine how licensing boards, voluntary certification agencies, and specialty boards address the continuing competence of their licensees and certificants, and what these agencies plan for the future; (3) an annotated bibliography of general articles, studies, and reports on continuing competence; (4) descriptions of current programs implemented or planned by regulators, private certification boards, and professional societies, and (5) reprints of abstracts of articles related to continuing competence obtained from a search of PubMed (available in hard copy only).

**Measuring Continuing Competence of Health Care Practitioners: Where are we now and where we are headed? June 2000 and February 2001.** These meetings were convened jointly by CAC and the Interprofessional Workgroup on Health Professions Regulation (IWHPR), a multiprofessional group formed in response to the Pew Health Professions Commission's call for reforms in education, licensure, and certification of the health professions. The conferences enumerated barriers that have frustrated efforts regulators and the professions and proposed strategies to address these barriers. A central recommendation called for CAC and major stakeholder groups to convene broad-based summits on issues surrounding continuing competence assessment and assurance (available in hard copy only).

**The Role of Licensure in Assuring the Continuing Competence of Health Care Professionals: A Resource Guide. 1995.** This guide includes the results of state reviews of the effectiveness of continuing education and examples of state statutes and regulations related to continuing competence (available in hard copy only).