Citizen Advocacy Center

MEASURING CONTINUING COMPETENCE OF HEALTH CARE PRACTITIONERS: WHERE ARE WE NOW — WHERE ARE WE HEADED?

PROCEEDINGS
of a Citizen Advocacy Center Conference held in June, 2000

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The Citizen Advocacy Center is grateful to the panelists and discussion leaders for sharing their expertise and opinions and to the other participants at this conference whose contributions informed and enriched the discussion of continuing competency assurance in the present and the future. It is our hope that disseminating these proceedings will help CAC and other stakeholders to realize the major recommendation to emerge from the conference which is to move deliberately toward convening an even more broadly-based, action-oriented national summit on continuing professional competence in 2002.

These proceedings are not a verbatim transcript of the conference but are a faithful rendition of the essence of the speakers' presentations and the subsequent discussion that occurred at the conference.

The Citizen Advocacy Center (CAC) is a unique support program for the thousands of public members who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory or other health policy boards, or selected by private sector institutions and agencies to serve on boards or advisory panels, public members are typically in the minority and are usually without the resources and technical support available to their counterparts from professional and business communities. CAC is a not-for-profit, 501(c)(3) organization created to serve the public interest by providing research, training, technical support, and networking opportunities to help public members make their contributions informed, effective, and significant.

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EXECUTIVE SUMMARY

In June, 2000 the Citizen Advocacy Center (CAC) convened a conference to examine the state of the art in continuing professional competence assessment and assurance. Several years had passed since the previous national conferences on this subject were held by CAC and the Interprofessional Workgroup on Health Professions Regulation (IWHPR). CAC believed it was time to convene this meeting to look at developments in the field: Are there new ideas? Are there more reliable ways of measuring continuing competence in either the regulatory sphere or the private sector? If so, what are they? If not, what are the obstacles to progress? What could the primary stakeholders do to help institutionalize continuing competence requirements at the regulatory and private levels?

The conference began with updates from licensing board officials and representatives of private certifying agencies in several health care fields — allied health, medicine, pharmacy, and nursing. Full accounts of these presentations appear in the following proceedings. After the panel presentations, the attendees engaged in a lengthy discussion of the barriers that have frustrated regulators and professions that have attempted to institutionalize continuing competency requirements. The meeting concluded with a discussion of promising strategies for overcoming the identified barriers.

The context for the discussion of barriers and strategies was the group's virtually unanimous consensus that the best way to accelerate progress would be to ask CAC and IWHPR to convene a third national summit — even more broadly based than the meetings previously held by the two organizations. It was agreed that the goal of this summit should be to identify action strategies and to elicit commitments from participants to take steps to overcome the inertia that has halted the introduction or expansion of continuing competency programs, despite growing sentiment that such programs would be desirable and worthwhile.

The prospect of convening an action-oriented continuing competency summit influenced the discussion of barriers and of strategies for overcoming them. Indeed, the summit was viewed as the vital first step in a search for solutions, important both for drawing widespread attention to the significance of competency assurance and for mobilizing the stakeholders to action.

The group felt strongly that an action-oriented summit should not retrace territory previously covered. Instead, the group agreed that the summit organizers should compile and distribute in advance of the meeting background information on the status of continuing competency initiatives in both the public and private sectors and on research in the field. The information package will enable summit attendees to start from the same knowledge base without having to devote valuable meeting time to yet another round of organizational updates.

The barriers to be addressed at a national summit fall into several general categories: legal, cultural, methodological, political, and financial. The group recognized that some barriers will take longer to overcome than others. But, even though a barrier may be entrenched, this was not felt to be a reason to postpone corrective action; rather, it simply may mean that a solution will take a long time to achieve. In the meantime, proponents of continuing competency assurance should tackle those problems that promise to be overcome in the shorter term to get the ball rolling.

The group identified the following barriers to be overcome:

Core Barriers:

- need for agreement on common terms and definitions;
- need for research and information to validate methodologies and approaches, including what to measure and how to relate competence assessment to patient outcomes;
- need for collaboration and cooperation among agencies, and between public and private sectors, to decide whom to target and how, to deal with turf issues, to educate stakeholders, and to coordinate patient safety activities related to continuing professional competence.

Administrative Feasibility Barriers

- need for resources and tools to be able to offer competency assessment, remedial education, mini-residencies, qualified preceptors, and more.

Public Credibility Barriers

- lack of public demand for health professions to demonstrate continuing competence and lack of understanding of the mechanisms by which continuing competence can be achieved resulting in a lack of public pressure on legislators, policy-makers, and the professions;
- perception that offering multiple pathways invites professionals to take the path of least resistance.

Professional Acceptance Barriers

- fear and resistance on the part of the professions, arising in part from expectations inculcated early in the educational process that competence will be assessed only once, at the time of initial licensure;
- territoriality within professions and boards.

Legal Barriers

- need to balance public protection vs. a licensed professional's property right and to answer questions about such issues as due process and fairness, legal liability, confidentiality, and open records laws as a disincentive to honest professional self-evaluation.

Economic Feasibility Barriers

- need to understand the costs and benefits of continuing competency assessment and assurance, and to agree on who is responsible for paying the costs.

STRATEGIES FOR OVERCOMING BARRIERS

The group discussion produced the following outline of promising strategies for overcoming the identified barriers. This is a list from which the summit planners can draw when constructing the background book and meeting agenda. Some stakeholder groups may find ideas they want to incorporate into their own strategic planning. Here is an abbreviated presentation of the strategies, which are spelled out in more detail in the body of the proceedings:

BARRIERS: All

STRATEGY: Convene a Multi-Disciplinary National Summit on Continuing Competence in 2002 to stimulate public dialogue about continuing competence and take advantage of attention and energy currently being devoted to error prevention and patient safety.

BARRIER: Need for Common Definitions and Terminology

STRATEGY: Expand the IWHPR's ongoing definitions project to involve CAC and other stakeholders.

BARRIER: Need for Agreement on What to Measure and How

STRATEGY: Develop a research agenda and set priorities.

BARRIER: Need for collaboration and cooperation among responsible parties and stakeholders

STRATEGY: Facilitate information sharing and cooperation among all the stakeholder groups that should be in the loop.

BARRIER: ADMINISTRATIVE FEASIBILITY

STRATEGY: Analyze and compare the feasibility of various approaches; e.g., triggers and markers vs. profession-wide continuing competence requirements.

BARRIER: Need for Professional Acceptance and Public Credibility

STRATEGIES: Modify professional expectations and educate the public and legislators.

BARRIERS: Need for Legal Defensibility

STRATEGIES: Help licensing boards find answers to questions such as: What happens when a professional demonstrates a competence deficiency? Does a self-assessment put the professional in potential trouble with the licensure system? Can we separate ongoing competence from discipline, just as we separate initial competence from discipline? Help develop model legislation requiring continuing competency assessment and assurance.

BARRIER: Cost of Competency Assurance Programs

STRATEGY: Forecast comparative costs of alternative routes to competency assurance per practitioner and per regulatory board (there is already some basis for this in pilot tests of portfolios, computer simulated testing, etc.) Factor in the cost to the practitioner for failure to demonstrate continued competence and subsequent loss of job or patient base. If professionals' expectations were different, they may not resist the cost. For example, it is widely accepted by professionals that they are responsible for paying for the initial licensure test and for CE. From regulatory agency point of view, change legislators' attitudes and get appropriations for continuing competency assurance.

CONCLUSION

The Citizen Advocacy Center and the International Workgroup on Health Professions Regulation were encouraged to move forward toward convening the broadly co-sponsored action summit to flesh out these and other promising strategies in support of continuing competency assurance. Initial steps will include soliciting support from the broadest possible group of stakeholders and then arranging for research and drafting to prepare comprehensive background materials. All of the participants at the June 2000 CAC conference were urged to put the subject of continuing competence on the agendas of theirs and related organizations' meetings and conferences to generate interest and support for the 2002 summit and enlist assistance in completing the ground work. CAC and IWHPR were also encouraged to explore options for the creation of a non-governmental national center for continuing professional competence which would serve as a resource and clearinghouse to assist with the conceptualization and implementation of continuing competency programs and to coordinate them with related activities in realms such as patient safety, medical error prevention, and scope of practice definition and reconciliation.

BACKGROUND

Rebecca Arnold LeBuhn, Executive Vice President of The Citizen Advocacy Center (CAC) explained that CAC began looking at health professional continuing competence in the early 1990's, believing that, from a consumer protection point of view, it does not make sense to assess a professional's competence only once in the course of a career. CAC published research in 1995 comparing how regulatory boards and private sector certification agencies were approaching continuing professional competence at that time. Regulatory agencies relied for the most part on mandatory continuing education requirements while many private certification agencies were experimenting with techniques for assessing continuing competence and some were requiring periodic re-certification. CAC concluded that both the public and private sectors have important roles to play in measuring and assuring continuing competence; the question is how to divide and share responsibilities.

The 1995 publication concluded with a list of public policy questions related to the comparative effectiveness of competency assessment tools and the legal and economic ramifications of requiring demonstrations of continuing competence. These questions became the agenda for a major national conference on continuing competence hosted by CAC in 1996. Two distinct schools of thought about continuing competence became apparent during the conference. One of these, the "continuous quality assurance model," calls for periodically assessing the competence

of every member of a profession. The other, the "triggers and markers model, " would single out certain individuals within a profession for competency assessment because complaints have been filed against them, or they are resuming practice after a long absence, or because of some other variable that indicates there might be weaknesses in their practice. The consensus of the participants at the 1996 conference was to strive for a continuing competence process that draws from both of these approaches. At that point, CAC passed the baton to the Inter-Professional Workgroup on Health Professions Regulation (IWHPR), a loose coalition of several health care professions, which convened a Continued Competency Summit in Chicago in 1997 to examine in detail the various techniques being employed at the time to assess continuing professional competence.

Several years having passed since these two national conferences, CAC believed it was time to convene this meeting to look at developments in the field: Are there new ideas? Are there more reliable ways of measuring continuing competence in either the regulatory sphere or the private sector? If so, what are they? If not, what are the obstacles to progress? What could the primary stakeholders do to help institutionalize continuing competence requirements at the regulatory and private levels?

CAC believes even more stakeholders need to be involved in establishing and sustaining a system for assuring continuing competence. In addition to the regulatory agencies, private certification agencies, professional associations, employers, educators, and others need to be brought into the picture. In addition, some of the tools used to measure continuing competence may have additional applicability as professions — or sub-groups within a profession — develop new skill sets or expand their scopes of practice. Hopefully this meeting will be the first step in preparing for another major national conference on continuing competence, one that includes the broadest possible group of stakeholders and that produces a consensus on strategies for overcoming the obstacles that have slowed progress in the past.

The Inter-Professional Workgroup's Involvement in Continuing Competence

Mark Lane, Vice President of Professional Standards and Examinations, Federation of State Physical Therapy Boards, spoke in behalf of the Inter-Professional Workgroup on Health Professions Regulation (IWHPR), an informal group of professional associations and regulatory bodies for those professions affected by licensure, certification, registration, or some other form of regulation. The group's mission is to "serve as a forum of health professional associations and certification and regulatory associations who meet to exchange information, identify issues of common concern, and, when desirable, seek to influence public policy related to health care regulation."

One of the group's first actions was to compose a public response to the Pew Health Professions Commission's recommendation that regulatory agencies do more to ensure the continuing competence of health care professionals. In response, Pew helped support the Chicago Summit on Continued Competence. Although there was a rich exchange of information, the Summit left many questions unanswered. The second Pew Health Professions Commission report placed an even greater emphasis on continuing competence and urged professions to collaborate in their efforts to make progress in this field.

IWHPR continues to share updates about the professions' continuing competence activities. It is apparent that the professions have not progressed far since the Chicago Summit. A major obstacle has been convincing professionals themselves of the need for a continued competence program. Regulators and consumers may see a need for it, but professions that have considered requiring demonstrations of continued competence have dropped their projects in the face of pressure from their membership. Members of a profession have to recognize the need for continuing competence programs before it will be possible to make changes in professional practice acts.

Finding the resources to implement a continuing competence program is also a problem, particularly for some of the smaller professions. Another obstacle is the absence of proven models. The portfolio model is popular, but there are questions about how reliably self-assessment measures and assures competence. In addition, there is a lack of agreement about what to measure. Are we talking about assuring professional competence at entry level, or does the definition of competence change as a professional gains experience or enters a specialized practice? Does continued competence involve more than just assuring that the practitioner is not harming the patient? Is there a quality and efficacy aspect, also? These and other questions the group struggled with in Chicago remain unresolved.

The IWHPR has identified four areas in which the professions might collaborate in hopes of moving forward toward common goals. These five areas are:

Definitions: Consumers would benefit if the professions can agree on definitions related to continued competence.

Assigning Responsibility for Assuring Competence: Assuming continued competence is the shared responsibility of regulators, certification agencies, professional associations, employers, and other entities, dividing and assigning roles is very complex task. A first step may be to identify and build upon effective techniques presently in use, rather than to place additional, duplicative requirements on professionals.

Research Agenda: Further research is needed, especially in connection with validating assessment tools and techniques.

Proposed Solutions: The IWHPR will continue to explore new or modified models for measuring and assuring competence and to be open to additional opportunities for collaboration.

Even with the best cooperation, there are things that the IWHPR cannot accomplish alone, but might achieve in cooperation with organizations like CAC. One of these is convincing professionals that it is desirable to measure and assure continuing competence. It is not enough to tell physical therapists, for example, that assuring continuing competence is a "good thing," but it would be persuasive to tell them that consumers of physical therapy demand and expect these assurances. In fact, many consumers would probably be surprised and disturbed to find out that professionals can renew their licenses without any demonstration of ongoing competence. The professions need to look beyond the IWHPR and include other stakeholders, including citizen groups, as they move forward.

Another national summit would be likely to generate a lot of interest around the country, especially if it involves more than just updating one another on existing programs and plans. The summit should focus on what needs to happen in order to move forward and to find answers to some of the remaining questions.

PANEL: WHAT'S NEW AMONG THE ALLIED HEALTH PROFESSIONS?

Gary Smith, Chair, National Commission for Certifying Agencies, Associate Executive Director of the National Board for Respiratory Care, Inc., and Executive Vice President of Applied Measurement Professionals, explained the continuing competence activities of these organizations. The National Organization for Competency Assurance (NOCA) was created during the Carter Administration (when it was called the National Commission for Health Certifying Agencies) primarily to accredit voluntary certification entities and slow down the proliferation of licensure. Now NOCA has about 260 member organizations and member testing agencies.

The National Commission for Certifying Agencies (NCCA) is part of NOCA. NCCA puts forth national accreditation standards and employs a peer review process for accrediting voluntary certification boards. Each board's entire certification process is reviewed, including governance, structure, resources, type of assessment mechanisms used, validity and reliability of the certification, responsibilities to the candidates for certification and to the public, and recertification standards. To date, NCCA has accredited 42 voluntary certification organizations.

The standards for accreditation were last revised in 1985. There has been considerable change in continuing competency activities since then, including the proliferation of on-the-job certifications and certifications to operate specific pieces of medical equipment. In response to these changes, NCCA initiated a standards revision process in 1997. To show the importance the member organizations attach to the validity and to the public's perception of certification, the standards revision process has been funded by donations from NOCA member organizations and NCCA accredited agencies.

The standards revision is being done by four task forces. The first looked at governance, purpose of the certification, resources devoted to it, and current standards. The second looked at current procedures in testing, measurement, and evaluation to be sure the certification would be reliable and valid and meaningful to the public. A third group is looking at the responsibilities to stakeholders, including discipline, information disclosure, confidentiality of records, and so forth. A fourth task force is looking at recertification.

The continuing competence standards NCCA has used in the past were very general. The new standards will require that a certifying entity have a policy for periodic recertification. The entity will have to demonstrate that the program measures or enhances the continued competence of the practitioner. There will be guidelines for developing and evaluating program rationale and effectiveness, and for defending the fairness of any process for measuring and assuring competence. NCCA is considering convening a colloquium some time next year to discuss the standards and guidelines and their implementation in order to get widespread public input.

The National Board for Respiratory Care (NBRC) is the national voluntary credentialing organization for respiratory therapists. It has been certifying respiratory therapists since 1960 and in the last few years has enjoyed a partnership with state regulatory agencies as respiratory therapy licensure has begun to proliferate around the country. The NBRC has conducted voluntary re-credentialing activities since 1975. (NBRC chose to use the term re-credentialing as opposed to continuing competence).

In 1984, respiratory therapy testing was converted into a hierarchical job analysis-based system in which every graduate of an accredited school takes an entry-level examination. Questions on the advanced examinations cover either additional tasks or tasks on a higher cognitive level than those tasks covered on the entry-level exam. The advanced practice test has a written portion and a branching logic clinical simulation examination consisting of ten patient management problems. The NBRC board voted to change its voluntary re-credentialing policy to include recognition (and a new certificate) of re-credentialing for those individuals who pass an advanced level examination for the credential that is being renewed. To encourage participation, the re-credentialing examinations are offered at very low fees — less than $100. Unfortunately, participation in the program has been disappointing.

Reacting to the new NCCA standards, the PEW Commission reports, and the work done by CAC, the NBRC appointed a commission in 1998 to revisit its re-credentialing program. The charge to the commission is to "investigate methods of assuring the continued competence of credentialed individuals, consistent with the accreditation standards of NCCA and to make recommendations for consideration by the board of trustees." The commission is comprised of representatives from NBRC, the American Association for Respiratory Care, the Committee on Accreditation for Respiratory Care, a state licensure agency, and a public member. The commission is expected to make its recommendations by the end of the year. Its current thinking is that if you don't tell an applicant for a credential that the credential will be good for only a certain limited period of time, you can't go back later and change the requirements. So, whatever the commission recommends, it is not likely to affect those who are currently credentialed.

Rumors about the commission's recommendations have spread within the profession and caused some apprehension and misunderstandings. Some have the erroneous impression that everyone in the profession will be re-tested and that the NBRC is adopting re-credentialing simply to generate revenue.

NBRC concluded that it needs to provide options. These are likely to include continuing education, for the time being, with requirements consistent with state license renewal regulations so that CE credits can be used for both purposes. The bottom line is that credentials issued after July 1, 2002 will be likely to bear a five year expiration date. That timing will give fair warning to students presently entering advanced study that the credentials they earn will be time-limited and that they will have to demonstrate their continuing competence in some fashion to be re-credentialed.

Therapists ask why NBRC is pursuing mandatory requirements. Some of the more obvious reasons are 1) to maintain NBRC's NCCA accreditation for credentials beyond the entry level; 2) to supplement most licensure laws which address minimum levels of proficiency. In the meantime, for those whose philosophy is that the best evidence of continuing competence is a

lack of evidence to the contrary, some of the new medical error reporting mechanisms will improve our knowledge of the actual performance of practitioners.

Roy Swift, Consultant to educational, certification, licensure and health care organizations, former Executive Director of the National Board for Certification in Occupational Therapy, and Member of the Board of Directors of the Council on Licensure, Enforcement, and Regulation (CLEAR) suggested that some of the difficulties flow from taking too narrow a view of continuing competence and from assuming that the licensure and certification bodies are responsible for doing the whole job. There are many other players who must come to the table and participate.

Defining continued competence requires looking at the workplace where competence exhibits itself. Credentialing organizations need to understand developments in health care systems that affect competence and change scopes of practice and assumptions about who should be doing what. Competence grows out of the workplace. We need to research those things in the workplace that facilitate competent practice and those that undermine it.

The National Commission on Continuing Competency in Occupational Therapy defines continued competence this way:

Continuing competence is the ongoing application and integration of knowledge, critical thinking, interpersonal and psychomotor skills to safely and effectively deliver occupational therapy (or other health care) services within the context of a practitioner's role and environment.

Rather than thinking of continued competence as increasing knowledge, skills or abilities, the definition refers to the ongoing application and integration of these attributes. The Commission asked employers to describe what qualifications they believe competent occupational therapists and therapy assistants must possess. The employers identified these qualities: critical thinking; technical skills to meet job responsibilities; achievement of patient outcomes; attitude and spirit to be a team player; initiative, flexibility, creativity and independence.

Looking at the subject from the other side of the coin, the Institute of Medicine's recent report, To Err is Human, focused attention on errors. Credentialing bodies such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) have a responsibility to look at those errors. For their part, consumers are showing a growing interest in knowing who is disciplining practitioners and for what kinds of actions or omissions. Some argue that the data in the National Practitioner Data Bank should be made public. Others question the usefulness of that data for consumer decision-making, while still others question its clarity or accuracy.

What is the current focus of continued competency programs? One focus is examinations to test a practitioner's knowledge and skills, such as the examinations just described for respiratory therapists. Physician assistants also have a continuing competency exam, one version of which can be taken at home. The portfolio approach to continuing competence involves a sampling of professional experience. We need better techniques for discerning whether the experiences sampled are relevant to competence.

A third approach is continuing professional education. There seem to be four primary reasons for challenging the effectiveness of continuing education as a means of assuring competence. First, there is a lack of needs assessment for participants in continuing education experiences. The faculty rarely knows who is in the audience and the participants in the audience rarely do a self-assessment. Lectures are geared to the average professional, without regard to the specific needs of the individuals in attendance.

Second, continuing education takes a pedagogical approach even though research shows that people retain only about 10% of what is presented in a lecture format. Third, the quality of learning is rarely assessed. Participants aren't tested or otherwise asked to demonstrate what they learned. Fourth, continuing education experiences are not applied to the workplace.

Yet, the workplace is a natural setting for adult learning. John Dewey's theory holds that informal adult learning occurs when the learning is self-directed and active and the subject is a problem that has immediate application to the job. Albert Bandura's social learning theory holds that "most human behavior is learned through modeling ... the capacity to learn by observation enables people to acquire large, integrated patterns of behavior without having to form them gradually by tedious trial and error."

According to another theory, organizations contribute to individual learning through the processes of intuition, interpretation, integration, and institutionalization of standards, routines and policies. Workplace informal learning research identifies several learning situations and tools that facilitate the acquisition of knowledge. These include conversation and dialogue; modeling and mentoring; personal relationships and interactions; self-esteem and self-confidence; novelty and change of equipment and concepts; problems and complications; policies and procedures; and supervision. Qualitative research in the workplace can help identify those factors that contribute not only to adult learning but also to continued professional competence.

Competence is first the responsible of the individual. Licensure bodies have a legal mandate to assure professional competence, but rarely have sufficient resources, so they tend to look to the national certification body in their profession. Professional associations and certification organizations that set national standards for the professions need to work with licensure agencies. At least one court of law has ruled that continuing competency assurance is desirable and would be a plus for the professions as well as consumers. Academic accreditation organizations need to stimulate changes in teaching methodologies to favor effective adult education techniques. Institutional accreditation organizations, such as JCAHO, need to promote continuing learning systems within the workplace. A national entity is needed to direct coordinated research into continued competence that includes all these stakeholders.

PANEL: WHAT'S NEW IN MEDICINE?

Stephen Miller, MD, Executive Vice President, American Board of Medical Specialties (ABMS) explained that the concept of voluntary specialty certification was first advanced in 1907 in a speech given by an ophthalmologist. It took another decade before there was a single specialty board. As of the year 2000, the 24 boards belonging to ABMS issue 37 primary certificates and

88 sub-specialty certificates. Of all the licensed physicians in the United States, approximately 89% are certified by an ABMS board.

The intent of certification is "to provide assurance to public that a physician certified by a medical board has the knowledge, skills, and experience required to provide quality patient care in that specialty." There is no mention of the "competence" in that mission statement. There has been resistance to the term in some medical circles because "competence" has been viewed by many as meaning the minimum acceptable standard, equivalent to being legally qualified. At some point, it became recognized that the initial certification process was not adequate, making it necessary to have "re-certification," which ABMS defines as "to assure continuing competence."

In March, 1998, ABMS commissioned a task force on "competence." The goal of the task force is not only to maintain, but also to improve the quality of care. All ABMS boards have committed to re-certification and 18 or 19 are already doing it by using an examination similar to the original certification examination. That is inadequate because it is not possible in a written examination to document competence in a clinical practice.

Why are we concerned with continuing competence? Because medicine is a profession in which it is moral to be competent, fit and capable of taking care of patients — and to maintain that competence. There is also a moral obligation to be current. Furthermore, there are tremendous external factors forcing the issue, including changes in technology and information. The public is more sophisticated about asking questions, garnering knowledge and knowing what to do with that knowledge. Professionals must acknowledge that, as individuals, they make mistakes, and that systems allow mistakes to occur.

Under the current system, undergraduate medical training takes 4 years; graduate training takes between 3 and 8 years, post-graduate learning occurs during a career of practice. The content of what is taught in medical school is selected by a faculty and overseen by an accrediting body, the Liaison Committee for Medical Education (LCME). The indicators that someone has successfully completed the education are graduation and passage of the USMLE. In graduate medical education, a faculty defines the content of the specialty being learned and the ACGME is the accrediting body. The indicators of successful completion are graduation from the program and eventually board certification by one of the ABMS member boards.

There is no standardized curriculum or content during the thirty- or forty year span of practice. Continuing medical education is available in a wide assortment of subjects. There is a group that oversees continuing medical education, the ACCME, but teaching is not based on documented evidence of how adults learn, nor is course selection necessarily targeted to an individual practitioner's needs. Re-certification may be an indicator of successful completion, but it may not be an adequate one.

One vision for the future involves accreditation of the content of post-graduate education in each specialty by a cooperative venture between the applicable specialty society, the specialty board and the CME accrediting agency. The indicators of having successfully and continuously maintained certification would be reliable documentation that physician specialists certified by ABMS member boards are indeed competent and maintain their competence.

The ABMS task force developed a list of six general competencies which specialists and residents-in-training will have to demonstrate (medical students will have to demonstrate similar competencies). The competencies are: 1) medical knowledge; 2) patient care; 3) practice-based learning; 4) interpersonal skills and communication; 5) professionalism; and 6) system-based practice. So, what should occur in medical education is a continuous process of learning and self-improvement from the first day of medical school until the day of retirement. ABMS is currently fleshing out what each of these general competencies means in each specialty. It will then develop reliable, valid and feasible tools to allow us to measure these competencies as a basis for maintenance of certification.

It took 25 years to persuade people to think in terms of re-certification and now ABMS Boards are talking about "continuous maintenance of certification." As with initial certification, the maintenance of certification program is voluntary. It applies only to those people who are granted time-limited certificates, which is an increasing number as the boards adopt this program.

To maintain a certification, individuals must provide the specialty board with documentary evidence of professional standing, such as the maintenance of an unlimited license to practice medicine and the ability to obtain a credential from a hospital or other health care organization. A specialty board will probably consider malpractice histories and felonies. It will look for a commitment to a program of life-long learning and self-assessment, hopefully one that is tailored to individual needs and that includes documentation of skill enhancement and behavior change rather than simply accumulated hours.

There will have to be evidence of cognitive expertise and that may be the old, re- certification examination. Even though a specialist may have narrowed his or her scope of practice, there is still a basic core of knowledge that must be demonstrated in addition to specialty-specific knowledge. To really assess the competence of a physician, we must find ways to evaluate performance in practice in addition to basic science learned in medical school. This is a daunting task.

There are other important issues. Assessing continuing competence is a very expensive proposition — in dollars and time required. There are significant legal issues, such as, what do we do with someone who has been in practice for decades and cannot pass the board examination? How do we deal with the fact that a physician may pass the board and then cause injury to a patient? Is that the board's responsibility?

The major constraints to measuring and improving the quality of medical care in the United States are primarily cultural and not technical. The health care professions have to demonstrate to others that they can do this and that there are tools to do it and, most importantly, they have to get buy-in from the professionals themselves.

Furthermore, stakeholders have to work together. ABMS boards will undoubtedly work more closely with state licensing agencies, but how to resolve the legal issues involved remains uncertain. The reason things are done to or for professionals by legislatures and others is usually that the profession itself has not done as well as it should have done to mind its own house. Each

health profession must recognize that it has a responsibility to ensure continuing professional competence — something the public thinks the professions have been doing all along.

George Barrett, MD President of the Federation of State Medical Boards and member of the North Carolina Medical Board was unable to attend due to a last-minute medical emergency. Dr. Barrett has been a pioneer in developing programs for early-identification and intervention with physicians whose practice has fallen below acceptable levels. That is what he would have talked about had he been able to attend. Instead, David Swankin, President, Citizen Advocacy Center, made brief remarks based on materials from Dr. Barrett and others affiliated with the Federation of State Medical Boards (FSMB).

In the introduction to their article in the Federation Bulletin (Vol. 86 No. 3, 2000) entitled, "The Post-Licensure Assessment System," David Johnson, Gerald F. Dillon, and Thomas Henzel observed that:

Clearly, medical examining boards have taken seriously their medico legal responsibility for protection of public health. But vigilantly guarding the front door alone (the issuance of a medical license) does not suffice in maintaining the ongoing responsibility for protecting public health. Former President of the Minnesota Board of Medical Practice, Dr. M. J. Martin, alluded to this "guard the front door" mentality when he said, "After the license is granted, most boards do not concern themselves with the ongoing competency." By not vigorously and proactively confronting the issue of clinical competency, medical boards reduce their options for addressing physician dyscompetence in anything but a disciplinary context.

Dr. James Winn, Executive Vice President of the FSMB, spoke at CAC's 1996 meeting on continuing competence. The proceedings from that meeting say that Dr. Winn: took the position that regulatory resources can be used most efficiently and effectively by concentrating competency assessment on practice environments where no one else is watching or in individual situations where there is reason to believe there may be problems with continuing competence. He did not speak directly to the relationship between licensure and private credentialing except to the extent that a change in specialty certification status is one of a number of potential markers or triggers that regulatory boards might use to isolate those licensees whose competence needs to be assessed and whose skills need to be expanded or refreshed.

There is a major division over whether regulators should require a demonstration of continuing competence from every licensee or only certain identifiable subgroups of the licensee population. The strongest argument advanced at the CAC meeting in support of targeting subgroups is the economic argument that no board can afford to assess the continuing competence of all licensees, even if by doing so it would solve all the problems of reliability and validity.

The FSMB continues to espouse an approach that would isolate those individuals who most need competency assessment and then make sure they demonstrate continuing competence. The most recent Federation Bulletin says that:

In May 1998 the Federation of State Medical Boards and the National Board of Medical Examiners activated a joint initiative called the Post-Licensure Assessment System (PLAS). PLAS provides diagnostic assessment and evaluation services for use in profiling physicians'

clinical performance and assessing physician competency to practice medicine. With the solid foundation and the joint resources of both the Federation and the National Board of Medical Examiners, PLAS combines the long tradition of the Federation's services on behalf of state medical boards of the United States and Canada with the Board of Medical Examiners' psychometric expertise in test development.

PLAS performs the first step in the competency assurance process — assessment. It is not self-assessment, but rather it is peer assessment. To do this, PLAS acquired the Colorado Personalized Education for Physicians Program (CPEP), a program that performs an assessment, lays out an educational or remedial program, assists in implementing that program, and monitors progress. The process begins with a two to three day assessment focusing on the physician participant's medical knowledge, clinical reasoning, communication skills, and patient care documentation. The next step is to determine education objectives and design a focused, personalized education program, based on the findings of the assessment. The program assists the participant in arranging the activities necessary to achieve the educational program and monitor progress. The program then does follow-up evaluation to document fulfillment of the educational objectives and to report the findings to the participant and a relevant organization, as appropriate.

The CPEP program accepts self-referrals as well as referrals by hospitals, other institutions, and licensing boards. In other words, it was conceived as far more than a program for licensing boards. It is a confidential program; it is not a peer review organization; it has no disciplinary authority. Reasons for participation include licensure action, peer review concerns, and self-referral at a time of change in specialty. Licensure boards use assessment and remediation services as part of an investigation, as an alternative to an investigation, and as part of a consent order.

Assessment is the key to meaningful continuing competency assurance. Even if in the short-run nothing more is accomplished than to improve continuing education by tying it to assessment, that alone would be a significant step forward. An example of a continuing education program that makes sense is the one for accountants. Every time the Congress changes the tax code, licensed accountants must earn at least some of their continuing education hours studying the new tax code. And they have to pass a test afterwards.

DISCUSSION

Comment — The PLAS program is fascinating, but the cost would be prohibitive for many professionals who don't have a comparable income. Do you think the price would decline with economies of scale? Also, looking at the airline analogy, pilots face the risk of going down with the plane, which gives them a powerful incentive to maintain their competence. There are also risks involved in what health care professionals do and perhaps thinking about these risks will help motivate professionals to accept the notion of mandatory continuing competence.

Swankin — To carry the analogy further, the Federal Aviation Administration program is imposed by law, but carried out by the pilots' employers. It's the airline that certifies its pilots, consistent with regulatory models.

Miller — The PLAS program is for people who have been identified by themselves or others as being in trouble. We need a filter mechanism that finds these people more efficiently and effectively. On a broad scale, every nurse, physical therapist, physician, or other health care professional who makes errors costs money and other limited resources. Once we answer the question, "How safe do we want medical care to be?" we will know what kind of resources we are willing to commit. I think PLAS is a marvelous program, but by itself, it can never address the problem of 750,000- 800,000 physicians, not to mention the health care team.

Comment — The costs are borne by the small percent of the physician population that is in trouble. For physicians that a medical board sends to the program, the $7,500 tuition is not considered to be burdensome because a career is at stake. You made the point during your talk that the obstacles standing in the way of continuing competence are more cultural than technical. Please expand on that a bit.

Miller — I was referring to the attitude that, "Once I have acquired my license, I've done it and I don't want to do it again." It is the profession which used to be unquestioningly revered whose skills are being questioned.

Swankin- I think the cultural hurdle affects every profession. Pilots know they will be re-tested. It is time to give students in the health care professions the expectation that they will be required to demonstrate their continuing competence in the future.

Comment- We tend to talk about competence in terms of individuals when positive outcomes do not always depend upon one individual but on a team that must communicate and cooperate in reaching a decision about the appropriate course of action. The health care system and the credentialing agencies bear a big part of the responsibility for competence.

Miller — Everyone has accepted that system-based practice is here to stay. But, culturally, it is questioned. When you say "system" to a physician, his or her first thought is "managed care system." One of the measuring tools that several ABMS boards are using very successfully consists of a peer review/patient review mechanism which includes a review by other health care professionals of the performance of the individual in question. This appears to be a relatively cost-effective way to obtain useful information.

Comment — What is the responsibility of the managed care plans?

Miller — I would hope that when they credential individuals they satisfy themselves that the individuals are competent. Their other responsibility is to develop controls and safeguards so that inadvertent systems errors and breakdowns in communication don't occur to the detriment of patient care. I don't think health plans are responsible for maintaining competence. I don't think they could do it, nor would I want to see them involved in that.

Comment — Physicians are credentialed and privileged in a hospital. The rest of the health professions, in general, are employees. There is an institutional responsibility to provide an environment for competent practice to occur. In our regulatory agency we are getting complaints related to a nurse's performance when the heart of the matter is a workplace issue because she has been expected to work long, consecutive shifts. No one can be competent under those

circumstances. The agencies responsible for regulating institutions need to be part of this dialogue if we want it to address systems issues.

PANEL: WHAT'S NEW IN PHARMACY?

Lucinda Maine, Senior Vice President, Professional and Public Affairs, American Pharmaceutical Association (APhA) explained that APhA has two roles in the area of pharmacy credentialing. The first is to co-sponsor post-licensure certification for pharmacy practitioners at the specialty level, the non-specialty or generalist level, and at the unlicensed, or pharmacy technician level. Second, APhA is committed to making sure that pharmacy credentialing programs are psychometrically sound and legally defensible so the public, the profession, employers, and regulators can be confident that they are valid and reliable.

APhA's House of Delegates recently adopted a new two-part policy statement. The first part says that, in cooperation with other state and national associations, APhA should develop a voluntary process for assessing pharmaceutical care competence. The second part states APhA's opposition to regulatory bodies utilizing continuing competence examinations as a requirement for the renewal of a pharmacist's license. There are clearly questions and tensions within the professions about the role of licensure boards in post-licensure credentialing.

Twenty-five years ago, APhA created the Board of Pharmaceutical Specialties which now offers five areas of specialty recognition: pharmacotherapy; psychiatric pharmacy practice; oncology pharmacy practice; nutrition therapy practice; and nuclear pharmacy practice. After 25 years, only 3,000 out of approximately 200,000 licensed practitioners have earned specialty certification through examination. So, in contrast to medicine and nursing and other disciplines, pharmacy remains largely a generalist practice where 90% of the practitioners have earned a single bachelor's degree. Soon, all pharmacy graduates will earn a 6 year doctor of pharmacy degree which is much more patient-focused and therapeutically- grounded than the traditional five-year degree which was generally very drug product and chemistry-oriented.

At the specialty level there are changes involving multi-disciplinary certification. APhA is working with the American Nurses Credentialing Center and the American Association of Diabetes Educators to launch a three-discipline advanced clinical specialist certification in diabetes patient management. The specialty examination will probably be available in early 2001.

At the non-specialist level, pharmacy has two models. The first is disease-specific recognition in partnership between APhA, NABP, the National Association of Chain Drug Stores and the National Community Pharmacists' Association. This is a unique situation in which two trade associations where most generalist pharmacists practice, the professional association, and the association representing state licensing boards joined together to offer disease-specific examinations. This partnership occurred in response to marketplace demand from HCFA and Mississippi's Medicaid program for pharmacists qualified to offer patient care management for diabetes, asthma, anti-coagulation therapy and lipid therapy in rural and largely under-served locations. The examination, though developed to meet the acute needs of Mississippi, is now available nationally. Almost 2,000 individuals have taken the test in about 2 years. (In contrast, 3,000 people have sought the specialist model of recognition in 25 years.) In another model, the

American Society of Consultant Pharmacists, which represents those people who provide care to nursing home residents and others in residential care facilities, offers an age-specific credential through the Certification Council for Geriatric Pharmacy (CCGP).

APHA is committed to quality assurance in credentialing, grounded in task-analysis. This commitment, along with changes in practice, in education, and in models for post-licensure recognition, led the profession to form the Council on Credentialing in Pharmacy. This policy body meets periodically to share information and grapple with questions such as the need for developing quality standards for pharmacy credentialing programs and, if they are developed, what relationship those standards might have to existing credentialing and certification programs.

Our primary responsibility now is education within the profession about post-licensure credentialing models. Confusion arises because continuing education providers market "certificate training courses" which become confused with credentialing and certification. Tens of thousands of pharmacists have come to these programs — usually between 15 and 30 contact hours of training — to learn things like immunization skills. These courses often have a hands-on skills component taught by public health nurses. Those skills are being incorporated in an increasing number of undergraduate pharmacy degree programs.

In Ontario a pharmacy-specific continuing competence process administered by the provincial regulatory authority consists of portfolio construction, and random written and skill- based assessment (at the College of Pharmacy's expense). The process is run by a consultant rather than agency staff. So far, no practitioner has lost his or her license. The pharmacists who have participated have found the experience informative and helpful in their professional development.

Pharmacy operates with an anti-credentialing bias. If you take all of the generalist and specialist credentials that have been awarded to pharmacists post-licensure, we would not exceed 6,000 out of the 200,000 or so licensed practitioners. Clearly pharmacists view their license as the document that allows them to practice and do not attach importance to an additional credential which is neither a ticket to privileging nor to payment. So, those who seek a credential do so out of some personal motivation.

There are clearly questions and concerns within pharmacy and other professions regarding the interplay between certification, voluntary recognition programs, competence assessment, and licensure. Pharmacists worry about things that could potentially jeopardize their licensed status. Having said all of that, pharmacy as a profession is increasingly willing to acknowledge the issues of medical safety and the role of well-trained, well-supervised and well- deployed specialists in making medication use as safe as it can possibly be.

Pharmacy is one of a few, if not the only profession where the same state agency licenses both the individual practitioner and the place of practice. Over 70,000 pharmacy technicians have earned the voluntary pharmacy technician certification in the 5 years it has been available. We think there are about 200,000 pharmacy technicians in practice. Everyone embraces the concept of a partnership between the pharmacist and the technician where increasingly the technician will be responsible for most of the management of routine drug distribution functions, or the processing of prescriptions, freeing the pharmacist's time for more monitoring of prescriptions,

dosage, patient counseling, and other professional tasks. In order to do that, we need more uniformity in pharmacy technician training, which is mostly on-the-job at present. Now that there is a national, validated certification, employers are increasingly requiring that their technicians be certified.

Carmen Catizone, Executive Director, National Association of Boards of Pharmacy (NABP) shared NABP's experience when it attempted to introduce continuing competence to the pharmacy profession. He emphasized that the overwhelming majority of pharmacists are conscientious, competent and dedicated to their patients. Licensing boards have to deal with that small percentage of pharmacists who are not competent, not dedicated to their patients, and who need to be removed from the system, or placed in some sort of remedial program to get them back in focus.

Two serious adverse reactions to medications were recently reported in the media. One involved the death of a child; the other a serious adverse event because of a medication error. When incidents like this occur, the media asks: What is the basic disciplinary process for a pharmacist? If a pharmacist makes a mistake and a patient is killed, is that pharmacist removed from practice, either temporarily or permanently? Licensing boards try to work very closely with the profession, but cannot forget that their primary responsibility is to the public. When patients are harmed, consumers expect the person responsible to be held accountable.

When NABP introduced the concept of continuing competence, it was trying to respond to the public concern about whether the pharmacists they interact with are competent. NABP was not criticizing the profession; it was recognizing that there has been a philosophical change in the way consumers approach health care practitioners. It used to be that professionals would say, "Trust me to be competent because I practice every day." Now, patients are saying, "Demonstrate to me that you are competent because my life and well being are in your hands."

In the late 1990's three things came into focus for NABP. First, a literature review revealed that as long ago as the 1970's the professions recognized a need for some sort of post- licensure continuing competence activity. Pharmacy's response was to establish continuing education, even though its relevance to continuing competence was already being questioned. Pharmacy had a strong accrediting body for continuing education courses and excellent standards. However, not all practitioners took continuing education seriously. There was no way to evaluate what percentage of pharmacists was participating in CE. NABP's second realization was that there is no demonstrated correlation between continuing education and continuing competence.

The third factor was that more and more pharmacy errors were coming to the attention of state boards. NABP isn't sure whether this was due to better reporting or to an increase in errors. Pharmacy boards do not have a baseline against which to compare the number of errors being reported today. Large corporations and attorneys argued against quantifying errors on the grounds that such documentation would only invite lawsuits, which would increase liability without solving the problem.

NABP concluded that something needed to be done. Bolstered by the Pew Health Professions Commission's recommendations that professions grapple with continuing competence, NABP

adopted a continuing competence assessment program. In 1995, it began to do psychometric work and approached testing companies to help develop a computer-adaptive examination.

At first the profession did not pay much attention to the program, but when it did, the profession attacked the NABP and its leaders. Canada has an assessment program that costs $1,200 per candidate. The cost to do this type of assessment in the United States would be closer to $2,000 per candidate. Providing individualized assessments for 200,000 pharmacists — or for the 10,000 or so who enter the profession each year — would not be feasible.

Given the cost and the opposition of the profession, NABP decided to do a general assessment of pharmacists' knowledge and practice in the hope that the profession would respond positively to a program in which practitioner assessments made it possible to select continuing education programs that are more structured, more balanced, and more appropriate for addressing an individual pharmacist's deficiencies.

NABP made several errors in bringing the proposal forward. NABP didn't do all its homework to find out how the profession felt about continuing competence and when we tried to adapt the program to the criticisms the professions was raising, NABP leadership was charged with saying inconsistent things. The state boards did not know how to react. Most of their members are, after all, members of the profession and they were facing significant pressure from their colleagues and professional associations who believed NABP wanted to re-examine everyone in order to collect the revenue. There was an intense struggle between the profession, NABP, and the boards over the best way to go.

In 1998, the State of Mississippi adopted its disease state management program in four major areas where 80% of their Medicaid costs were being incurred: asthma, diabetes, coagulation therapy, and hypoepidemia. Mississippi asked if NABP could do an examination for them because they wanted an objective, outside measure for evaluating whether pharmacists are qualified to deliver patient care in these areas. So, the NABP board decided to pull back the continuing competence proposal and give disease state management a try instead. The ultimate goal is to get pharmacists to take responsibility for their continuing competence. Whether it is accomplished through a continued competence assessment program or through disease state management, the net result is that pharmacists provide better, more competent care and are able to provide objective proof of their qualifications to patients, state agencies, reimbursers, insurers, and others.

A criticism from some in the profession is that one can't break down pharmacy practice into different specialties because it is generalist practice. But, when NABP considered a generalist examination for continued competence, critics said it would not work to take a generalist approach because practice is specialized. Now, critics say the disease state management approach is flawed because pharmacy is a generalist practice.

NABP has decided to pursue the course it thinks necessary, listening to the public and its members and working with the profession. We realize we will not get consensus from the profession and that some of our future proposals will be at least as controversial as those of the past. APHA and the other groups that have joined with us in disease state management are dong a tremendous job through immunization and other programs, but we are still not comfortable that

the majority of pharmacists are committed to assessing their own competence, documenting it, and presenting it to the public. So, the NABP Board is considering resurrecting the continuing competence assessment program and looking at how it interfaces with disease state management. We do not know if the profession will join us this time.

What has NABP accomplished? First, the profession has acknowledged that continuing competence needs to be addressed, although there is no consensus as to how to address it. Professional associations use rhetoric to impress the public and legislators, but in reality, the profession continues to oppose any continuing competence program that includes competency assessment.

Comment: How long do you think it will take before a state mandates that every practitioner must take an exam or otherwise demonstrate his or her continuing competence?

Maine — Like any other massive change in regulation, it will take some cataclysmic event. I don't think even the tragic errors reported in the media are enough. It does seem indefensible that boards have no tools to use when they are confronted with a suspicion of lack of competence. At APHA, we are pretty certain that there has been an increase in errors — due to the pace and volume of outpatient pharmacy practice. But, we are not convinced that the errors are necessarily due to an incompetent practitioner. In addition to continuing a dialogue about practitioner competence assessment, we need to think seriously about the adequacy of site practice inspection and regulation.

Catizone — In answer to the first question, I don't think the profession will ever allow a continuing competence examination. Since the release of the Institute of Medicine report, the professionals suggest peer review, profile maintenance, and other concepts that are difficult to implement and only delay the final decision. Studies in Australia and elsewhere have shown that professionals cannot be relied on to correct individual failures, and that peer review has not been effective. Some state boards may pass a continuing competence requirement despite the objections of the profession, but that would be a small nucleus.

To the other question, we don't know whether the current entry-level examination tests the right competencies. We would like to think it does, but practitioners tell us there are different skill sets for people who have been in practice for a few years. We can tell you that students graduating from pharmacy schools are bright and talented, but they have problems communicating information to their patients and interpreting that information so that it is meaningful.

Comment — How many licensing boards have recommended that practitioners take the disease-state management tests?

Catizone — So far, Mississippi is the only state. We have not promoted the exam as a continuing competence examination.

Maine — The Mississippi model is not for continued competence assessment, but for credentialing for specialty practice or to support an application for collaborative practice with a physician. Initially, the disease state management exams were paper and pencil. Now over 20

boards collaborate with the credentialing body to make these examinations available nationally on a computer platform.

Comment — Earlier, we heard that the medical specialty boards of ABMS are committed to requiring demonstrations of competence for recertification. They are also committed to the notion of everyone re-demonstrating core competencies as well as specialty skill sets. The physicians who demonstrate competence through ABMS are using a non-regulatory system. In the case of pharmacy, most practitioners are generalists and rely on their licenses as evidence of competence rather than seeking specialty certification. Let's assume we all buy into the notion that the public has a right to assume that having a license means a practitioner is competent. Doesn't it follow that in professions such as pharmacy where most practitioners are generalists, the licensing board has to require demonstrations of continuing competence? However, in professions where there is specialty certification and re-certification, the licensing authority can choose to recognize the private certification as evidence of competence.

Maine — I agree with your premise that there must be tools for professionals to gain and affirm their competence to practice in their chosen area. And, the tools have to be well enough constructed that the publicly accountable regulatory bodies can trust them and use them. The critical questions for debate have to do with what models are appropriate, who should develop them, and who should bear the cost. In Canada, funding was available through licensing fees and there was good dialogue between the regulators and the profession in developing their system. So, yes, there has to be a way to assess continuing competence, but I hope we can find a model that is not wholly driven and housed within the regulatory system.

Comment — Does the disease state management testing program provide for continuing competence assessment?

Catizone — The plan is to evolve the disease state management testing into a computerized patient simulation or some other program that includes not only the assessment of didactic knowledge but also the application of knowledge and skills in clinical performance. The pass rate on the initial licensure exam is about 95%, but the pass rate for disease state management exams is closer to 50-60%, which tells us that it measures different knowledge and skills.

Comment — Are you planning to use a CAT exam for re-licensure?

Catizone — NABP is considering offering an assessment via a CAT technique and then looking to the profession to develop other assessments and programs for pharmacists to correct their deficiencies. NABP intends to talk with the professions before hand this time around, but if we run into resistance, we will be back where we were a few years ago. We have to start somewhere and unless there is a better model, we'll start with the CAT exam.

PANEL: WHAT'S NEW IN NURSING?

Carol McGuire, Assistant Executive Director, Kentucky Board of Nursing recalled that when the great accountability/responsibility debates surfaced in nursing in the 1950's and 1960's, nursing's response was mandatory continuing education (MCE). The Kentucky nursing board has required mandatory continuing education for re-licensure since 1980. The quintessential question

remains, "How do you know someone is competent for continuing licensure even if they have met continuing education requirements?"

Most of the studies find no correlation between continuing education and nursing practice changes. There were too many intervening variables, especially in the practice environment, over which the practitioner had no control. In the search for new models, Kentucky is moving away from a minimum expectation model to a quality assurance paradigm for licensing individuals.

Kentucky's 1978 mandatory continuing education law required that all nurses be responsible and accountable for making decisions and taking actions based upon their educational preparation and experience in nursing. There is a mandatory reporting requirement under which anyone who is aware of incompetent practice is required to report it, whether a consumer, another professional, or the employer. Using those two pieces of statutory language together with the National Council of State Boards of Nursing's 1996 "Assuring Competency and Regulatory Responsibility," which provides a definition and standards of nursing competence, the Kentucky nursing board developed a position paper called "The Accountability and Responsibility of Licensees to Assure Nursing Competence."

This document was the product of internal board work, so during the public comment period nurses reacted as if the board were making a direct attack on their ability to perform competently. The board tried to explain that its purpose was to ensure that already competent nurses remained so, and that those who needed remedial interventions got them. Still, the nurses didn't trust the board. The board did succeed in introducing legislation in 1998 that would have changed all the references in the laws to "mandatory continuing education" to "competency validation." That would have shifted the whole focus of what the board could do about competence requirements.

The 1998 legislative package was not explicit about the impact on an individual nurse. The legislator who agreed to introduce the measure received so much heat from the nursing constituency that, when it became obvious that it would not pass, she withdrew the legislation. The board decided its error had been not to include the nursing constituency in the development of the concepts. So, in 1999, the board empanelled a competency task force, which included the consumer board members. The board views competence as two-pronged: initial competence to enter and continuing competence to remain in practice. One cannot look at one without looking at the other. Still, the board decided that continued competence was the easiest piece for the task force to tackle. It held four all-day meetings in search of a consensus about what continuing competency maintenance should look like.

Among the task force ground rules was an agreement that the actual discussions of the task force were confidential. At the end of each meeting, a press release was prepared to summarize what the group had agreed upon. It was disseminated widely and worked well to assuage distrust.

One of the task force's resources was the findings of a poll in which nurses identified what they thought members of the profession would need to know in 2005. The most frequent response was "critical thinking," defined as: "sound judgment and wise action in complex, unique and uncertain situations." The respondents also indicated that nurses in 2005 would need direct care

and management skills for both acute and chronically ill care, an ability to adjust when things do not go as planned, an ability to collaborate with other providers of health services, and also an ability to work independently without readily available support. The survey results indicated that nurses also will need skills for managing other licensed personnel, skills for managing resources within the care setting, and computer literacy. When considering competency validation mechanisms, the task force took into account what the nursing population said they think they will need to know in 2005.

The nursing board had envisioned implementing the 1998 legislation through a competency portfolio, but found that nurses reacted very negatively to the concept. The roots of this negativism turned out to be the difficult and time-consuming academic portfolio that many nurses had to complete to move from a diploma level to an academic model. In contrast, the board saw the continued competency portfolio as a way in which the individual could assemble his or her biography to show how good they are — a mechanism for career verification. We foresaw that a nurse could choose from among skills assessment inventories or skills assessment tools, such as re-testing or specialty certification.

The board felt there needed to be some kind of cognitive appraisal of knowledge base, through, for example, a peer review mechanism. The way to find out how a nurse is functioning is to talk to the nurse that comes onto the following shift. The board also saw formal academic training as a choice, or continuing education directly related to that person's area of practice. And, it saw a partnership between the regulatory body and the nurses' employers so that the Board could get feedback on how the individual functions in the workplace.

When the task force considered nurses' reactions to the recommendations, the first thing to go was the portfolio model. Also, nurses objected to eliminating mandatory continuing education, so it was retained. The task force's compromise was to allow nurses to choose among several options for competency validation. These are:

- 30 hours of approved CE;
- current certification from a national certifying body in the current area of practice; or
- 15 hours of CE and one of the following:
- completion of a research project as principal investigator, co-investigator or project director;
- publication of a nursing related article in a refereed professional journal;
- a professional nursing presentation; or
- an employer evaluation that is satisfactory for continued employment.

Because this time we had involved nursing groups in the development of the concept, and because we gave them a menu of choices, it was easy to get competency validation through the 2000 legislature. Another technique to inform and reassure the nursing population was to draft the administrative regulation that would implement the statute and include it with every piece of the proposed statutory language that was circulated to the nursing constituency. Knowing exactly how the statute would work in practice took the anxiety away.

The statute contains the following definition of competence: "The application of knowledge and skills and the utilization of critical thinking, effective communication, interventions and caring

behaviors consistent with the nurse's practice role within the context of the public's health, welfare and safety." This definition provides the basis for determining what to test and how to evaluate competence.

One day there will be a nationwide virtual reality testing program for assessing and measuring clinical competencies that cannot be measured in paper and pencil tests. Such a program would probably begin with practitioners identified by a triggers and markers methodology but would ultimately include entire professions. This may be far in the future, but in Kentucky, the Board of Nursing is a catalyst stimulating changes in thinking about initial and continuing competence.

Mary Smolenski, Director, Certification Service, American Nurses Credentialing Center (ANCC)

Incorporated in 1991 independently of the American Nurses Association, ANCC certifies more than 30 specialty areas and accredits continuing education. It also recognizes hospital nursing services through the Magnet Recognition Program, and it recently created an Institute for Research, Education and Consultation to support ANCC's other functions.

ANCC offers several options for recertification. One is a practice component, usually 1500 hours over a five year period. Continuing education options include contact hours (50% of which must be in the individual's specialty area), academic credit, presentations and lectures, research and publications, and precentorship with students at the same level as the individual's certification. ANCC offers a test option, but only about 3% of certificants choose to take a test to recertify.

Although continuing education continues to be a major prerequisite for recertification, there is still no valid research to show that continuing education correlates to competence. Nor is there evidence to support other methods for maintaining or assessing competence. So, ANCC commenced research in 1996-7 on competency assessment for recertification.

One of the few fields where there is mandatory recertification is advanced practice nursing. At least 46 states require nurse practitioners to be certified in order to earn and maintain a license to practice. So, ANCC designed its research to explore techniques to more accurately measure the competencies of nurse practitioner at five year intervals.

The research methodology employs computer simulated case studies to measure skills such as critical thinking, decision making, and the ability to decide how to handle a case within a certain time frame. The candidate reads a scenario on interactive video or CD and answers questions. Depending on the answers given, the scenario branches out and leads the candidate in certain directions, making it possible to more accurately test the candidate's ability to make decisions related to the case situations.

We plan to evaluate other recertification approaches, including the portfolio method which is popular at present. The top ten outcome competencies found in ANCC's role delineation studies for adult and family nurse practitioners will be related to items in the portfolio. Candidates will be asked to address them, perhaps in the context of a case scenario.

About 25 different stakeholders from the United States and Canada helped with the study design. The group agreed on definitions and a competency model, and evaluated the pros and cons of various methodologies and evaluation strategies. The methodology will be refined and the competencies will be linked to test questions, portfolio components, and the case studies that will be used to test competencies.

In 1999, ANA identified five core issues on which to concentrate its resources. One of these is continuing competence. An expert panel was assembled from among representatives of state nursing associations, the ANA Board of Directors, the American Nurses' Foundation, the Academy, the National Council of State Boards of Nursing, and the Nursing Organization Liaison Forum. Their charge is to develop policy recommendations and a national plan that professions can use to guide their approaches to continued competence.

ANA subscribes to the idea that the profession needs to take an active role in defining continued competence and how nursing should view it. ANA supports a continued professional nursing competency process built on a portfolio that allows a nurse to document ongoing activities that demonstrate continued competence. The portfolio consists of five areas:

- 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.

Nurses are encouraged to re-visit the portfolio yearly or whenever there is a change in practice roles. The portfolio project will be tested on a pilot basis with three types of individuals: the ANCC research group; volunteer RNs who will get contact hours for participation; and nurses who have been the subject of disciplinary action by state boards of nursing but who are using the portfolio mechanism to identify remediation to correct for the identified deficiencies. It is evident from the pilot phase that there is already good collaboration between ANA, ANCC, the National Council and individual state boards of nursing.

ANCC is also cooperating in the development of an interdisciplinary exam that will test for specialized as well as core knowledge, skills and abilities in the overlapping fields of nursing, pharmacy and dietetics. ANCC is working toward a process by which advanced practice nurses can satisfy some of their contact hour requirements by taking continuing medical education courses.

Another project under development is modular certification, sometimes called a "certificate of added qualification," based on the concept that learning is lifelong. Nurses need to keep up with new developments without having to obtain a total recertification. So, they can add additional modules to their basic certification. The two that are currently available are case management and ambulatory care.

ANCC is often asked how nurses can learn whether a course is a good one — whether it is approved by some accrediting organization. So, a task force is exploring standardized ways of

looking at skill sets to help evaluate courses in, for example, case management or IV therapy. This approach would facilitate more nurse mobility in hospitals. It would enable nurse executives to know when someone is competent in a particular area.

ANCC is also engaged in certification research. Our scholar in residence is studying the impact of certification on patient outcomes, on the nurse, and on the facility or employer. The first phase of this research was a survey asking nurses to identify what they think certification does for them. Some of the responses were: "Certification makes me feel more confident in my practice." "I feel as if I identify problems earlier." "I feel as if I initiate actions to solve those problems earlier than my cohorts do." Some of the research findings are on the ANA Nursing World Web site. Also, the honorary society of nursing, Sigma Theta Tau, will offer a web site with interactive case studies nurses can visit to update their knowledge. Peers evaluate the case studies to determine whether the options are correct from the practice perspective and there is a chat room where nurses can converse with those experts.

GROUP DISCUSSION: IDENTIFYING AND OVERCOMING BARRIERS TO CONTINUING COMPETENCY INITIATIVES

For the remainder of the meeting, David Swankin, President of the Citizen Advocacy Center and Vickie Sheets, Director of Policy and Credentialing for the National Council of State Boards of Nursing led the group in a discussion of strategies for overcoming the numerous and complex barriers encountered by professions and regulators that have attempted to institute continuing competency assessment and assurance programs.

Third National Summit is Proposed

The context for the discussion was the group's virtually unanimous consensus that the best way to accelerate progress would be to ask CAC and IWHPR to convene a third national summit — even more broadly based than the meetings previously held by the two organizations. It was agreed that the goal of this summit should be to identify action strategies and to elicit commitments from participants to take steps to overcome the inertia that has halted the introduction or expansion of continuing competency programs, despite growing sentiment that such programs would be desirable and worthwhile.

The prospect of convening an action-oriented continuing competency summit influenced the discussion of barriers and of strategies for overcoming them. Indeed, the summit was viewed as the vital first step in a search for solutions, important both for drawing widespread attention to the significance of competency assurance and for mobilizing the stakeholders to action.

The group felt strongly that an action-oriented summit should not retrace territory previously covered. Instead, the group agreed that the summit organizers should compile and distribute in advance of the meeting background information on the status of continuing competency initiatives in both the public and private sectors and on research in the field. The information package will enable summit attendees to start from the same knowledge base without having to devote valuable meeting time to yet another round of organizational updates.

The barriers to be addressed at a national summit fall into several general categories: legal, cultural, methodological, political, and financial. The group recognized that some barriers will take longer to overcome than others. But, even though a barrier may be entrenched, this was not felt to be a reason to postpone corrective action; rather, it simply may mean that a solution will take a long time to achieve. In the meantime, proponents of continuing competency assurance should tackle those problems that promise to be overcome in the shorter term to get the ball rolling.

The group identified the following barriers to be overcome:

Core Barriers:

- need for agreement on common terms and definitions;
- need for research and information to validate methodologies and approaches, including what to measure and how to relate competence assessment to patient outcomes;
- need for collaboration and cooperation among agencies, and between public and private sectors, to decide whom to target and how, to deal with turf issues, to educate stakeholders, and to coordinate patient safety activities related to continuing professional competence.

Administrative Feasibility Barriers

- need for resources and tools to be able to offer competency assessment, remedial education, mini-residencies, qualified preceptors, and more.

Public Credibility Barriers

- lack of public demand for health professions to demonstrate continuing competence and lack of understanding of the mechanisms by which continuing competence can be achieved resulting in a lack of public pressure on legislators, policy-makers, and the professions;
- perception that offering multiple pathways invites professionals to take the path of least resistance.

Professional Acceptance Barriers

- fear and resistance on the part of the professions, arising in part from expectations inculcated early in the educational process that competence will be assessed only once, at the time of initial licensure;
- territoriality within professions and boards.

Legal Barriers

- need to balance public protection vs. a licensed professional's property right and to answer questions about such issues as due process and fairness, legal liability, confidentiality, and open records laws as a disincentive to honest professional self-evaluation.

Economic Feasibility Barriers

- need to understand the costs and benefits of continuing competency assessment and assurance, and to agree on who is responsible for paying the costs.

STRATEGIES FOR OVERCOMING BARRIERS

The group discussion produced the following outline of promising strategies for overcoming the identified barriers. This is a list from which the summit planners can draw when constructing the background book and meeting agenda. Some stakeholder groups may find ideas they want to incorporate into their own strategic planning.

BARRIERS: All

STRATEGY: Convene a Multi-Disciplinary National Summit on Continuing Competence in 2002 to stimulate public dialogue about continuing competence and take advantage of attention and energy currently being devoted to error prevention and patient safety.

Actions:

- Seek broad co-sponsorship of the summit from the regulatory and accrediting organizations that customarily participate in such conferences and from other stakeholders, including employers, continuing education providers, academicians, consumer organizations, third-party payers, health systems, institutional accrediting organizations, and so on;
- Write to each stakeholder group and ask them to designate a representative to serve on an informal planning group;
- Conduct a comprehensive, systematic review of what various professions and regulatory agencies have done and are doing; seek funding from governmental or private sources to support a literature search and stakeholder survey;
- Prepare a document that characterizes the present attitudes and state of the art *vis a vis* continuing professional competence;
- Offer this discussion of barriers and promising strategies as straw action plan for the 2002 summit;
- Frame questions that need to be addressed in charting a course for the future;
- Propose alternative continuing competence models and let the states and the professions choose which ones they want to experiment with;
- Consider assigning different interventions different weights; e.g., earning an advanced degree by itself demonstrates continuing competence while earning continuing education credits is a partial demonstration which must be supplemented by something else.

BARRIER: Need for Common Definitions and Terminology

STRATEGY: Expand the IWHPR's ongoing definitions project to involve CAC and other stakeholders.

Actions:

- Identify the terms that need to be defined and collect definitions currently in use;
- Draft additional definitions (remembering it is important to use language that the public will understand), circulate them for comment, and seek agreement on the use and definitions of terms;
- Involve educators, institutional accreditors, Medicare, Medicaid, and other stakeholders in the process;
- A short list of examples of the terms that need to be defined includes:
    - competence — initial and continuing
    - core knowledge v. specialty
    - licensing
    - credentialing — (differentiated from licensing)
    - re-credentialing
    - credential maintenance
    - privileges
    - minimum competence
    - professional development
    - continuing education (continuing professional education)
    - self-assessment
    - portfolio
    - professional profile

BARRIER: Need for Agreement on What to Measure and How

STRATEGY: Develop a research agenda and set priorities.

Actions:

- Conduct a literature search to determine what research on continuing competence has been done (in health and other fields);
- Consider convening a meeting of researchers and stakeholders for the purpose of creating a research agenda prior to the action summit;
- Approach AHRQ to seek funds to support research agenda development and research;
- Present that research agenda to all the stakeholders at the 2002 summit.
- Research Questions include:
    - What is competence?
    - What is the correlation between competence, performance and patient outcomes?
    - What are valid measures of competence?
    - What competency models and competency assessment models exist?
    - How does the workplace contribute to competence (positively and negatively)?
    - What is the relationship regulatory discipline and incompetence?
    - What is the relationship between competence and hospital and other health system privileging and credentials?
    - Does remedial education result in improved competence?
    - What technologies most efficiently enhance competence?
    - How do practitioners feel about continuing competence?

- How do consumers feel about continuing competence?
- How can practitioners be convinced that continuing competence is of value to them?
- How do professionals feel about their level of competence and the perception of their peers?
- How do professionals perceive the various kinds of continuing competence activities?
- What do professionals give as the reason for taking a particular continuing competence activity?
- How does education affect competence as opposed to workplace training?
- What other variables affect the impact of education on competence (e.g., workplace obstacles; attitudinal obstacles)?
- What is the difference between incompetence, mistakes, and wrongdoing?
- Are root cause analysis methods relevant to competency assessment?
- What is the relationship between ethics, motivation and competence, using the example of a surgeon who knows he should scrub up but just doesn't do it?

BARRIER: Need for collaboration and cooperation among responsible parties and stakeholders

STRATEGY: Facilitate information sharing and cooperation among the stakeholder groups listed below, and any others that should be in the loop.

Actions:

- Invite the following stakeholder groups in the national summit and other related activities
  - accreditors of institutions
  - accreditors of individuals
  - accreditors of systems
  - accreditors of academic institutions
  - accreditors of continuing education providers
  - professional associations
  - private certification agencies
  - licensing boards and their associations
  - legislators
  - practitioners and their associations
  - consumers and consumer organizations
  - state health departments
  - educators
  - continuing education providers
  - third party payers
  - employers — e.g., hospitals, health plans
  - federal agencies, including HCFA, HRSA ,and AHRQ
  - media
  - NGA and NCSL
  - liability insurers and risk managers
  - health care human resource mangers

- Develop specific suggestions for information exchange and cooperation to give shape to this otherwise vague, but popular concept. Examples include:
    - practitioner-specific and profession-specific information exchange among accrediting agencies, employers, and educators;
    - feedback to regulatory boards from employers about the performance of practitioners who have been disciplined;
    - feedback to schools and continuing education providers from regulatory boards and employers about the clinical performance of graduates.

BARRIER: Administrative Feasibility

STRATEGY: Analyze and compare the feasibility of various approaches; e.g., triggers and markers vs. profession-wide continuing competence requirements.

Actions:

- Survey licensing boards concerning what they would need (over and above funds) to implement one or another model; e.g. what staff resources? what technology upgrades? and so on;
- Conduct research to determine whether different approaches are appropriate for different professions, for different individuals, for different competency assessment methodologies, e.g. demonstrating competence on a piece of equipment vs. demonstrating competent interactions with patients.

BARRIER: Need for Professional Acceptance and Public Credibility

STRATEGIES: Modify professional expectations and educate the public and legislators.

Actions:

- Change the expectations of students in health professional schools regarding requirements for demonstrating continuing competence for license renewal and re-certification.
- Conceptualize continuing competence modules; e.g.: the module for portfolios, the module for triggers and markers, the module for directed continuing education, and so on. (This approach would make it possible to address costs, administrative feasibility, legal issues, etc. for various modules, rather than across the board. It would also make it easier to research and analyze various methodologies, leaving the debate over the best package until we have more experience with the variables on which to base sound decisions.)
- Examples of strategies for generating professional demand for demonstrating continuing competence are to:
    - include the professions in the research and development of continuing competence models and in planning and execution of the 2002 summit;
    - include recredentialing information in practitioner profiles;
    - develop assessment tools leading to reflective practice;
    - generate data to show the value-added for demonstrating continued competence.

- Examples of strategies for generating public awareness and demand are to:
- sponsor a "Smokey the Bear" type public awareness campaign;
- interest reporters in the subject and invite them to the summit; include a media panel on the agenda;
- press for practitioner profiles for all professions, including recertification information;
- educate consumers about questions to ask to ascertain their health care providers' continuing competence status.

BARRIER: Need for Legal Defensibility

STRATEGIES: Help licensing boards find answers to questions such as: What happens when a professional demonstrates a competence deficiency? Does a self-assessment put the professional in potential trouble with the licensure system? Can we separate ongoing competence from discipline, just as we separate initial competence from discipline? Help develop model legislation requiring continuing competency assessment and assurance.

Actions:

- Encourage licensing boards and credentialing agencies to initiate and participate in the legislative process and influence the form of the statutes requiring continuing competency assessment and verification;
- Monitor demonstration projects to provide information on medical error prevention and adverse event and adverse action reporting, particularly the confidentiality protections that are associated with these projects;
- Move beyond the IOM report's analysis of the need for legal protections surrounding reporting of errors and look at legal protections that would remove fears about the misuse of continuing competence requirements;
- Research and draft concepts for offering legitimate legal protection;
- Differentiate those cases where a practitioner is competent, but does not perform appropriately — e.g., scrubbing up, or keeping proper patient records — from cases where the practitioner has practice skill or knowledge deficiencies that are susceptible to remediation.

BARRIER: Cost of Competency Assurance Programs

STRATEGY:

Forecast comparative costs of alternative routes to competency assurance per practitioner and per regulatory board (there is already some basis for this in pilot tests of portfolios, computer simulated testing, etc.) Factor in the cost to the practitioner for failure to demonstrate continued competence and subsequent loss of job or patient base. If professionals' expectations were different, they may not resist the cost. For example, it is widely accepted by professionals that they are responsible for paying for the initial licensure test and for CE. From regulatory agency point of view, change legislators' attitudes and get appropriations for continuing competency assurance.

Actions:

- Develop cost / benefit projections;
- Discuss alternatives, such as requiring problem practitioners to pay the costs of the program, or 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 competence 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 this 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 case loads.

CONCLUSION

The Citizen Advocacy Center and the International Workgroup on Health Professions Regulation were encouraged to move forward toward convening the broadly co-sponsored action summit to flesh out these and other promising strategies in support of continuing competency assurance. Initial steps will include soliciting support from the broadest possible group of stakeholders and then arranging for research and drafting to prepare comprehensive background materials. All of the participants at the June 2000 CAC conference were urged to put the subject of continuing competence on the agendas of theirs and related organizations' meetings and conferences to generate interest and support for the 2002 summit and enlist assistance in completing the ground work. CAC and IWHPR were also encouraged to explore options for the creation of a non-governmental national center for continuing professional competence which would serve as a resource and clearinghouse to assist with the conceptualization and implementation of continuing competency programs and to coordinate them with related activities in realms such as patient safety, medical error prevention, and scope of practice definition and reconciliation.