

# **Continuing Professional Development**

## **Step One: Meaningful Assessment**

### **Proceedings from a Citizen Advocacy Center Conference**

**June 22, 2011**

*Note: These proceedings are not a verbatim transcript, but they are faithful to the speakers' presentations and the subsequent questions and comments. For the complete content of the conference, you can find the speakers' PowerPoint presentations at <http://www.cacenter.org/files/powerpoint/ContinuingCompetence2011/index.html>.*

#### **Introduction**

The Citizen Advocacy Center (CAC) convened this conference in light of the growing consensus that any meaningful continuing professional development scheme must begin with an assessment of the knowledge and skills an individual needs to reinforce to maintain his or her current competence.

CAC's *Roadmap to Continuing Competence* recommends routine periodic assessment. It reads in part:

Periodic assessment is the key to tailoring lifelong learning programs to the needs of individual healthcare professionals and to demonstrating continuing competence over the course of one's career. Assessment pinpoints the knowledge gaps that can be filled by continuing education or other professional development mechanisms. Assessment also is used to determine whether a practitioner competently applies his or her knowledge and skills in clinical situations....

There are two key questions that have to be answered about assessment: who should be assessed and who should do the assessing.... The question of who should do the assessing is more difficult to answer. Self-assessment is the option many voluntary credentialing organizations and some regulatory agencies have written into their emerging competency or professional development programs. This approach is likely to be more acceptable to many professionals than third-party assessment. It appears to be, therefore, a comparatively painless way to introduce periodic assessment into the routines of professional careers.

But, critics of self-assessment point out that it does not provide the same degree of public accountability afforded by third-party assessment. They also wonder about relying on a professional's judgments about their own strengths and weaknesses.

Third-party assessment is by definition more objective and more accountable. It is also more expensive than self-assessment and potentially more disruptive to practice. Moreover, there are not a sufficient number of third-party assessment programs available right now to perform the task. So, hybrid approaches have potential appeal, such as methodologies combining self-assessment or professional portfolios with independent evaluation and consultation at the workplace and random review by certification and regulatory agencies.

CAC's Roadmap foresees that self-assessment is likely to predominate in nascent programs, but the goal is to move to independent third-party assessment over a period of time. Self-assessment tools need to be developed by third parties according to publicly developed standards. The pilot projects called for in the roadmap offer an opportunity to evaluate and compare various assessment methodologies: self-assessment, third-party assessment and a hybrid combination of the two.

Regardless of the chosen methodology, profession-wide periodic assessment must be mandated and performance assessment should have a high degree of correlation with real situations in practice settings. Advancements in information technology offer the possibility of evaluating electronic medical records and practitioner-specific practice profiles against practice guidelines and peer performance in order to assess individual clinical competence and, significantly, to determine the impact over time of continuing competency assurance on patient outcomes.

## **Is Self-Assessment Reliable? What Does the Literature Conclude? Research Conducted by the Association of State and Provincial Psychology Boards**

### **Robert Brown, Chair, Maryland State Board of Examiners of Psychologists**

There are many ways to think about competence. It is clear that professionals have to retain what they learn in graduate training and to acquire new skills during their careers appropriate to their current practice. They must learn new knowledge based on research findings and new practice methods, new theories, new assessment tools and treatment approaches and new technologies.

Looking back, graduate school was reassuring in lots of ways. While academicians do try to teach clinical skills and judgment, by and large, students are taught what they need to know in a series of core courses prescribed by the faculty. Students are lectured to, coached, tested, observed, and given feedback.

After students graduate, many practice in isolation or behind closed doors. Some are supervised, particularly early in practice, but that supervision is typically cursory and not

hands-on. Professionals take courses in subjects they feel they need to know, rather than subjects selected by others based on what each professional needs to know.

Consumers expect that healthcare providers are competent throughout their professional careers and most are surprised when they learn that regulatory bodies are not acting to ensure continuing competence. Professional societies assume that professionals can determine what kind of skills, knowledge, techniques, approaches, and theories they should be familiar with, and that they can select from the options available to acquire new learning, to stay updated, or to acquire new skills. The assumption that individuals engage in reflection and can accurately self-assess has been the cornerstone of adult education and continuing professional education.

Continuing education is one of several approaches to continuing professional development. One of the things that the psychology boards are trying to do is to broaden the definition, so that in addition to mandatory seminars, credit can be given for peer contacts, portfolios, publications, etc.

What are some of the challenges associated with continuing competence? One is the definition. What competencies are the relevant for individual practitioners? For most professions, declarative knowledge is what the licensing exam assesses. By and large, exams don't get at the delivery of services. They don't get at judgment and the ability to discriminate one situation from another. They don't get at applying knowledge to a set of facts, nor do they assess attitude.

How can we measure competence in ways that are true to consumer expectations, are acceptable to professionals, and are economically and practically feasible? Self-assessment is one of the reasonably economical ways to do this.

Other methods include objective tests and observation by experts. HIPPA regulations make it difficult to observe live patients, but simulations are an alternative. Practice audits, professional profiles are other methods. Patient outcomes are complicated because they are affected by the skill of the practitioner and many other variables, such as the type of illness involved, the resources available to the patient, and institutional constraints.

What can we do about maintaining and enhancing the competence of professionals, knowing that outcomes are not always going to be the most reliable measure of competence?

How accurately can people self-assess their own professional development needs? By this, I mean self-assessment in terms of what is my practice like. What do I do? What kind of skills do my colleagues and peers have? What demands are there on my professional time? What kind of treatment is indicated in particular cases? What is my patient population? It is difficult to mandate something that applies to everybody because professionals specialize in different areas.

Even if a professional can decide accurately what they need, how do they know that a particular educational experience is going to meet that need? How accurately do professionals evaluate what they have learned? There has been a movement to use test questions to determine what people have learned.

The research suggests that people aren't very good at assessing our needs, determining whether the experience meets the needs, and evaluating how much we have learned from the experience. In other words, self-assessment is not useless, but it is not very promising.

What about the accuracy of self-assessment? Poor Richard's Almanac said, "There are three things extremely hard: steel, diamonds, and to know one's self." Charles Darwin said, "Ignorance more frequently begets confidence than does knowledge."

Both of these statements impart some wisdom, and while they do not rule out the potential usefulness of self-assessment, they do temper any excitement that self-assessment is going to be the answer.

Some of the more prominent findings in the literature include these. Learners are not necessarily accurate in assessing their own knowledge as compared with when they are actually tested. Students and practitioners tend to avoid areas that are difficult for them and stay with what they are already good at. At least in Western societies, even people with the lowest objective ratings of competence rate themselves above average. Recent studies found that physicians have a limited ability to accurately self-assess, when self-assessments are compared to measured competencies. People who are less competent tend to exaggerate the quality of their knowledge and their performance more than do more competent people.

What are the sources of bias in self-assessment? Self-assessment of knowledge learned in continuing education (CE) is more related to satisfaction with the course than it is to actual learning. So, self-assessment is generally a more useful indicator of how learners feel about a course than it is an indicator of how much they learned from the course.

Other sources of bias include differences in self-esteem. People with high self-esteem are often more willing to accept that they have deficits than people with low self-esteem. People who fear negative evaluation will rate themselves more highly. People can become defensive if others challenge what they have learned or know. People who are not competent often are not able to recognize competence in others.

People who are more competent are more likely to recognize knowledge and skills they should acquire. People who need continuing professional development the most are the ones most likely to fail to recognize the need.

Should we give up on self-assessment? The evidence is mixed. People can be trained to increase the accuracy of their self-assessment.

The better question is: When and how and can self-assessments be useful? I said earlier that self-assessment indicates how satisfied a learner is with the learning experience. This satisfaction may serve as a motivating factor to do more.

Providing objective feedback, in the form of tests or other measures, can improve the accuracy of self-assessment. This feedback is most useful during the learning process, rather than at the conclusion. The feedback about learners' self-assessments helps students learn how to more accurately evaluate their own performance in the future.

Feedback is complicated. If it is too complimentary, it could interfere with motivation to learn more. If it is critical, it could motivate someone to learn more. On the other hand, critical feedback may prompt another learner to conclude that the evaluation was biased and discourage further learning.

How can self-assessment be used productively? Self-assessment should play a role in continuing professional development, but it should not be relied on solely as a measure of competence or new learning. Self-assessment may be a competency that can be developed among professionals. Self-assessment should be facilitated / supported by providing training and objective measures of feedback and peer feedback at multiple points longitudinally in the learning process. Learners should be given the opportunity to compare their actual knowledge and performance to motivate poor performers to learn more.

**Question:** My professional association has had conversations about continuing competence for many years. What is your perspective on how regulated professions should tackle this? We have a political challenge to get our constituents to accept the idea that they need to do more than just attend continuing education courses.

**Brown:** This is a critical point. People become anxious and sometimes huffy about being evaluated. I don't know the answer.

**Comment:** It depends on how it is done. I have a grandchild who wasn't doing well in math. The teacher could send a letter home threatening that the child will be held back if he doesn't improve. Or, the teacher can send a note saying the child isn't performing up to grade level and the school would like to help him by keeping him after school a few minutes for personalized tutoring.

**Brown:** There is a body of literature about steps that can be taken to encourage peoples' motivation. I'm not sure professional societies are doing much in that regard.

**Comment:** I would argue that this is a cultural issue. We have to start teaching in our undergraduate training programs that assessment and evaluation and continuing professional development are a part of being a professional.

**Comment:** The Federation of State Medical Boards is undertaking an initiative on maintenance of licensure. We believe committed leadership is necessary to make it

happen. State boards should do it because they have a mandate to protect the public. The public wants it because they deserve the highest quality care by the most competent professionals. Physicians should do it because they really care about their patients and care about giving them the best care. If professionals want to perpetuate the system of self-regulation, they need to incorporate procedures for periodically evaluating licensees.

**Brown:** I believe most professionals want to provide the best services they can. The problem is, how do they know when they are not providing the best possible services? This requires some sort of objective assessment in addition to self-assessment.

## **The Assessment Program Developed by the National Association of Boards of Pharmacy (NABP)**

### **Carmen Catizone, Executive Director, National Association of Boards of Pharmacy**

Our road to continuing professional development has been straight and narrow at times and a very crooked route at times, and we wound up in a completely different place than we ever imagined.

One barrier we faced is economic. Professionals say they are too busy to engage in continuing professional development activities. They are concerned about the impact on their licensure if they don't perform well. They are also concerned about the cost.

We also encountered questions about whether our continuing professional development program would inhibit a professional's ability to practice and to exercise the privilege they earned through licensure. Another twist is the involvement of other agencies, such as the Federal Trade Commission, which alleges that the dental board in North Carolina engaged in anti-competitive activity when defining the scope of practice. Where does the state board's authority end and the FTC's authority begin?

Our journey started almost thirty-five years ago. In 1967, the Department of Health and Human Services recommended mandating continuing competence requirements. In 1970, the Public Health Service questioned the relevance of continuing education to continuing competence and recommended a multi-faceted approach, including peer reviews, professional standard review, re-examination, and self-assessment techniques.

The pharmacy profession decided to establish continuing education requirements, just as other professions did. We believed that if professionals engaged in continuing education, they wouldn't need the mandate that HHS and others were calling for. The accrediting bodies began to approve providers of continuing education to make sure certain standards were met. Eventually, all the states mandated continuing education.

From the regulatory perspective, the boards of pharmacy and the educational accrediting bodies did all they could to ensure that continuing education would be valuable. But, there was no way to control practitioners who waited until their CE was due for

relicensure and hastily read journals and submitted their CE credits. There was no way to monitor that process, no way to say to the practitioner that we don't believe you have actually learned anything or benefitted from that CE. One of the lessons we learned at NABP is that voluntary works best when it is mandatory.

We got a wakeup call in 1997 when it was again recommended that states should require each board to develop, implement, and evaluate continuing competence requirements. We interpreted this to mean that the public no longer believed the "Trust me" philosophy that the healthcare professions had adopted. To say that, "We are learning; we are self-policing; we are competent; we have continuing education requirements" was no longer good enough. The public wanted more. They wanted a "Show me" approach that validated continuing competence.

NABP heeded that call and adopted the recommendation of the Pew Health Professions Commission that "states consider requiring the demonstration of continued competence through some sort of testing mechanism." The message was clear to us that continued competence needs to be assessed, so there needs to be a testing mechanism. They didn't say portfolios. They didn't say reflection. They didn't say let the profession develop it. They said state boards, continued competence, an assessment mechanism.

We looked at the literature to learn how we might measure competence across all practice settings and all levels of specialization. One study from Minnesota showed that fifty-three percent of the medications prescribed to patients were to treat twelve indications, not the ones you would expect: asthma, diabetes, and high cholesterol. In contrast, a study of Medicaid patients and emergency room visits in Mississippi found that those three disease states represented seventy percent of the medications being reimbursed by the state Medicaid program.

So, we realized that pharmacy practice varies by state, by sub-population, and by other factors. We decided we needed to develop a continuing competence mechanism that takes the same approach as the initial licensure examination. Why not use the initial licensure exam to assess continuing competence? Because we found that practitioners in practice for two years or more behave differently than new graduates, so we had to modify the continuing competence exam to measure that subtle difference.

We introduced a continued competence assessment mechanism in 1998 and offered it to boards on an optional basis initially, with the expectation that it would eventually become mandatory for relicensure. It was a computer adaptive multiple-choice tool, which pharmacists could use to assess their knowledge. We intended that completion of the tool would be followed by CE, portfolios, and other methods to address any weaknesses discovered in the assessment.

When we rolled this out to the profession, it generated accusations, controversy and conflict. We were accused of creating the program to generate revenue by selling the assessment tool. The professional associations asked why the regulatory boards should be earning this revenue, even though we planned to run the program at close to cost.

During the debate, these questions came up:

Who defines competence? The professional association said they define it and when the boards become involved, things become punitive. We said the public and regulatory groups define competence and are responsible for it, working with the profession.

Who is responsible for competence? Employer groups wanted to address competence internally, saying they fire incompetent people and don't want regulators involved.

What is the evidence to show competence? Some argued that specialty certification is an indication of competence. Others said that holding a license in good standing should be evidence of competence.

There is truth in all these arguments, but the bottom line for regulators is to demonstrate to the public that every practitioner is competent. A license in good standing sends an important message, but members of regulatory boards know that the resources available to state boards prevent them from becoming involved in a lot of activities to the level necessary.

Hearing all these critiques, we put together a pharmacist self-assessment mechanism. We used the same blueprint, but made it less high stakes. We made it available online instead of secure testing centers. We said to pharmacists: self assess and based upon the results, decide on a CE program for yourself appropriate to your practice and your needs.

The license to practice allows a pharmacist to practice in any setting, from hospital to retail, and in any specialty from pediatric to geriatric. That is why we put together a general assessment that cuts across all practice settings and allows an objective assessment of the pharmacist's competence across multiple areas.

We tried everything to make this a tool that pharmacists would use. The fee was reasonable. Some states recognized the tool for some portion of the CE requirement, providing a mandatory incentive to use the tool. Accommodating requests from the profession, NABP agreed to waive the fee in some states in an effort to persuade pharmacists to participate.

Participation was so disappointing that the program was disbanded and the continuing competence assessment mechanism was never launched. Practitioners are not ready or willing to participate.

So, the recommendations dating back some thirty-five years are now off our table. Some pharmacists are asking why pharmacy can't take the approach being taken by the Federation of State Medical Boards. We say fine, you take the lead. We tried and got no positive response.

So, we scrapped a mandatory continuing competence for state boards. We scrapped the pharmacist self-assessment mechanism. We went back to our member boards and asked what they need to fulfill their daily responsibilities. They replied that they are having trouble assessing practitioners who come back into practice after a lapse.

We have decided to develop an examination to give boards of pharmacy a pharmacist assessment remedial education tool. It will be a computer adaptive exam that pharmacists can take in a secure environment, such as the pharmacy board office. It will consist of 210 operational items in three distinct domains. Based upon a survey of pharmacy practice, we found that fifty percent of the remedial examination will cover the practice of pharmacy and the rest will cover prevention of medication errors and ethics.

We are also launching a program to accredit community pharmacies. It will focus on continuous quality improvement and advancing the practice of pharmacy to the next level so that pharmacists provide patient-centered care. We are giving the boards the tools to look at quality of care and clinical outcomes and to assess practitioners.

We are waiting to see if there is public demand for more continuing competence initiatives. Unfortunately, it is usually a horror story involving a medication error that garners public attention and leads to legislative changes.

**Comment:** You say you don't hear public demand for continuing competence. AARP Virginia did a survey a few years ago that found that the public assumes that licensing boards are monitoring ongoing competence and believes that healthcare providers should be assessed at least every five years. CAC once hosted a debate between officials from the Federation of State Medical Boards and the National Council of State Boards of Nursing about who needs to demonstrate current competence. The Federation representative said doctors should be assessed when there is a reason to believe they aren't competent. The spokesperson for the National Council said this is not a disciplinary matter, but a question of raising all ships, so every licensee should be assessed. So, it is disappointing to learn that NABP ended up where you have.

**Catizone:** We readily admit making mistakes along the way. When we introduced the continued competence assessment, we thought we were doing the right thing, but we came on too strong, and the profession viewed it as a disciplinary mechanism rather than something that would help practitioners. If we try again, we will be sure that the profession views our initiative as non-punitive. But any mechanism has to have teeth and be objective. If it is no more than a self-assessment by practitioners, it won't be valuable to our member boards.

**Comment:** It is very important to be clear that this is not about discipline, but about encouraging and supporting lifelong learning and continuing practice development. The public may be relatively quiet about this, but as regulators, our job is to engage the public because they are our biggest ally.

**Catizone:** One of the consequences of reduced resources is that boards don't have the time to engage in public outreach activities.

## **The Assessment Program of the Commission on Dietetic Registration**

### **Grady Barnhill, Director of Recertification and Professional Assessment, Commission on Dietetic Registration**

We have self-assessment in four different areas, one of which is a portfolio process. The self-assessment simulations are products used to prepare for specialty certification exams to obtain a credential. Our self-assessment series and assess and learn series are more closely related to continuing professional development.

We developed these products because we wanted a new way of looking at recertification. The first step in the process is self-reflection, which includes questions such as: What am I good at? What do I enjoy? What practice areas do I prefer? What knowledge or skills do I want to add?

Step two is a subjective self-assessment component. It is a checklist based on more than 150 learning need codes. Users assess what they know in each area, what they would like to learn, and at what level. It is easy to use, easy to develop, inexpensive, non-threatening, and it encourages reflective practice. It is voluntary because we do not require users to submit documentation of this step. So, we don't have any participation data to show whether it is being used.

Because self-assessment may not be accurate, we developed an objective self-assessment series. Objective self-assessment is less biased and it can be used in a normative way. And, it is based on a common metric rather than individual standards.

We started using an objective self-assessment tool in 1991. It was developed by the Penn State University Division of Continuing Professional Education and the W.K. Kellogg Foundation. It included performance objectives: what should a practitioner know and be able to do? It focused on the application of knowledge in practice. The original plan was to develop 42 modules covering 21 practice areas.

We used subject matter experts and conducted pilot tests. The modules were scenario based with realistic support materials. Some included video taped interviews, lab test results, and so on. Certificants would look at each scenario and then answer multiple-choice questions based on the materials and submit the sheets for scoring. We provided rationales for why answers were right or wrong. The users loved the normative feedback showing how they compared to their peers.

Follow up evaluation reveals how well the individual performed on a particular task, how important any particular task is to their current work, and how interested the person is in developing the necessary skill. From this, flows a learning plan.

How did it work? The cost was \$65.00. People received 7 CPE units.

By 2004, sales had dropped to about 100 per year, out of 75,000 practitioners. The feedback from those who completed the series was outstanding. There were administrative challenges, storage issues, and currency concerns.

We concluded that making a program like this voluntary isn't effective. The product ends up being used most by those who need it least.

The second-generation objective self-assessment program is called Assess & Learn. These are online case-based scenarios using realistic clinical information, documents, case notes, lab tests, descriptive information, interview transcripts, evidence-based sources, and referrals to additional learning opportunities. Because it is online, there are no production or storage costs.

How is this working? It was an effort to streamline the self-assessment process and it is much less expensive than the earlier version. The modules provide realistic and sufficient clinical information and context. The feedback is simple and directly related to the performance of tasks. Feedback is not normative, but indirect links are provided for learning planning. It is self-scoring, which saves staff time. The online format enables candidates to sign on at their convenience.

We sold 350 units in 2010 – already three times better than the older version. This is still a small number, given that there are now 81,000 practitioners.

What we learned from all this is

- Control costs
- Leverage technology
- Keep it simple
- Provide incentives to participate (avoid voluntary)
- Provide utility and normative feedback to participants

Where should we go from here?

We will be using the same instrument for the initial assessment and the demonstration of competence at the end. If you do well in the initial self-assessment, you will be exempt from some or all of the continuing professional development hours for the recertification period. We think that this “carrot” or value-added incentive will be a good way to get better buy-in to the program.

**Question:** How much does the new product cost? How long does it take to complete?

**Barnhill:** It costs about \$50.00 per person, so it is more economical. The startup costs were about \$20,000.00 to get into the computer platform. It can be completed in five hours or less. The older module took closer to seven hours.

**Question:** Have you considered making this mandatory for recertification?

**Barnhill:** We are looking at possibly restructuring our credential. One of the things we are looking at is the vexing issue of focus areas. If we redo our initial certification exam to accommodate five different focus areas so candidates will take the basic core exam and then choose additional questions in a focus area, that sets the stage for us to develop self-assessment in focus areas.

I think one of the best models is mandatory self-assessment that practitioners are not required to pass. It is easier to sell a mandatory self-assessment that gives practitioners information, but they don't necessarily have to pass. At worst, they would have to do targeted CE in the areas where they are weakest. Many people really like getting feedback.

**Question:** Are employers interested in using this to assess their workforce?

**Barnhill:** One large employer has incorporated our portfolio process into their management scheme. We have not seen an employer requiring completion of the Assess and Learn series.

**Question:** Have you analyzed the user population?

**Barnhill:** We do not have good data on the participants, but it is a great idea to obtain demographic data.

## **The Assessment Program of the National Board for Certification in Occupational Therapy**

### **Margaret Bent, Managing Director, Competency Assessment, National Board for Certification in Occupational Therapy**

NBCOT has developed tools for assessment and self-directed learning for initial certification and renewal. The primary competency assessment for initial certification is an examination at either the occupational therapist registered (OTR) level or the certified occupational therapist assistant (COTA) level. The content is driven by periodic in-depth practice analysis studies based on large-scale surveys of practicing OTs about skills and attributes they need in their daily practice. Nothing that appears on the examinations should be outside the content of the practice analysis.

The examinations provide evidence of entry-level competence. They are computer-delivered on demand. There are multiple-choice sections in both exams and a clinical simulation section for the OTR exam.

We began using the clinical simulations in 2009. They are very popular with the students because they help them to think and make decisions as they would in practice. They are

designed to simulate actual situations a therapist is likely to encounter in every day practice.

They typically start with a description of a fictional client. The applicant is then asked what type of assessment is appropriate and what kind of treatment plan would be recommended based on the results of the assessment. The various sections complete the full picture of that client or patient. The simulations are dynamic in that there are lists of decisions and actions a candidate can choose. When they choose an option, a feedback box appears on the screen giving information about the consequences of that decision or action.

The simulation questions are designed to measure a candidate's knowledge and critical reasoning ability sequentially across the continuum of care, beginning with screening and continuing to formulating conclusions, providing and adjusting interventions and assessing outcomes. These questions take about ten minutes to answer. The majority of candidates agree that the simulation portion of the test covers situations that practitioners typically experience in the clinical practice.

We see self-assessment as the key to our certification renewal program. We promote lifelong self-reflection and encourage certificants to identify their learning needs and develop a plan that will benefit their practice. During the three-year recertification cycle, certificants are encouraged to complete some level of self-reflection and 36 professional development units. There are 28 different ways to accrue these units.

Last year, we introduced an option to renew with a practice area of emphasis. This is optional because some practitioners want to be viewed as generalists, able to move from one practice area to another. Others want to be viewed as specialists.

Our annual audit of a sample of the renewal group finds a compliance level of about 92 - 96 percent over six years. Reclassification of Certification Status is the renewal process for people who have been noncompliant or inactive. Part of the process is completion of one of the general practice self-assessment tools.

We have designed several study tools, including online practice tests, an Occupational Therapy Knowledge Exam, and entry-level self-assessment tools. Applicants use these tools to prepare for the entry-level exam. The objective is to identify candidate strengths and weaknesses. We encourage students to complete a self-assessment before going out on clinical rotations. We encourage a 360-feedback loop where students, supervisors and other colleagues independently complete the self-assessment tool.

Tools developed for certification renewal include self-assessment tools, a professional development tracking log, a professional development provider registry, an "Essentials Credentials" toolkit, and NBCOT's Connect E-zine.

Since April 2010, 59,274 certificants have used the self-assessment tools. They are designed to empower certificants to engage in critical self-reflection with the ultimate

goal of assessing current levels of proficiency within the domains of occupational therapy practice. The self-assessment tools cover these areas of practice: general practice, older adult, physical disabilities, mental health, pediatrics, orthopedics, and community mobility. Certificants can choose to complete the general practice tool and another one related to their current or anticipated practice area. The score report reveals areas of strength and weakness. It also provides links to professional development resources from the provider registry.

The uses of these tools include: documenting strengths in specific practice areas, identifying gaps in knowledge and skills, identifying professional growth opportunities, linking current abilities to critical job skills and performance plans, assessing learning needs prior to re-entry or transitioning between practice settings, assessing staff competence for planning in-service education.

NBCOT'S future plans for its recertification program include a review and a practice analysis study to be completed in 2012 which will identify the knowledge and skills necessary for ongoing competence. The practice analysis will reveal the knowledge required to transcend all practice areas, such as communication skills, ability to use evidence-based practice, ability to demonstrate effective service, and so on.

The results of the practice analysis will be used to develop tools to enable us to measure ongoing competence. Renewal requirements will be enhanced to embrace self-reflection, knowledge assessment and traditional continuing education.

**Question:** How are you linking the continuing competence requirements of voluntary certification with mandatory licensure?

**Bent:** We have worked with the state licensure boards to make our requirements consistent with theirs. We don't want to introduce a different set of requirements.

**Question:** What can be done with the information from the self-assessments? Could a state regulatory board request the results if, for example, they have a re-entry candidate for licensure who has completed a self-assessment, or if there were a disciplinary case before them?

**Bent:** The results of a self-assessment are not shared with any third parties. In a disciplinary situation, I could see the results of a self-assessment being used in evidence, but that has not happened so far.

**Question:** The first speaker addressed the limits of self-assessment. What do you do to overcome some of these limitations?

**Bent:** Remember that NBCOT certification is voluntary so we don't want to be burdensome. We want to support the professional development and clinical practice of certificants. The tools we have developed help the individual focus on where he or she

needs to go in terms of their own development, rather than having something imposed by an external body.

**Comment:** I am impressed with your provider registry and it occurs to me that it would be useful to identify courses that correspond to any weaknesses identified in an assessment.

**Question:** Do re-entry candidates have to take a test in addition to completing the self-assessment?

**Bent:** No, they do not have to take a test and they do not have to re-take the initial certification exam. But, they have to complete the self-assessment tool and the professional development unit requirements and submit all the documentation to verify completion.

**Question:** What kinds of questions are used in the self-assessment tool? Is this available online?

**Bent:** It is available online. The first section of the self-assessment asks about specific knowledge and skills an occupational therapist uses in a practice setting. The second section looks at ability to interpret the results of a client assessment. The third domain relates to detailed intervention strategies. The fourth relates to professional practice, including such things as documentation, working within clinical systems, and so on.

## **The Assessment Program of the North Carolina Board of Nursing**

### **Linda Burhans, Associate Executive Director, North Carolina Board of Nursing**

The North Carolina Board of Nursing uses a reflective practice model for continuing competence and encourages a commitment to lifelong learning. We determined that continuing competence is important for public protection. It serves an important regulatory function and contributes to patient safety and quality care.

Our board began working seriously on continuing competence after the Pew Health Commission report in the mid-1980ies. In 1998, we began developing a strategic plan for creating a continuing competence program in the state. At that time, the Board of Nursing had no requirements for even continuing education. In 1999, we began working with stakeholders, including public members, practicing nurses, employers and educators.

That group determined that it was important to look at more than just continuing education. By 2001, the board staff recommended a reflective practice model to the board. That model was based primarily on work done in Canada and Kentucky.

By 2002, we had developed tools and in 2003, focus groups were held across the state to evaluate the tools, seek recommendations for modifications, and explore options for

implementation. In 2004, we implemented a Web-based pilot, giving nurses an opportunity to fill out some of the self-assessment forms and give the board feedback.

In 2005, legislation was passed requiring continuing competence as a condition of renewal or reinstatement of a license. The board promulgated rules applying to RNs, LPNs, and APRNs.

Our reflective practice approach is based on individual responsibility. It requires routine biannual self-assessment at the time of license renewal. Nurses identify their strengths and opportunities for growth and improvement in their practice. Then they implement a learning plan, focusing on the areas they have identified for development.

We ask that when conducting their self-assessment, nurses compare themselves to existing standards of practice. We want them to collect feedback from peers, colleagues, supervisors, and/or patients. Licensees can choose from any one of eight learning options ranging from national certification to 30 contact hours of continuing education, to refresher or academic courses, to publications and presentations, and a combination of CE and active practice. Licensees are randomly selected for audit of the documentation showing that they completed the requirements. We do not require that the self-assessment or learning plan be submitted to us. Nurses told us they were uneasy about sharing a self-assessment with a regulatory agency.

Our challenges in implementation included resistance from licensees, employers, educators, and a little bit from the public. There was a fear of change and uncertainty about the time commitment and the cost. Nurses wondered where they would find educational opportunities. The biggest worry employers expressed was that the board would interfere with the supply of nurses by prohibiting non-compliant nurses from working.

We tried to overcome that resistance by focusing on public safety and nurses' responsibility for professional accountability and lifelong learning. We also tried to balance stakeholder viewpoints and concerns. We tried to stay realistic and to compromise.

We also tried to communicate as much as possible. Every nursing bulletin and our board Web site contained information about the program as it evolved. Board members and staff explained the program in every speech and public presentation.

Among the lessons learned is that it is impossible to communicate enough. Regardless of our efforts, a small number of licensees will fail to comply and will require disciplinary action. Their reasons for non-compliance remain a mystery to me. Most of the fewer than 30 nurses who have been disciplined for not meeting the requirements have also not come to the administrative hearing when their license was revoked.

We know we are dependent on self-assessment and we know that that is far from ideal. Our nurses are still getting used to the process of self-assessment. It is easiest for nurses

who work in large academic hospital centers where they are working in a learning environment and have lots of resources and peers and supervisors they can talk to about their self-assessment. It is more difficult in small facilities or a physician office situation.

We suspect that most of the nurses in the state are not putting as much time as the board would like to see into their self-assessment and learning plans. Most of the nurses choose either to do the 30 hours of continuing education or the 15 hours of continuing education and work hours. But, there are nurses who have used national certification, refresher courses, or academic education.

The National Council of State Boards of Nursing is continuing to work on continuing competence, but the member boards are not ready to move forward. There are still nursing boards that have no requirements for relicensure.

**Question:** Certifiers worry that people will drop out rather than meet recertification requirements. This appears not to be true. What is your drop out rate at a regulatory board?

**Burhans:** We also worried about a wholesale loss of nurses. We saw a small increase in non-renewals in the first two-year period, but it has stabilized back to the rate we saw before implementing the program.

**Question:** What is your definition of “active practice?”

**Burhans:** Active practice means the person is functioning in a nursing role, where the person’s job description requires that he or she be a nurse. They do not have to be delivering direct patient care. So, as a regulatory nurse, I am using my nursing knowledge all the time and this is considered my active practice. But, I couldn’t be working for IBM developing new operating systems. I might be working for IBM as a nurse consultant working on clinical systems.

**Question:** It seems intuitive that if nurses keep up their skills and knowledge, assess their needs, and engage in professional development, their practice will be better. How do you think you can measure outcomes from the program?

**Burhans:** We did not do any pre-assessment and we have not looked at outcomes. We are struggling in any case with how to separate out which clinicians in a team setting are affecting patient outcomes. Anecdotally, we have received calls from nurses who have said they didn’t think they needed this program but they are glad they completed the self-assessment because it made them aware of areas where they needed to update their knowledge and skills.

**Question:** Please expand on what has taken place at the National Council Delegate Assembly.

**Burhans:** I can't supply details, but I know that some of the discussions have centered on objective measures of continued competence up to and including the development of a new test. Oftentimes, as soon as the word "test" is uttered, resistance increases.

**Question:** How was the legislative process? Second, does the statute protect the self-assessment and learning plan documents from discovery in the event of a malpractice lawsuit?

**Burhans:** Adding the continuing competence requirement to our practice act was basically a walk in the park. It was an easy sell in the context of public safety. The nurses association was fully on board.

There is no specific language in the law or the rules that protects the privacy of the self-assessment and the learning plan.

**Question:** You were ahead of the curve for licensing boards. Have you considered changes in your program to bring it up to the current state of the art?

**Burhans:** We have always expected the program to evolve. Currently, we are looking at what the board of nursing in Washington State is developing. They have just begun a continuing competence program into which they have incorporated a feedback mechanism. We know that we need to move our program forward in North Carolina, but we haven't decided what shape that will take.

## **The Assessment Program of the National Certification Corporation**

### **Fran Byrd, Director, Strategic Initiatives, National Certification Corporation**

For several years, the NCC Board of Directors believed it is a good idea to tie continuing competence to the maintenance of NCC credentials. The question was not "should it be done?" but "could it be done – and could it be done in a way that our certificants would embrace lifelong learning as an integral part of their certification maintenance process?"

In 2005, NCC embarked on a demonstration project to validate the need for a continuing competence initiative. Fifteen hundred randomly selected women's healthcare practitioners were asked to do an assessment of where they thought they stood in their practice. They then completed a 100-item multiple-choice tool, which would more objectively assess where they stood. The tool covered three levels: entry to practice, "cutting edge" practice, and a combination of both levels.

The board wanted to determine if nurses could self-assess their areas of weakness. They also wanted to collect data showing whether assessment should relate to entry level or recent practice in a specialty. The pilot was also designed to give nurses feedback regarding their specialty knowledge and competence. Finally, the pilot looked at developing CE to meet identified learning needs.

The pilot results showed that individuals do not correctly assess where they are strong and where they have gaps of knowledge. So, NCC decided to develop a more objective evaluation tool and to keep the assessment at the same level as the current certification exams in specialties. For NPs, that is entry into practice. For other nurses, it is a level of two years' expertise in the field. One reason for this is that there is already a task analysis and content validation for the current core exam.

Based on the pilot, NCC decided to design a system of focused feedback for each certificant, so they can see where gaps exist. The plan was to create content categories reflecting the core competencies for each specialty and to rate the results of the assessment to create a personalized education plan. The plan also called for enhancing the existing NCC self-assessment program modules so the results are coded to help certificants match their education plan to a specific module.

The assessment is a 125-item multiple-choice computer-delivered tool based on the knowledge competencies for each specialty. The items are co-related with the competency categories on the certification exam and they are weighted to equal 50 hours of CE across all categories. The competency categories are different for each specialty, such as inpatient obstetric nursing, neonatal intensive care nursing, and the women's health care nurse practitioner specialty.

We developed a platform allowing certificants to access the assessment from their own personal computers. This was important to us because the pushbacks from the profession are concerns about time, cost, and inconvenience. In addition to built-in security features, prior to be allowed access to the assessment, certificants sign an agreement acknowledging that this is a secure evaluation tool to be taken by them alone.

We implemented the program in two stages. The first is an orientation stage, which went live in June 2010. In 2014 the process will become binding.

We mailed an explanatory brochure to every certificant, posted information on the Web site, and mailed reminder post cards prior to each maintenance cycle. There are still people who don't read the material.

The binding stage began in April 2011 for those individuals whose renewal is in 2014. They need to take this assessment to direct what their CE can be to maintain their credentials. The assessment has to be completed prior to their beginning to do CE.

If I were an individual with a June 30, 2011, cycle deadline, I would submit my maintenance assessment this time. I would earn credit for 5 hours of CE for taking the assessment, dropping the requirement from 45 to 40 hours. Having taken my specialty assessment, I have my individualized education plan now and can look for conferences, modules, and other educational opportunities consistent with my education plan.

The Specialty Index Report is issued immediately upon completion of the assessment, plus the corresponding education plan. It is sent to my password-protected account on

the NCC Web site. This is because certificants told NCC it is important to them to have control over where this information goes.

The assessment uses mathematical calculations on a one-to-ten scale in each competency content category. For establishing whether I need additional education in a particular area, NCC set a 7.5 or higher cut off. There is a carrot in the program because if I earn 7.5 or higher, I will not be required to have additional education in that area. However, if I show weaknesses, I will have to complete a CE requirement in addition to the fifteen-hour baseline requirement in my specialty.

NCC doesn't call the assessment a test. People don't pass or fail. We don't use the terms "need" or "weakness." We use terms that are not threatening. If you want buy-in, your constituents have to feel the program is there for positive reasons, rather than to be a club.

The resistance has not been as bad as we feared. We think introducing the program with the "Try it, you'll like it!" orientation phase overcame some resistance. There are no fees. The emphasis is on the assessment/evaluation tool versus an exam or test. Delivery is convenient on one's own computer. The five-hour credit for taking the assessment is a carrot for the current cycle.

Among the lessons learned, no matter how much information you provide, people don't read it. Any process dependent on computer systems will create headaches associated with compatibility, Internet outages, etc.

This has been a dynamic process from the start, and we expect to see refinements in the process, the content of the assessment tool, and in NCC's continuing education resources. We are working toward having a better platform to handle this function. Changes will be based on what we see in content validation and task analysis, what the psychometrician tells us based on a review of the results of an assessment, and feedback from the NCC population.

In terms of NCC's CE, we are working on multi-media formats, podcasts, PowerPoint with audio, avatar-based simulations, and procedural review for advanced practice nurses.

**Question:** Could you talk more about the security of the assessment, given that it is completed in people's homes?

**Byrd:** Our IT people can see people's log-in and log-out times and they can tell if more than one person has logged in from the same place. The assessment tool is timed to take 2 hours and 15 minutes. The bottom line is that we are looking to our certificants to embrace lifelong learning. If they can look up answers or have a discussion group in that length of time, more power to them. If security appears to be a big problem, we will look at it further. At this point, we feel it is not a key concern.

**Question:** What are the requirements for certificants who do not want to participate in the self-assessment piece?

**Byrd:** We have an “opt-out” process, which will come into effect in stage two because we don’t want to deny anyone the right to maintain their certification. It is intentionally an onerous process to discourage its use. If people refuse to take the assessment, it is impossible to say where their strengths and weaknesses are, so they are required to take 50 hours across the five content areas of their specialty. Also, the maintenance fee is higher.

**Question:** How do you determine how many hours of CE are needed for areas of weakness?

**Byrd:** It is based on the percentage of items in the core exam for each particular area.

**Question:** How many items did you decide was necessary to get reliability in each area? How much is the initiative costing?

**Byrd:** The 125 item exam was based on the spread in the core exam. As to the cost, we had a head start because we have our own testing platform already in place. The additional development of the specialty assessment was about \$40,000.00. Our content experts are volunteers.

## **Assessing the Communications Skills of Physicians in Training as a Condition of Entering a Residency Program**

**Ann Jobe, Executive Director, Clinical Skills Evaluation Collaboration. National Board of Medical Examiners**

Graduates from a U.S. medical school who want to become licensed as a physician, have to take the USMLE and be in a residency program. Graduates from an international school have to have all their credentials verified, take the USMLE and do another residency in the United States.

The USMLE is the product of a partnership between the Federation of State Medical Boards and the National Board of Medical Examiners (NBME), which creates a single pathway for US graduates and international graduates to demonstrate competence to practice without supervision. This replaces state-based exams and separate national exams for U.S. and for foreign medical graduates.

USMLE is a computer-based multiple-choice examination. It assesses medical knowledge, clinical pathology, pharmacology, pathophysiology, and so on. It assesses clinical knowledge and clinical skills. In addition to multiple-choice, there is a small component that is computerized case simulations, similar to those described on occupational therapy.

Licensure usually occurs while graduates are in residencies. Re-licensure is the responsibility of the state licensing authority, not USMLE. Board certification and maintenance of certification is the responsibility of specialty boards. Most medical students take the first two USMLE exams (12CK and clinical skills) before they graduate from medical school and take step three while they are in residency.

USMLE is important because it is a performance assessment, on Miller's scale of Knowledge / Competence / Performance / Action. In other words, candidates "show how" to do something.

Kirkpatrick's criteria are 1) Reaction; 2) Learning; 3) Behavior; and 4) Results. We want to see results, change in organizational practice, benefits to patients and clients. So we look at what assessments we are doing that bring about change in our culture, and why. Because we assess communication, we are assessing something very different than standard computer-based exams assess.

How did the NBME develop its exam? The first exams in 1916 were voluntary and took a week to complete. From 1922-1950, exams included essay questions and observed patient encounters. In the 1950ies, "selective response" (multiple-choice) questions replaced essay questions. The bedside oral examination demonstrated more about the raters than it did about the test-takers. It was eliminated in 1964.

The NBME then started looking for something reliable to assess performance. In 1960, they tried to assess clinical performance using videos in large auditoriums. It didn't work. They tried "latent-image management" problems. That didn't work either. Everything reverted to multiple-choice in the 1980ies, even knowing that this does not get at performance.

The public was saying that physicians don't listen. The most frequent complaints to medical boards related to communication. Litigation was skyrocketing and most malpractice cases involved communication. The Joint Commission agrees that the communication breakdown is the basis for sentinel events. In nearly 3,000 sentinel events the root cause was communication breakdown.

Take home message: high level skills in "bedside medicine" is the cornerstone of safe, quality patient care.

Some medical schools have courses in clinical communication skills. Still, more than 60 percent of medical graduates said they had never been observed doing a complete history and physical.

NBME and the Educational Commission for Foreign Medical Graduates (ECFMG) wanted to assess clinical skills. ECFMG implemented the Clinical Skills Assessment exam in 1998. It is a national standardized assessment using standardized patients. However, it was only for international medical graduates.

The clinical skills evaluation collaboration was created in 2003 by the presidents of NBME and ECFMG who saw no reason for two competing examinations and created the Clinical Skills Evaluation Collaboration (CSEC). The first administration of the clinical skills examination occurred in June 2004.

The state boards and the USMLE composite committee felt this exam would be a national validation of the clinical skills of medical graduates. The medical schools and medical students and the AMA opposed the exam, arguing that schools were already assessing students.

As of May 2011, CSEC has examined 229,091 candidates with 2,749,092 standardized patients. We have five centers in Atlanta, Chicago, Houston, Los Angeles, and Philadelphia that run 5-6 days a week. We have 2 – 3,000 examinees a month, which is about 24 per day at each center. It costs about \$1,100.00 per examinee.

The cases include important situations typically found in a clinic, a doctor's office, emergency department, or hospital. There is a blend of cases in each exam for an undifferentiated physician. We try to be sure everyone has a comparable level of difficulty for the exam, regardless of which test site.

We build our blueprint to relate to system, gender, age, and acuity. Every exam involves 12 encounters, which take 25 minutes apiece – up to 15 minutes with the standardized patient and 10 minutes to write a patient note.

It is a pass/fail exam and they have to pass all three sections in a single administration. Communication and interpersonal skill are rated by our standardized patients who are people from the lay public representing all different backgrounds. Examinees are assessed on their ability to ask questions and explain and counsel to patients, their professional manner and rapport, respect, privacy, modesty, comfort, empathy.

Spoken English proficiency is included because 43% of examinees are international graduates. The integrated clinical encounter has two pieces. One is data-gathering and the other is patient notes – communication of the findings. For data-gathering, standardized patients use checklists to indicate whether the appropriate questions have been asked and the appropriate physical was done. The patient note is evaluated by physician raters, who evaluate the conclusions and recommendations for what to do next.

The failure rate for U.S. examinees is about 3-4 percent, mostly because of deficiencies in the integrated clinical component. This represents 500-600 individuals. For international graduates, the failure rate is around 25 percent, also because of weakness in the integrated clinical component.

Why do we use standardized patients and not physicians as raters? Because physicians may decide to deviate from the checklist and then there isn't standardization. Standardized patients are less expensive, more available, and easier to train to be standardized. Studies have shown that physicians are unable to distinguish standardized

patients from real patients. Standardized patients are more accurate than physician raters. There is a one-way mirror in the exam rooms, so other observers can look in and assess the accuracy of the standardized patients' rating.

We believe we are enhancing patient protection by assessing communication skills and improving quality and safety. The educational validity of the exam is proven. The majority of medical schools now have clinical skills centers. Most use standardized patients for teaching. Most have clinical skills courses.

What do I worry about? In the exam, we often see "paint-by-the numbers" rote performance by examinees. However, real life situations are unique and test-taking strategies may not apply. Another thing that is concerning is that examinees may short-cut the exam because they know they won't find physical findings, such as a heart murmur. The exam does not effectively assess whether an examinee can discern abnormal findings. The exam is only a snapshot. It is not longitudinal, so I am not sure it will ever be able to assess whether an individual can distinguish abnormal from normal.

But, we are trying to assess whether an individual can synthesize and integrate all the information gathered from a patient. Another thing that is concerning is that this is a high-stakes exam, and just like any other important activity, there are secondary review courses that are money-makers.

We provide feedback in a grid that shows examinee's performance compared to national standards. However, they don't receive this feedback until 4-6 weeks after the test.

What is CSEC working on? Enhancements to the exam, such as counseling patients about behavioral change, delivering bad news, disclosing errors, negotiating a treatment plan which includes patient preferences, starting medication, health literacy, medication reconciliation, functional status assessments, communicating with more than one person in the room, using an interpreter, functioning in a team environment, hand-offs.

What is measured is important. Individuals and organizations change their behavior in the lens of high stakes examinations.

Potential opportunities include collaboration with specialty boards that provide assessments for certification, partnering with graduate medical education, partnering with certification and licensure to administer assessments for other professions.

**Question:** Please say something more about assessing practice teams.

**Jobe:** It is on the horizon, but we haven't settled on a protocol. We are thinking of assessing how a physician reacts when challenged by a standardized nurse or other team member. We would welcome input.

**Question:** What do you think about assessment using simulations?

**Jobe:** I am a proponent of simulations for educational purposes, but I'm not sure they would be effective in high-stakes exams, especially assessment of communication. I think simulations would be useful for longitudinal assessments.

**Question:** Please talk a bit about patient-physician communication.

**Jobe:** There is some literature showing that there are behaviors and communication patterns that lead to increased patient adherence and better outcomes. We are in the process of changing our scale to reflect the behaviors that are being used more consistently across disciplines and specialties. It doesn't take away from individual style, but there are some essential components of communication that we believe we can observe and assess. If a person can easily communicate findings, but is unable to develop respect and foster a relationship of trust, the outcome is not as positive.

We don't have data showing that outcomes are improved with good communication, but the Medical Council of Canada has had a clinical skills exam longer than we have and researchers have shown that there are improved clinical outcomes. The data also links those who did poorly on a communications scale with more substantive complaints to the licensing authority. I would like to do an outcomes study at NBME, but since we are changing the communications scale, it doesn't make sense to do a study based on the old scale.

**Question:** How do you see clinical skills assessment being used for continuing competence?

**Jobe:** I have had conversations with several of the specialty boards and encouraged them to use our test for initial certification, let alone recertification. I ask them if they are sure every one of their residency programs is of the same caliber and if they can guarantee every graduate is of the same competency. A few specialty boards are thinking about it. I don't know if they would use the test for recertification, but I think the place to start is initial certification. If we were to assess all the graduates in every specialty, we would probably have to establish some more centers incrementally.

## **Discussion: Points to Consider When Developing an Assessment Program**

**Cynthia Miller Murphy, Executive Director, Oncology Nursing Certification Corporation**

ONCC is looking at improving our measurement of continuing competency. I am going to walk you through our decision-making process and identify questions we still have to answer.

I like a definition of competence that talks about knowledge and skills in the context of doing something successfully and applying prior experience to new situations with good

effect. Competence helps those around us feel more comfortable and inspires others to seek knowledge.

We can define competence, but how do we reliably measure it? ONCC's mission refers to having the knowledge to practice competently, but we aren't sure we can measure whether our certificants actually do.

When we began in 1986, we were one of the few nursing organizations that required recertification, by passing the test again. The pass rate was high, but the average recertification rate was only 59 percent, implying they weren't re-certifying because they didn't want to take the test.

In 2000, we launched a points renewal option, where nurses can acquire points in 7 or 8 different categories, one being CE, others being publishing a paper, teaching a course, earning academic credit, and so on – in addition to having the required number of practice hours. It has increased our recertification rate up to 74%. We still have 5% choosing to re-test. Those who aren't in active practice have to earn points and take the test.

Of the points, at least 60% must be in the oncology specialty. The problem is that an individual can get all his or her CE in one area or subspecialty. But, their credential says that they are certified broadly.

In 2010, we initiated a Mega-Issue discussion about “How should ONCC implement a more rigorous process for the measurement of continued competency?” We use an approach called “knowledge-based governance,” which asks four important questions followed by dialogue about the pros and cons of all available choices.

Question 1: What do we know about our stakeholders' needs, wants and preferences that are relevant to this issue?

Our stakeholders fall into three groups: nurses, employers, and healthcare consumers. We know that nurses want to become certified and remain certified. We know they don't want to take a test again. Paying for certification is considered an obstacle by many of them. Half the nurses have their initial certification paid for by employers, but only 38% have their recertification paid for by their employers. We know that consumers think it is important to verify current competence.

Question 2: What do we know about the current realities and evolving dynamics of our stakeholders' environment that is relevant to the issue?

We looked at the economy, technology trends, and so on. We know there is a nursing shortage, but there are also unemployed nurses. We know computer-based testing and electronic recertification are very popular. The trend, as evidenced by the American Board of Medical Specialties, is toward much more rigorous recertification requirements. There is a drop-off in conference attendance, but an increase in electronic education.

Question 3: What do we know about the capacity and strategic position of our organization that is relevant to this issue?

We have a platform for our online practice tests, but don't have the capacity to administer an assessment tool in house. This will be a huge financial investment, but we are a stable organization. We have the human resources and can retain consultants to supplement.

Question 4: What are the ethical implications of our choices?

There isn't a lot of data to support any particular approach to recertification. We looked at consistency with our mission and the implications for quality and safety. We looked at our certificants' likely perception of our decisions and the effect on access to recertification.

We identified options and looked at the pros and cons of each. One option is to make no changes. Or, we could postpone changes until we have more data. We could require a portfolio, or require re-testing. We considered requiring CE in all areas of the test blueprint.

What we decided to require, with lots of advice and help from NCC, is individual learning needs assessment (ILNA) based on a blueprint and targeted CE related to results. We won't call this self-assessment, because the assessment will be administered and scored by ONCC. ONCC will instruct examinees as to what CE and other professional development activities they need to complete.

We formed another task group including consumers, educators, managers, and nurses in different roles. We decided there were many more benefits than barriers for all our stakeholders. We think if it is communicated well, nurses will think of it as an advantage. Most likely, most of them will need to obtain fewer points, but in targeted areas.

We know we will need many more volunteers for test development in each of our five active programs and two retired programs. It will require psychometrician and test vendors. We are evaluating proposals. We need to address legal issues, such as test security, reliability, and identification of CE sources in all the content areas.

We have a timeline that is fairly rapid. The assessment has to be available to certificants a couple of years prior to when we require them to use the system. New certificants will use the diagnostic score report for their certification exam to identify the CE needed for the first cycle.

Eventually, we will probably have to raise recertification fees because it will cost us more. We will be careful not to raise the fees at the time the ILNA is being launched. Communication and marketing will be very important, beginning in 2012, assuming that the program will be in effect in 2015.

We have a research team that is working on short- and long-term goals for the program and evaluation strategies. We want to be able to collect evidence related to outcomes measures. We may ask certificants to conduct a self-assessment after completing the assessment we administer to see if there is any correlation. It would be good data for us to have to demonstrate to our constituency why we want them to take the ILNA.

We need to develop something equally rigorous for those who refuse to take the assessment and for the holders of our two retired credentials. We want to offer a mechanism for the renewal of more than one credential at a time.

**Question:** What percent of oncology nurses are certified?

**Miller-Murphy:** We don't really know the universe, but we estimate that there are about 63,000 oncology nurses of whom we certify 32,000. The membership society has 35,000 members.

**Question:** Has your 74% recertification figure changed since 2000?

**Miller-Murphy:** That percentage has drifted to 74% since we put in the point system and as the certificants got used to the program.

**Question:** Have you thought of ways to incentivize certification and recertification?

**Miller-Murphy:** Recertification is mostly employer or workplace-driven. There is a program of "magnet recognition" for hospitals that promote professional nursing practice and pay for certification and recertification of their employees. Certified nurses can make up to \$10,000.00 more per year. State boards will recognize certification as a way to meet re-licensure requirements. Nevertheless, our surveys show that oncology nurses get certified for intrinsic, not extrinsic reasons.

**Question:** The conversation today differentiated between pure self-assessment as opposed to more objective types of assessment using a tool. Objective assessment tools have to include feedback so examinees know where they didn't do well. Has anyone considered using volunteers from another geographic area to provide personalized feedback –similar to mentoring – to help people structure their continuing professional development plan?

**Comment:** The North Carolina Physical Therapy Board began developing a continuing competence program several years ago after hearing a keynote speaker from a Canadian pharmacy board. His view was that if professionals are "engaged" in their profession, it helps ensure competence. Our board developed a menu of activities, including CE, online courses, volunteerism, specialty certification, and so on. This was necessary in our state where development opportunities are not readily available in rural areas.

**Miller-Murphy:** I think engagement is changing and membership societies are recognizing that there will be fewer face-to-face encounters and more electronic engagement.