NBCRNA Continued Professional Certification (CPC) Program

Evolution and Development
2008 - 2014

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About this Report

This report summarizes the work performed in the development of the CPC Program from 2008 through 2014. It includes the following materials:

- The 2011 NBCRNA Survey Summary
- The 2011 AANA Survey Results
- The Literature Citations in Support of the CPC Recommendations
- The Literature Summaries in Support of Continued Competence
- Summary of Program 2011 - 2014

Acknowledgement

The Continued Professional Certification (CPC) Program has evolved over the last eight years. It has been built upon an evidence-based review of the credentialing research and the shift towards continued competency in nursing, medicine, and other professions.

More importantly, it has been developed by many certified registered nurse anesthetists who have generously volunteered their time and energy to develop and refine this program. The CPC Program has benefited as well from the thousands of nurse anesthetists who have provided their thoughtful comments, questions, feedback, and recommendations throughout the process of development.

The NBCRNA thanks those who have directly and indirectly contributed to the development of a recertification program that will advance the value and status of the nurse anesthetist profession and meet the needs of future nurse anesthetists. As the CPC Program is implemented, the NBCRNA is dedicated to the ongoing review and analysis of the program and its components with input from the AANA, certificants, and other stakeholders.
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Executive Summary

The Continued Professional Certification (CPC) Program is a process that has been developed by NBCRNA to replace the current recertification requirements for certified registered nurse anesthetists. The CPC Program addresses evolving expectations among patients, employers, and certifying bodies, as well as changes in the science and practice of anesthesia.

Consistent with its responsibilities, the NBCRNA undertook an analysis of its recertification program beginning in 2008, with the objective of ensuring that the program has rigor and quality commensurate with the ongoing needs of its constituents. The findings of a benchmarking study encouraged the definition of continuing competence for the profession as a philosophy through which to evaluate issues and guide the recertification program. The practice analysis provided demographic information about the community of nurse anesthetists and, more significantly, took note of the changing responsibilities they have as their careers advance. An extensive review of the literature contributed to an assessment of current trends.

Underlying the CPC Program is a fundamental emphasis on continuous growth and professional development throughout a nurse anesthetist's career via lifelong learning and assessment. Equally important is to ensure that the aspects of nurse anesthesia addressed by the CPC Program are essential, regardless of practice setting, patients, and conditions.

A key part of the NBCRNA’s mission since initially presenting the proposed CPC Program was to facilitate an open comment period that encouraged all CRNAs to share their feedback and recommendations concerning the proposed changes. The goal was to use this feedback to identify and assess the concerns of the CRNA community about the proposed changes and to incorporate additional ideas into the final criteria for the CPC Program.

This report documents the process that was undertaken to develop the CPC Program and the evolution of the program that took place as a result of input from stakeholders, certificants, and others. NBCRNA has continued to refine the program, working with ANA to ensure the program effectively meets the needs of nurse anesthetists. This report covers in detail the developments leading up to the adoption of the initial version of the CPC Program and provides a summary of the changes made to date.
Development of the Plan

Analysis: Benchmarking and Practice Analysis

Consistent with its responsibilities, the NBCRNA undertook an analysis of its recertification program beginning in 2008, with the objective of ensuring that the program has rigor and quality commensurate with the ongoing needs of its constituents. The analysis involved two major projects in 2008—a benchmarking study and a practice analysis. The benchmarking study summarized key issues and current practices in the renewal of professional licensure and certification. The findings of the benchmarking study encouraged the definition of continuing competence for the profession as a philosophy through which to evaluate issues and guide the recertification program. The practice analysis provided demographic information about the community of nurse anesthetists and, more significantly, took note of the changing responsibilities they have as their careers advance.

The Recertification Task Force

NBCRNA formed and appointed individuals to a Recertification Task Force in the fall of 2010 with the expectation that the group would represent the diversity of the discipline in broad terms. NBCRNA informed the AANA Board of Directors of the intent of the NBCRNA to assemble a task force to reevaluate the recertification process, and requested that one member of the AANA Board sit on the task force to represent the AANA interest. AANA responded by designating a member to participate.

The Recertification Task Force met by conference call in December 2010 for an orientation and later met in person in January 2011. The Recertification Task Force discussed key concepts related to recertification, the trends that concern this aspect of credentialing as revealed in the readings, and the recertification practices of other certification bodies, including other anesthesia certifications.

Definitions

The Recertification Task Force reached consensus on a definition of continuing professional competence as it addressed the perspective of the significant stakeholders in the recertification of nurse anesthetists. The task force also defined the term stakeholders as it applies to the CPC Program. These foundational definitions provide a philosophy about recertification that guided the design of the proposed CPC Program.

Continuing Professional Competence is an ongoing, multimodal, and progressive process that maintains and enhances proficiency in nurse anesthesia practice and is a concept that ranges on a continuum from entry-level proficiency to complete mastery. The determination of what knowledge and skill equate to proficiency at the level required for continued professional certification requires judgment about the needs of patients and the range of services that experienced nurse anesthetists provide. The knowledge base and skill set for nurse anesthetists includes (but is not limited to) patient-centered care, work in interprofessional teams, evidence-based practice, quality improvement, and informatics.

Stakeholders refers to the different groups that have an interest in the recertification of nurse anesthetists. Stakeholder groups include the public, patients, their families, anesthesiologists, other physicians, hospitals, other employers, regulatory bodies, continuing education program providers, NBCRNA certificants, and the American Association of Nurse Anesthetists. In general, all stakeholders benefit when the content of the recertification program is targeted at an appropriate level of proficiency.

Communication

Throughout 2010, the NBCRNA attended over 30 state association meetings targeting 2,000 nurse anesthetists and hosted 10 focus groups to discuss the importance of the NBCRNA and the future of recertification. The focus groups took place at AANA meetings such as the Assembly of School Faculty, Mid-Year Assembly, Fall Assembly of States, and Annual Meeting. Educators, practitioners and students were invited to participate in these sessions. NBCRNA then drew upon the practice analysis and meeting participant feedback, supplemented by a broad range of research regarding the need for and value of continued competence efforts in health care, to assemble the proposed Continued Professional Certification Program.
Documents and Research
Between 2008 and 2011, the Recertification Task Force and NBCRNA Board conducted an extensive review of medical and scientific resources from the previous 30 years to evaluate the current CRNA recertification program and to develop the initial proposed Continued Professional Certification (CPC) Program. In an effort to facilitate review by all stakeholders, executive summaries were created for all resources, providing both a synopsis of the subject matter and key findings. All resources were summarized in full and were not limited only to findings supporting the CPC Program.

Strong evidence was found supporting all elements of the proposed CPC Program and key findings are presented in Appendixes D, E, and F. All executive summaries of the resources reviewed are included in Appendix E. The CPC Committee and NBCRNA Board continue to ensure that the CPC Program reflects the literature and evidence, and have further cumulated additional resources from 2011 – present that are listed in Appendix F.

Initial Proposal
The Recertification Task Force met in person again in March 2011. These meetings were supplemented by numerous conference calls. The Recertification Task Force developed a proposal, which was submitted to the NBCRNA Board of Directors for discussion and approval. The initial proposed CPC Program components were presented to the NBCRNA Board in May 2011 and later unanimously approved.

CPC Public Comment and Feedback
The proposed CPC Program was opened for full, comprehensive public review and comment from September 6, 2011 to November 14, 2011.

The NBCRNA stated at the outset of the public comment period on the proposed CPC guidelines that stakeholder feedback was a critical and valued part of the process, and that the feedback and input provided would be used to inform, improve, supplement, refine, or even remove program elements prior to final approval by the NBCRNA Board of Directors.

During the CPC public comment period, all CRNAs and stakeholders were encouraged to complete a survey to provide the NBCRNA with valued feedback as well as comments about the program. Stakeholders were encouraged to direct questions about the proposed CPC process to NBCRNA via email.

Since the proposed CPC Program was announced on August 6, 2011 and over the course of the public comment period, the NBCRNA received thousands of comments, emails, calls, survey responses and letters about the initial CPC proposal. The NBCRNA received approximately 4,200 CPC survey responses, 920 emails, 280 questions via the CPC blog (Tumblr), and 900 phone calls related to the CPC Program. Posts on social media sites operated by the NBCRNA were also noted and reviewed. All comments and feedback were captured and reviewed by NBCRNA Board and staff members on a weekly basis – no comment, question, or suggestion was overlooked.

The communications received by NBCRNA contained a wealth of ideas related to possible changes in the proposed program. Many of the ideas came from actively practicing nurse anesthetists who are committed to ensuring that their credential continues to be recognized as a standard of excellence. NBCRNA feedback collected from the initial CPC presentations at state nurse anesthesia meetings, which were well-received and followed by thoughtful questions and helpful suggestions, was also funneled into the public comment process.

As a part of the open and inclusive comment period, the NBCRNA developed and deployed a “feedback loop” process using the association’s blog to amplify and encourage even more participation in the public comment period. Relevant and thought-provoking questions from stakeholders were extracted from the feedback loop, answered, and posted online in a timely format at the CPC Tumblr site to inspire additional thinking and constructive ideas on how to improve the proposed CPC guidelines. The NBCRNA also made a variety of relevant resource documents available during the comment period to better inform stakeholders through the NBCRNA website.
NBCRNA CPC Committee

To manage the process, NBCRNA appointed a CPC committee in September of 2011 to review all feedback and make recommendations for program modification to the Board of Directors based on stakeholder suggestions. The CPC Committee was supported by a team of internal staff leaders and external consultants. They were charged with considering the recommendations from all NBCRNA stakeholders, the credentialing requirements of other professions, and the research literature on continued competence in an effort to further improve the proposed CPC Program.

NBCRNA State Presentations on the Initial CPC Program

Complementing the CPC public comment period process, NBCRNA Board members and staff presented at 32 state meetings with a total audience of approximately 4,150 members, including CRNAs and other stakeholders. They presented and explained the proposed CPC Program, answered questions about its goals and components, and listened to comments, suggestions, and concerns, which were brought back to be addressed by the CPC Committee. This process took place during the fall of 2011.

NBCRNA Communication

NBCRNA recognized that some CRNAs felt caught off guard by the proposed CPC Program presented at the 2011 AANA Annual Meeting and misunderstood the proposed changes to be firm, as opposed to in draft stage and open to public comment. The immediate CRNA feedback to the presentation also revealed that some CRNAs did not understand the distinction between NBCRNA and AANA, and why it was important for the organizations to be independent of each other.

In an effort to provide more information, NBCRNA issued monthly emails and one hard copy mailing to over 35,000 CRNAs during the open comment period. These communications described the CPC Program process overview, kept CRNAs up to date on the comment period, and addressed common misunderstandings.

2011 to the Present

Since the initial proposed CPC Program, the CPC Committee and NBCRNA Board have continued to refine the components, based on input from the AANA, certificants, and other stakeholders. Almost every component of the CPC Program has been analyzed and revised to ensure that the CPC Program will have practice-related validity and that the aspects of nurse anesthesia addressed by the CPC Program are essential, regardless of practice setting, patients, and conditions.
The Open Comment Period (September 6, 2011 to November 14, 2011): Themes and Findings

Introduction

A key part of the CPC Committee’s mission since unveiling the proposed CPC Program was to facilitate an open comment period that encouraged all CRNAs to share their feedback and recommendations concerning the proposed changes. The CPC Committee’s goal was to use this feedback to identify and assess the concerns of the CRNA community about the proposed changes, and incorporate additional ideas into the proposed CPC Program.

The committee established three online tools for soliciting feedback on the proposed CPC Program: a survey, Tumblr blog, and email address. These online tools made it possible for stakeholders to provide feedback on the proposed CPC Program directly to NBCRNA at times and from locations convenient to their schedule. The NBCRNA used multiple online tools to allow for both open comments regarding the proposed program, as well as structured responses that guided stakeholders to address the proposal’s specific elements. The CPC Committee also reviewed AANA’s survey, developed independently, to further bolster the amount of CRNA feedback included in the CPC review process.

Method

A member of NBCRNA read every survey response, Tumblr submission, and email sent to the CPC Committee. Every submission was recorded by date in either Word documents or an Excel spreadsheet. The unedited text was also recorded. These documents were then shared with the entire CPC Committee for review. The large number of responses to each online tool — 4,200 to the survey, 280 to Tumblr, 920 emails — did not permit the CPC Committee to respond to each submission directly. However, the Tumblr blog was used to give detailed responses to recurring themes and questions received by the committee. AANA compiled the 6,631 responses to their survey and provided them to NBCRNA, which was also shared with and reviewed by the CPC Committee.

NBCRNA made a concerted effort to communicate the details of the feedback period to all CRNAs and encourage their participation, including: announcements of feedback opportunities at the unveiling of the proposed program at the national conference; announcements during presentations at each subsequent state conference; links on the homepages of both the NBCRNA and CPC websites; regular email blasts to over 35,000 CRNAs; one hard copy mailing to over 35,000 CRNAs; and automated responses to emails encouraging senders to also submit comments to the Tumblr site and survey. The number of responses received by NBCRNA, while high, amounted to a relatively small percentage of CRNAs. The data suggests that many of the emails were sent by people who also filled out the survey and submitted questions to the Tumblr site.

Overview of Analysis

To formally analyze the online communications, the CPC Committee used a methodology modeled after content analysis studies. A representative percentage of randomly selected responses were chosen from the entirety of responses received during the open comment period. Using independent consultants to ensure greater reliability, the responses in the sample were individually evaluated for the topics they addressed, their tone (i.e., supportive, not supportive, neutral), and any recommendations they made for the proposed CPC Program. The topics discussed in the feedback were recorded quantitatively to determine which issues were of greatest concern to respondents. The specific recommendations were forwarded to the CPC Committee who performed a SWOT analysis of each recommendation to assess its viability.

Emails

NBCRNA established a specific email address to allow stakeholders to submit open comments about the proposed CPC Program. NBCRNA received 920 emails during the open comment period, with the vast majority received during the first four weeks. Ten percent of the emails were sampled for issues addressed. More than 25% of the emails expressed concern over the exam, the most common issue referenced. Approximately 15% submitted opinions over the increase of CEUs, potential costs and the lack of a grandfathering clause. Recommendations from the emails are compiled in the list below.
The CPC Committee established the Tumblr site as a way for NBCRNA to provide responses to the common themes in the feedback and frequently asked questions. The site worked much like a blog. Users were encouraged to submit questions and comments through the site, which were collected on the backend and classified with similar submissions. Once a trend arose from the submissions, or a recurring question was identified, the CPC Committee collaborated on a response that answered the question and provided greater details about the topic.

The committee did not respond to each of the 280 individual submissions because of the volume and similarity of the submissions. However, each submission was reviewed and shared, unedited, with the entire committee. The committee randomly analyzed 20% of the submissions. The potential cost was the largest issue of concern, appearing in 24% of the sampled submissions. Grandfathering and training each appeared in 22% of responses. These issues are often connected with cost, which appeared in 24% of responses.
**NBCRNA Survey**

The email address and Tumblr site allowed respondents to submit feedback in an unstructured format. The committee felt it was important to also have a structured mechanism though, to elicit specific feedback for developing concrete recommendations and so designed the survey to guide people to address specific elements of the proposed CPC Program, although the survey contained open-ended questions.

The survey received 4,200 unique responses. The bar graphs depicting the answers to structured questions are shown in Appendix B. Ten percent of the general, open-ended responses were sampled for recommendations and issues of concern. Although 31% of comments expressed a general negative attitude toward the proposed CPC Program, 24% specifically addressed the exam as a concern. Related to those comments were the 18% of respondents who proposed some type of grandfather clause, often specifically for the exam. Recommendations from the survey comments have been included in the recommendations list below.

![NBCRNA Survey Comments](image)

**AANA Survey**

The AANA developed its own survey, collecting 6,631 responses through mail, fax and in hard copy at state conferences and provided the raw results to NBCRNA. The data reflected concerns similar to those identified through the NBCRNA survey, in particular, the exam, grandfathering, and training. The CPC Committee analyzed the AANA survey using the same method used on the NBCRNA survey. The bar graphs depicting the structured questions are shown in Appendix C. Recommendations have been included in the recommendations list below.

![AANA Survey Comments](image)
Recommendations
The following recommendations regarding the CPC Program were taken from the randomly selected sample of survey responses, Tumblr submissions, and emails.

Recertification
- Instead of the CPC Program, the criteria for receiving the original CRNA certification should be made more rigorous.

Training (Continuing Education Units, Modules, Access to Training)
- The program should include a self-assessment exam to guide CRNAs' choices of which CEUs to take.
- CRNAs should be able to accumulate case data to support their skill-set, accompanied by a supervisor's evaluation, to receive CEU credits or exemption from the test.
- CEU requirements should be dependent on test performance.
- Design CEUs to give people credit toward PhDs or count PhD courses as evaluated CEUs. Replace CEUs and the exam with a work study booklet.

Core Competencies
- CRNAs who only do administrative work should have the option of completing a modified recertification process that gives them an administrative designation.
- CRNAs doing only administrative work should be required to refresh their clinical skills in a general hospital setting as part of the CPC Program.

Practice Requirements
- The exercises required to be recertified after not completing 425 hours in a year should be proctored hours of anesthesia administration by the recertification candidate.
- Increase the practice requirements.
- Spread the practice requirements over a number of years to compensate for pregnancies, illnesses, and other pauses in practice.
- CRNAs working in rural hospitals that do not demand the 425 working hours a year should receive a waiver for the practice requirements.

Recertification Exam
- The CPC should include smaller, more frequent "quizzes" that determine if someone has to take the larger test at the end of the 8 years.
- The number of times a candidate can take a recertification exam should not be limited.
- Rather than a pass-fail exam, CRNAs should just be mandated to take more CEUs in the areas of poor performance on the exam.
- NBCRNC should host practice tests at state meetings in the years leading up to the implementation of the test to prepare CRNAs and alleviate anxiety.
- The CPC Program should not only include a written examination, but a skills test as well.

Grandfathering
- Place people on a recertification probationary period if they make documented errors, rather than mandate all CRNAs participate in the CPC Program.
- A grandfather clause should be created not just based on a CRNA's practice years, but documented errors and malpractice claim history.
- Grandfather clause should be created for CRNAs practicing more than 5 years...more than 10 years...all current CRNAs...the same as Anesthesiologists' grandfather clause.
Cost/Time

- The NBCRNA should guarantee the majority or entirety of CEUs will be available to take online to offset the increase costs imposed by the greater number of CEUs and added test
- Use online testing rather than testing centers to keep costs and time spent to a minimum.
- Provide free review and test prep courses.
Recertification Practices in Other Fields

Introduction
The Institute of Medicine's reports and discussions on quality of medical care have focused on a systems-based approach to quality improvement. In the late 1990s, member organizations of the American Board of Medical Specialties (ABMS) started the process of defining new requirements for physician recertification. The ABMS maintenance of certification initiative calls for evidence of the following (Brennan et al., 2004):

1. Professional standing
2. Lifelong learning and periodic self-assessment
3. Cognitive expertise as demonstrated by a secure examination
4. Performance in practice

To assess current trends, the NBCRNa conducted an extensive review of recertification practices across a wide range of medical fields. Complete comparison tables can be found in Appendix A of this report. Fields which were reviewed included:

Advanced Practice Nurses
- Nurse anesthetists
- Certified nurse midwives
- Nurse practitioners

Independent Health Care Providers
- Anesthesiologists
- Medical Examiners
- Optometrists
- Pharmacists
- Podiatrists

Other Dependent Health Care Providers
- Anesthesiologist assistants
- Occupational therapists
- Physical therapists
- Physician assistants

Frequency for Recertification

Advanced Practice Nurses
The current recertification cycle for nurse anesthetists is the shortest among surveyed nursing professions. Nurse anesthetists currently recertify every two years while nurse midwives and nurse practitioners recertify every three to five years.

Independent Health Care Providers
The recertification cycles for surveyed independent provider specialties ranges from five to ten years.

Other Dependent Health Care Providers
Recertification cycles for other medical professions range from two years (Anesthesiologist Assistants) to ten years (Physical Therapists).

Continuing Education
Direct comparison of continuing education (CE) requirements is complicated by differing recertification cycle lengths across medical professions. To facilitate analysis, the CE requirements for each profession were standardized to
hours/year, even though most of the certifying agencies only require that a total number of hours be completed over the course of the entire cycle to fulfill the requirements.

### Advanced Practice Nurses

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<tr>
<td>Nurse Anesthetists</td>
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<td>Nurse Practitioners (NCC) high</td>
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<td>Certified Nurse Midwives high</td>
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<tr>
<td>Nurse Practitioners (AANP)</td>
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### Independent Health Care Providers

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<tr>
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<td>Pharmacists low</td>
<td>4.3</td>
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<tr>
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### Other Dependent Health Care Providers

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### Compiled List of All Professions

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</tr>
<tr>
<td>Physical Therapists</td>
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</table>

Nurse Anesthetists currently require the highest number of CE hours per year among nurses reviewed, although they (along with Anesthesiologist Assistants) are in the upper-middle range when compared to all fields that were reviewed. Among the three groups of medical fields reviewed, those specializing in anesthesia ranked at or near the top of each individual group for most CE hours required per year.

### Recertification Examination

Of the twelve medical fields reviewed, nine (75%) make use of a recertification exam while three (25%) do not. Of the nine fields using recertification exams, seven fields require the exam for recertification and two fields have an exam as an option for recertification. Of the three fields that do not require a recertification exam, one (certified Nurse Midwives) plans to require an exam within the next five years.

### Professional Work Requirements

Of the twelve medical fields reviewed, five (42%) had professional work requirements of some kind for re-licensure, while seven (58%) did not. Of the three groups reviewed (nurses, doctors, other), nurses had the most fields...
requiring proof of professional work experience with two out of the three (67%) fields of nursing having a required number of practice hours. Of the five fields that have professional work requirements, three have a minimum number of practice hours required, while two require other forms of proof of practice.

Re-entry into Practice
In general, becoming recertified in the reviewed medical fields after being away from active practice involves sitting for either a recertification exam (if used by the certifying agency) or the initial certification exam.

Different medical fields allow different timeframes for recertification after being out of active practice or allowing certification to lapse, but retaking an examination is a requirement for the vast majority of reviewed medical fields.

A few examples of timeframes used for different medical fields include:

- Nurse anesthetists – demonstrate “substantial engagement” for up to five years, otherwise a refresher course is required, as is re-taking the initial certification exam
- Nurse practitioners (AANP) – Must demonstrate 1,000 practice hours over the past five years, otherwise re-take the initial certification exam
- Nurse practitioners (NCC) – If more than 12 months after lapsed certification, re-take initial certification exam
- Anesthesiologists – Must have been out of practice for over 12 years, then either repeat CA3 year; 12 month fellowship or in-training exam
- Optometrists (ABO) – If more than three months after lapsed certification, re-take initial certification exam
- Physical therapists - 200 hours over past three years or re-take initial certification exam
- Physician assistants - 300 hours over past six years to take recertification exam or may sit for initial certification exam at any time

Other options for recertifying after lapsed certification include:

- Continuing education – Pharmacists (certain specialties), Occupational therapists
CPC Presentations at State Conferences

Introduction
The NBCRNA provided speakers to present the proposed CPC Program at state meetings in the fall of 2011. The presentations were intended to provide information and allow the opportunity for interactive dialogue on the future of recertification of nurse anesthetists.

Three specific objectives for the meetings were established. They were to:
1. Provide an overview of nurse anesthesia credentialing and trends in continued competence.
2. Discuss the proposed NBCRNA Continued Professional Certification (CPC) Program for the recertification of nurse anesthetists.
3. Promote audience participation by addressing common concerns about the CPC, taking questions related to the CPC Program, and recording the participants’ recommendations and feedback for the CPC Committee’s consideration.

Speakers representing NBCRNA presented at 32 state meetings in front of 4,150 attendees.

Discussion
The meetings offered an opportunity to clarify the CPC Program and obtain feedback that could be considered by the CPC Committee. The individuals who presented the proposed CPC Program at state meetings reported the questions and comments they received during their presentations, which fell into the following categories:

- General Feedback
- Training/Continuing Education requirements, Modules
- Practice Requirements
- Recertification Exam
- Grandfathering
- Cost/Time
- Reinstatement requirements
- Preparation for CPC and for the Exam
CPC Committee/Delphi Process: Revisions to Initial CPC Program Criteria

Introduction
The CPC Committee was created in September 2011 to oversee and manage the CPC Program process, with the support of a team of staff leaders and external consultants. They were charged with considering the recommendations from all NBCRNA stakeholders, the credentialing requirements of other professions, and the research literature on continued competence in an effort to further improve the proposed CPC Program.

Summary of the CPC Committee Activities
Since its formation, the CPC Committee met each week via teleconference to discuss and evaluate information about the proposed CPC Program. During their weekly meetings, members of the CPC Committee conducted an analysis of the topics raised by respondents each week and considered how to respond to concerns, comments, and suggestions. Sources of information included e-mails, letters, and phone calls from stakeholders; responses to communications developed by the NBCRNA members and staff; feedback obtained at state anesthesia meetings; and literature addressing topics relevant to the CPC proposal; submissions to the NBCRNA CPC web site during the open comment period; and surveys conducted by the NCRNA and AANA boards of directors.

Based on its analysis, the CPC Committee developed some potential modifications to the original CPC proposal. The focus of the committee's modifications was twofold. First, the proposed modifications needed to be consistent with the patient safety goals of the original proposal. Second, the proposed modifications needed to address the major concerns of the stakeholders.

The proposed modifications addressed the concerns of cost, time, professional practice requirements, recertification testing, and re-entry into practice. To further evaluate the potential modifications, and solicit additional recommendations, the committee decided to assemble a group of experts who had a broad understanding of the goals of the CPC process and the issues associated with the process. The committee identified 16 individuals who agreed to participate in a Delphi Panel Group.

The Delphi Panel
The role of the Delphi panel was to assist in establishing a valid set of CPC Program items that were consistent with the vision of the NBCRNA and addressed identified concerns of stakeholders. The Delphi panel was composed of individuals identified within the profession as leaders in certification, education, and practice development. The expert panel consisted of members who have appropriate training, experience, and qualifications in the area being evaluated. In order to minimize biases, selection of the panel of experts included careful consideration of individual demographics and attributes critical to the substantive area under review. Members were selected from different geographic locations with unique expertise in various areas of anesthesia education and practice.

The Delphi Process
The Delphi process, developed in the 1950s by the Rand Corporation for use in U.S. military intelligence, was conceived as a judgment tool in which group experts evaluate the reliability and validity of subject matter. This survey method makes use of structured group opinion and discussion to generate group consensus, assess priorities, and quantify the judgments of experts. The Delphi process is a valid method for the systematic solicitation and collation of informed judgments on a particular topic.

The Delphi process is thought to be a more reliable method for expert analysis than a face to face group discussion. It has four characteristics that make it an effective decision-making tool: anonymity, interaction with feedback, statistical group response, and expert input. The form of the Delphi process employed for this evaluation consisted of data sets and rounds of discussion. All information distribution took place under controlled conditions. Each round was conducted electronically, which assisted in maintaining anonymity. Overall comments were encouraged in each round, and distributed to the other panel members, which helped the panel understand some of the thoughts and concerns of other panel members while maintaining anonymity. Below is a summary and analysis of the results.
Delphi Process Round #1

In the first round, the Delphi Panel was presented with the original CPC proposal and the potential modifications developed by the CPC Committee. Each component was assigned to one of six categories:

1. Length of Certification
2. Competency Modules
3. Continuing Education
4. Recertification Examination
5. Professional Work Requirements
6. Re-entry Into Practice

Participants were asked to review the material and select the recommendations they felt best fit the attributes of a sound and effective CPC Program. They were also invited to provide any recommendations they felt would better suit the CPC Program. This round was designed to encourage members to add any recommendations they felt would improve the proposed CPC Program.

If any of the panel members added recommendations, those would be evaluated by the rest of the panel in subsequent rounds, along with the original recommendations that had been accepted by more than 20% of the panel members.

The first round of the Delphi process resulted in responses scattered among the choices. This is typical of a first round Delphi process when the panel is a truly diverse group of individuals with independent opinions.

Length of Certification: The two items presented in the category were evenly split, with one item added for the next round.

Competency Modules: All items made it through the first round along with four additional options provided by panel members.

Continuing Education: This category resulted in the most number of panel-added options at six. All items presented made it to the second round.

Recertification Examination: This category contained the only item that was rejected by the panel in the first round. The original proposal for an exam that had to be successfully completed during the second four-year recertification cycle but no later than December 31, 2023 to remain certified (high stakes) did not obtain more than 20% acceptance by the panel. Four items were added for the next round.

Professional Work Requirements: All items made it to the next round, and two additional items were added.

Re-entry into Practice: All items made it to the next round, and two additional items were added.

Delphi Process Round #2

In the second round, the items initially found acceptable by more than 20% of the panel members, and those items contributed by the panel were compiled and ranked. For each item in the data set, panel members were asked whether they “strongly agreed,” “agreed,” “disagreed,” or “strongly disagreed.” The round demonstrated the strength of opinion for each item.

Length of Certification: The concept of a two-year certification period was rejected. The panel felt that the certification period should be four years and felt strongly that a compliance audit every two years might be a good option.

Competency Modules: The panel felt strongly that competency modules should be part of the CPC process, and they also felt strongly that completion of the modules should allow for CE credit. They did feel there was some value in additional modules to cover updates in the core competency modules and other professional aspects. More panel members disagreed than agreed with the concept of reduced costs for those who did not want CE credits for the modules.

Continuing Education: The section on continuing education developed the most widespread division between agreement and disagreement in all categories. The only strong areas of opinion were disagreement that all
credits should be assessed, that the CE requirements should be every two years, and that failure to meet the requirements every two years would result in revocation of certification.

**Recertification Examination:** The panel felt that some sort of grandfathering or delayed institution of a “high stakes” exam should be instituted. Sixty percent of the panel strongly disagreed with the concept of eliminating the exam while 33% of the panel did express some level of agreement that the exam should be eliminated.

**Professional Work Requirements:** This category continued the theme of disagreement with a two-year certification period. There was agreement with the proposed 425-hour annual work requirement to be audited every two years in the four years cycle.

**Re-entry into Practice:** The original CPC proposal for re-entry into practice failed to gain more than 20% agreement in this round. There was support for either a flexible or firm plan to help individuals re-enter the professional after loss of certification. However, the strongest agreement was to “address the re-entry plan at a future date and not make it part of the current CPC discussion.”

**Delphi Process Round #3**

In the third round, all items that were marked either “strongly agreed” or “agreed” in the second round by more than 20% of the panel were evaluated by the panel once again. In previous rounds, each item was being evaluated on its own merits. In the third round, it was time to evaluate the items as they compared to each other. In this final round, the panel was asked to choose the items that were the “best fit” for the final CPC Program.

**Length of Certification:** A vast majority of the panel members (94%) answering the survey felt that the certification period should be 4 years with an audit being completed every two years. Individuals not completing at least half of the required components would receive a letter of compliance.

**Competency Modules:** Two of the items were selected by more than 20% of the panel. One was to have two modules in addition to the four core competency modules which would cover updates to the core competencies and other professional issues that might be tested in the re-certification exam (44%), while (25%) chose one additional module to cover updates to the core competencies.

**Continuing Education:** This category was divided into two distinct themes.

The first theme concerned the number and type of CE credits required. The option of “keeping the current CE requirements” was rejected by the panel. The responses were divided among all three options:

- “15 assessed and 20 non-assessed credits per year” (the original proposal) was selected by 25% of the panel
- “an annual requirement of 15 assessed and 10 non-assessed credits” was selected by 25% of the panel
- “incremental increases of assessed and non-assessed credits” was selected by 38% of the panel

The second theme concerned the approval process, which would impact the cost of obtaining CE credits. The option for non-assessed CE credits to be self-monitored and audited was selected by 75% of the panel.

**Recertification Examination:** As originally proposed, a competency examination should be required every 8 years. However, it was recommended that all CRNAs certified before 2015 be allowed to use the results of the initial examination to be completed by 2023 as a “self-assessment.” Those taking the exam for self-assessment but failing to meet a passing standard in predetermined categories would be required to take additional continuing education credits in that category in order to retain certification. The requirement for additional continuing education would provide for remedial action to encourage certificants to improve their knowledge in areas of weakness. The provision to initially exempt those certified before 2015 from having to pass a recertification exam would gradually implement the requirement for all CRNAs to pass an exam by the year 2031.

**Professional Work Requirements:** The panel rejected the option of a one-year audit on the 425-hours annual work requirement, and were split between a two-year audit with continuing education required for non-compliance (58%), and a four-year audit (38%).
Re-entry into Practice: A program with pre-determined criteria for re-entry into practice was chosen by 44% of the panel while 31% of the panel selected the option to “remove this topic from the current discussion.” Only 25% felt the re-entry criteria should be considered on an individualized basis.

CPC Committee Recommendations for Changes to the Initial CPC Program Criteria

After evaluating CRNAs’ feedback on the proposed CPC Program, and refining alternatives through a Delphi process, guided by the original focus of encouraging lifelong learning, providing for demonstration of competency, and maintaining patient safety, the CPC Committee recommended the following:

Starting Date of CPC Program: As originally proposed, the CPC program would begin in 2016. The CPC Committee believed that resetting the start date to 2016 would provide valuable time to ensure that consensus is reached on recommendations.

Length of Certification: As originally proposed, the certification period should be four years. In addition, the program should include a “progress audit” for each certificant to be completed every two years. Individuals not completing at least half of the required components should receive a letter reminding them of the four-year requirements.

Competency Modules: As originally proposed, the program should include a requirement to complete 4 modules every four years on subjects addressing core competencies in anesthesia. The NBCRNA should consider adding 1 or 2 additional types of modules: one would cover updates to the core competency modules, while the other would address professional issues beyond the core competencies that would be included in the recertification examination. In addition, the modules should provide continuing education credit, which would require prior approval by the AANA CE Committee.

Continuing Education: As originally proposed, the continuing education requirements should be divided into “assessed” and “non-assessed” components. The assessed activity requirement should remain as proposed at 15 CE units per year. Consideration should be given to reducing the originally proposed 20 non-assessed CE units per year to a requirement of 10 CE units per year. An alternate option to consider would be to start the non-assessed requirement at 10 units and incrementally increase the requirement to 20 units over a period of time.

In addition to the number of credits required under each category, the CPC Committee recommended that the assessed credits be prior-approved by the AANA CE committee, while the non-assessed credits are self-monitored by the certificant, but audited by the NBCRNA as necessary. This option would allow the NBCRNA to more efficiently manage the criteria for non-assessed credit while reducing the overall cost to the certificant.

Recertification Examination: As originally proposed, an examination should be required every eight years; however, the CPC Committee recommended that all CRNAs certified before 2015 be allowed to use the results of the initial examination to be completed by 2023 as a “self-assessment.” Those taking the exam for self-assessment but failing to meet a passing standard in predetermined categories would be required to take additional continuing education credits in that category, over and above the minimum requirements that must be met by all certificants, in order to retain certification. The provision to initially exempt those certified before 2015 from having to pass a recertification exam in the initial cycle would gradually implement the requirement for all CRNAs to pass an exam by the year 2031.

Professional Work Requirements: As originally proposed, the CPC Program should require 425 practice hours per year; however, the committee recommended that this requirement be audited on a two-year cycle, which would essentially create a practice requirement of 850 hours every two years. An alternative would be to use a four-year audit cycle that would create a requirement of 1,700 every four years. The NBCRNA needs to determine if action should be taken for those not meeting the requirement annually, every two years, or every four years.

Re-entry into Practice: The CPC Committee recommended that a re-entry program be established with predetermined criteria. Certificants will want to know what actions can be taken to regain certification if they fail
to complete the CPC requirements. Although the criteria for re-entry can be addressed at a future date, the CPC Committee believes that it is important for the CPC Program to contain a reasonable re-entry path option.
History of Changes to the CPC Program From 2011 through 2014

The Continued Professional Certification Program (CPC) is a process that has been developed by NBCRNA to replace the current recertification requirements for certified registered nurse anesthetists. The CPC Program addresses evolving expectations among patients, employers, and certifying bodies, as well as changes in the science and practice of anesthesia. Underlying the program is a fundamental emphasis on continuous growth and professional development throughout a nurse anesthetist's career via lifelong learning and assessment.

The NBCRNA’s CPC Program has been almost eight years in the making. It has not only been built and based upon the latest research and analysis of nurse anesthetists practices, but has been informed by input, feedback, and comments from a wide variety of stakeholders. The CPC Program has undergone revision since its first introduction in August 2011. The purpose of the revision process was to ensure that the final criteria reflected a flexible and relevant program for CRNAs, regardless of their practice situation.

The Recertification Task Force, Fall 2010

NBCRNA formed a Recertification Task Force in the fall of 2010, which included a member of the AANA Board of Directors. The Task Force was charged with reevaluating the recertification process for nurse anesthetists. Members of the Recertification Task Force participated in presentations in over 30 state association meetings targeting 2,000 nurse anesthetists and hosted 10 focus groups to discuss the future of recertification. The Task Force reviewed medical and scientific resources to evaluate the current recertification program, and reviewed the results of a professional practice analysis and benchmarking activities conducted by the NBCRNA between 2008 and 2010.

First CPC Criteria Proposed, August 2011

The Recertification Task Force presented the first proposed criteria for the CPC Program to NBCRNA Board of Directors in May 2011. The NBCRNA Executive Committee presented the proposed criteria to the AANA Executive Committee in June 2011, with a subsequent presentation to the full AANA Board in August 2011. The AANA Board accepted the proposed preliminary draft and NBCRNA presented it to the CRNA community and the AANA membership in August 2011. Shortly after this, the proposed CPC Program was opened for full comprehensive public review and comment. The NBCRNA reviewed and considered over 13,000 comments received from CRNAs and the AANA. NBCRNA representatives attended state meetings to engage with members, CRNAs, and other stakeholders to talk about the proposed CPC Program, as well as answer questions and solicit input.

Following the introduction of the initial draft of the CPC Program at the August 2011 AANA Annual Meeting and the ensuing 3-month open comment period, the NBCRNA established a CPC Committee comprising practicing CRNAs and consultants to collect and review CRNAs’ comments, questions, and recommendation. The CPC Committee, informed by many factors, revised the initial criteria of the CPC Program.

The revised criteria for the CPC Program were then shared with a panel of individuals identified within the nurse anesthetist profession as leaders in certification, education, and practice development. This panel worked to refine the committee’s list of recommendations, using a consensus-building process known as the Delphi Process.

First Major Revision of CPC Criteria, January 2012

In January 2012, the CPC Committee presented to the NBCRNA Board of Directors the information collected and refined recommendations for changes to the CPC Program, based on results from the public comment period. The NBCRNA Board approved:

- The professional work requirement for a specified number of hours of practice was removed.
- The non-assessed CE requirement was reduced to 10/year.
- Professional activity units were first introduced to the CPC program.
- Credit earned from the Core Modules could be applied to meet assessed CE credits.
- The CPC Examination would be phased into the CPC Program, with the requirement date for meeting the passing standard moved to 2032.
- The CPC Program start date was moved back 1 year, to January 1, 2016.
Second Major Revisions of CPC Criteria, January 2014 through August 2014

In the fall of 2013, a second CPC survey was conducted of the CRNA community. As a result of direct discussions with the AANA and with members of the CRNA community and a review of survey feedback, the NBCRNA Board of Directors approved additional revisions to the CPC criteria:

- Life support courses will be able to be reported as Class A credits if they were pre-approved and assessed, or as Class B credits if they were either excess Class A credits or not pre-approved and assessed.
- For each domain area in which a nurse anesthetist does not meet a performance standard on the CPC Examination administered during the second 4-year cycle (beginning January 2020), the nurse anesthetist will take an additional Core Module.
- The NBCRNA and the AANA agreed that the AANA Continuing Education Committee would continue to be responsible for the development of the criteria for assessed CE.
- Core Module would continue to require electronically delivered assessment, but the delivery mode of the module itself was expanded beyond web-only and the cap on CE credits was removed. Further, vendors will determine which module performance objectives will be covered in a module, based on the latest evidence.

Third Major Revision of CPC Criteria, August 2014 through December 2014

In the fall of 2014, the NBCRNA Board of Directors approved additional revisions to the CPC program components:

- At the request of the AANA, on behalf of the membership, NBCRNA Board of Directors approved changes to the terminology of CPC Program components:
  - The term assessed continuing education requirement was changed to Class A credits.
  - The term Professional Activity Unit (PAU) was changed to Class B credits.
  - The term Diagnostic was removed from the CPC Examination description. Both the performance standard and passing standard CPC Examinations will be called CPC Examination.
- The CPC Program start date was moved back to August 1, 2016.
- CPC Core Modules will be voluntary for the first 4-year cycle.
- Additional options will be explored beyond retaking a CPC module for CRNAs who do not meet the performance standards of the “low stakes” CPC Examination during the 2020-2024 recertification cycle.

The Final Criteria for the CPC Program, December 2014

Since the initial proposed criteria for the CPC Program, the CPC Committee and NBCRNA Board have continued to refine the components, based on input from the AANA, certificants, and other stakeholders. Every component of the CPC Program has been analyzed and revised to ensure that the CPC Program will have practice-related validity and that the requirements of the CPC Program are essential, regardless of practice setting, patients, and conditions.

The history of changes to the CPC Program components is summarized in Table 1.
<table>
<thead>
<tr>
<th>Length of Cycle</th>
<th>Initial Program (August 2011)</th>
<th>Changes in Current Program (December 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Two 4-year cycles</td>
<td>Same</td>
</tr>
<tr>
<td>Start date</td>
<td>January 1, 2015 start date.</td>
<td>Start date moved to August 1, 2016</td>
</tr>
<tr>
<td>Certification and Licensure</td>
<td>Recertification is contingent on having initial certification and a current and valid registered nursing and/or advanced nursing practice license or a Certified Registered Nurse Anesthetist by NBCRNA or its predecessor(s).</td>
<td>Same</td>
</tr>
<tr>
<td>Work/Practice</td>
<td>Documentation of at least 425 hours per year in nurse anesthesia work practice with requirements for individuals who do not document compliance with the professional work practice requirement.</td>
<td>Requirement for a specified number of hours removed.</td>
</tr>
<tr>
<td>CE Requirement: Assessed</td>
<td>15 credits per year in assessed CE.</td>
<td>Same number of credits per year. Allowing (assessed) life support courses to be reported. AANA CE Committee will develop assessed CE criteria. The term “Class A” credits introduced at AANA’s request.</td>
</tr>
<tr>
<td>CE Requirement: Non-Assessed</td>
<td>20 credits per year in non-assessed educational activities.</td>
<td>Reduced to 10 credits per year. Allowing life support courses to be reported. PAUs changed to “Class B” credits at AANA’s request.</td>
</tr>
<tr>
<td>CPC Modules</td>
<td>Four core modules in every four-year CPC cycle, one module in each of four core competency areas.</td>
<td>CPC Core Modules will be voluntary for the first 4-year cycle. Modules provide assessed CE credits. Module delivery mode expanded beyond web-only. Module CE caps removed.</td>
</tr>
<tr>
<td>Examination</td>
<td>Successful completion of a standardized recertification examination every 8 years (at any time during the second four-year recertification cycle).</td>
<td>Pass/Fail exam will be phased in over 20 years (passing standard moved from 2023 to 2032). Exam in the first 8-year interval will require meeting a performance standard. Options will be explored beyond taking a CPC module if a performance standard is not met on the first CPC Exam.</td>
</tr>
<tr>
<td>Reentry Program</td>
<td>If more than 90 days have transpired, these individuals will be required to satisfy the eligibility criteria for recertification at the time of their reapplication as well as apply for and pass the entry-level National Certification Examination (NCE).</td>
<td>Complete 4-year CPC cycle requirements and take CPC examination; complete activities in an accredited simulation center; evidence of employment in nurse anesthesia within 12 months of completing first two requirements</td>
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### Table 2: Evolution of CPC Program Changes 2011 Through 2014

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<tr>
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<tbody>
<tr>
<td>Length of Cycle</td>
<td>Four years</td>
<td>progress audit for each certificant, to be completed every 2 years.</td>
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<tr>
<td>Start date</td>
<td>January 1, 2015 start date</td>
<td>Start date moved to January 1, 2016.</td>
<td></td>
<td></td>
<td></td>
<td>Start date moved to August 1, 2016</td>
</tr>
<tr>
<td>Certification and licensure</td>
<td>Initial certification, Current and valid license</td>
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<tr>
<td>Work/Practice</td>
<td>At least 425 hours per year in nurse anesthesia work practice</td>
<td>Requirement for a specified number of hours removed.</td>
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<tr>
<td>CE Requirement</td>
<td>15 credits per year in assessed CE.</td>
<td>Assessed credits must be prior approved</td>
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<tr>
<td>Non-assessed CE</td>
<td>20 credits per year in non-assessed educational activities</td>
<td>The term &quot;Professional Activity Units&quot; introduced</td>
<td>Categories and values defined</td>
<td></td>
<td></td>
<td>PAUs changed to &quot;Class B&quot; credits</td>
</tr>
<tr>
<td>CPC Core Modules</td>
<td>Four core modules in every recertification cycle, one in each of four core competency areas.</td>
<td>After public comment, the Board approved modules will provide assessed commencing education credits</td>
<td>Module instructional designs and recognition panel process approved</td>
<td>Requirement that assessment delivered electronically returned; module delivery mode expanded beyond web-only and module CE caps removed.</td>
<td></td>
<td>CPC Core Modules will be voluntary for the first 4-year cycle</td>
</tr>
<tr>
<td>Examination</td>
<td>Recertification exam every 8 years</td>
<td>Fast/Fail exam will be phased in over 20 years.</td>
<td>Passing standard moved from 2015 to 2022. Exam in the first 8-year interval will be diagnostic.</td>
<td>Completion of one core module for each domain in which a performance standard was not achieved on the CPC diagnostic exam.</td>
<td></td>
<td>Options will be explored beyond taking a CPC module if a performance standard is not met on the first CPC Exam</td>
</tr>
<tr>
<td>Reentry Program</td>
<td>If more than 90 days have transpired, satisfy the eligibility criteria for recertification at the time of reapplication and pass the entry-level NCE</td>
<td>Complete 4-year CPC cycle requirements: Complete activities in an accredited simulation center; employment in nurse anesthesia within 12 months of completing first two requirements</td>
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# Appendix A: Recertification Practices of Other Fields

## Table A.1: Recertification programs in advanced practice nursing.

<table>
<thead>
<tr>
<th>Recertification program components</th>
<th>Nurse anesthetists (current)</th>
<th>Certified nurse midwives</th>
<th>Nurse practitioners (AANP)</th>
<th>Nurse practitioners (NCC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency for recertification</strong></td>
<td>Every 2 years</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Current licensure</strong></td>
<td>Unrestricted license as a registered nurse</td>
<td>Unrestricted license as a registered nurse</td>
<td>Unrestricted license as a registered nurse</td>
<td>Unrestricted license as a registered nurse</td>
</tr>
<tr>
<td><strong>Continuing education</strong></td>
<td>40 hours continuing education</td>
<td>20 hours CE; complete 3 self-learning modules each cycle that accounts for 18-20 CE credits per module</td>
<td>75 hours continuing education</td>
<td>15-50 hours continuing education</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td>Not required</td>
<td>Proposed over the next 5 years: Assessment of Performance in Practice and Standardized Cognitive Assessment</td>
<td>Optional: computer-based exam or CE plus practice</td>
<td>Specialty Assessment Evaluation: 125 questions reflecting the core certification specialty knowledge competencies (2010-2013)</td>
</tr>
<tr>
<td><strong>Practice</strong></td>
<td>Substantial engagement (850 hours) in the practice of nurse anesthesia over 2-year period</td>
<td>Not required</td>
<td>1,000 hours</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Re-entry</strong></td>
<td>2-3 years: Submit record of practice demonstrating substantial engagement within the past 3 years</td>
<td>Take and pass the exam, and submit an average of 10 ACNM/ACCME continuing education contact hours per year since the date of last certification (up to a maximum of 100 hours)</td>
<td>1,000 practice hours over 5 years or re-take initial certification exam</td>
<td>Retake examination if more than 12 months after certificate lapse</td>
</tr>
<tr>
<td>Recertification program components</td>
<td>Anesthesiologists (ABIME)</td>
<td>Medical Examiners (ABCO)</td>
<td>Optometrists (ABO)</td>
<td>Pharmacists (BPS)</td>
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<tr>
<td><strong>Frequency for recertification</strong></td>
<td>Every 10 years (if certified after 1990)</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
<td>Every 10 years</td>
</tr>
<tr>
<td><strong>Current licensure</strong></td>
<td>Current license as a medical doctor</td>
<td>Current unrestricted state medical license</td>
<td>Unrestricted license to practice optometry</td>
<td>Valid therapeutic license</td>
</tr>
<tr>
<td><strong>Continuing education</strong></td>
<td>350 continuing education units in 10 years (200 prior to the Maintenance of Certification Assessment, or MOCA)</td>
<td>15-35 hours of continuing education every 5 years, depending on recertification method</td>
<td>120 hours of continuing education every 5 years</td>
<td>100 total points every three years from continuing education activities</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td>MOCA in years 7 to 10 of each cycle</td>
<td>Written examination or “alternate pathway” of continuing education</td>
<td>Closed-book examination every 10 years</td>
<td>Recertification examination every 9-10 years</td>
</tr>
<tr>
<td><strong>Practice</strong></td>
<td>Clinical practice is required and evaluated locally, with case evaluation and clinical simulation</td>
<td>Nil required</td>
<td>Nil required</td>
<td>Nil required</td>
</tr>
<tr>
<td><strong>Re-entry</strong></td>
<td>If not more than 12 years, recertification can involve - repeat CA3 year; 12 month fellowship or re-training exam</td>
<td>No formal policy</td>
<td>No formal policy; Certification is tied to state licensure.</td>
<td>If lapsed, given up to 3 months to meet all MOC requirements. Otherwise, required to re-take certification exam.</td>
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</table>
## Table A.3: Recertification programs in other dependent health care providers.

<table>
<thead>
<tr>
<th>Recertification program components</th>
<th>Anesthesiologist Assistants</th>
<th>Occupational Therapists</th>
<th>Physical Therapists</th>
<th>Physician Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency for recertification</strong></td>
<td>Every 2 years</td>
<td>Every 3 years</td>
<td>Every 10 years</td>
<td>Every 6 years</td>
</tr>
<tr>
<td><strong>Current licensure</strong></td>
<td>Not required</td>
<td>Not required</td>
<td>Current licensure to practice physical therapy</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Continuing education</strong></td>
<td>40 continuing education units</td>
<td>36 Professional Development Units every 3 years</td>
<td>One of multiple activities to obtain points for Professional Development Portfolio</td>
<td>300 hours of continuing education over the 6-year certification maintenance cycle, logging a minimum of 100 hours every 2 years</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td>Examination for Continued Demonstration of Qualification Exam every 6 years</td>
<td>Not required</td>
<td>Written examination or Professional Development Portfolio every 10 years</td>
<td>By the end of the sixth year of the certification maintenance cycle, PA-C designees must have also passed a recertification exam</td>
</tr>
<tr>
<td><strong>Practice</strong></td>
<td>Not required</td>
<td>Not required</td>
<td>In general, candidates are required to document evidence of continued direct patient care activities in the specialty area, the equivalent of 200 hours per year since the date of most recent certification. Two hundred of the total hours must have occurred within the last two (2) years</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Re-entry</strong></td>
<td>Any practitioner who has permitted his/her certification to lapse may re-enter the certification process by applying for and successfully completing a Certifying Examination for Anesthesiologist Assistants</td>
<td>Requires documenting 36 Professional Development Units, but no formal lapse policy</td>
<td>200 practice hours within last 3 years are required or you have to go through initial certification again</td>
<td>300 practice hours over past 6 years to take recertification exam or may sit for initial certification exam at any time</td>
</tr>
</tbody>
</table>
## Appendix B: NBCRNA Survey Summary

Continued Professional Certification (CPC) Survey Nurse anesthetists have been participating in the same process for recertification for the past 33 years. When that recertification process was originally created it placed the CRNA credential at the forefront.

### Survey Status: Active
Launched: 9/19/2011 11:21 AM   Closed: VAR

<table>
<thead>
<tr>
<th></th>
<th>Email Invites</th>
<th>Visits: 5394</th>
<th>Partial: 0 / 0</th>
<th>Screen Outs: 0 / 0</th>
<th>Over Quota: 0 / 0</th>
<th>Completes: 3884 / 3847</th>
</tr>
</thead>
</table>

### 1. Please select the category that best describes you

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified registered nurse anesthetist</td>
<td>3270</td>
<td>67%</td>
</tr>
<tr>
<td>Public</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>Nurse</td>
<td>15</td>
<td>3%</td>
</tr>
<tr>
<td>Hospital Administrator</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>67</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>3813</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 2. Number of years working in your profession

<table>
<thead>
<tr>
<th>Years</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>1429</td>
<td>27%</td>
</tr>
<tr>
<td>11-19</td>
<td>962</td>
<td>20%</td>
</tr>
<tr>
<td>20 and over</td>
<td>1442</td>
<td>28%</td>
</tr>
<tr>
<td>Total</td>
<td>3811</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 3. Age in years

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>25-30</td>
<td>183</td>
<td>4%</td>
</tr>
<tr>
<td>31-40</td>
<td>684</td>
<td>22%</td>
</tr>
<tr>
<td>41-50</td>
<td>1056</td>
<td>26%</td>
</tr>
<tr>
<td>51-60</td>
<td>1363</td>
<td>34%</td>
</tr>
<tr>
<td>&gt;60</td>
<td>428</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>3813</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 4. The CPC program identifies four core competencies (anesthesia management techniques, applied clinical pharmacology, human physiology, and pathophysiology and anesthesia technology). Do you agree these competencies represent core areas of knowledge that should be mastered by CRNAs?

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3276</td>
<td>88%</td>
</tr>
<tr>
<td>No</td>
<td>433</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>3709</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 5. The CPC program proposes a five-year recertification cycle. Do you feel five years is an appropriate cycle?

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2847</td>
<td>51%</td>
</tr>
<tr>
<td>No</td>
<td>1867</td>
<td>49%</td>
</tr>
<tr>
<td>Total</td>
<td>3714</td>
<td>100%</td>
</tr>
</tbody>
</table>

---

8725 W. Higgins Rd.
Suite 525
Chicago, IL 60631

NBCRNA
855-285-4658
www.NBCRNA.com
708-669-7636 :: fax
### CPC Program Development 2008 - 2014

#### 9. The CPC program proposes online competency modules (1 in each of the four core competency areas) be completed every 4 years. Is this timeline appropriate?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>1740</td>
<td>49%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>1804</td>
<td>51%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3544</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### 10. The CPC program proposes 35 continuing education credits be required each year (14.5 every four years), and that 15 of the credits completed each year include an end-of-year activity assessment. Are these requirements reasonable?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>959</td>
<td>25%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>2567</td>
<td>75%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3526</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### 11. The CPC program proposes that individuals out of practice for more than 12 months must be required to complete new core competency modules and the continuing education credit requirements for the reactivation cycle and pass a reactivation examination. Are more than 12 months out of practice a reasonable time frame for these requirements?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>1458</td>
<td>41%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>2218</td>
<td>59%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3676</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### 1.2. Which of the following professional activities should count for consideration for the Continuing Education (CE) credit requirement (select all you believe should apply):

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced research (related to the profession)</td>
<td>1012</td>
<td>50%</td>
</tr>
<tr>
<td>Administration in professional roles and corporate level committees</td>
<td>1257</td>
<td>59%</td>
</tr>
<tr>
<td>Authorship of how chapters and peer reviewed articles</td>
<td>2125</td>
<td>50%</td>
</tr>
<tr>
<td>B-learning</td>
<td>1884</td>
<td>49%</td>
</tr>
<tr>
<td>Faculty in-service (practice relevant) program</td>
<td>2061</td>
<td>51%</td>
</tr>
<tr>
<td>Independent study program on topics related to nuclear medicine</td>
<td>2054</td>
<td>63%</td>
</tr>
<tr>
<td>Lectures presentations</td>
<td>2123</td>
<td>50%</td>
</tr>
<tr>
<td>Meeting attendance</td>
<td>2056</td>
<td>70%</td>
</tr>
<tr>
<td>Preceptorship of graduate nuclear medicine students (clerk)</td>
<td>1227</td>
<td>57%</td>
</tr>
<tr>
<td>Participation in simulation-based education</td>
<td>2620</td>
<td>62%</td>
</tr>
<tr>
<td>Technical career advancement</td>
<td>1212</td>
<td>62%</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>808</td>
<td>33%</td>
</tr>
</tbody>
</table>

#### 1.3. Are there any other compensatory factors you believe should be added to meet the ongoing learning goals of the cpc program?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>198</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>2792</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2990</td>
</tr>
</tbody>
</table>

#### 1.4. Other comments:

[No comments appear to be provided.]

---

27
### Appendix C: AANA Survey Results

#### 1. What is your opinion about the NBCRNA’s proposed Continued Professional Certification (CPC) program?

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Strongly Agree</td>
<td>212</td>
<td>3.33%</td>
</tr>
<tr>
<td>4</td>
<td>Agree</td>
<td>701</td>
<td>10.66%</td>
</tr>
<tr>
<td>3</td>
<td>Neither agree nor disagree</td>
<td>208</td>
<td>3.11%</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
<td>1515</td>
<td>23.05%</td>
</tr>
<tr>
<td>1</td>
<td>Strongly Disagree</td>
<td>3402</td>
<td>52.21%</td>
</tr>
<tr>
<td>0</td>
<td>Don’t know about the proposed CPC program (Skip to question No. 4)</td>
<td>75</td>
<td>1.14%</td>
</tr>
</tbody>
</table>

Mean: 1.88  | Responses: 6,079

#### 2. After the announcement of the proposed changes at the AANA Annual Meeting in Boston on August 7-11, 2011, I was provided with adequate information (by access to websites, emails, or printed literature) to understand the proposed NBCRNA CPC program.

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Strongly Agree</td>
<td>470</td>
<td>7.20%</td>
</tr>
<tr>
<td>4</td>
<td>Agree</td>
<td>2430</td>
<td>37.22%</td>
</tr>
<tr>
<td>3</td>
<td>Neither agree nor disagree</td>
<td>892</td>
<td>13.66%</td>
</tr>
<tr>
<td>2</td>
<td>Disagree</td>
<td>1562</td>
<td>23.93%</td>
</tr>
<tr>
<td>1</td>
<td>Strongly Disagree</td>
<td>1137</td>
<td>17.42%</td>
</tr>
<tr>
<td>0</td>
<td>Don’t know about the proposed CPC program (Skip to question No. 4)</td>
<td>37</td>
<td>0.57%</td>
</tr>
</tbody>
</table>

Mean: 2.93  | Responses: 6,928

#### 3. Prior to learning about this issue, who did you believe was responsible for determining the requirements for CRNA recertification? (Please check all that apply)

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>American Association of Nurse Anesthetists (AANA)</td>
<td>3193</td>
<td>48.16%</td>
</tr>
<tr>
<td>2</td>
<td>Council on Accreditation of Nurse Anesthesia Educational Programs (COA)</td>
<td>1048</td>
<td>16.12%</td>
</tr>
<tr>
<td>3</td>
<td>National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA)</td>
<td>1000</td>
<td>61.61%</td>
</tr>
<tr>
<td>4</td>
<td>Other entity</td>
<td>75</td>
<td>1.15%</td>
</tr>
</tbody>
</table>

Mean: 6,503  | Responses: 6,503

#### 4. After learning about this issue, who do you believe is responsible for determining the requirements for CRNA recertification? (Please check all that apply)

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>American Association of Nurse Anesthetists (AANA)</td>
<td>2034</td>
<td>31.08%</td>
</tr>
<tr>
<td>2</td>
<td>Council on Accreditation of Nurse Anesthesia Educational Programs (COA)</td>
<td>762</td>
<td>11.64%</td>
</tr>
<tr>
<td>3</td>
<td>National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA)</td>
<td>5298</td>
<td>80.94%</td>
</tr>
<tr>
<td>4</td>
<td>Other entity</td>
<td>114</td>
<td>1.74%</td>
</tr>
</tbody>
</table>

Mean: 6,544  | Responses: 6,544

#### 5. Prior to receiving this survey, were you aware that the NBCRNA has opened a Public Comment period regarding the CPC Program? (www.nbcrna.org.com from September 6, 2011 through November 14, 2011)

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>4708</td>
<td>74.61%</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>1470</td>
<td>25.39%</td>
</tr>
</tbody>
</table>

Mean: 6,579  | Responses: 6,579
CPC Program Development 2008 - 2014

6. Do you know the proposed timeframe for the implementation of the various components of the proposed CPC program?

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>2792</td>
<td>57.66%</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>2795</td>
<td>42.34%</td>
</tr>
</tbody>
</table>

7. How concerned are you with the following CPC components?  Total Number of CEUs required during each cycle

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Greatest Concern</td>
<td>2093</td>
<td>31.46%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1279</td>
<td>19.51%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>1353</td>
<td>20.43%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>777</td>
<td>12.17%</td>
</tr>
<tr>
<td>5</td>
<td>5 Least Concern</td>
<td>1063</td>
<td>16.21%</td>
</tr>
</tbody>
</table>

Changing the cycle from every 2 years to every 4 years

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Greatest Concern</td>
<td>945</td>
<td>14.76%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>770</td>
<td>11.56%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>1074</td>
<td>16.42%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>1095</td>
<td>16.78%</td>
</tr>
<tr>
<td>5</td>
<td>5 Least Concern</td>
<td>1593</td>
<td>24.25%</td>
</tr>
</tbody>
</table>

Requirement of a test for recertification

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Greatest Concern</td>
<td>5033</td>
<td>76.65%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>570</td>
<td>8.69%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>356</td>
<td>5.42%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>282</td>
<td>3.08%</td>
</tr>
<tr>
<td>5</td>
<td>5 Least Concern</td>
<td>482</td>
<td>6.13%</td>
</tr>
</tbody>
</table>

Lack of "grandfathering" for previously credentialed members

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Greatest Concern</td>
<td>4832</td>
<td>73.51%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>657</td>
<td>10.02%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>316</td>
<td>4.64%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>211</td>
<td>3.22%</td>
</tr>
<tr>
<td>5</td>
<td>5 Least Concern</td>
<td>476</td>
<td>7.23%</td>
</tr>
</tbody>
</table>

Rule for absence from practice for 12 months or more

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Greatest Concern</td>
<td>1672</td>
<td>25.97%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1206</td>
<td>18.74%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>1985</td>
<td>27.75%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>742</td>
<td>11.03%</td>
</tr>
<tr>
<td>5</td>
<td>5 Least Concern</td>
<td>1032</td>
<td>16.03%</td>
</tr>
</tbody>
</table>

Cost of CEUs and/or testing

<table>
<thead>
<tr>
<th>Value</th>
<th>Response</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Greatest Concern</td>
<td>2466</td>
<td>45.27%</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1482</td>
<td>26.83%</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>1064</td>
<td>16.23%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>488</td>
<td>8.73%</td>
</tr>
<tr>
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Access to testing facilities and/or CEU opportunities

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<td>1227</td>
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<td>65+</td>
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9. How long have you been a practicing CRNA?

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<td>2-3 years</td>
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<td>4-5 years</td>
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<td>6-10 years</td>
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<td>5</td>
<td>More than 10 years</td>
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10. Do you currently hold, or have you previously held within the past 10 years, any volunteer position(s) with your state association and/or ARNA?

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<td>No</td>
<td>5593</td>
<td>85.75%</td>
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Appendix D: Synopsis of Studies Used to Support CPC Recommendations

NBCRNA Continued Professional Certification Program Literature Review
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Introduction

A commonly asked but misguided question often asked when evaluating a proposed shift to a continued competency model of recertification is, “Where is the evidence that healthcare professionals are not competent?” The subject of competence can be a sensitive one to groups of experienced, educated professionals. It is important to understand however, that the fundamental goals of any continued competency program are continuous quality improvement and patient safety, and that these programs are not intended to find “bad apples.”

The Recertification Task Force and NBCRNA Board conducted an extensive review of 60 medical and scientific resources from the past 30 years to evaluate the current CRNA recertification program and to develop the initial proposed Continued Professional Certification (CPC) Program. Key findings supporting both the move to continued competency and the CPC Program are presented in this section, while full executive summaries of each resource can be found in Appendix F of this report.

“Documenting competence is becoming essential—not optional—and is likely to become mandatory in the near future for initial and continuing licensure and certification, and perhaps even for employment.” (Lenburg 1999).

Competence

- Continuing professional nursing competence is ongoing professional nursing competence according to level of expertise, responsibility, and domains of practice as evidenced by behavior based on beliefs, attitudes, and knowledge matched to and in the context of a set of expected outcomes as defined by nursing scope practice, policy, Code for Nurses, standards, guidelines, and benchmarks that assure safe performance of professional activities. (American Nurses Association Expert Panel on Continuing Competence)

- Best practices - In the literature, three traits of best-practices in continuing competence emerge. Continuing competence should take (1) a multi-step approach (2) that uses a triangulation of tools (3) in an iterative process.

- Swankin, LeBuhn, and Morrison declare a five-step model “most promising,” pointing out that the first four steps (periodic assessment, development of personal plan, implementation of the plan, and documentation) represent quality improvement while the fifth (demonstration of competence) represents quality assurance.
Why measure competency?

1. **Healthcare reform** - The increasing complexities of healthcare delivery and changing market conditions have forced health policy-makers to promote the assessment of initial competence of students and new graduates and the continuing competence of experienced and certified practitioners (Lenburg 1999)

2. **Organizational performance**: Comparing assessments of competence and job performance may indicate the extent to which the organization provides the support needed for quality care.

3. **Liability and ethics**: Healthcare organizations are responsible for the quality of care their staff provide and consequently must ensure that their staffs are competent and can meet standards for the provision of care.

4. **Risk management**: Competency assessments can be used to monitor organization-wide knowledge of policies and procedures related to high-risk areas. Feedback from these assessments can be used for training and continuing education of providers and to improve overall organizational performance.

5. **Certification and recertification of providers**: Competency assessment is an integral part of the certification and recertification processes of service providers.

6. **Planning for new services**: Competency assessment can help managers identify providers who are competent to provide a new clinical service. Providers who need improvements in specific knowledge or skill areas when a new service is offered, and providers who are ready to act as mentors of newly trained providers.

7. **Measuring training outcomes**: Competency assessment can determine the efficacy of training interventions in closing knowledge and skill gaps and to assess and improve training. Low scores on competence assessments after training may indicate that the training was ineffective, poorly designed, poorly presented, or inappropriate.

8. **Selection of new staff**: Competency assessment is useful when recruiting new staff to ensure they can do the job they are hired to do or could do it with reasonable orientation/training.

9. **Individual performance improvement**: Competency assessment can play an important role in an organization’s performance improvement initiatives.

10. **Supervision**: Competency assessments can guide healthcare managers in providing performance improvement feedback to healthcare providers.


- Because a series of national commissions documented significant problems related to safety and quality in the U.S. health care system, providers need to be prepared with a different set of competencies than are developed in educational programs today.


- "Consumers deserve to know that health care professionals not only are competent as they begin their careers, but also that they are exerting every effort to ensure that they remain competent throughout their careers. The fundamental basis for any health profession's interaction with the public must be demonstrable competence."

• Continued competence is a critical challenge for regulatory boards in the 21st century.

• Continuing competency is coming and it is coming soon.

The Need for Change

• Increasingly, there is a demand for professional accountability through recertification because of concerns about professional negligence and increased awareness of medical errors.

• Events in both education and medicine in the past 25 years precipitated a new look at continuing education:
  1. No Child Left Behind
  2. Institute of Medicine report - up to 98,000 preventable deaths from medical errors per year

• Because the pace of change in the world today is fast, professions must look beyond initial licensure, certification, and competence and assess workers’ abilities throughout their careers. “[C]ompetence is not reflected by a single measure in time. Instead, it is an ongoing commitment made to the individual, the profession and to consumers” (Bryne and Waters, pp. 8-9).

• “Recommendations for assuring continuing competence have been on the table for nearly fifty years. It is time to act!” (Citizen Advocacy Center, 2004, p. ii)

• Experience vs. outcomes - Overall, 32 of the 62 (52%) evaluations reported decreasing physician performance with increasing years in practice for all outcomes assessed.

• This review of empirical studies suggests that physicians who have been in practice for more years and older physicians possess less factual knowledge, are less likely to adhere to appropriate standards of care, and may also have poorer patient outcomes.

• Therefore, this subgroup of physicians may need quality improvement interventions.

• A total redesign of learning and assessment is required to promote competence in today’s complex practice environments.
  1. Employers and practitioners have begun to question what teachers are teaching. They resent spending time and funds to “reteach” graduates and to provide extensive orientations before they can safely implement the skills required in professional positions.
  2. Graduates feel that they have had tremendous workloads while in school, and yet are under-prepared and lacking in confidence in practice.

• New laws are required to demonstrate competency, with state professional licensing boards being the logical entity to assess competency and quality. This new model must go beyond continuing education courses and require some form of a five-step model that includes periodic assessment of knowledge.

• With more than 3 million members, the nursing profession is the largest segment of the nation’s health care workforce. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care
overhaul since the 1965 creation of the Medicare and Medicaid programs. A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

- Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care.

- The instruments we use for re-certification are the same ones we use for initial certification, and they do not seem well-suited for this purpose.

- Specialty boards have been pressured by specialty societies and slow to implement re-certification programs as a result.

Support for a Multi-Modal Approach

- Periodic demonstration of knowledge, skills and judgment are critical to public safety

- Methods such as multi-source evaluations may be a necessary next step, particularly when interpersonal skills, communication skills and professionalism need to be evaluated.

- Another important finding of the benchmarking study was that a variety of procedures should be used in the recertification program—not just continuing education.
  1. Variety is important because members of almost any field specialize after earning their initial certification

- The literature suggests that any single tool may be inadequate, especially when so few studies exist that prove a clear link between any one method and improved quality of professional service and improved outcomes for consumers.

Examinations

- Physician certification processes that include testing are significantly correlated with superior patient outcomes.

- Increased formal education and training leads to improved test scores.

- A positive relationship exists between recertification examination performance and patient volume as well as complexity of patient problems reportedly seen in practice.

- The ABMS maintenance of certification initiative calls for evidence of the following:
  1. Professional standing
  2. Lifelong learning and periodic self-assessment
  3. Cognitive expertise as demonstrated by a secure examination
  4. Performance in practice
Public support for repeated cognitive testing has been strong, with 87% of patients who were surveyed saying that they believe a physician should take an examination of knowledge periodically.

Physicians scoring in the top quartile were more likely to perform processes of care for diabetes and mammography screening than physicians in the lowest physician quartile, even after adjustment for multiple factors.

These findings suggest that physician cognitive skills, as measured by a maintenance of certification examination, are associated with higher rates of processes of care for Medicare patients.

High performance on the examination may be a marker for more effective physician behaviors in other competencies that promote better care.


All health care provider organizations should have periodic provider recertification with measurable demonstration of continuing competency. Testing is one method of a measurable assessment of knowledge.

Competency assessment can determine the efficacy of training interventions in closing knowledge and skill gaps and to assess and improve training. Low scores on competence assessments after training may indicate that the training was ineffective, poorly designed, poorly presented, or inappropriate.


Secure examinations of medical knowledge and clinical judgment can provide an effective means to assess whether physicians have incorporated new knowledge over time.

-Decades of research work in test development and psychometrics has led to current high stakes cognitive examinations with high reliability and reproducibility.


The process to evaluate competence may need to come from external assessment.


There is no reason why physicians cannot or should not be examined for current knowledge and information that presumably is the basis for the understanding and treatment of disease.

-This alone does not provide assurance of daily competence in the care of patients. It could be argued, however, that serious failure on such an examination, indicating gross deficiencies in current knowledge and information, must be related to some degree of incompetence.


Periodic competence assessments should be considered for those areas that are considered low-volume, high-risk, or critical (Centra Health 1999). Low-volume competencies are those that occur so infrequently that they need to be assessed at least annually to ensure that providers are still able to perform these duties. High-risk competencies are those that put the patient and/or organization at risk if not performed to standard.


Nurse Practitioners have expressed a great sense of pride and accomplishment upon passing the Objective Structured Clinical Examination (OSCE). Many Nurse Practitioners have commented on the hard work to prepare for the exam and the anxiety inherent in the process; however, the endpoint was worth the effort and emotions.

-“Having done an OSCE and being successful definitely provided credibility to physicians I work with and those outside of my workplace. They see doing an OSCE as a gold standard for determining whether a practitioner is safe to practice. An OSCE allays any fears that a Nurse Practitioner does not have the skills and knowledge to provide primary care.”

A likely reason for the relationship between the time since board certification and the frequency of treatment intensification is the educational efforts many physicians engage in before taking the examination.


Continuing Education

- Health care agencies should not rely solely on continuing education to maintain competency.

- The recertification movement has seen two major shifts over the past several decades as a result of research findings and government policies: a shift from a one-time certification model to a recertification method that primarily uses continuing education, and then a shift to a continued competence or maintenance of certification approach, which recognizes that good clinicians should be committed to and proactively involved in lifelong professional development.
  -Recertification in Advanced Practice Nursing - General Trends and Current Practices (PDF)

- Continuing professional development (CPD), includes components of CE but has a broader focus, such as teaching how to identify problems and apply solutions, and allowing health professionals to tailor the learning process, setting, and curriculum to their needs.

- A new, comprehensive vision of professional development is needed to replace the culture that now enrolls continuing education in health care.

- The science underpinning continuing education for health professionals is fragmented and underdeveloped.

- The state medical boards are accepting a specified number of hours of approved continuing education programs as a basis for relicensure. This is not an index of professional competence and many of the leaders in the field of medical licensure regard this as but the first step in an evolving process that will ultimately assess competence.

- Two key elements in a physician’s clinical judgment:
  1. Information collected from the patient through an accurate, complete medical history and focused physical examination
  2. Physician’s working medical knowledge

- Despite the low quality of the evidence, Continuing Medical Education (CME) appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes.

- An important impact of Maintenance of Certification (MOC) on Continuing Medical Education (CME) is the requirement of lifelong learning and self-assessment, creating a direct link between MOC and CME.

Competency Modules

- Self-assessment: 78% percent agreed or strongly agreed that the modules provided a valuable overall learning experience and helped them identify important areas for further study, while 71% said the knowledge modules raised their awareness on how to improve patient care.

- The modules provide realistic and sufficient clinical information and context. The feedback is simple and directly related to the performance of tasks.
  -CAC Meaningful Assessment of Competence (PDF)
• Related to the Practice Improvement Modules (PIMs), diplomats report that they value the information they receive about their practice, often describing the “aha” moment when they review their performance data and uncover an area of suboptimal practice where they are doing less well than expected.
  1. Research studies on the PIMs have found that it is often the physician’s first experience with performance measurement and improvement.


Self Assessment
• Self-assessment of performance correlates poorly with a provider’s actual competence

• However, evidence suggests that physicians do not maintain their knowledge and skills or effectively self-assess their performance on their own.
  1. 73% of articles reviewed in a study by Choudhry et al reported decreasing performance on some or all of the outcomes assessed with increasing years in practice.
  2. Studies assessing how physicians actually perform in practice demonstrate major gaps between known appropriate standards of practice and what physicians actually do. Often, basic standards of care are performed in only 50% of patients.

• Physicians require “good data” to ensure that their interpretations and reflections are accurate around their performance and learning needs. However, research demonstrates that physicians are not accurate in generating this information through isolated self-assessment.


  • Self-assessment is not useless, but it is not very promising.

- Citizen Advocacy Center (2011), Meaningful Assessment of Competence

Learning and Psychological Concepts
• With the rate of turnover of knowledge now estimated to be 4 to 7 years, serious questions must be raised considering the appropriate time interval for re-certification processes.


• In the areas of psychological investigation, thecrists recognize a complex interaction between problem-solving that relies on readily accessed habits of behavior and problem-solving that involves slower interrogation and processing of a knowledge base.
  1. Error prevention depends on recognizing that different behaviors are necessary to prevent mistakes or oversights arising from these respective types of problem-solving.
  2. Certification and maintenance of certification evaluate a physician’s evidence of possessing the requisite habits of practice (practice performance assessment) and robust knowledge (cognitive examination) needed to prevent both types of errors.

• A physician who performs well on a certification examination and who maintains certification by routine review of the medical literature presumably has demonstrated ability to access a base of clinical knowledge and uses this same skill and knowledge when faced with a patient problem. Common sense suggests that the physician with a broad and readily manipulated knowledge base will be more likely to arrive at the correct answer to a clinical question, although no empirical studies are available on this point.


Experience and assessment drive adult learning. Assessment helps physicians to recognize and address gaps in knowledge and performance.


Public Support for Continuing Competence
• The public expects, in return for the privilege of self-regulation, that physicians undergo a rigorous, periodic examination of knowledge.
80% of respondents agreed with a recent MSNBC poll that asked the public whether “all specialists should be required to take a test to renew their certification.”


Gallup poll of the general public about views on certification and maintenance of certification:

1. The survey revealed that certification and maintenance of certification are highly valued by the public.
2. Patients expect and would prefer that physicians demonstrate skills that are just beginning to be addressed by the ABMS requirements in their maintenance of certification programs.
3. Respondents indicated that physicians should be evaluated more frequently than is currently required by any board.
4. Respondents indicated that they would be likely to change their own behavior to ensure that they are treated by a certified physician.


The public expects ongoing, effective demonstration of competency.

The primary beneficiaries of a national program for assessing and assuring competence will be health care consumers.

Patients have every right to assume that a health care provider’s license to practice is the government’s assurance of his or her current professional competence, and clinicians themselves would like assurance that those with whom they practice are current and fully competent.


Who is asking about re-licensure and recertification? Studies, articles and reports are cited from:
1. US Public Health Service
2. Pew Taskforce on Health Care workforce Regulation
3. NCSBN Essential and Continued Competence Subcommittee
4. NCSBN NP&E Committee
5. Institute of Medicine
6. Citizen Advocacy Center

Currently at the core of the consumer’s concern in protecting their health and treating illness in their families is the education, training, and updated knowledge of their physicians.

In a survey of adults in the United States, Canada, and the United Kingdom, Americans were significantly less satisfied with their own physician’s care than either the Canadians or the British.

1. There is reason to be concerned about the increases in expenditures per enrollee in Medicare, the substantial increase in payments for orthopedic surgery, and what appears to be declining satisfaction with services.

Consumers should not have to wait until an accumulation of malpractice suits provides clues that a clinician’s practice may be below standard.

The combination of traditional, sound professional standards and the developing new knowledge about how to protect and advance quality medical care is at the core of consumer commitment to certification and recertification.


More than 95 percent of Virginians in an AARP study believe that health care professionals should be required to show they have up-to-date knowledge and skills to provide quality care as a condition of retaining their license. Ninety percent of respondents indicated it is the least very important for health care professionals to periodically be re-evaluated to show they are currently competent to practice safely.

More than 68 percent of respondents incorrectly believed that currently “health care professionals are required to demonstrate they have up-to-date knowledge and skills needed to provide quality care.” Health
care professionals do not need to provide an evaluation and assessment of their knowledge and skills to become re-licensed.

-CAC AARP Virginia Strategies to Improve Health Care (PDF)

- For midwives, as for other health care professionals, assessment of competency must first focus outwards, on the public midwives serve, not the profession. The public deserves to see continuing demonstrable competence from midwives. The methods to achieve that goal have changed over time, and will probably continue to change in the future, but the goal itself has never changed, and should never change.

- Reports such as the Bristol Inquiry in the UK and the publication of To Err is Human by the Institute of Medicine in the US, have further contributed to the general loss of public trust in the health services.

Grandfathering

- By periodically lengthening the period of training required by new applicants and “grandfathering” those certified under earlier standards, the medical specialty boards not only increase the costs of market entry to new practitioners but also create an appearance of greater homogeneity within the board-certified ranks than in fact exists.
  1. Consumers are thus induced to underestimate the differences between physicians, and physicians are limited in the ways they can differentiate themselves from their competitors.

Government Intervention

- The time for choice is at hand. If the specialty boards do not move forward with recertification, they will have far less cause to complain about government intervention in the process.

- Environmental factors influencing the future of regulation:
  1. Limited access to healthcare is creating many problems
  2. Decreasing state budgets which force distorted prioritization by regulators because there aren’t the funds to discipline everyone who should be disciplined
  3. Increasing deficits that force states to cut costs One way to cut costs is to eliminate licensing boards
  4. Economic recession, which is hindering to drive regulation
  5. The aging population
  6. Technology, which changes the ways care is delivered
  7. Professional associations, which promote their particular agendas and lobby the legislatures
  8. The public
  9. National healthcare reform

- What might happen if we do not change our regulatory path?
  1. Scope of practice decisions would no longer be made by the professions
  2. Boards will be deemed ineffective and be eliminated
  3. Continued competence will be mandated and it won’t necessarily be a good system
  4. Licensure requirements will be reduced
  5. There will be a mandated focus on outcomes
  6. There will be stricter requirements for sunset review
  7. There will be an increase in public members and fewer licensee members
  8. There will be forced licensure compacts to improve mobility within the United States and globally
  9. Elimination of licensure altogether
  -Citizen Advocacy Center (2010). The Future of Regulation
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Nurse Anesthesia

Advancing Recertification for Nurse Anesthetists in an Environment of Increased Accountability

National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA)

2011

Citation: Plaus, Muckel, and Henderson: “Advancing Recertification for Nurse Anesthetists in an Environment of Increased Accountability.” (Article Submitted to the AANA Journal for Publication) pg 1-18.

Synopsis

Article Submitted to the AANA Journal for Publication

The purpose of this article is to present essential concepts and current developments related to competence and continuing competence for nurse anesthetists.

Establishment of the Council on Certification of Nurse Anesthetists (1975) and Council on Recertification of Nurse Anesthetists (1978) officially separated the AANA from the certification and recertification processes. By this action, the profession recognized that credentialing mechanisms, which include examination and certification, function to protect and benefit the public.

The NBCRNA has undertaken an involved analysis of the essential concepts and objectives related to continuing competence and recertification in nurse anesthesia. The three-year investigation into continuing competence involved two studies, a certification industry benchmarking study to determine trends and programs in other professions, and a recertification practice analysis to determine the knowledge and skill required of recertified nurse anesthetists. Discussions have also included the possibility of specialty recognition programming as part of the recertification framework.

The expectation is that stakeholders will review the planning discussion and advise on ways to ensure that ongoing stakeholder needs may be addressed through recertification. The NBCRNA has established a Website (www.nbcnacpc.com) and blog (www.nbcrna.tumblr.com) through which to communicate information about recertification program planning discussions and to actively seek input.

Key Findings

Historical Background

- This article provides a concise timeline of the evolution of credentialing for nurse anesthetists, starting with the introduction of the first qualifying examination in 1945 through the certification examination including alternative item types in 2009
- The profession has required recertification since 1978. The requirements for recertification have included documentation of continuing education credits, clinical practice, current nursing licensure and no impairment that could interfere with the administration of anesthesia.
- The NBCRNA Council on Certification of Nurse Anesthetists certification program was one of the first national certification bodies in 1992 to be recognized and approved by the Accreditation Board for Specialty Nursing Certification of the American Board of Nursing Specialties, which promotes the highest quality of specialty nursing practice through the establishment of standards of professional specialty nursing certification

Current Perspective
The NBCRNA investigation has identified that there is a paradigm shift towards progressive recertification processes which focus on lifelong learning (or ongoing enhancement of competence), continuous professional development, and the opportunity for individuals to demonstrate their continuing competence.

Two studies in particular are cited as providing sound foundations for a deliberative process to identify future requirements to document continuing competence for nurse anesthetists:
1. *Practices and Requirements of Renewal Programs in Professional Licensure and Certification*
2. *Recertification Practice Analysis for Nurse Anesthetists*

The NBCRNA is proposing the following definition of “continuing competence” to provide direction for the recertification of nurse anesthetists:

“Continuing competence, and thus continuing professional certification, in nurse anesthesia is an ongoing, multimodal, and iterative process focused on safe and effective care.”

Through the recertification process, the NBCRNA endeavors to ensure that nurse anesthetists maintain essential knowledge and skill, and familiarity with current scientific and technological developments.

**Recertification Benchmarking Study**

The NBCRNA conducted a thorough consortium benchmarking study in collaboration with several other leading certifying bodies and the Institute for Credentialing Excellence, which included:
1. A review of published literature on recertification over the ten-year period prior to its publication
2. A survey of 331 certification and licensure organizations, representing a wide range of professions

An important finding of the benchmarking study was that developing a meaningful definition of continuing competence gives clear direction to the design of recertification programs.

Another important finding of the benchmarking study was that a variety of procedures should be used in the recertification program—not just continuing education
1. Variety is important because members of almost any field (including nurse anesthesia) specialize after earning their initial certification
2. Helps to ensure that multiple sources of data inform NBCRNA’s decision to award or withhold recertification

Other vehicles that have value for assuring quality to stakeholder groups include:
1. Self assessments
2. Peer and supervisor assessments
3. Performance reviews and references
4. Continuing employment
5. Improved continuing education (with an end-of-course assessment)
6. Portfolios

The NBCRNA endorses the primary recommendation of the study: Continuing competence programs should take a multi-step approach that uses a triangulation of tools in an iterative process.

**Recertification Practice Analysis**

The NBCRNA undertook a recertification practice analysis to find answers to the following questions:
1. Should expectations for the continuing competence of nurse anesthetists be different from expectations for initial certification?
2. If so, how?

All active certified nurse anesthetists were asked to participate in the validation survey component of the project, and 6,650 (23.5%) provided qualified, usable responses
1. Responses to items in the demographic portion of the survey support the conclusion that participants constituted a reasonably representative sample of certificants across a variety of practice settings.

Results of the study validated that there are three broad domains for the recertification knowledge base for nurse anesthetists.
1. **Clinical practice** - establishes a baseline of knowledge and skill that goes beyond the content of the National Certification Examination (NCE)

2. **Practice evaluation and improvement** - places responsibility on the working nurse anesthetist for analyzing the effectiveness of different practices for various populations and recommending improvements in the systems in which they work

3. **Professional responsibility** - personal, legal, and ethical duties related to patient care and safety
   - The study concluded that these domains and tasks, along with the knowledge and skill required for their successful performance, supply a reasonable basis for NBCRNA's recertification program(s).
   - The potential future development of a recertification self-assessment and competency assessment can guide the continued professional certification lifecycle for nurse anesthetists

**Recertification in Related Disciplines**

- In the late 1990s, member organizations of the American Board of Medical Specialties (ABMS) started the process of defining new requirements for physician recertification. Central to these requirements is the expectation that certified physicians will have to undertake periodic assessment.

- Other organizations requiring periodic assessment:
  1. American Board of Anesthesiology (ABA)
  2. National Commission for the Certification of Anesthesia Assistants (NCCAA)
  3. National Certification Corporation (certifies nurse practitioners in several specialties)

- This article includes a table comparing recertification requirements of nurse anesthetists to both Anesthesiologist Assistants and Anesthesiologists
  1. Nurse anesthetists are the only profession in this table to not require a recertification examination

**Other Possibilities for NBCRNA Recertification**

- Important drivers for the recertification of nurse anesthetists:
  1. **Patient needs for competent care**
  2. Increasing attention of the public and other credentialing programs to issues related to continuing competence

- Simulation assessment
  1. Simulation can include the use of virtual applications or even actual demonstration at established centers and computer scenarios for a variety of practice situations
  2. Due to wide scope of nurse anesthesia practice, geographic access and costs, implementation of standard requirements would be challenging.

- Specialty recognition
  1. Under this scenario, nurse anesthetists who specialize in an area of practice (i.e., pain, obstetrics, pediatrics) can document their specialty knowledge and practice, complete a focused assessment, and renew their certification as nurse anesthetists at the same time.
Advanced Practice Nursing and Credentialing of Specialty Nursing

Continuing Competence in Selected Health Care Professions

Burden S. Lundgren, MPH, RN
Clare A. Houseman, PhD, RN

2002


Synopsis

Health services professionals are confronting the challenge of maintaining and improving competence over the course of lengthy careers in diverse practice specialties. This article reviews the efforts of a selection of health care professions to ensure lifetime competence and reviews some of the challenges encountered in these efforts. Although each profession has its own issues, significant generic questions are common to all.

Key Findings

Continuing Competence

- State health professions regulatory boards rarely have required demonstration of continuing competence after initial licensure.
- Concern for the continuing competence of health professionals has been an important issue at least since the consumer movements of the 1960s.
- The Alabama Board of Nursing authorized a project to determine public attitudes and expectations about continuing competence and found that 89% of the public believes there is need for nurses periodically to show competence.
- NCBSN definition of continuing competence:
  1. "The application of the knowledge and the interpersonal, decision-making and psychomotor skills expected for the nurse’s practice role, within the context of public health, welfare and safety."
- Kane offers an alternative definition:
  1. "The level of an individual’s competence in some area of practice can be defined in terms of the extent to which the individual can handle the various situations that arise in that area of practice."

Continuing Education

- There is evidence to indicate that there is no link between continuing education and improved professional practice.
- Hewlett and Eichelberger suggested that not only is there no established link between continuing education and competence, but also there is none between continuing education and patient outcomes.
- It is the consumer who bears the costs of continuing education.
  1. Consumers paid nearly $70 million yearly in higher eye examination costs alone in states that had continuing education requirements for optometrists.
- The Pew Health Profession Commission Reports of 1995 argued that the accumulation of continuing education credits and the activities of disciplinary boards do not ensure competence.
  1. In light of the Pew reports, many states (7 in 1998 and 12 in 1999) introduced continuing competence legislation for health care professionals.
Continuing Competence Activities of a Selection of Health Care Professions

Dental Hygienists
- In general, the only requirement for continuing competence for dental hygienists is mandated continuing education for relicensure in 46 states and the District of Columbia. The average requirement is 8 to 12 hours per year.
- The profession is experiencing pressures from the American Dental Association (ADA) with regard to ensuring competence.

Dentists
- The AADE has released “Criteria and Mechanisms for Continued Competency in Dentistry.” This document establishes 17 criteria for competency mechanisms and suggests that continuing competence could be shown by many different means, including:
  1. Examinations
  2. Credentialing through a uniformed service of the Department of Veterans’ Affairs
  3. In-office audits
  4. Case presentations
  5. Standardized, simulated case evaluation
  6. Continuing dental education programs with measurable outcomes assessment

Dietitians
- Certification for specialty areas.
- Specialty certification must be renewed every 5 years.
- Fellow designation applicants must submit a portfolio that includes information on the following:
  1. Education (master’s degree minimum)
  2. Experience (at least 8 years of work experience)
  3. Professional achievement
  4. Professional contacts
  5. Approach to practice
- Fellow certification is granted for a 10-year period. Fellows who wish to recertify must submit an updated portfolio for evaluation.

Occupational Therapists
- In 1999, NBCOT issued a report on continuing competence in occupational therapy with the following recommendations:
  1. All occupational therapists should be required to maintain and verify continuing competence throughout their careers
  2. National, uniform standards for continuing competence should be adopted
  3. A national, uniform, system of measuring continuing competence should be adopted
  4. A defined collaborative model for maintaining and verifying continued competence should be implemented
  5. A periodic review mechanism should be established to evaluate the effectiveness and efficiency of the continuing competence system, and improvements should be implemented as indicated
  6. A comprehensive plan to inform and educate stakeholders about the importance of continuing competence and systems to support it should be developed and implemented

Pharmacists
- In 1995, the American Pharmaceutical Association House of Delegates adopted a policy on continuing competence. The policy:
  1. Advocates that pharmacists maintain their professional competence throughout their professional careers
  2. Recommends that employers evaluate prospective and current pharmacist employees based on demonstrated competencies in pharmaceutical care and experience, in addition to education
3. States that the American Pharmacuetica Association will develop and implement curricular-based
continuing education programs leading to certificates of competence in pharmaceutical care
4. Proposes the convening of a task force to develop and implement a voluntary program that enables
pharmacists
   • The National Association of Boards of Pharmacy has announced that it is developing a competency
   examination for voluntary use by state boards of pharmacy.

Physicians
   • Time-limited (7–10 years) certificates now are coming due for most of the 24 American Board of Medical
   Specialties (ABMS) boards.
   • An ABMS task force on competencies is looking beyond reliance on cognitive examination methods and
   debating how patient outcomes, quality improvement, and physicians’ lifelong learning could be
   incorporated in the certification process.
   • The American Medical Association (AMA) believes that maintenance of competence is a responsibility
   of the individual practitioner. Continuing competence requirements should not be imposed until "reliable and
   cost-effective means of assessing competence are developed."
   1. AMA has urged the ABMS to reconsider its position concerning recertification.

Registered Nurses
   • Since 1985, NCSBN has published many reports addressing diverse issues in continuing competence. One
   of the Council’s major contributions has been the development of a model for a professional portfolio for
   promoting professional development for all nurses and for regulatory boards to work with nurses who meet
   criteria that trigger an audit.
   • Problems with portfolios include:
     1. A requirement for different types of education (e.g., self-reflection)
     2. A change in teacher/student roles (e.g., students set educational goals)
     3. Costs of portfolio keeping and evaluation
     4. Validation issues
     5. Time requirements for nurses in keeping their profiles
     6. Ethical issues (e.g., description of incidents relating to patients)

Issues with Measuring Continuing Competence
   • Is competence multilayered? It is possible only to evaluate a sample of behaviors and extrapolate to the
   practice totality.
   • Is competence multidimensional? Girot identified the coordination of cognitive, affective, and motor skills
   as basic to competence in nursing.
   • Appropriate mechanisms for ensuring continuing competence must depend on the accepted definition of
   competence. In theory, if capacity is the core of the definition, basic knowledge testing may address the
   issue. If the ability to apply skills is included in the definition of competence, however, testing methods must
   allow for demonstration of that ability.
   • Evaluation methodologies that include practical assessments and tests of abstract information:
     1. Peer review
     2. Client/case review
     3. Supervised practice experience
     4. Computer simulations
     5. Client feedback
     6. Use of standardized practice scenarios
     7. Practice evaluations.

Citizen Advocacy Center Report on Continuing Competency Requirements
   • Review of requirements of 52 voluntary health care professional certification organizations
   • The uncertainties inherent in ensuring continuing competence are well reflected in the varying
   methodologies employed by these organizations.
   • Most require continuing education hours or recertification examinations (written or oral) or both.
• Little agreement existed concerning the time intervals between recertification processes. Ten years is common, but so is 5 years.
• With the rate of turnover of knowledge now estimated to be 4 to 7 years, serious questions must be raised considering the appropriate time interval for recertification processes.

Economics of Continuing Competence
• The costs of ensuring competence in the end are borne by the consumer.
• It would seem prudent for state and professional groups to engage in research that would show whether continuing competence requirements would confer benefits outweighing their costs.
• A possibility is to target at-risk physicians based on triggers such as:
  1. Health status or age
  2. Number of complaints
  3. Number of malpractice claims, settlements, or judgments
  4. Multiple or frequent changes in practice location
  5. Changes in area of practice without formal retraining
  6. Adverse actions by PROs or third-party payers
  7. Failure of specialty board recertification examination
  8. Practice that is not subject to other peer review (e.g., no affiliation with a hospital)

Discussion and Conclusion
• Demanding additional credentials from practitioners is an anomalous activity at this time when public and professional attention has been turned to the necessity of examining entire systems to eliminate errors and improve care.
• All groups engaged in the study of continuing competence should pay greater attention to the roles of institutions and health care systems in ensuring competence to ensure that professional practice exists in a competence-friendly environment.
• Professional organizations are investing considerable resources in the development of new requirements for practitioners with little or no evidence to tie the new requirements to improvement in health outcomes.
• The authors recommend no additional requirements on practitioners without careful examination of the costs and benefits of such requirements.
Meeting the Ongoing Challenge of Continued Competence

National Council of State Boards of Nursing

2005


Synopsis

This paper discusses the past, present and future of professional competence within the health care industry, and its implications for nurses.

Continued competence has been studied and talked about. There have been proposed regulatory approaches but there has not been agreement on what to do about it. The nursing profession “…has clearly seen the need for continuing competence but has grapple with how this can be universally accepted by all nurses.” (Bryant, 2005, p. 25) But increasingly licensing boards are being challenged to provide assurance to the public that licensees meet minimum levels of competence throughout their careers, not only at the time of entry and initial licensure. Continued competence is a critical challenge for regulatory boards in the 21st century.

Key Findings

Problems Finding a National Regulatory Solution for Evaluating Continued Competence

- Competence is multifaceted and may be difficult to measure.
- The sheer volume of nurses in practice makes it difficult to identify feasible and meaningful yet cost-effective regulatory approaches.
- There is no agreement on who should be responsible for continued competence.
- Nursing careers take widely divergent paths, varying by professional role, settings, clients, therapeutic modalities and other professional criteria as well as level of health care delivery.
- In addition, there is the inherent evolution of practice from the new graduate-entry-level to the experienced-focused practice level of competence.
- Thus, it is not clear what standard should be used to evaluate continued competence. Should the standard be based upon:
  1. Current entry-level competency for the profession (i.e., NCLEX)?
  2. Generalist core competency each licensure level (RN, LPN/VN, APRN)?
  3. Focused areas of practice for?
  4. Essential emerging knowledge?
  5. Some combination of the above?
  6. None of the above (something not yet identified and/or articulated)?
- It is not clear how to evaluate whether a standard has been met.
- It is not clear what to do if a licensee cannot demonstrate continued competence. (NCSBN, 1996).

New Questions

- How can boards of nursing be more effective in protecting the public?
  1. Boards could be more proactive in providing the public assurance that practitioners continue to be safe years after completing education and first becoming licensed. Knowing that at one point in time a nurse was qualified is not enough.
- What could boards require that would be creditable with the public and acceptable to the profession?
  1. Replace current periodic renewal processes with more substantive requirements for “licensure maintenance.”
• Why should nurses have to do more to maintain licensure?
  1. Licensure is a privilege and just as boards identify requirements for initial licensure, board identify the requirements to renew licensure.

• What could demonstrate licensure maintenance?
  1. Start with an assessment of the nurse’s practice to direct professional development activities.

• What are activities that have credibility with the public and are meaningful to nurses?
  1. The public needs assurance that nurses have current knowledge and are safe practitioners. The nurse needs the incentive of value added to one’s career and practice.

• Licensure maintenance rather than continued competence — isn’t this just semantics?
  1. Talking about continued competence makes professionals feel singled out and vulnerable.
  2. Licensure maintenance implies universality, something required of everyone.

Who is Asking about Re-licensure and Recertification?
• Studies, articles and reports are cited from:
  1. US Public Health Service
  2. Pew Taskforce on Health Care workforce Regulation
  3. NCSBN Essential and Continued Competence Subcommittee
  4. NCSBN NP&E Committee
  5. Institute of Medicine
  6. Citizen Advocacy Center

Review of Approaches Already in Use
• Nursing regulation
  1. The most common continued competence requirement for nursing licensing boards is continuing education.
  2. Other nursing board approaches to continued competence include requiring a specified number of practice hours (21 boards for RNs, 22 boards for LPNs/VNs; also see NCSBN Models) or a nursing refresher course if a nurse who has had an inactive license seeks to return to practice.
  3. Three states require a competency examination under specific circumstances (e.g., an extended number of years out of practice).

• Other Health Professions
  1. Many health professions continue to require continuing education as the primary continued competence activity.
  2. One of the first health professions to look for new approaches to continued competence was the Commission on Dietetic Registration who first developed self-assessment modules in 1989.
  3. Continuing competence requirements for physical therapists is most often through continuing education and practice hours.
  4. The National Certification Board of Occupational Therapists (NCBOT) developed a portfolio approach that requires occupational therapists (OT) to accumulate a set number of professional development activities for each renewal cycle.
  5. Members of the American Boards of Medical Specialties (ABMS) have been moving toward periodic recertification to maintain board certification, including: 1) evidence of professional standing; 2) Evidence of a commitment to lifelong learning and involvement in periodic self-assessment to guide learning; 3) evidence of cognitive expertise based on an examination; and 4) evidence of evaluation of performance in practice.

NCSBN 2005 Midyear Meeting discussion
• Is it the duty of the board of nursing to assure consumers that competence is maintained throughout the lifetime of the license?
  1. The majority of participants said yes.
  2. Some attendees perceived continued competence as an employer responsibility.
  3. One person asked, in the face of the nursing shortage, how rigorous the process should be?
• Describe how your Practice Act & Rules address the maintenance of competence.
1. The most common approaches in current use were continuing education requirements and minimum practice hours.

- What are the essential components of an effective regulatory model for the maintenance of competence?
  1. The most common element reported was some form of assessment (examples included: self-assessment, core competency test for practicing nurse, Dorothy Del Bueno’s model, measurement process, measurement tool, core competency measurement by an affective-cognitive-sensory monitor, and regional assessment centers).

Fiscal Year 2005 Strategic Initiative

- The following Strategic Objective was assigned to the NCSBN Testing Services Department:
  1. “Strategic Objective #2. Develop an assessment instrument to measure continued competence of RNs and LPN/VNs.”

Discussion

- While a majority of physicians are professionally certified, it is estimated that less than 20% of nurses are.
  1. The medical model is not a good fit for nursing.

- One possibility for nursing is for the NCSBN to revisit their Continued Competence Accountability Profile (CCAP) and the portfolio approach, however concerns include:
  1. It is a paper trail
  2. It is difficult to quantify and it raises questions of reliability and validity
  3. It can potentially be busy work with little relation to actual practice

- Periodic assessment is not an unrealistic expectation – it is opportunity for quality improvement.

- Assessment results do not have to determine “in or out.” Results could be used to provide feedback and direction to the nurse.

“Where is the evidence we aren’t competent?”

- It is true that research is needed to study the practice of experienced nurses.
  1. However, it is disingenuous to suggest that in the current environment and in the face of startling, frightening statistics involving error that assuring the maintenance of continued competence of health professionals, including nurses, is not needed.

- Continued competence has to be a collaborative effort, and stakeholders include:
  1. Nurses
  2. Employers
  3. Educators
  4. Nursing organizations
  5. CE providers
  6. Consumers
  7. Boards of nursing
Toward a Standardized and Evidence-Based Continued Competence Assessment for Registered Nurses

Published by Anne Wendt, PhD, RN, CAE Maryann Alexander, PhD, RN for JONA’S Healthcare Law, Ethics, and Regulation

2007


Synopsis

Article describing the methodology of a practice analysis and explain some brief preliminary findings from the 2006 RN Post Entry-Level Practice Analysis that will be the foundation for a continued competence assessment instrument for registered nurses. Knowledge of the steps in a practice analysis is integral to understanding how a continued competence assessment instrument is developed.

A nonexperimental, descriptive study was conducted to explore the importance and frequency of activities performed by post entry-level RNs and those activities that are part of core RN practice. More than 4,700 RNs responded to the survey. The 2006 RN Post Entry-Level Practice Analysis study collected data on core practice and the frequency and importance of RN activity performance. The Continued Competence Task Force of NCSBN reviewed the results of the study and noted that importance ratings provided by the RN respondents were comparable across facilities, specialty practices, years of experience and geographic regions.

Key Findings

Methodology

- Preliminary interviews with nurse leaders to identify trends in nursing and predict possible changes
- Developed RN activity statements (activities that nurses perform while in client care) with an SME panel
- Two forms of the survey were created to decrease the number of activity statements to which each individual participating in the study would have to respond
- Survey process: A sample of 20,000 RNs was sample was drawn. The survey average age of respondent RNs was respondents were not substantially selected. On average they had approximately 20 years of experience.
- Activity Performance Characteristics The participants were asked whether the activities on their survey form represented what they actually did in their positions. A majority indicated that the activities were representative of their current practice. This indicates that the survey was perceived by respondents as being a sufficient or a reasonable representation of their work.
- Most RN respondents (59.1%) reported practicing in hospitals. About 13.0% of RNs reported practicing in community-based/ambulatory care, and 6.3% practiced in long-term care, whereas 6.0% reported practicing in home healthcare.
- About 22.0% of RNs reported practicing in a type of specialty area that was not listed as an option.
- Respondents were asked to rate the importance of performing each nursing activity for RN practice considering client safety. Importance ratings were recorded using a 1 point scale, which ranged from “1 Not Important” to “4 Extremely Important.” Average total group importance ratings ranged from 2.80 to 3.87.
- Respondents were asked to indicate “Y” (yes) or “N” (no) as to whether an activity was part of core RN practice. Core practice was defined as "the essential knowledge, skills, and abilities needed to practice safely regardless of practice setting."
- Respondents were asked to rate the frequency of performance of all activities that were applicable to their work settings.
- On average, respondents reported practicing 36.3 hours per week as an RN. There was little variance across facilities and specialty practice.
• The majority of the respondents in the demographic subgroups indicated that the mean importance rating of each activity statement used for core competencies was at least 3.0, which corresponds as ‘important’ on the scale.

Conclusion
In general, findings indicate that nursing practice, as it relates to client care, is essentially the same regardless of facility, specialty, years of experience and geographic region. The results of this study can be used to develop core RN competencies for a continued competence assessment instrument. Although the practice analysis lays an essential foundation, extensive development and research are needed to produce a standardized, psychometrically sound, evidenced-based assessment instrument that will measure current nursing knowledge and skills and abilities for the post entry-level practitioner.
CCI Think Tank: Continued Competence Leadership Forum: From Pieces to Policy Post-Event White Paper

Competency & Credentialing Institute

2008


Synopsis

The Competency & Credentialing Institute (CCI) convened scholars and thought leaders in healthcare competency from across North America at a Think Tank September 16 – 19, 2007, to explore how nursing can collaborate to develop a framework for continuing competence driven by the principles of patient safety. This White Paper summarizes the collective understanding from the CCI 2007 Think Tank of how nursing can ensure ongoing competence development that enhances both the profession and patient care.

Using scenario planning, Think Tank participants identified challenges with the areas of competency evolution, educational reform, informational literacy, policy, multidisciplinary team learning and data management that must be addressed as part of any discussions on continuing competence. To further influence continuing competency and patient safety issues within nursing, the Think Tank participants recommend that an interdisciplinary coalition be created to develop, implement, and evaluate future initiatives.

Participants also heard about issues of consumer groups and how their physician colleagues are addressing continuing competence.

Key Findings

Assessment Tools

- Think Tank planners identified and critiqued tools and instruments currently used to assess and evaluate competence. One resource, Toolbox of Assessment Methods, was created jointly by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) and includes recommendations regarding the most suitable instruments and tools to assess competency of medical residents (ACGME, ABMS September 2000). This resource was shared with participants as a potentially useful tool to assess nurse continuing competence.

Consumer Perspective

- Joyce Dubow, representing AARP’s Office of Policy and Strategy, provided participants with a contextual background and a consumer perspective of continuing competence and patient safety.
  1. She proposed that requiring demonstration of continuing competence was one component of a broader healthcare reform strategy.
  2. A majority of injuries and deaths occurring in hospitals were viewed as preventable; causes of errors include communication problems, inaccurate medication prescribing behaviors, and the lack of adequate quality systems.
  3. Dubow suggested that quality improvement can be hastened through public accountability which, among other changes, can be accomplished by promulgating licensure requirements that address ongoing competence.
  4. Acknowledged that future research is still needed to find effective ways to measure continuing competence that is objective and fair to providers while leading to better patient care.

Participants’ Perspectives on Trends in Healthcare
There are many different models for competency assessment and evaluation, and these often are isolated from one another. Assessing continuing competence may be difficult due to limited financial or human resources. Further, there are no specific and agreed upon data to make a unified case for change.

They suggested that the areas supporting change include the more effective use of technology and other contemporary avenues of information sharing. Another positive support for change are nurse scholars who have the ability to conduct systematic research in the area of continuing competence and patient safety.

They also suggested that employers of nurses may provide support in the measurement, recording, and reporting of continuing competence.

**Physician Initiatives for Continued Competence**

- The Physician Accountability for Physician Competence initiative agrees that today’s system of physician self-regulation is not prepared to deal with rapid changes taking place in today’s environment.
- Contemporary issues impacting medicine’s initiatives for continuing competency:
  1. A growing sophistication of patients/public
  2. Globalization of economy/healthcare
  3. The role of government in healthcare
  4. Rapid changes in technology and science
  5. An aging population
  6. Rising costs of healthcare
  7. The ease of communication via the internet
- The group has coalesced around core principles for ensuring continuing competence:
  1. Periodic demonstration of competence
  2. Practice-based assessment
  3. Quality improvement
- 3 factors critical to success for both physician and nurse continued competence initiatives:
  1. A shared vision helps people stay focused
  2. Trust is foundational for progress
  3. Trust should not only be developed among participants, but ultimately among organizations

**Scenario Planning**

- The CCI Think Tank explored four future scenarios, allowing participants to step outside their current environment and to plan freely for a future time, unencumbered by today’s realities and limitations.
- Six common themes emerged, which illustrate a compelling case for change in nursing and healthcare:
  1. **Competence is evolutionary** – Each nurse must understand that competence is not reflected by a single measure in time
  2. **Educational Reform** - The importance and recognition of learning as a lifelong process must be communicated to all
  3. **Information literacy needs to be developed** – A new concept called “critical synthesis” emerged. To be successful in daily practice, nurses need to analyze and act on data quickly, which requires the ability to critically synthesize.
  4. **Impact on policy issues must be considered** - Nursing has a professional commitment to examine the impact of practice on policy issues and vice versa.
  5. **Work and learn in multidisciplinary teams** – Nursing must continue to seek alliances with a variety of members of the healthcare team (physicians, nurses, pharmacists and other professions)
  6. **Data management is crucial** - Data can be overwhelming, but it also can be critical in defining practice guidelines and standards. Currently, information systems and personnel often fail to communicate effectively or measure standards for safe patient care.

**Coalition Planning**

- On the final day of the Think Tank, a sub-group of participants discussed the value of establishing a collaborative coalition to drive this needed change. This coalition’s preliminary charter statement was drafted as follows:
“A collaborative initiative to build consensus for a process for continuing competence assessment for professional nurses that is practical, cost-effective, transparent, transferable, and a nationally-accepted platform to ensure patient safety and quality of care for the public.”

- Think Tank participants suggested that coalition stakeholders represent a myriad of groups, such as:
  1. Public forums
  2. Nursing organizations
  3. Funding sources
  4. Payers
  5. Risk management groups
  6. Educators and academicians
  7. Physician groups
  8. Credentialing bodies
  9. Quality groups
  10. Accrediting bodies

- Challenges were identified to addressing a complex issue such as continuing competence:
  1. There will be competition for attention, energy, and resources.
  2. Create buy-in from necessary stakeholders.
  3. Realize that groups have a tendency to move slowly.
  4. Challenge individuals to put aside differences.
  5. Relinquish individual power in favor of group power.
  6. Resolve whether the complex issue of initial competence is included as part of the overall dialogue.
  7. Address the resistance from states and other organizations that already have continuing competence programs.
  8. Capture the intellectual capacity of this esteemed group through strong facilitations and diligence.
  9. Realize that there will be challenges in maintaining momentum and focus in an environment where “initiative overload” is common.
Competency in Nursing: A Concept Analysis

Donna D. Scott Tilley, PhD, RN

2008


Synopsis

Competency is a topic of great interest to educators and administrators in practice disciplines, particularly health care disciplines such as nursing. This article focuses on the role of competency in nursing. Through a concept analysis process, various elements of competency were assessed. The defining attributes of competency are the application of skills in all domains for the practice role, instruction that focuses on specific outcomes or competencies, allowance for increasing levels of competency, accountability of the learner, practice-based learning, self-assessment, and individualized learning experiences. The learning environment for competency assurance involves the learner in assessment and accountability, provides practice-based learning opportunities, and individualizes learning experiences.

A review of nursing, medical, public health, and educational literature from the 5 years prior to January 2006 was conducted.

Key Findings

Definition

- A common understanding of what competency is does not exist.
- The reasons for the lack of clarity in defining competency include:
  1. That competency is multifaceted and difficult to measure
  2. The volume of nurses in practice makes it difficult to identify feasible and meaningful, yet cost-effective, regulatory approaches
  3. Agreement is lacking about who should be responsible for continued competency
  4. Nursing careers are widely divergent with various levels of practice
  5. There is an inherent evolution of practice from the new, entry-level graduate to the experienced nurse

History

- Beginning in the early 1980s, many boards of nursing began to explore the issue of competencies for graduating nurses in their states.
- Continued competency became a topic of intense and frequent discussion among nurses nationally in the 1990s as professional nursing organizations, consumer advocacy groups, and a rapidly changing health care environment led nursing to continue its efforts to create safe environments for patients.

Education

- Although education based on competency may be agreed upon, determining which competencies are most critical, at what level they should be demonstrated, and how to teach them remains unclear.
- Didactic course evaluation (the most common method) uses objective testing strategies to determine cognitive achievements, whereas competency-based education uses demonstration of skills and knowledge to evaluate performance potential.
- Many programs issue a grade for didactic content mastery and a pass–fail grade for clinical performance (Fordham, 2005). This practice further distances graduates from an expectation of an assessment of ongoing competence.
• The current literature implies that a consequence of a focus on competency in education is a narrowing of the gap between education and practice, leading to improved patient outcomes, clinical judgment, and accountability and self-assessment of learners.

Evaluating Continued Competency

• The NCSBN (2005) outlined several options for a basis for evaluation:
  1. The current entry-level National Council Licensure Examination (NCLEX)
  2. Generalist core competency at each licensure level
  3. Focused areas of practice
  4. Essential emerging knowledge
  5. Some combination of these

• Examinations: Research is looking to demonstrate that certification examinations are linked to competency or improved patient outcomes (Whittaker et al., 2000).

• Portfolios - Their evaluation continues to be a subjective process that is not easily amenable to standardization or objective assessment.

• Currently, the most common method of demonstrating continued competence for licensure renewal is continuing education.
  1. Little evidence exists that commonly used continuing education methods have any effect on clinicians’ behavior or patient/systems health outcomes.
Continuing Competency - What’s Ahead?

Published by Betty Burns, BA, CAE, Journal of Perinatal & Neonatal Nursing

2009


Synopsis

Article in Journal of Perinatal & Neonatal Nursing/July–September 2009 that addresses the necessity of continuing competency in the healthcare system, and its effect on the future of recertification. The article defines continuing competency as an ongoing part of a national discussion, involving all public and private agencies that have responsibility for licensing and credentialing.

“With the drive to make regulatory and certification processes more transparent to the public, regarding the ongoing capabilities of the individuals they license or certify, periodic assessment of knowledge, skills, and abilities will become a part of regulatory and certification requirements for nursing as well as for other healthcare professions.”

Key Findings

Public Policy Initiatives

- PEW Charitable Trust released a report Reforming Health Care Workforce Regulation, in 1995. The report recommended to address barriers from provisioning high-quality healthcare, focusing on calling for standardization within the regulatory community relative to statutory language and entry into practice requirements, development of mechanisms for both initial and ongoing assessment of competence of healthcare professionals, promotion of interdisciplinary regulatory efforts, establishment of overlapping scopes of practice where applicable, development of uniform disciplinary processes of healthcare professionals, and improved education of the public.

- The Institute of Medicine report, To Err Is Human: Building A Safer Health System, stunned the healthcare community by highlighting the costs in lives and dollars that are caused from preventable medical errors. The recommendations called for establishment of mandatory systems for reporting errors and adverse events and development of safety programs by regulatory and accreditation organizations.

- Citizens’ Advocacy Center Road Map: A fundamental principle of the road map is that all continuing competency efforts must be collaborative among all stakeholders Research should be conducted to link continuing competency efforts to potential changes in behaviors and practices of healthcare professionals, and any further continuing competency efforts must build upon those initiatives that have been proven to be effective.

- The National Council of State Boards of Nursing published a report on Exploring the Value of Continuing Education Mandates. On the basis of a survey of 2000 nurses, the report concluded that nurses seek out CE whether mandated or not, but if mandated, more unrelated CE is taken outside their work needs or interest.

The Certifiers

- After the initial certification examination, those certified by NCC must participate in the Certification Maintenance Program to maintain their certification. As with most certification organizations, there are two methods that are primarily used to maintain certification:
  1. Retesting
  2. CE

- Two initiatives that NCC has recently begun include:
  1. Requiring that all CE that is to be used for certification maintenance must be specific to the certification specialty area
2. An initiation of a continuing competency pilot testing program

**Upcoming National Certification Corporation**
- Goals:
  1. Ascertaining if certified nurses can self-assess content areas of weakness to address CE needs for maintenance of their certification by completing a survey on educational needs
  2. Collect data through testing, regarding whether maintenance could or should relate to basic entry-level content or recent practice/research in the field
  3. Correlate certified nurse assessment of knowledge to actual testing outcomes
  4. Provide feedback to the individual certified nurse on knowledge and skills
  5. Explore development of CE activities to address the identified educational needs of the certified nurse based on the pilot results
- Possible changes to the NCC maintenance process will be considered on the basis of the final analysis of this testing and study data.

**Mandating Continuing Competency**
- Self-Assessment: These are programs using outside data, national standards, industry data, or professional guidelines as benchmarks, which the individual professional can use to assess individual performance and identify practice strengths and weaknesses. This self-direction is also the weakness of such programs because there is little public accountability and no external review to determine how well the professional was able to successfully identify their educational needs.
- Peer Review: These programs involve peer participation in an organized review in determining the strengths and weaknesses of nursing practices. While a benefit is the one-to-one feedback and validation, the process can be complex, lengthy, hard-to-implement, and costly.
- Professional Portfolios: The time commitment to develop a professional portfolio can be seen as a barrier to its use. Because it is another primarily self-directed activity, there is also little external validation involved.
- Certification and Certification Maintenance Regulators especially in regard to advanced practice nurses require certification and its maintenance as a requirement for relicensure or recognition of advanced practice status in the specific jurisdiction. The limitations of these efforts are the same as for mandated CE, as this is the primary method certification organizations use for their maintenance programs.

**The Portfolio Approach**
- The Commission on Dietetic Registration, which oversees certification for dietitians, has developed a 5-step program that is designed to help individuals plan and implement and evaluate their educational needs for lifelong learning.
- American Nurses Credentialing Center has developed a Critical Portfolio mechanism that is designed to help both individuals and employers or any third party to provide a tracking system documenting an individual’s accomplishments.

**Future Challenges**
- As regulators, certification organizations and employers continue to explore and work on implementation of continuing competency assessment mechanisms, the challenges to accomplish a standardized system for continuing competency will be ongoing.

**Conclusion**
- As the continuing competency movement grows, 3 central concepts will underlie any continuing competency effort:
  1. It will involve lifelong learning for the nurse
  2. It will be transparent to the public
  3. It will be mandatory
• The specific nature of any continued competency program is still unknown. Furthermore, it remains unclear who will be responsible for its implementation. But 2 essential facts are clear and they are—continuing competency is coming and it is coming soon.
The Past, Present, and Future of Assessing Continuing Competency for Midwives

Published by Mary Barger, CNM, MPH, PhD, Barbara Camune, CNM, WHNP, DrPH, and Barbara Graves, CNM, MS, MPH, and Jacqueline Lamberto, MPH

2009


Synopsis

"Consumers deserve to know that health care professionals not only are competent as they begin their careers, but also that they are exerting every effort to ensure that they remain competent throughout their careers. The fundamental basis for any health profession’s interaction with the public must be demonstrable competence."

Commentary discussing why and how midwives arrived at the present changes in midwifery certification, and exploring potential future mechanisms for maintaining and demonstrating competence.

According to the Institute of Medicine, the knowledge explosion in medicine is one of the factors that can reduce the quality of care to consumers. Some things midwives used to “know” will have to be unlearned, in favor of knowledge and practices that will be of greater demonstrable benefit. As the knowledge explosion continues within midwifery, the profession also is increasing its understanding of more effective ways to maintain and demonstrate competence. The ways of ensuring continuing competence are also subject to change, as knowledge progresses and as management policy and consumer expectations move in new directions.

Key Findings

Background

By the early 1970s, the American College of Nurse-Midwives (ACNM) had taken a leadership role among health care professional organizations both in how it accredited educational programs and in how it assessed and certified the competency of its members. However, by 1990, certification processes had changed, and it became clear that for the certification process of nurse-midwives (NMs) to remain nationally recognized, the certification function of ACNM had to be separated from the membership and accreditation functions. Accordingly, in 1991, the ACNM Certification Council (ACC), now the American Midwifery Certification Board (AMCB), was incorporated as a distinct separate entity. At this time, all NM certificates issued by ACNM were transferred to AMCB, as were the tasks of developing and administering the initial certification examination and discipline procedures. When AMCB sought its initial accreditation by the National Commission of Certifying Agencies (NCCA), it became clear that NCCA strongly preferred time-limited certificates to lifetime certificates with no expiration date. In response to this recommendation, AMCB began issuing 8-year time-limited certificates to newly certified nurse-midwives in 1996.

Continuing Education and Recertification

The American Midwifery Certification Board developed the Certification Maintenance Program (CMP), which those with a time-limited certificate were required to complete in order to be reissued a midwifery certificate at the end of 8 years. CMP required a review of new knowledge in the full scope of midwifery practice through the completion of 3 self-learning modules. Each module contains a series of learning objectives that can be met by reading 15 to 22 articles and taking an open-book multiple choice test. In addition, CMP required 20 hours of continuing education based on an individual’s own self-assessment.

Who Should Assure Continuing Competency of Certified Nurse-Midwives and Certified Midwives?

In the white paper “Implementing Continuing Competency Requirements for Health Care Professionals,” the American Association of Retired Persons (AARP) Public Policy Institute argues that states are the appropriate regulatory body to assure the current competency of health care professionals. They advocate for general state laws that require the respective regulatory bodies to develop mechanisms to carry out this function.
The New Requirements for 2011
AMCB adopted significant changes to the process for midwifery certification in April 2009.

- NMs certified before 1996 will, beginning January 1, 2011, be issued time-limited certificates and required to participate in the CMP
- Decrease in the recertification cycle length from 8 to 5 years to comply with the Consensus Model for Advanced Practice Registered Nurse (APRN) Regulation
- The AMCB Board of Directors adopted four principles for certification maintenance that will guide its certification maintenance program into the future
  1. Documentation of professional standing
  2. Process of life-long learning
  3. Assessment of performance in practice
  4. Standardized cognitive assessment

What May Lie Ahead
As ever, the goal is to make the process of maintaining a high level of professional competence as efficient as possible for midwives, and to achieve greater accuracy in assessing that competence. There is evidence indicating a modest link between continuing education and improvements in professional practice. The most recent meta-analysis found improvement of serious outcomes but less effect for less serious ones and no effect when complex behavior change is required.

- An AARP white paper addressing the issue of continuing competency of health care professionals advocated a model that includes periodic assessment of knowledge, skills and clinical performance with feedback to allow development of a personal improvement plan, implementation and documentation of the plan and evaluation of its success.
- The American Board of Internal Medicine has developed a Web-based performance assessment process based on a provider's review of patient charts with a given condition, peer and patient feedback, and analysis of their practice environment. An evaluation of this process by providers showed that the tools were easy to use and that it was not as time-consuming as they anticipated
- By working through the self-assessment protocol, clinicians are able to identify areas they specifically should work on, make a much more efficient use of the time they devote to continuing education, and therefore gain knowledge and skills in just those areas most likely to improve their level of care

Conclusion
For midwives, as for other health care professionals, assessment of competency must first focus outwards, on the public midwives serve, not the profession. The public deserves to see continuing demonstrable competence from midwives. The methods to achieve that goal have changed over time, and will probably continue to change in the future, but the goal itself has never changed, and should never change.
Consensus model for APRN regulation: Licensure, Accreditation, Certification & Education

Completed through the work of the APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee

2009


Synopsis

The model presented in this paper for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group.

This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Key Findings

Advanced Practice Registered Nurses

- Advanced practice registered nurses (APRN) are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body.
- Each APRN is accountable to:
  1. Patients
  2. The nursing profession
  3. The licensing board
- APRNs are responsible for:
  1. Complying with the requirements of the state nurse practice act and the quality of advanced nursing care rendered
  2. Recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN’s expertise
  3. Consulting with or referring patients to other health care providers as appropriate
- All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies.

Types of APRNs

- Certified Registered Nurse Anesthetist
- Certified Nurse-Midwife
- Clinical Nurse Specialist
- Certified Nurse Practitioner
Continuing Competency Initiative - Changes to the NCC Maintenance Program

Handbook Prepared by the NCC

2010

Citation: NCC Continuing Competency Initiative Handbook.

Synopsis

A new Professional Development Certification Maintenance Program, implemented June 1, 2010, replaced the current Certification Maintenance Program. The new program included the use of a specialty assessment evaluation to identify targeted individual-specific continuing education needs, addressing knowledge gaps and provide a learning plan that the certified nurse can follow to meet certification maintenance requirements.

These changes are being initiated to assure that the continuing education options chosen by the certified nurse meet individual specific learning needs. This will assist in assuring the core certification specialty knowledge competencies as reflected on the current certification examinations are maintained in a formalized and individualized manner. The concept underlying this evaluation is to validate how well an individual maintains core certification specialty knowledge competencies using clinical practice experience, educational endeavors and/or professional development activities.

Since regulators, employers and other interested parties use certification to identify and validate the knowledge competencies and clinical expertise in the identified specialty, it is the responsibility of each NCC certified nurse to maintain the stated core certification specialty knowledge competencies.

Key Findings

The program is implemented in two stages:

- **Stage 1 (June 2010 - December 2013):** the specialty assessment evaluation was added in June, 2010. Through December 31, 2013, all NCC certified nurses have to take that evaluation, composed of 125 specialty knowledge competencies questions. There is no pass/fail criterion, and the evaluation is designed to assist in identifying your core certification specialty knowledge strengths and gaps. Evaluation earns five continuing education hours, applying to 45 hours maintenance specialty hour requirement.

- **Stage 2 (2014):** the specialty assessment evaluation will determine the amount and nature of continuing education needed to maintain certification. Four steps:
  1. Step 1: Hold a valid, current unrestricted nursing license
  2. Step 2: Each certified nurse will participate in a NCC specialty assessment evaluation.
  3. Step 3: A learning plan will be provided based on the results of the evaluation that identifies areas upon which education should focus and which reflect current standard of practice.
  4. Step 4: The number of continuing education hours and content of the continuing education will be determined by the specialty index report provided after the specialty assessment evaluation. The total number of required continuing education hours can range from 15 to 50 continuing education hours.

Taking the Specialty Assessment Evaluation

- There is no fee for the two-hour and 15-minute evaluation, accessible from the NCC website. Following the assessment, a specialty index report is given, using a scale of 0 – 10 for feedback in each major content area.

- Specialty knowledge competencies include women’s health care nurse practitioner, inpatient obstetric nursing, neonatal intensive care nursing, low-risk neonatal nursing, maternal newborn nursing

Need for the Professional Development Certification Maintenance Program
Changes expand the knowledge base needed to function in an increasingly complex health care environment, bringing greater accountability and transparency to the certification maintenance process while providing employers and the public a valid measure of assurance regarding the ongoing competency of nurses related to the certification specialty role. It also aligns NCC with other professions who have added continuing competency components to their maintenance processes including physicians, pharmacists, physical therapists and nurses in Great Britain, Australia and Canada.
The Future of Nursing - Leading Change, Advancing Health - Brief

Report prepared by the Institute of Medicine of the National Academies

2010

Citation: IOM Future of Nursing Report 2010 – Report Brief.

Synopsis

In 2008, The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing.

With more than 3 million members, the nursing profession is the largest segment of the nation’s health care workforce. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs. A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

The report offers recommendations for a variety of stakeholders—from state legislators to the Centers for Medicare & Medicaid Services to the Congress—to ensure that nurses can practice to the full extent of their education and training.

Key Findings

- The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation.
- The power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role.
- Recommendations presented in this report are directed to individual policy makers; national, state, and local government leaders; payers; and health care researchers, executives and professionals—including nurses and others—as well as to larger groups such as licensing bodies, educational institutions, philanthropic organizations, and consumer advocacy organizations.

Recommendations

The committee considered nurses across roles, settings, and education levels in its effort to envision the future of the profession. Through its deliberations, the committee developed four key messages that structure the recommendations presented in this report.

- Nurses should practice to the full extent of their education and training. Registered (RNs) nurses should continue education to become advanced practice registered nurses (APRNs). High turnover rates among new nurses underscore importance of programs that ease transition from nursing school to practice.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States. Efforts to cultivate and promote leaders within the nursing profession—from the front lines of care to the boardroom—will prepare nurses with the skills needed to help improve health care and advance their profession.
- Effective workforce planning and policy making require better data collection and an improved information infrastructure. Planning for fundamental, wide-ranging changes in the education and deployment of the
nursing workforce will require comprehensive data on the numbers and types of health professionals—including nurses—currently available and required to meet future needs.
Continued Competency and Board Regulation: One State Expands Options

Mary Beth Thomas, RN, PhD, Denise A. Benbow, RN, MSN, CMSRN, and Virginia D. Ayars, MS, RN

2010


Synopsis

State boards of nursing are mandated by state statutes to ensure the ongoing safe and competent practice of licensees. However, nursing practice is characterized by diversity in educational backgrounds, scope of practice, and variety of settings. As a result, regulatory agencies face many challenges. Both professional and vocational/practical nurses are affected by the rule changes. After years of study, the Texas Board of Nursing has identified two areas for change to the current regulatory model. This article describes the new models developed within the Board initiative.

- A recommendation that nurses obtain continuing education credit in the individual nurse’s area of practice.
- An acknowledgment of national specialty nursing certification as one method of demonstrating continuing competency in the nurse’s specialty or area of practice.

Key Findings

- The public expects ongoing, effective demonstration of competency.
- There are national issues in ensuring continued competency.
- Specialty certification is one method to demonstrate continued competency.

The National Council of State Boards of Nursing (NCSBN) (2007) outlined the following guiding principles for ensuring continued competency in nursing:

1. Nursing regulatory agencies should be the body responsible for upholding licensure requirements.
2. Individual nurses have the responsibility to demonstrate continued competency through acquisition and application of knowledge and skills.
3. Continued competency should be periodically assessed and validated.
4. Regulatory models should include a diagnostic assessment.
5. Regulatory authority for establishing competency should remain with the state board of nursing.

Of the 50 member boards of the NCSBN, 36 state boards of nursing mandate continued competency activities, mainly through requiring continuing education courses (Yoder-Wise, 2010). Fourteen states set forth specific content areas for continuing education courses, and 16 boards require a minimum number of practice hours for relicensure (NCSBN, 2007).

Issues in Ensuring Continued Competency

Methods to evaluate, monitor, and ensure ongoing competencies are a matter of disagreement and debate. Issues include:

1. State boards of nursing are held to legislative mandates that vary from state to state.
2. Allocating resources and determining who will pay for an initiative remains an issue.
3. The nursing profession is not only diverse in its scope and setting but also has many educational levels that make competency evaluation complex.
4. There is little evidence on which to base new models for competency evaluation.

Texas Study

The Texas Board found that a variety of mechanisms in the study had the potential to assure the public of safe nursing practice of licensees (Board of Nurse Examiners for the State of Texas, 2001). After the report was issued, the Texas Nurses Association (TNA) and other key stakeholders began working with the Board to develop a new framework for continued competency. In 2008, the TNA released a comprehensive document that outlined a new
model of career movement and influences on competencies (TNA, 2008). The document was based on Benner’s work of novice-to-expert professional development (Benner, 1984). This detailed work led to the following suggestion for Texas Board rule revision: Nurses should be required either to obtain continuing education credits in their individual areas of nursing practice or to hold national specialty nursing certification.

**National Specialty Nursing Certification**

Many certifying bodies require a nurse to complete more continuing education over the course of the certification period than state boards of nursing require for licensure renewal. To maintain or renew certification, the courses taken must meet the criteria set by the certifying body. These criteria generally align with the Texas Board requirements. The Texas Board believes that the option of using national certification to validate continued competency should be available for the different types of licenses, with comparable certification requirements for each type.

The American Board of Nursing Specialties (ABNS) is a membership organization for nursing certification boards and other affiliates. One arm of the ABNS, the Accreditation Board for Specialty Nursing Certification (ABSN), provides accreditation for nursing certification organizations.

**Public Comment on Changes to the Texas Board of Nursing Rules**

Because state statute directs that any changes to the Texas Board rules be presented for public comment, revisions to the Continuing Competency Rules of the Texas Board were published in the *Texas Register* for feedback from stakeholders. Due to expressed concerns that clinical practice hours would be required of stakeholders, specifically in nontraditional nursing roles, this section of the proposed rule is being reevaluated.

**Adopted Requirements for Continued Competency**

After adoption of the rule changes, which were effective August 16, 2009, the requirements for demonstrating continued competency in Texas now allow a nurse to attain, maintain, or renew an approved national nursing certification in the nurse’s area of practice. Alternatively, a nurse may complete 20 contact hours of continuing education during the 2-year licensure renewal cycle, as required by Board rules (Texas Board of Nursing, 2009). The certifications available through ABNS-approved certifying organizations generally require continuing education and practice hours in the specialty.
Anesthesiology and Anesthesia Assistants

Rules and Regulations 2010: Certification Process for Anesthesiologist Assistants in the United States

National Commission for Certification of Anesthesiologist Assistants, Incorporated (NCCAA)

2010

Citation: Rules and Regulations 2010: Certification Process for Anesthesiologist Assistants in the United States. Pg 1-29.

Synopsis

Official document outlining the ongoing certification process for Anesthesiologist Assistants, as administered by the NCCAA.

NCCAA awards a time-limited certificate to each candidate who successfully completes the initial Certifying Examination. Each anesthesiologist assistant is able to maintain current certification by registering requisite continuing medical education (CME) credits every two years, successfully completing a Continued Demonstration of Qualifications of Anesthesiologist Assistants (CDQ) examination every six years and successfully completing a CME audit in any year that the practitioner is audited.

The certification process operates on a continuing six year cycle:

<table>
<thead>
<tr>
<th>Year</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Certifying Examination</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CME Registration</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>CME Registration</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>CME Registration, CDQ Examination</td>
</tr>
</tbody>
</table>

In years two and four of the certification cycle, requirements for continued certification include submission of 40 creditable CME hours and payment of the CME registration fee. In year six of each certification cycle, requirements for continued certification include submission of 40 creditable CME hours, payment of the CME registration fee, and completion of the CDQ Examination.

Key Findings

Continuing Medical Certification

- If the practitioner has not registered 40 hours of CME credit and paid the CME registration fee in full at the deadline, then that practitioner will no longer be certified by NCCAA.
- If the practitioner fails to register 40 hours of CME and pay the full CME registration fee, the only way in which an individual can re-establish certification will be to apply for and successfully complete a Certifying Examination.
- CME hours exceeding the 40 required hours for a registration period will not be registered.
- The content for thirty (30) hours of each registration period must be in the field of anesthesia or one of its subspecialties. The content for the remaining ten (10) hours may be in any medical topic. ACLS instruction will be tabulated as anesthesia-related content.
The National Commission randomly audits CME submissions of practitioners on an annual basis. The practitioner who is selected for audit must comply in full in order to remain certified.

**Continued Demonstration of Qualifications of Anesthesiologist Assistants (CDQ) Examination**

- Only one component of the ongoing certification process
- Designed to test the cognitive and deductive skills of the practicing anesthesiologist assistant who has successfully entered and continues to participate in the certification process for anesthesiologist assistants administered by NCCAA
- Computer-based and prepared in cooperation with the National Board of Medical Examiners
- Contains 200 items in four one-hour blocks of 50 items
- Calculations during the Examination: The candidate will be provided with a marker board, dry erase markers, and an eraser for making calculations during the exam. Test center staff will instruct the candidate to write their CIN on the marker board before collecting the Scheduling Permit and escorting him/her to their assigned testing station.
- Each examination will be comprised of single best answer questions and matching questions
- If NCCAA, based upon all available information, decides that an irregularity has occurred, the score may be ruled invalid. An invalid score will not be reported. NCCAA may require the examinee to be reexamined no later than the next regularly scheduled examination, may revoke certification, and may take other corrective action deemed appropriate, including denial of admission to any future examinations.
- Eligibility for the CDQ Examination shall extend for three consecutive CDQ Examinations from the date of approval of application. During the period of eligibility, the examination candidate will have three opportunities to take and pass the CDQ Examination.
- CDQ examination content outline (16 categories):

<table>
<thead>
<tr>
<th>Category</th>
<th>PCT</th>
<th>Topics in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airways</td>
<td>8</td>
<td>anatomy, physiology, pathophysiology, management, all age groups</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>10</td>
<td>principles of anesthesia; volatile and gaseous anesthetics; anesthetic techniques; closed circuit anesthesia; special problems in anesthesia; premedication; preop evaluation and planning</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>10</td>
<td>cardiovascular anatomy, physiology, diseases, therapy; anesthesia for cardiac and vascular surgery; CPR; cardiopulmonary bypass; ECGs; echocardiography; pacemakers; AICDs</td>
</tr>
<tr>
<td>Hematology &amp; Coagulation</td>
<td>3</td>
<td>hematology; coagulation; immunology; transfusion; rheology; sickle cell</td>
</tr>
<tr>
<td>Instrumentation &amp; Monitoring</td>
<td>5</td>
<td>instrumentation; monitoring; electrical safety</td>
</tr>
<tr>
<td>Metabolism &amp; Endocrine</td>
<td>5</td>
<td>metabolism; GI medicine; nutrition; endocrinology; obesity; malignant hyperthermia; liver transplantation, including anesthesia; alcoholism; diabetes mellitus</td>
</tr>
<tr>
<td>Neuro</td>
<td>5</td>
<td>neuro anatomy, physiology, diseases, therapy; neuroanesthesia; ESTs; EEGs; evoked potentials</td>
</tr>
<tr>
<td>Neuromuscular</td>
<td>5</td>
<td>neuromuscular histology, physiology; muscle relaxants, reversal agents; NMB monitoring; neuromuscular diseases and therapy; special problems; all age groups</td>
</tr>
<tr>
<td>Obstetrics &amp; Perinatology</td>
<td>5</td>
<td>obstetrics &amp; perinatology: anatomy, physiology, diseases, therapy; obstetrical anesthesia, including all regional anesthesia; special problems</td>
</tr>
<tr>
<td>Pediatrics &amp; Neonatology</td>
<td>5</td>
<td>pediatrics &amp; neonatology: anatomy, physiology, diseases, therapy; pediatric preop evaluation and planning; pediatric anesthesia; special problems; all pediatric coverage, excluding airways, neuromuscular, and regional</td>
</tr>
<tr>
<td>Pediatrics &amp; Neonatology</td>
<td>8</td>
<td>basic pharmacology of all drugs except volatile and gaseous anesthetics; pharmacokinetics; pharmacodynamics; also includes drugs with several different usages, drugs not in other categories, drugs that would be in two or more categories; toxicology; drug abuse</td>
</tr>
</tbody>
</table>
Booklet of Information: Certification and Maintenance of Certification

American Board of Anesthesiology

2010

Citation: American Board of Anesthesiology. (2010). Booklet of Information: Certification and Maintenance of Certification. Raleigh, NC: American Board of Anesthesiology.

Synopsis

The American Board of Anesthesiology (ABA) announced changes to the ABA Maintenance of Certification in Anesthesiology (MOCA) exam.

This booklet gives notice that as of January 2010, the ABA recertification exam is no longer available for recertification for Anesthesiologists. Only the MOCA will now be available. A major difference between the exams is that the opportunity to answer as few as 150 out of 200 questions is no longer available. All 200 questions must now be answered.

Key Findings

MOCA Exam Construction

- Primarily tests clinical issues, although there will be some questions related to common scientific concepts
- Tests a broad-based clinical knowledge set that most anesthesiologists, regardless of practice setting, would generally be expected to know
- Approximately 50 of the exam’s 200 questions will test clinically-relevant concepts in six subspecialty areas:
  1. Pediatric
  2. Cardi thoracic
  3. Obstetric anesthesia
  4. Neuro-anesthesia
  5. Critical care
  6. Pain medicine
- The MOCA exam will not ask questions related to highly subspecialized knowledge
  1. Questions will be asked about common subspecialty issues, however.

Exam Pass Rate

- Of the 373 ABA diplomats who took the January 2010 MOCA exam, 92.7% passed
- Diplomates who were in the seventh or eighth year of their 10-year MOCA cycles did better (97% pass rate) than those in their ninth or tenth year (88% pass rate).
- ABA encouraged Anesthesiologists to take the MOCA exam earlier in their MOCA cycle rather than later, allowing more than one opportunity to pass the exam.
Mounting Board Demands Foster Growing Unease

Ted Agres, Published by Anesthesiology News

October 25, 2011

Citation: Mounting Board Demands Foster Growing Unease by Ted Agres Anesthesiology News ISSUE: OCTOBER 2011 | VOLUME: 37:10

Synopsis

Article on the support and criticism behind the new Federation of State Medical Boards (FSMB) framework for maintenance of licensure. The article mentions the new rules for continued certification NBCRNA proposed in August 2011. The new framework, introduced in April 2010, requires physicians to also pass periodic knowledge and skills tests and to demonstrate performance standards using patient data from their own practices.

Key Findings

- Anesthesiologists and other physicians are becoming increasingly concerned that conditions for maintaining board certification may also become unofficial requirements for maintaining state licensure.
- Many physicians also worry that they may have to duplicate the expensive and time-consuming board maintenance of certification requirements to retain their medical licenses.
- Supporters claim the process keeps physicians up to date in knowledge and practice and improves patient safety.
- Critics complain that the testing methodology does not represent current practice because it prohibits access to reference materials and doctors must study for tests in specialty areas that they do not practice and have no intention of doing so.
- Although the American Medical Association (AMA) supports lifelong learning, delegates at the AMA’s annual meeting in June expressed concern that new rules for maintenance of licensure would force them to duplicate CME and other maintenance of certification requirements.
- Individual physicians can expect to pay several thousand dollars to complete the maintenance of certification process – furthering a belief that maintenance of certification has less to do with improving quality of care than with collecting additional fees for examination and other services on the part of specialty medical boards and their related societies and associations.
- The medical boards, all not-for-profit corporations, deny having a profit motive and maintain that the new requirements encourage lifelong learning, support physician competence, and improve clinical outcomes and patient safety.
- So far, it appears that nearly all anesthesiologists who are required to undergo MOCA are in the process of doing so. 99.6% of the 2000 cohort of ABA diplomates is expected to complete the MOCA program by 2013.
- NBCRNA in August announced proposed new rules for continued certification, including a standardized examination every eight years. The response has been vocal and about evenly split, said Wanda Wilson, PhD, CRNA, executive director of the American Association of Nurse Anesthetists.
- Karen Plaus, PhD, CRNA, executive director of the NBCRNA, said her organization would consider the feedback and comments before making a final recommendation to its board.
Physician

Professional Competence, Relicensure, and Recertification

Holden W. D.

1987


Synopsis

The medical profession is being challenged to provide more assurance to the public that individual practitioners are in fact preserving and extending their professional competence as innovations in the diagnosis and therapy of disease become an acceptable form of medical practice.

Until just prior to this article's publication, it was presumed that all physicians, having demonstrated a degree of competence by receiving a license and, in many instances, a board certificate, would continue to exhibit the same degree of competence throughout their practicing careers. The public challenge implied that this is not necessarily true and that objective evidence of continuing competence, periodically, should be required of all physicians.

Key Findings

Model Medical Practice Act

- In July 1976, the Georgetown University Health Policy Center issued a document entitled "Model Medical Practice Act" with the intent to provide to the state medical boards several general and specific principles applying to the licensure and relicensure of physicians. Relevant recommendations included:
  1. Independent medical practitioners shall be required to apply for relicensure every six years.
  2. The board (state medical licensing board) shall through its employees and agents determine the competence of all applicants for relicensure by the use of appropriate uniformly applied evaluation techniques that determine that the applicant has been providing a satisfactory level of care.
  3. The state medical licensing board may accept a recertification statement by any recognized specialty board.

- A major challenge is defining "competence" for each of the specialties that are recognized by the American Board of Medical Specialties (ABMS)
  1. This could be done by addressing multiple components a physician's professional activity:
     - Knowledge
     - The use of knowledge
     - Technical skills
     - Behavioral characteristics
     - The process of care employed by the physician
     - Outcomes of the patients cared for
     - Ethical approach to practice
  2. However, this is a task the state boards were neither directed to carry out by legislation nor equipped to do.

A Proposal for Credentialing Health Manpower

  1. Key recommendation: establish a national non-federal council to evaluate criteria and policies for the purpose of approving certifying organizations, to participate in the development of national
standards for credentialing health occupations, and inform the federal government of the organizations approved.

2. All of these statements suggested strongly the desire of the federal government to intrude into the processes of licensure and certification and to coerce acceptance of its role by the use of reimbursement procedures.

Public demand for assurance of professional competence

- At the time this article was originally published in 1977, it was evident that the public, through its elected representatives, was demanding the demonstration of the continued competence of physicians.

- The government is progressively making statements and enacting legislation that portend a dominant and directing role in the process unless the private sector of medicine accepts the challenge and assumes the responsibility itself in a way that assures the that professional competence is indeed being evaluated and addressed appropriately.

- All that the public is requesting, aside from reduced costs, is assurance that a physician is continuing to perform acceptably and effectively in the practice of medicine.

Continuing Education

- Continuing education does not measure competence in practice and there is very little objective data that demonstrate that continuing medical education leads to either increased competence or to improved patient care.

- The state medical boards are accepting a specified number of hours of approved continuing education programs as a basis for relicensure. This is not an index of professional competence and many of the leaders in the field of medical licensure regard this as but the first step in an evolving process that will ultimately assess competence.

Examination

- The specialty boards are approaching the process of recertification in a variety of ways but an essential ingredient utilized by all is an examination.

- There is no reason why physicians cannot or should not be examined for current knowledge and information that presumably is the basis for the understanding and treatment of disease.

- This alone does not provide assurance of daily competence in the care of patients. It could be argued, however, that serious failure on such an examination, indicating gross deficiencies in current knowledge and information, must be related to some degree of incompetence.

Integration of methods

- It is desirable, if not necessary, that continuing medical education, relicensure, and recertification be viewed as component parts of a process that must be integrated—with the objective of assuring the public that a physician continues to display competence and perform effectively.
Challenges in Recertification

Robert B. King, M.D

1989


Synopsis

The greatest change to the practice of medicine this century is the move toward re-certification focused on clinical performance and satisfactory outcomes - to assess physician performance in practice.

Key Findings

There are several factors in play when viewing the challenges to re-certification:

- Certification has limits to its ability to predict future practice capability - the quality of a practice over time may be less than initially expected at the time of certification.
- Physicians’ practice patterns change over time - due to resources, age, health and other factors, practices may change over time, requiring periodic reevaluation for quality assurance.
- Specialization may create new patterns of practice - as long as medicine partners with science and technology, we should assume that increased specialization will continue and the definition of specialization itself may change depending on job function or location, and may be age, behavioral, disease or disorder-related.

Most people think the purview of re-certification should be within the American Board of Medical Specialties (ABMS). Re-certification is not a new concept. In 1932, the Association of American Medical Colleges urged the requirement of continuing medical education, and in 1940, ABMS first recommended time-limited certificates to assure the skills of certified physicians were updated. Other boards, such as American Board of Family Practice, American Board of Internal Medicine and American Board of Emergency Medicine, have already initiated mandatory re-certification programs.

Other techniques being assessed for physician performance include multi-station examinations; electronic patient simulation; live patient simulation; hospital and office record audits; tests for technical skills; peer rating; patient satisfaction ratings; chart simulated recall (discussions); and process and outcome studies.

There are four factors inhibiting the implementation of acceptable re-certification programs:

- Voluntary re-certification programs do not work, primarily due to low participation
- The instruments we use for re-certification are the same ones we use for initial certification, and they do not seem well-suited for this purpose
- We have not clearly differentiated certification from re-certification
- Specialty boards have been pressured by specialty societies and slow to implement re-certification programs as a result.

Re-certification seems to be a reasonable extension of the specialty boards' earlier function with regard to certification. Their wide experience with a variety of instruments aimed at evaluating learning and performance has prepared them well to assume responsibility for this natural extension of their certification programs.
Because the tools used for certification may not make a good fit for re-certification programs, since they test the knowledge needed for training versus practice, we need a re-certification tool that tests practice performance. Determining the consequences of a physician’s patient care should be the primary focus.

Outcome criteria needs to take into account factors such as intake criteria; intensity of an illness; definable outcome criteria; and a spectrum of sociological, psychological, biomedical, economic, education, ethical, and moral vectors. All of these are forces in every health care delivery system and in every physician’s practice, while some are not under the physician’s control or influence.

Conclusion
The Institute of Medicine in 1974 noted in a policy statement the quality of health care “should be measured by results . . . .” Only practice performance (especially outcome and perhaps process) needs to be evaluated as a means of assuring quality performance in practice. Self-assessment exams should also continue as another important educational program of specialty societies.
Recertification in the United States

Published by John J Norcini in BMJ Volume 319

October 1999

Citation: Recertification in the United States John J Norcini BMJ VOLUME 319 30 OCTOBER 1999 www.bmj.com 1183-1184

Synopsis

Article on how to improve recertification in the United States.

The goals of recertification are to improve the care of patients, to set standards for the practice of medicine, to encourage continued learning, and to reassure patients and the public that doctors remain competent throughout their careers. To meet these goals, an ideal program for recertification should have three components for evaluation:

- To ensure that doctors are providing good care in practice an assessment of patient outcomes is needed.
- To ensure that doctors are aware of recent advances in medicine and have the potential to treat the broad range of less frequent but medically important problems, an evaluation of medical knowledge and judgment is needed.
- To ensure that doctors exhibit professionalism a review of credentials (for example, a valid license and attestation of competence from the hospital or other local authorities) and the judgments of peers and patients are needed.

Key Findings

Patient outcomes: Many healthcare systems give doctors a “report card” detailing their performance in areas such as screening, prescribing, and patient satisfaction. However, outcomes assessment for a national recertification program faces significant technical obstacles in data collection and in the number of cases that need to be sampled to have confidence in the results. Treatment is often provided by healthcare teams, so it is difficult to attribute a particular patient outcome to a single doctor. Patients with the same condition often vary in complexity for a variety of reasons including the severity of the disease, comorbid conditions, and patient compliance. There is considerable variation in the patient mix from one doctor to another.

In response to these issues, a recertification program should include a secure monitored test of competence. The trend in the United States is to offer these examinations on computer. For example, the American Board of Anesthesiology (www.abanes.org) currently offers its recertification examination on computers at sites around the country for a restricted period of time. Several of the boards are now planning to do likewise and to have the examination available for several periods of time throughout the year.

This will ease access, offer quicker feedback, allow the inclusion of video based and audio based test material, and permit rapid retakes of the examinations for those who are unsuccessful.

Professionalism: Ethical conduct and the quality of the relationship between doctor and patient must be assessed along with technical skill. An assessment of these aspects of competence is important because patients are vulnerable to inefficient doctors or those whose conduct is unethical.

Most boards address this need by requiring a valid license to practice medicine and ensuring that no disciplinary actions have been taken against the candidate. Additionally, testimonials from local credentialing bodies, such as hospitals, are often collected. Previous research has shown that selection of peer raters by the doctor does not bias the final results, so candidates distribute the forms themselves. Respondents call a free telephone number and
interactive voice response technology collects their answers to each of the questions on the form. When they have ratings from 10 peers and 25 patients, the candidates have completed the module.

Feedback to candidates is currently a summary of the ratings. Further information about completing the patient satisfaction and peer assessment module appears on the BMJ’s website. Plans for the future include normative information (how a doctor compares with his or her peers) and ultimately the development of standards for performance.

Preliminary work has been successful and the board has voted to make this part of recertification mandatory over the next five years.
Certification and Specialization: Do They Matter in the Outcome of Acute Myocardial Infarction?

John J. Norcini, PhD, Harry R. Kimball, MD, and Rebecca S. Lipner, PhD

December 2000

Citation: Norcini JJ, Kimball HR and Lipner RS. (2000) Certification and Specialization: Do they matter in the outcome of acute myocardial infarction? Academic Medicine 75(12) 1191-1198.

Synopsis

Report on study to learn whether there are differences among certified and self-designated cardiologists, internists, and family practitioners in terms of the mortality of their patients with acute myocardial infarction (AMI).

The study looked at data on all patients admitted with AMI were collected for calendar year 1993 by the Pennsylvania Health Care Cost Containment Council and analyzed. Certified and self-designated family practitioners, internists, and cardiologists were compared with respect to the characteristics of their patients' illnesses.

Study found that lower patient mortality from AMI was associated with treatment by an attending physician who was a cardiologist, cared for larger numbers of patients, was closer to his or her year of graduation from medical school, and was certified. Previous studies have shown that patient volume is predictive of reduced patient mortality, and this result was replicated here. Likewise, findings seem to corroborate previous work that has shown that specialization, proximity to graduation from medical school, and hospital location are related to attending physicians' performance.

Key Findings

- There were statistically significant differences among specialties and certification status for all of the variables except the presence of cardiomyopathy. Compared with the other specialties, the cardiologists had younger patients who were more often men and less severely ill as indicated by the Admission Severity Group and predicted mortality.
- As a group, non-certified physicians, regardless of specialty, had graduated from medical school before certified physicians, and they treated more of their patients in hospitals that lacked advanced cardiac care.
- Cardiologists' patients were less often on Medicare and less often treated in hospitals located in rural or urban communities. Not surprisingly, the cardiologists handled a greater volume of AMIs than did the primary care physicians.
- Within each specialty, certified physicians' patients had slightly higher predicted rates of mortality, but they had lower actual rates of mortality.
- Predicted mortality (all measures of severity of illness, as well as payer) had the strongest relationship with a patient's death.
- A patient being treated in an advanced cardiac care facility did not make a statistically significant difference with respect to his or her mortality, but the location of the hospital did affect mortality. A hospital located outside a rural or urban community was associated with 17% less mortality.
- When all other variables were kept constant, every additional 16 cases of AMI a physician treated (i.e., an increase in the volume of patients seen by a physician) was associated with a 10% decrease in mortality.
- There was a 5% increase in AMI patients' mortality for every year since the physician had graduated from medical school.
- In terms of a physician's specialty, treatment by either a family practitioner or an internist (as compared with a cardiologist) was associated with a 25-26% increase in AMI patients' mortality.
- Certification was also significantly related to mortality. When all other variables were held constant, certification was associated with a 15% reduction in AMI patients' mortality.
Conclusion

The unique contribution of this study is that findings show that an attending physician's certification status is also associated with AMI patients' mortality, even when taking into account many other variables. The findings support the validity of the certification processes of specialty boards. In our study, certification was associated with lower mortality, irrespective of a physician's specialty, even after taking account of severity of illness, hospital characteristics, patient volume, and years since graduation from medical school.

Findings demonstrate the need to be careful when using physicians' self-designations of their specialties to compare the outcomes of their patients. Certification is associated with the quality of the medical schools physicians attend as well as a variety of graduate experiences, including faculty-resident ratio and length of training. The findings of our study suggest that these aspects of the educational process may be associated with patients' outcomes as well. Certification could serve as a useful intermediate outcome, until it is possible to collect enough clinical data to permit direct comparisons between educational processes and patients' outcomes. Lower mortality rates among patients with AMI might be obtained by limiting their treatment to those physicians who are certified, are relatively recent graduates from medical school, and have considerable experience with this condition.
Specialty Board Certification and Clinical Outcomes: The Missing Link

Lisa K. Sharp, PhD, Philip G. Bashook, EdD, Martin S. Lipsky, MD, Sheldon D. Horowitz, MD, and Stephen H. Miller, MD, MPH

2002

Citation: Sharp LK, Bashook PG, Lipsky MS, Horowitz SD, Miller SH. “Specialty board certification and clinical outcomes: the missing link.” Academic Medicine 2002: 77(6) 534-542.

Synopsis

Specialty board certification status is often used as a standard of excellence, but few systematic reviews have examined the link between certification and clinical outcomes. The authors evaluated published studies tracking clinical outcomes and certification status. Specifically, they questioned whether board certification by one of 36 general specialties recognized by the ABMS correlated either positively or negatively with clinical outcomes defined as accepted national standards of care.

Key Findings

Certification and Outcomes
- Of the 33 findings, 16 demonstrated a significant positive association between certification status and positive clinical outcomes
- 3 revealed worse outcomes for certified physicians
- 14 showed no association
- In addition to board-certification status, many factors unrelated to the physician affect clinical outcomes, such as:
  1. Type of clinical setting
  2. Size of support staff
  3. Systems of clinical care

Certification Background
- Most hospitals, managed care organizations, and health insurance plans require board certification for physicians wishing to obtain clinical privileges and join provider panels.
- The two largest organizations that accredit hospitals and other health-care-provider organizations, the Joint Commission on Accreditation of Healthcare Organizations3 and the National Committee for Quality Assurance,4 incorporate board certification into their accreditation standards.
- The public uses board certifications a measure of a physician’s expertise, despite well-documented statements by the ABMS and the member boards that board certification is but one of several qualifications to be considered in assessing the quality of a physician’s clinical care.
- Certification has been associated with increased medical knowledge, superior training, and certain aspects of patient care.

Examinations
- Higher scores on certification examinations correlate with measures of better patient care.

Training
- Ratings in training correlate with clinical knowledge.

Data Sources
- Studies published between 1966 and July 1999 in three databases:
  1. OVID–Medline
  2. Psychological Abstracts (PsycLit)
Limitations

- The most common was incomplete verification of board certification status.
  1. Up to 18% of physicians misrepresent their clinical credentials.
- Methodologic unit of analysis to obtain a stable estimate of each physician's measured patient care outcomes
  1. Most studies pooled patient data across physicians, negating the possibility of measuring an individual physician's performance.
- Combining data for physicians from specialties into a single grouping based on certification status
The Role of Physician Specialty Board Certification Status in the Quality Movement

Brennan, TA, Horwitz R, Duffy FD, Cassel CK, Goode LD Lipner RS.

2004


Synopsis

The Institute of Medicine's reports and discussions on quality of medical care have focused on a systems-based approach to quality improvement. The objective of this article is to summarize evidence and theory about the role of a physician's current board certification status in quality improvement.

The first body of evidence includes the validity of board certification demonstrated by the testing process, the relationship of examination scores with other measures of physician competence, and the relationship between certification status and clinical outcomes.

The second body of evidence involves the adaptation of error prevention theory to medical care. Patient safety is enhanced when problem-solving uses readily accessed habits of behavior, the same behavior necessary to achieve board certification.

The third body of evidence, obtained through a Gallup poll, demonstrates that certification and maintenance of certification are highly valued by the public. The majority of respondents thought it important for physicians to be reevaluated on their qualifications every few years and that physicians should do more to demonstrate ongoing competence than is currently required by the profession. We conclude that a physician's current certification status should be among the evidence-based measures used in the quality movement.

Key Findings

Background

- The traditional physician approach to quality, e.g., certification, has received minimal notice within the new quality movement.
- The Institute of Medicine's To Err is Human report focused on safety, but also called for continuous quality improvement through change in systems of medical care.
- Many leaders in the profession agree that physicians must do more to demonstrate to the public that they are skilled and knowledgeable. This momentum predates the IOM quality reports but is given further impetus by the general activism surrounding quality.

Maintenance of certification

- The ABMS maintenance of certification initiative calls for evidence of the following:
  1. Professional standing
  2. Lifelong learning and periodic self-assessment
  3. Cognitive expertise as demonstrated by a secure examination
  4. Performance in practice

Board certification as a measure of individual physician quality

- Over the last 30 years, ABMS boards have evaluated the effectiveness of certification focusing primarily, until recently, on initial certification.

Validity of the testing process

- All ABMS boards set standards for passing the secure examinations using widely accepted, credible standard-setting methods.
Continuous monitoring of the standards set by the expert question-developers show them to be credible, valid, and reproducible over time, and different sets of experts arrive at comparable judgments.

Relationship of examination scores with other measures of physician competence

- Certification examination results are correlated with:
  1. Type of medical school training
  2. Amount of formal training
  3. Supervisor assessment of clinical skills
- A positive relationship exists between recertification examination performance and patient volume as well as complexity of patient problems reportedly seen in practice.
- Performance on recertification examinations has a small but significant positive correlation with:
  1. Length of training
  2. Initial certification examination scores
  3. Composition of the clinical practice

Patient and peer self-assessment measures

- Patient and peer self-assessment measures have a small but significant positive correlation with:
- Internal medicine program director ratings of overall clinical performance
- Communication skills rendered nearly 10 years previously

Relationship between certification status and various clinical outcomes

- Conclusions in this area are mixed.
- Review of the literature on studies published between 1966 and 1999:
  1. More than half support a positive relationship between board certification status and clinical outcomes.
  2. Of the studies that did not demonstrate a positive association, the majority showed no association between certification and clinical outcome measures.
- Although the evidence on clinical outcomes is mixed, it is nonetheless promising that better outcomes are associated with physician certification and maintenance of certification in many studies.

Certification and greater patient safety

- The quality movement, especially the part focused on patient safety, has relied as much on cognitive psychological concepts, guided as much by theory and common sense, as by evidence of outcomes.
- In the areas of psychological investigation, theorists recognize a complex interaction between problem-solving that relies on readily accessed habits of behavior and problem-solving that involves slower interrogation and processing of a knowledge base.
  1. Error prevention depends on recognizing that different behaviors are necessary to prevent mistakes or oversights arising from these respective types of problem-solving.
  2. Certification and maintenance of certification evaluate a physician’s evidence of possessing the requisite habits of practice (practice performance assessment) and robust knowledge (cognitive examination) needed to prevent both types of errors.
- A physician who performs well on a certification examination and who maintains certification by routine review of the medical literature presumably has demonstrated ability to access a base of clinical knowledge and uses this same skill and knowledge when faced with a patient problem. Common sense suggests that the physician with a broad and readily manipulated knowledge base will be more likely to arrive at the correct answer to a clinical question, although no empirical studies are available on this point.

Certification in the public’s eye

- Research suggests that patients pay very little attention to the scorecards and measures that predominate in the quality movement, often because of what and how information is presented.
  1. Key question for patients is, “How do I find a good physician?”
- Gallup poll of the general public about views on certification and maintenance of certification:
1. The survey revealed that certification and maintenance of certification are highly valued by the public.
2. Patients expect and would prefer that physicians demonstrate skills that are just beginning to be addressed by the ABMS requirements in their maintenance of certification programs.
3. Respondents indicated that physicians should be evaluated more frequently than is currently required by any board.
4. Respondents indicated that they would be likely to change their own behavior to ensure that they are treated by a certified physician.

Conclusion

- Reasonable empirical evidence suggests that certification and maintenance of certification programs will improve quality, and more research is under way. That evidence is supported by the theory of error prevention and even by common sense assumptions about medical practice.
Who Is Maintaining Certification in Internal Medicine—and Why? A National Survey 10 Years after Initial Certification

Published by the Annals of Internal Medicine

2006


Synopsis

The American Board of Medical Specialties (ABMS) adopted a framework, called Maintenance of Certification (MOC), for all certifying boards to evaluate physicians’ competence throughout their careers, with the goal of improving the quality of health care. The MOC participation rates of the American Board of Internal Medicine (ABIM) showed that 23% of general internists and 14% of subspecialists choose not to renew their respective certificates.

There is no denying that state-of-the-art knowledge on the part of the individual physician remains a key factor in ensuring quality care. The 24 certifying boards of the American Board of Medical Specialties (ABMS) now issue time-limited certificates to physicians who meet rigorous standards through a process that recognizes that medical knowledge and practice must be renewed to demonstrate ongoing competence in an environment with rapidly changing medical information and technology.

To study U.S. internists’ perceptions about the forces driving them to maintain certification, the ABMS designed a mail survey, sent to physicians in the U.S. originally certified in internal medicine in 1990, 1991 or 1992.

Key Findings

- Of those still working in the field of internal medicine or its subspecialties, approximately half report being required to maintain their specialty certificate by at least 1 employer, but only approximately one third of those who completed or enrolled in MOC report this requirement as a reason for participating.
- Those who completed or enrolled in MOC do so more for positive professional reasons than for monetary benefits or professional advancement.
- The most common reasons for not participating are the perceptions that it takes too much time, is too expensive, and is not required for employment.
- Respondents were volunteers from an early cohort of diplomates entering the program, and those with less positive attitudes may have responded at higher rates. Results are based on self-reported data, and misconceptions about program requirements may have led to some inaccurate responses.
- The relatively large percentage of general internists who left internal medicine mostly to work in another professional field explains why rates of MOC participation for general internists seem lower than those for subspecialists (77% vs. 86%).
- Although positive professional reasons clearly have a compelling internal influence on program participation, it is less clear whether employers’ requirements are an equally compelling external influence.
- Although half of all respondents report that MOC is required by 1 of their employers, only one third of those who participate in the program describe it as a reason for participating.

Reasons for Participating in MOC

- The most common reasons, which characterize more than half of the respondents, are to maintain or improve one’s professional image and to update knowledge.
- Approximately half report participating to maintain or improve the quality of patient care or safety, and approximately one third report participating for personal preference or interest or because it is required for employment.
- Approximately one quarter report participating for professional advancement or to maintain or improve patient satisfaction, and only approximately 10% report participating for direct monetary benefits.
A greater percentage of general internists (42%) than subspecialists (20%) say they participate in internal medicine MOC because it is required for employment. Also, a greater percentage of those who completed internal medicine MOC than those who enrolled say they participate because it is required for employment.

**Reasons for Not Participating in MOC**

- The most common reason for not participating in internal medicine MOC was that it was perceived to take too much time.
- Sixty percent of general internists and 59% of subspecialists did not participate in internal medicine MOC, and 48% of subspecialists did not participate in subspecialty or added qualifications MOC for this reason.
- Slightly more than half of the subspecialists reported not participating in internal medicine MOC because it was not relevant to their current practice.
- For all kinds of MOC, approximately one third did not participate because it was not required for employment or it was too expensive.
- Approximately 30% of general internists and subspecialists who did not participate stated that it was because there was no monetary benefit; this reason was less common for subspecialists (16%) regarding their internal medicine certificate.
- A greater percentage of general internists than subspecialists perceived the internal medicine MOC requirements as unclear.

**Conclusion**

Respondents value professional development— in the form of maintaining or improving one's professional image, updating knowledge, and improving the quality of patient care. This suggests that the profession recognizes maintenance of certification as one way of demonstrating professional development and a commitment to quality. Certifying boards must continue to set standards and develop evaluation programs that assess lifelong learning and practice improvement. Professional societies and certifying boards should work together to develop education and evaluation tools that help physicians maintain high-quality patient care throughout their careers, in a manner that does not unduly burden them in terms of time and resources. In tandem, specialty societies must continue to deliver quality medical education programs and foster professional development by linking education and clinical care in active rather than passive settings. The validity of the education and evaluation programs must be continuously assessed through research efforts that include demonstrating the relationship between program participation and performance and the quality of care provided by internists.
Assessing Quality of Care, Knowledge Matters

Eric S. Holmboe, MD
Rebecca Lipner, PhD
Ann Greiner, MCP

2008


Synopsis

A commentary on the relationship between medical knowledge and quality and how the secure examination component of specialty board certification—with its primary focus on assessing physician knowledge, diagnostic acumen, and clinical judgment—is an important complement to current performance measures.

Key Findings

- What is often overlooked in quality improvement is that effective microsystems must have highly competent clinicians, who possess sufficient knowledge and clinical skills to make and execute evidence-based decisions, exercise informed clinical judgment, and deal effectively with uncertainty.

Medical Knowledge and Quality

- Two key elements in a physician’s clinical judgment:
  1. Information collected from the patient through an accurate, complete medical history and focused physical examination
  2. Physician’s working medical knowledge

Changes in Physician Clinical Judgment Over Time

- Research suggests that, on average, clinical skills tend to decline over time
- Practice experience is not enough and physicians must engage in continuous professional development, including board certification, to retain competency.
- Problem of aging knowledge among experienced physicians
- Older physicians may tend to rely too heavily on nonanalytic thinking (e.g., pattern recognition) over time, leading to premature closure about a diagnosis.
  1. When new knowledge emerges that should change the approach to patient care, the physician must incorporate this new information into clinical reasoning.
  2. In a study of a recertification examination, Day et al found that physicians did much better on test questions of stable, unchanged medical knowledge than on new knowledge developed since their medical training.

Testing and Retesting of Clinical Judgment

- Decades of research work in test development and psychometrics has led to current high stakes cognitive examinations with high reliability and reproducibility.
- Secure examinations of medical knowledge and clinical judgment can provide an effective means to assess whether physicians have incorporated new knowledge over time.
- Evidence to support the link between board certification examinations and quality:
  1. Norcini et al found that mortality was lower for patients with acute myocardial infarction cared for by certified physicians.
  2. Prystowsky reported that certification in surgery was a significant predictor of lower mortality and complication rates for colorectal surgery.
  3. Pham et al found an association between the rate at which preventive care services were delivered for Medicare patients and the certification status in internal medicine or family medicine.
Secure Examination as an Act of Professionalism

- The majority of physicians who have taken the American Board of Internal Medicine’s maintenance of certification examination reported on the survey they completed at the end of the examination that the content was fair and relevant.
- The public expects, in return for the privilege of self-regulation, that physicians undergo a rigorous, periodic examination of knowledge.
- Certification boards are obligated to ensure their examinations are a relevant and meaningful measure of cognitive competence.
Association Between Maintenance of Certification Examination Scores and Quality of Care for Medicare Beneficiaries

Eric S. Holmboe, MD; Yun Wang, PhD; Thomas P. Meenan, MD, MPH; Janet P. Tate, MPH; Shih-Yieh Ho, PhD, MPH; Katie S. Starkey, MHA; Rebecca S. Lipner, PhD

2008


Synopsis

This study sets out to determine associations between general internists’ performance on the American Board of Internal Medicine maintenance of certification examination and the receipt of important processes of care by Medicare patients.

Physicians were grouped into quartiles based on their performance on the American Board of Internal Medicine examination. The main outcome measures were the associations between diabetes care, using a composite measure of hemoglobin A1c and lipid testing and retinal screening, mammography, and lipid testing in patients with cardiovascular disease and the physician’s performance on the American Board of Internal Medicine examination, adjusted for the number of Medicare patients with diabetes and cardiovascular disease in a physician’s practice panel; frequency of visits; patient comorbidity, age, and ethnicity; and physician training history and type of practice.

Key Findings

Support for Cognitive Testing

- A systematic review found a negative relationship between physician experience and performance.
- Public support for repeated cognitive testing has been strong, with 87% of patients who were surveyed saying that they believe a physician should take an examination of knowledge periodically.
- One Canadian study found that family physicians’ scores on an initial licensing examination had predictive validity for future performance on a number of quality measures up to 6 years after the examination.

American Board of Internal Medicine (ABIM) Maintenance of Certification Details

- All internists must now complete the MOC program every 10 years to receive a new certificate.
- To renew a certificate, physicians must complete a set of formative self-assessment activities and pass a rigorous recertification examination.
  1. The examination evaluates the extent of the candidate’s knowledge and clinical judgment (i.e., cognitive skills) in areas in which an internist should demonstrate competence, including treatment of both common and uncommon conditions that have important consequences for patient care (www.abim .org). The examination also includes questions about diagnosis, treatment, and prevention.

Study Demographics

- Approximately 37% of the cohort were women
- 26% had trained in a foreign medical school
- nearly 23% failed the initial certification examination on their first attempt
- Approximately 60% of these physicians worked in practices of 10 or fewer physicians with nearly 20% working as solo practitioners.

Study Results
• Physicians scoring in the top quartile were more likely to perform processes of care for diabetes and mammography screening than physicians in the lowest physician quartile, even after adjustment for multiple factors.
• There was no significant difference among the groups in lipid testing of patients with cardiovascular disease.
• These findings suggest that physician cognitive skills, as measured by a maintenance of certification examination, are associated with higher rates of processes of care for Medicare patients.

Possible Explanations
• Many physician offices currently lack effective systems to ensure that these processes of care occur without direct physician involvement.
  1. Physicians with better cognitive skills may be more effective in remembering to do the “right thing” or in creating systems.
• Physicians with higher levels of cognitive skills competency may either gravitate toward or create better systems of care delivery.
• High performance on the examination may be a marker for more effective physician behaviors in other competencies that promote better care.
Maintenance of Certification, Maintenance of Public Trust

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2011


Synopsis

Article offers a consolidated, concise history of the Maintenance of Certification (MOC) program, which is the official certification policy of the American Board of Medical Specialties (ABMS). It discusses what plastic surgeons need to know to successfully complete the American Board of Plastic Surgery's own Maintenance of Certification requirements. The authors justify each step of the board's Maintenance of Certification process in terms of how it improves the quality of care delivered to plastic surgery patients; present research demonstrating that the public supports the maintenance of certification processes for all physicians; and that continuing education, formal assessment and improvement initiatives are linked to a better and more evidence-based medical practice.

Key Findings

- While each specialty board's MOC program is required to meet basic criteria, ABMS member boards are responsible for devising their own methodology for executing the MOC core principles.
- The MOC program itself has been controversial due to the perceptions of physicians of its numerous requirements. Despite some resistance to the MOC program, literature exists that supports the process.
- The first specialty medical association formed in 1917. The predecessor of the ABMS was an advisory board that formed in 1933, representing the interests of medical specialty fields and the numerous specialty medical associations that had since formed. The advisory board was renamed ABMS in 1970 after a reorganization.
- Today, ABMS has 24 specialty member boards, which as a group offer 37 general specialty certificates and 94 subspecialty certificates. ABMS sets the standards for the boards' certification processes and ensures these processes are carefully met. ABMS has members in 89 percent of all licensed U.S. physicians.
- Each specialty board creates an initial certification examination to assess the relevant medical expertise and clinical decision-making skills of physicians who have completed graduate medical education programs within that specialty. ABMS reviews these examinations.
- ABMS joined forces with the Accreditation Council for Graduate Medical Education to develop a curriculum of six "core competencies" that they believe are important for proficiency in any specialty: medical knowledge; patient care; interpersonal and communicative skills; professionalism; practice-based learning and improvement; and systems-based practice. ABMS incorporated measurements of these competencies into their board specialty certification process.
- Evidence-based health care practices began to be adopted in the U.S. in the 1960s and 1970s, requiring more accountability from physicians and hospitals to justify their practices and decisions.
- Concerned about the gradual decline of physician clinical skills and medical knowledge, the ABMS instituted periodic recertification as its official policy in 1973. Throughout the next two decades, most boards switched from granting lifetime certificates to offering time-limited certificates that physicians need to renew every 6 to 10 years by successfully repeating the examination process.
- Quality concerns remained at the forefront of public discussion in the 1980s and 1990s due to variations in health care practices and quality-of-care-gaps when comparing outcomes across health care systems.
Much of these concerns were tied to the underuse or misuse of important evidence based processes of care. Research found that preventable errors in U.S. hospitals caused as many as 98,000 deaths per year. Hospital administrators and physicians failed to translate subject matter knowledge into evidence-based medicine, proper clinical decision-making and patient care.

- In response to this quality gap, numerous oversight groups and programs came into existence, including the “pay-for-performance” reimbursement system.
- The ABMS created the MOC program in response to public demands for physician accountability. It is designed to be a more inclusive assessment of a physician’s knowledge and clinical skills. The program has four components: professional standing; lifelong learning and self-assessment; cognitive expertise; and practice performance assessment. In 2000, the ABMS’s 24 member boards voted to change their certification from periodic recertification by examination to the ongoing assessment process of the MOC program. ABMS approved all 24 member boards’ MOC program proposals by 2006. While the traditional knowledge examination was kept as a requirement, other facets of the MOC were included such as ongoing continuing education, participation in self-assessments and improvement efforts in the years between examinations.
- ABMS instituted a subcommittee, the Committee on Monitoring and Oversight of MOC, to provide an active oversight role and ensure that member boards are fulfilling essential ABMS requirements. To verify that MOC guidelines are being followed and enforced, member boards submit regular reports to subcommittee on the state of their MOC program and physician participation. The directors review each board’s program for continued compliance with the general guidelines.
- AMBS MOC program requirements include: physicians maintaining their medical licenses; taking ongoing Continuing Medical Education credits; passing a traditional knowledge examination; and assessing data on the diagnoses, treatments and outcomes of the surgeon’s patients.
- After the data assessment is done, member boards create a portfolio comparing the physician’s diagnoses, treatment decisions and patient outcomes with peers. Doctors then provide a self-assessment, plan and timeline for improvement, with the board later assessing whether the self-improvement plan is working.
- There is a marked increase in time, money, and energy that physicians now invest in maintaining specialty certification.
- Many studies demonstrate a positive and statistically significant association between specialty board certification and greater compliance with recommended treatments and superior patient outcomes. Several studies associate certification with lower mortality and complication rates for a number of surgical procedures. Another study showed that patients who saw board certified physicians were more likely to receive recommended preventative care such as vaccines and health screenings.

Summary
Support from the medical community and public has been strong for continuing physician education and self-assessment/improvement initiatives. The ABMS’s official “overarching goal” for the MOC is to “protect the public and patients by attesting to the quality, safety, and effectiveness of U.S. medical practitioners.”
Maintenance of Certification: 20 Years Later

Wendy Levinson, MD
Eric Holmboe, MD

2011

Citation: Levison W, Holmboe (2011) Maintenance of Certification: 20 years Later American Journal of Medicine 124(2) 180-185.

Synopsis

The American Board of Internal Medicine (ABIM) instituted a significant change to their certification program in 1990: all certifications in internal medicine and its subspecialties would be valid for a period of 10 years, and interns would be required to maintain their certification through a Maintenance of Certification (MOC) program. While many interns objected to the new, more periodic requirements – approximately 85% chose to participate in the MOC.

This article describes the rationale, the components of the present program, the evolving research evidence and characteristics of interns who have participated over the last 20 years, and the limitations and future of MOC.

Key Findings

Rationale for MOC

- Studies have found that certified internists provide patients with higher rates of preventive services, improved care for hypertension, and lower mortality rates in patients with myocardial infarction compared with care delivered by noncertified internists.
- However, evidence suggests that physicians do not maintain their knowledge and skills or effectively self-assess their performance on their own.
  1. 73% of articles reviewed in a study by Choudhry et al reported decreasing performance on some or all of the outcomes assessed with increasing years in practice.
  2. Studies assessing how physicians actually perform in practice demonstrate major gaps between known appropriate standards of practice and what physicians actually do. Often, basic standards of care are performed in only 50% of patients.
- 80% of respondents agreed with a recent MSNBC poll that asked the public whether “all specialists should be required to take a test to renew their certification.”

MOC in 2010

- The American Board of Medical Specialties (ABMS) requires 4 components for every MOC program:
  1. Evidence of professional standing (license to practice)
  2. Participation in lifelong learning and self-assessment
  3. Evidence of cognitive expertise (examination)
  4. Assessment of practice performance
- The ABIM program requires diplomates to pass a secure examination in their subspecialty once every 10 years.
  1. Computer-delivered test typically composed of 180 multiple-choice questions.
  2. The examination in each specialty is designed by a test-writing committee comprising specialists in that area; ABIM psychometricians ensure that each examination is reliable and valid.
- ABIM added a self-assessment of practice performance requirement to the program in 2006. Acknowledging that knowledge alone was not enough to determine if physicians had the skills and judgment to deliver quality care, tools known as Practice Improvement Modules (PIMs) were developed.

Science and Theory of MOC
Experience and assessment drive adult learning. Assessment helps physicians to recognize and address gaps in knowledge and performance.

Physicians require “good data” to ensure that their interpretations and reflections are accurate around their performance and learning needs. However, research demonstrates that physicians are not accurate in generating this information through isolated self-assessment.

1. The least competent physicians are unfortunately also the least skilled in assessing their abilities and performance.

2. Evidence exists that overall competence may actually decline with age.

3. MOC provides a useful assessment vehicle for practicing physicians to accurately and rigorously assess their knowledge and performance gaps.

Evidence for ABIM’s MOC Program

1. Small but evolving body of literature
2. Two recent articles (Turchin et al and Holmboe et al) provided validity evidence by correlating performance on the examination with performance in practice.

1. Results are consistent with a body of evidence from 16 separate studies on the relationship between initial certification examinations and subsequent clinical practice.

2. Related to the PIMs, diplomates report that they value the information they receive about their practice, often describing the “aha” moment when they review their performance data and uncover an area of suboptimal practice where they are doing less well than expected.

1. Research studies on the PIMs have found that it is often the physician’s first experience with performance measurement and improvement.

Participants and Feedback

1. 30% of diplomates completed their certification before the introduction of MOC and hold certification that is valid indefinitely; they are often called “grandfathers.”

1. ABIM encourages grandfathers to recertify voluntarily, but only 1.7% enroll in MOC and only one-half of that percentage complete the process.

2. Subspecialist certification is optional, but has a high participation rate (82%), indicating that internists and the organizations within which they practice place value on maintaining board-certification status.

3. ABIM asks diplomates to complete a survey about the value and experience regarding their participation on each component of MOC.

1. Self-assessment: 78% percent agreed or strongly agreed that the modules provided a valuable overall learning experience and helped them identify important areas for further study, while 71% said the knowledge modules raised their awareness on how to improve patient care.

2. Examination: Diplomates rate the overall experience once they have taken the examination highly (84%), and most believe that their MOC examination is a relevant test of their knowledge (61%). 15% disagreed or strongly disagreed that their MOC examination was a fair assessment of clinical knowledge in their discipline, and 4% were dissatisfied with the testing experience.

Limitations and the Future of MOC

1. There is a need for the secure examination to be more tailored to specific practice areas and to provide electronic resources to look up information as one does in practice.

2. Diplomate concerns:
   1. Time required
   2. Cost

3. An important upcoming change is that the MOC program will become more continuous, requiring internists to participate on a regular basis rather than preparing only near the time of recertification.
Comparison of Professions

Recertification in Advanced Practice Nursing: General Trends and Current Practices

Jeannine Bailey, Promissor

2007


Synopsis

The 1996 Institute of Medicine (IOM) report, which said that as many as 98,000 people die in hospitals each year due to medical errors has fueled reforms across the medical field. One such reform is improving the ongoing competence of healthcare workers through recertification.

The recertification movement has seen two major shifts over the past several decades as a result of research findings and government policies: a shift from a one-time certification model to a recertification method that primarily uses continuing education, and then a shift to a continued competence or maintenance of certification approach, which recognizes that good clinicians should be committed to and proactively involved in lifelong professional development.

This paper focuses on the recertification practices of advanced practice nursing and other medical fields analogous to nurse anesthetists, with a special focus on examination practices. It first reviews recertification developments in the literature, presenting research and policy highlights, and then surveys current recertification practices used in the field.

Key Findings

Literature Review

- The IOM found that the most prevalent recertification requirement was continuing education or retaking the original certification examination.
  1. They recommended that skills and knowledge be assessed in clinical settings and rigorous tests be used to evaluate proficiency.
  2. The Citizen Advocacy Center (CAC) echoed this sentiment with their five-step roadmap that included periodic assessment.
- The National Council of State Board of Nursing (NCSBN) acknowledges that there is no clear consensus of how continued competence should be regulated, but indicate that periodic assessments, such as formal examinations, self-assessments, and clinical practice reflections are reasonable requirements.
- In relation to Advance practice registered nurses (APRNs) the NCSBN recommends including some or all of the following:
  1. Continuing education
  2. Clinical practice
  3. Examinations
  4. Portfolios
  5. Practice evaluations

Survey of current recertification practices

- A total of twelve types of certifications from nine different organizations were surveyed:
  1. One MD
  2. One PA
  3. Ten APRNs (one CNM, six NPs, and three CNSs)
• The recertification time cycle had a range of 3 – 10 years, with a mean of 5.5 years
• Recertification programs involved a wide-range of activities including re-examination, practice hours, and professional development activities
• Of the twelve types of certifications, ten presented an examination method and two did not.
  1. Of the ten examinations offered, two were a requirement for recertification and eight were offered as an optional activity.
  2. The two certifications requiring examinations were the only non-APRN certifications surveyed (for MDs & PAs); they also were the only examinations that were different than the original certification examination.

Physicians (MD)
• In 2001, American Board of Medical Specialties (ABMS) approved the transition to a Maintenance of Certification program (MOC) by the end of 2005, which encourages a lifelong learning approach to certification.
• Participants complete requirements every 10 years.
• MOCA exam is similar to the pre-existing recertification exam
• MOCA examination requirements:
  1. At least 200 LLSA credits
  2. Evidence of PPAI
• If MOCA requirements are not met by the end of the ten-year certification cycle, the physician will lose their certification until the MOCA program is complete

Physician Assistants (PA)
• Six-year recertification period using a two-part method where certification materials are submitted and then a recertification examination is passed.
• Certification materials include logging a minimum of 100 hours of continuing medical education (CME) credits every two years.
• Physician Assistant National Recertifying Exam (PANRE):
  1. A PA may take the exam starting the fifth year, which would allow up to four attempts to pass the examination.
  2. Exam is different from the initial certifying examination and consists of 300 multiple-choice questions.
• If certification lapses, there are two ways to regain the credential: Candidates must either pass the original certification examination, or pass PANRE if CME requirements are fulfilled

Certified Nurse Midwives (CNM; APRN)
• Nurses certified after 1995 are automatically enrolled in the Certificate Maintenance Program (CMP), which requires recertification every eight years
• Two recertification options:
  1. AMCB Certificate Maintenance Module Method. 3 modules. Each contains:
     • Current professional journal articles
     • Open-book module examinations
     • Answer sheets to be mailed
  2. Reexamination
• Requires 20 hours of continuing education activities
• If requirements are not met in the specified time period, individuals must retake and pass the certification examination and complete continuing education requirements.

Nurse Practitioners (NP; APRN)
• Nurses recertify every five years either by either:
  1. Passing an examination or
  2. Completing 1,000 clinical practice hours in their specialization area and 75 hours of continuing education.
• Exam is the same one used for initial certification
**Obstetric, Gynecologic, and Neonatal Nurse Practitioners**
- Certifications must be maintained every three years through the Certification Maintenance Program.
- Two options for renewal:
  1. Forty-five hours of continuing education
  2. Reexamination
- The examination is the same as that used for initial certification.

**Certified Pediatric Nurse Practitioners**
- Seven-year recertification cycle
- Annual recertification activities:
  1. Self-assessment exercises (SAEs)
  2. Continuing education
  3. Clinical practice
  4. Preceptor activities
- If requirements are not met, the examination must be retaken and passed for recertification.

**Clinical Nurse Specialists (CNS; APRN)**
- Four-year recertification cycle
- To be eligible to renew certification, nurses must have a minimum of 2000 practice hours, with at least 400 hours in the last year.
- For renewal, nurses have the option to complete either 60 continuing education credits (including professional publications) or pass the certification examination.
Continued Competency

The framework, concepts and methods of the Competency Outcomes and Performance Assessment (COPA) Model

Carrie B. Lenburg, EdD, RN, FAAN

2000

Citation: Lenburg, C.B. (nd) The framework, concepts and methods of the Competency Outcomes and Performance Assessment (COPA) Model.

Synopsis

The purpose of this article is to describe the importance of a framework that supports learning and assessment methods focused on practice competencies. The integration of essential concepts in developing and implementing competency outcomes, interactive learning strategies, and psychometrically-sound performance assessment methods are also important subjects.

The Competency Outcomes and Performance Assessment (COPA) model is explored in detail to illustrate the integration of these concepts into an effective framework that supports competency outcomes and assessment required for contemporary practice.

Key Findings

Background

- Fundamental problems associated with developing and implementing competency-based programs can be linked to a lack of emphasis on them in teacher preparation, with resulting deficits in programs preparing nurses for general or specialized practice.
- The reorganization of existing programs to integrate outcomes-oriented learning and performance assessment concepts presents a broad array of issues and concerns for those involved in developing them or being evaluated by them.
  1. Typically, instructors find it difficult to give up content and skills traditionally considered essential. It is easier to keep adding rather than to make the hard choices to deliberately reorganize content and methods.
- A total redesign of learning and assessment is required to promote competence in today’s complex practice environments.
  1. Employers and practitioners have begun to question what teachers are teaching. They resent spending time and funds to “reteach” graduates and to provide extensive orientations before they can safely implement the skills required in professional positions.
  2. Graduates feel that they have had tremendous workloads while in school, and yet are under-prepared and lacking in confidence in practice.

COPA Model

- The COPA Model uses four guiding questions to create an organizing framework for making the transition to a competency outcomes and performance assessment system. It specifies a set of core competency categories that are fundamental to professional practice and recommends interactive learner-focused learning strategies to promote competence in all of them.
  1. What are the essential competencies and outcomes for contemporary practice?
  2. What are the indicators that define those competencies?
  3. What are the most effective ways to learn those competencies?
  4. What are the most effective ways to document that learners and/or practitioners have achieved the required competencies?
- It uses a constellation of ten psychometric concepts and related principles to develop and implement objective performance assessment procedures.
1. The concept of examination is foundational to all the others; the evaluation episode is constructed and implemented as an objective examination to determine competence, not to promote learning per se.

- **Performance Evaluation**: Competency Performance Assessments (CPAs) are used for didactic and Competency Performance Examinations (CPEs) are used for clinical situations to promote accountability for competence in all of the core practice skills.
  1. CPAs are designed for use in non-clinical, didactic, classroom-type situations and for related types of assignments, such as projects, poster presentations, analyses of reports, research articles, or writing manuals or reports.
  2. CPEs are used in clinical, client-related environments and corresponding critical elements are more exacting as they take into account the legal, ethical and professional components of responsible care of actual persons.
  3. Thus, the whole range of practice competencies can be objectively assessed using a similar set of psychometric concepts, protocols and policies, regardless of where they are learned, or the type of skills involved.

- The Model provides an example of a holistic, integrated, and flexible system to promote competent practice that is applicable to education and service purposes and diverse specialties and settings.
Measuring the Competence of Healthcare Providers

NeerajKak, Bart Burkhalter, and Merri-Ann Coope

2001

Citation: Kak, N, Burkhalter B. and Cooper M. (2001) Measuring the Competence of healthcare provider. Operations research issue paper 2(1) Bethesda MD. Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project.

Synopsis

The Quality Assurance Project endeavors to improve healthcare provider performance. The QA Project developed this paper on measuring competence to guide healthcare systems in improving their performance through better hiring, job restructuring, re-organization, and the like. The paper focuses on competence and reviews several studies that have contributed to the understanding of competency in medical education and healthcare settings. Understanding the causes of poor performance of healthcare providers is crucial to high quality healthcare. To the extent poor performance is caused by low competence, improving competency would improve performance. This paper provides a framework for understanding the key factors that affect provider competence. Different methods for measuring competence are discussed as are criteria for selecting measurement methods. Also, evidence from various research studies on measuring the effectiveness of different assessment techniques is presented.

Competence encompasses knowledge, skills, abilities, and traits. It is gained in the healthcare professions through pre-service education, in-service training, and work experience. Competence is a major determinant of provider performance as represented by performance with various clinical, non-clinical, and interpersonal standards. Measuring competence is essential for determining the ability and readiness of health workers to provide quality services. Although competence is a precursor to doing the job right, measuring performance periodically is also crucial to determine whether providers are using their competence on the job. A provider can have the knowledge and skill, but use it poorly because of individual factors (abilities, traits, goals, values, inertia, etc.) or external factors (unavailability of drugs, equipment, organizational support, etc.).

"Documenting competence is becoming essential—not optional—and is likely to become mandatory in the near future for initial and continuing licensure and certification, and perhaps even for employment." (Lenburg 1999).

Key Findings

- Competence is one of many determinants of performance. The relationship between competence and performance is complex.

- Competency can be measured using a variety of methods, including tests presented in a written format or on a computer, in an interview, or through a simulation or work sample. Each assessment method has its strengths and weaknesses. While written tests or interviews can assess knowledge, assessments using models or job samples can closely assess skills.

- All assessors must be trained to give accurate reports and evaluations of competency. The length and content of the training depends on the expertise of the assessor, the competency to be assessed, the assessment instrument used, and the conditions for evaluation. Different types of assessors, including supervisors, peers, patients, and observers, can accurately report and assess healthcare provider competency.

- Checklists are particularly useful for giving feedback to the healthcare provider and for use by non-expert raters. Detailed checklists are also useful for self-evaluation as they provide a teaching tool and a job aid. However, some raters may be unwilling to use checklists, which can be long and time-consuming. It is necessary to determine a length that provides useful feedback and that assessors will use.

- Written or computerized tests are an effective way to measure knowledge but not to assess skills that are required for some tasks.
• Competency can be assessed using tests or inferred from performance that has been assessed using simulations or work samples.
• Both internal factors (motivation, agreement with a standard, self-efficacy, inertia, etc.) and external factors (supervision, feedback, availability of resources, community, peer expectations, and incentives) affect whether a healthcare provider will apply his or her competence.
• Detailed and immediate feedback to the healthcare provider about his or her competence is useful for both learning and improving performance.
• Standards of competency must be defined carefully, even for expert assessors.
• The effective ways to measure competency include evaluations of performance by experts or trained observers, reports from patients (especially trained or standardized patients), and objective structured clinical examinations.

Criteria for selecting measurement methods

Validity
Validity concerns the degree to which a particular measurement actually measures what it purports to measure. Below are some findings from the literature about the validity of various competency measures:
• Assessments of medical records are not good indicators of healthcare provider competence, largely because many medical procedures are not recorded (Franco et al. 1997; Hermida et al. 1996; Norman et al. 1985).
• Performance on tests is inconsistently correlated with performance with patients (Jansen et al. 1995; Sloan et al. 1993). Written, oral, and computerized tests are primarily measures of knowledge: patient care requires several skills and abilities in addition to knowledge.
• There is substantial evidence that the OSCE method can be used to effectively assess a wide variety of competencies (Coliver and Williams 1993; Elinick et al. 1993; Stillman et al. 1986).
• Norman et al. (1985) found only moderate correlation between the evaluations of performance by the standardized-patient method and by patient records. Lyons (1974) reported similar low correlations between medical records and medical care.

Reliability
Reliability refers to the consistency of scores for a particular person with respect to a particular competency when evaluated by different methods, by different raters, or for more than one patient. Below are some of the findings about the reliability of competency measures:
• Raters use different criteria in evaluating the competence of healthcare providers (Norman et al. 1985). The consistency in ratings provided by different raters is low to moderate (Stillman 1993).
• Performance with one patient does not represent performance on other cases (Cohen et al. 1996; Franco et al. 1996; Norman et al. 1985; Reznick et al. 1992). In order to obtain adequate reliability, multiple patients are required (Coliver and Williams 1993; Sloan et al. 1993).
• Clarifying the checklist improves the reliability of the ratings (Coliver and Williams, 1993).
• Trained peers can accurately assess healthcare provider performance (MacDonald 1995).
• Healthcare provider self-assessments are consistent with their observed performance with patients (Jansen et al. 1995; Mac Donald 1995; Bose et al. forthcoming).
• Both patients and caretakers of patients accurately report healthcare provider performance (Coliver and Williams 1993; Franco et al. 1996; Hermida et al. 1996). While these reports can be used as inputs into an evaluation of competence, they are not measures of competence.

Feasibility
Resources are required to design and implement an assessment of competence. Decisions to determine which measure to use should reflect the following issues:
• The number of individuals to be assessed.
• The time available for the assessment.
• The willingness of the assessor to use the assessment instrument.
• The willingness of the healthcare provider to accept the assessment.
• The extent of training available those who will participate in the assessment.
The resources (funding, assessors, equipment, space, etc.) available for the assessment.
The time, staff, and funding available for development and pretesting of instruments.
The competency to be assessed.

Competency
Why Measure Competency?

- **Healthcare reform** - The increasing complexities of healthcare delivery and changing market conditions have forced health policy-makers to promote the assessment of initial competence of students and new graduates and the continuing competence of experienced and certified practitioners (Lenburg 1999)
- **Organizational performance** - Comparing assessments of competence and job performance may indicate the extent to which the organization provides the support needed for quality care.
- **Liability and ethics** - Healthcare organizations are responsible for the quality of care their staff provide and consequently must ensure that their staffs are competent and can meet standards for the provision of care.
- **Risk management** - Competency assessments can be used to monitor organization-wide knowledge of policies and procedures related to high-risk areas. Feedback from these assessments can be used for training and continuing education of providers and to improve overall organizational performance.
- **Certification and recertification of providers** - Competency assessment is an integral part of the certification and recertification processes of service providers.
- **Planning for new services** - Competency assessment can help managers identify providers who are competent to provide a new clinical service, providers who need improvements in specific knowledge or skill areas when a new service is offered, and providers who are ready to act as mentors of newly trained providers.
- **Measuring training outcomes** - Competency assessment can determine the efficacy of training interventions in closing knowledge and skill gaps and to assess and improve training. Low scores on competence assessments after training may indicate that the training was ineffective, poorly designed, poorly presented, or inappropriate.
- **Selection of new staff** - Competency assessment is useful when recruiting new staff to ensure they can do the job they are hired to do or could do it with reasonable orientation/training.
- **Individual performance improvement** - Competency assessment can play an important role in an organization’s performance improvement initiatives.
- **Supervision** - Competency assessments can guide healthcare managers in providing performance improvement feedback to healthcare providers.

Restrictions on competency assessments
For budgetary or other reasons, many health organizations may not routinely measure competence across the breadth of workplace tasks until a performance problem becomes apparent. Also, some competencies may be difficult to describe precisely or evaluate accurately.

Key Competencies to be Evaluated
Periodic competence assessments should be considered for those areas that are considered low-volume, high-risk, or critical (Centra Health 1999). Low-volume competencies are those that occur so infrequently that they need to be assessed at least annually to ensure that providers are still able to perform these duties. High-risk competencies are those that put the patient and/or organization at risk if not performed to standard. Critical competencies are ones that are critical for effective performance. Competencies required in the following key areas should be assessed to ensure that healthcare workers are able to perform infrequent, high-risk, and critical healthcare activities.

Strategies for Improving Provider Competence
- **Lecture programs and conferences** disseminate information about new innovations among health workers and other staff. These programs cover information on the current scope of practice or changes in the art and science, based upon scientific information learned from current medical research.
- **Continuing education (CE) courses** are an effective way of keeping health workers abreast of new innovations in their field of specialization.
• **Refresher programs** enable health workers to review the original training program in a condensed number of hours. However, refresher programs do not help in expanding the cognitive or psychomotor ability above the entry level.

• **Self-education** is another way health providers can improve knowledge in specific areas. Self-education may involve manuals or computer-based training.

• **Case reviews** rely on patient-care reports, audio/video tapes of services, and laboratory and other diagnostic reports.

• **Grand rounds at health facilities** with a diverse patient population provide a unique learning opportunity for novices.

• **Sentinel-event review**, involving a review of an unexpected occurrence (mortality or morbidity), provides an opportunity to conduct a root cause analysis.

• **Mentoring/precepting**, provided by more experienced health professionals, is a good strategy for improving skills of novices and new-entry health professionals.
Practices and Requirements of Renewal Programs in Professional Licensure and Certification

National Organization for Competency Assurance

2008

Citation: Henderson: "Practices and Requirements of Renewal Programs in Professional Licensure and Certification." (ICE formerly NOCA) 2008: pg 1-17.

Synopsis

Literature review of existing renewal requirements and practices and an industry-wide survey of organizations. The data in the study indicate that more needs to be done to ensure the continuing competence of licensed and certified professionals in virtually every field, with specific recommendations that include:

1. Defining continuing competence and using the definition as a guiding philosophy to identify requirements and identify effective program components.
2. Going beyond continuing education to triangulate strategies that will work to ensure continuing competence.
3. Devoting the resources required to develop renewal program components that are rigorous and meaningful to participants and stakeholders.
4. Creating an iterative renewal process to ensure continuing competence throughout the career.

Sources were evaluated on their apparent relevance and currency, drawing primarily on recommendations from an advisory committee whose members represent a variety of fields and organizations in the debates over and realities of relicensure, recertification, and continuing competence.

Recommendations from the advisory committee were augmented with online research via Google (http://www.google.com), Google Scholar (Google’s engine for searching cross-discipline peer-reviewed papers, theses, books, abstracts and articles, from academic publishers, professional societies, preprint repositories, universities and other scholarly organizations; http://scholar.google.com), and ERIC (the Education Resources Information Center, the world’s largest digital library of education literature; http://www.eric.ed.gov).

The primary focus of the literature was on the United States and sources from 2000 or later, as the point of departure was the previous work of an unpublished literature review by the National Commission for Certifying Agencies’ Task Force on Recertification that covered recertification and continuing competence from 1970 to 1999, using 22 articles and 4 books.

Key findings

- Events in both education and medicine in the past 25 years precipitated a new look at CE
  1. No Child Left Behind
  2. Institute of Medicine report - up to 98,000 preventable deaths from medical errors per year

- American Nurses Expert Panel defines "Continuing Professional Nursing Competence"
  1. Used as primary definition for this paper
  2. Must be: "definable, measurable, and can be evaluated"
  3. Without this definition in place, conversation is based on widely variant assumptions

"Continuing professional nursing competence is ongoing professional nursing competence according to level of expertise, responsibility, and domains of practice as evidenced by behavior based on beliefs, attitudes, and knowledge matched to and in the context of a set of expected outcomes as defined by nursing scope practice, policy, Code for Nurses, standards, guidelines, and benchmarks that assure safe performance of professional activities." (American Nurses Association Expert Panel on Continuing Competence)
Self-assessment
• Self-assessment does have its drawbacks, and critics argue that it does not offer the public accountability of an outside or third-party assessment, and that too much is left to the professional’s personal (and perhaps self-serving) interpretation (Citizen Advocacy Center, 2004; Vandewater).

Examination support
• The American Board of Medical Specialties maintenance of certification uses a four-part framework—professional standing, lifelong learning and periodic assessment, cognitive expertise as demonstrated by a secure examination, and performance in practice.

Best Practices
In the literature, three traits of best-practices in continuing competence emerge. Continuing competence should take (1) a multi-step approach (2) that uses a triangulation of tools (3) in an iterative process.

Multi-step Approach
Four or five steps are commonly included, with documentation inherent but not spelled out separately in some models:

1. Assessment, or reflection
2. Development, or planning
3. Implementation, or action
4. Documentation
5. Demonstration, or evaluation

Swankin, LeBuhn, and Morrison declare a five-step model “most promising,” pointing out that the first four steps (periodic assessment, development of personal plan, implementation of the plan, and document) represent quality improvement while the fifth (demonstration of competence) represents quality assurance (p. v).

Triangulation of Tools
• The literature suggests that any single tool may be inadequate, especially when so few studies exist that prove a clear link between any one method and improved quality of professional service and improved outcomes for consumers.

Iterative Process
• As noted earlier, because the pace of change in the world today is fast, professions must look beyond initial licensure, certification, and competence and assess workers’ abilities throughout their careers. “Competence is not reflected by a single measure in time. Instead, it is an ongoing commitment made to the individual, the profession and to consumers” (Bryne and Waters, pp. 8-9).

Need for Change
• “Recommendations for assuring continuing competence have been on the table for nearly fifty years. It is time to act!” (Citizen Advocacy Center, 2004, p. i)
• We must rely on common sense instead of waiting on incontrovertible evidence because, in the end, everything is a surrogate marker for ideal outcomes.
Competence Literature Review

Kathryn Schroeter, PhD, RN, CNOR

2008

Citation: Schroeter, K. (2008) Competence Literature Review. CCI.

Synopsis

For the purpose of this review, the concept of competence will be divided into categories of competence, lack of competence and factors that affect/impact competence. Further category divisions are needed when reviewing categories of competence in nursing roles.

Key Findings

Part I: Competence

- Competence refers to potential ability and/or capability to function in a certain situation while competency focuses on actual performance in a situation. This means competence is required before one can achieve competency. Competency includes the understanding of knowledge, clinical, technical, and communication skills, and the ability to problem solve through the use of clinical judgment. Competence is the ability to perform a specific task, action or function successfully.

- A definition of continuing competence is “the ongoing ability of a registered nurse to integrate and apply the knowledge, skills, judgment, and personal attributes required to practice safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs.”

- Performance alone may not be an adequate indicator of competence as a nurse can answer a question correctly on an exam but from an incorrect premise. Similarly, a nurse may have the skill or knowledge to perform a task but fail to perform it correctly in an examination situation. Many nursing specialty organizations offer examinations and other processes for certification, suggesting that certification is associated with continued competency.

- Competence can be defined as both performance, the ability to perform nursing tasks, and ‘psychological construct’. It is the ability to effectively integrate cognitive, affective and psychomotor skills when delivering nursing care.

- Elements of nursing competence include:
  1. **Practice and Educational settings**: Includes critical thinking, teaching, human caring relationships, management, leadership, knowledge integration.
  2. **Regulatory Oversight**: Provides entry-level competency, generalist core-competency for the profession and testing for license.
  3. **Individual Evaluation**: Includes performance reviews, peer reviews, professional certification, self-assessments and continuing mastering of skills.
  4. **Public Expectation**: Includes nurses’ mastery of current technology, optimal health care outcomes, complementary and alternative health care and consumer involvement in health care decisions.

- A 2003 Institute of Medicine report viewed professional competency as a shared responsibility of both the public and private sectors. The report recommended that all professional boards move toward requiring licensed health care professionals to periodically demonstrate their ability to deliver care within five competencies: 1) deliver patient centered care; 2) be members of an interdisciplinary team emphasizing; 3) evidence-based practice; 4) quality improvement; and 5) informatics.

- The primary focus of competence in nursing has primarily been in the area of clinical practice settings. It is in this setting where there exists the highest risk of harm and/or poor patient outcomes that can be directly linked to nursing practice activities. A 2001 Institute of Medicine report concluded that all health care professionals should receive specific education regarding patient-centered care. The training that these professionals receive should be on an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and information.
Continued competence can be achieved by conducting research, seeking regulatory mandates, using evidence based methods to demonstrate continuing competence, changing educational programs, and reforming continuing education programs.

Factors that impact competence include mentoring, system and environmental issues, ethics, and the evaluation of competence.

Mentoring is a powerful tool that can help build competence, leadership skills, self-awareness and morale.

Improved patient outcomes are associated within organizational environments that develop and maintain competency in nursing care. The practice setting that best supports professional nurses have the following characteristics: include clinical care emphasizing quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability; recognize contributions of nurses’ knowledge and expertise to clinical care quality and patient outcomes; empower nuraca’s participation in clinical decision making and organization of clinical care systems; maintain clinical advancement programs based on education, certification, and advanced preparation; and demonstrate professional development support for nurses. Learning and competence occur best in environments in which the nurse feels empowered and able to freely learn.

Ethics and competence involve two related aspects; the ethical nurse who practices competently and the second is being ethically competent. The development of ethical competence is important when it comes to reducing practice errors, retaining nurses in health care and focusing on patient safety. The American Nurses Association (ANA) Code of Ethics asserts that the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient. The ANA notes that “as an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice...” This provision specifically directs nurses to take some type of action to support the rights of their patients. Powerlessness may affect a nurse’s ability to be a patient advocate and may also contribute to a nurse’s sense of moral distress. In order for nurses to practice ethically, they must feel safe in their practice setting such that their management team supports appropriate nursing actions.

Qualification for practice is assured by licensing laws and by professional standards. Assuring competency in nursing includes licensing exams for practice entry, continuing education for renewal of license, work-based orientation programs, and graduation from an accredited program of study. Continuing education and testing provides a limited picture of an individual’s knowledge and/or skill acquisition at one point in time. Laws and rules are generally considered to uphold the lowest minimum standard for practice. Licensing laws for example, protect patients from harm, but do not hold professionals accountable to a skill level that promotes quality. Competency is a complex construct that requires numerous measures.

Part II: Role Competence

Role competency reviews the competency of staff nurses, nurse educators, and nurse managers/administrators.

In a study of nursing staff competence, work strain, stress and satisfaction in elderly care, found that the lack of competence development, high levels of work strain and low levels of work satisfaction among nursing staff have been associated with high turnover. The expansion of computer-driven technologies into modern health care suggests that many of the important competencies of the 21st century nurse will encompass mastery of computer technology.

While technical skills and knowledge specific to the discipline remain fundamental to health profession education, complex challenges inherent in the health care system have forced educators to contemplate the hidden curriculum embedded in clinical education.

Nurse managers influence all aspects of the nursing environment.

Conclusion

Because a series of national commissions documented significant problems related to safety and quality in the U.S. health care system, providers need to be prepared with a different set of competencies than are developed in educational programs today.
Recertification and Continuing Competency

Published by Lenora G. Knapp, PhD, Cary List, CFP, CA, Financial Planners Standards Council

2009

Citation: Knapp and List: Chapter 9: “Recertification and Continued Competency.” ICE Handbook: pg 205-220.

Synopsis

Literature review that explores the goals and concepts underlying recertification, introduces a number of recertification methods and processes, and identifies the challenges certifiers face in promoting continuing competence. The chapter entry describes issues certifiers should consider when selecting and implementing recertification processes.

The knowledge and skills required for competent occupational and professional performance evolve and change over time. In highly technical fields in particular, the rapidity of change is staggering — in fact, knowledge can become obsolete in a matter of months. As a consequence, it is now generally accepted that professional certification should be valid for a specified period of time, after which it expires, unless the holder of the credential engages in activities required by the certifier to renew or maintain his/her certification.

Recertification also helps to ensure that the credential will retain its credibility and value. Without recertification process, there would be a risk that the value of the credential would diminish over time as the knowledge and skills of entire cohorts of certificants become outdated. Eventually, confidence in the credential would be lost, and the certification would become meaningless to stakeholders.

Key Findings

Recommendations for Continuing Competency Programs

- To what competence standard should certificants be held? It appears that to date, many (and perhaps the majority) of certifiers have adopted as their recertification competence benchmark a knowledge/skill level equivalent to that required for initial certification.
- Structuring of the Recertification Process - Some certifiers permit certificants to choose from among several different options for recertification (e.g., either continuing education or re-examination). Credit- or point-based systems are another way to structure the recertification process. These systems require that certificants achieve a specified number of credits or points from participation in a variety of occupational/professional development activities.
- Considerations When Selecting an Assessment Method – Certifiers must balance fidelity and feasibility when determining which assessment(s) to utilize for measuring continuing competence. Fidelity is the degree to which an assessment reflects or represents the criterion under study (e.g., professional competence). One of the major challenges of high-fidelity assessments is the feasibility of implementing them. Assessments which have high fidelity typically do not perform as well psychometrically as assessments which may have lower fidelity and face validity (e.g., multiple-choice examinations). However, the latter offer a convenient and cost-effective way to broadly sample and objectively measure an individual’s knowledge and skills.
- Considerations When Developing CE Requirements
  There are a number of decisions that certifiers must make when formulating continuing education requirements.
  1. Specified topics may be broadly stated (e.g., “construction and finance” for a construction financial professional) or more narrowly defined (e.g., only the topics contained on the certification examination content outline will qualify).
  2. The CE should be provided by a registered or approved sponsor when there are already a substantial number of continuing education programs offered by registered/approved provider.
3. Certifiers may require that qualifying CE include an assessment to confirm that participants mastered the program content.
4. For face-to-face programs, credit allocation is straightforward and typically based on face time (e.g., one credit hour per each hour of the course). For self-study and online programs, certifiers generally rely on the program sponsor’s estimate of the number of hours required for completion.

- Considerations When Developing Professional Development Activity Requirements
  1. Certifiers generally designate a limited set of activities which will qualify for fulfillment of recertification requirements. The activities selected typically are those which are verifiable and directly related to the occupation/profession.
  2. Certifiers that recognize professional development activities must determine how many points/credits/hours to allocate for each activity.
  3. As with CE, documentation requirements range from simple attestations to a description of each activity, including relevant particulars (e.g., dates during which the activity took place, the organization/publisher involved).
  4. Certifiers may permit certificants to earn professional development activity credits at any point during the recertification cycle or may require that a portion of the credits be earned each year or within a specified period of time immediately preceding the recertification deadline.

General Considerations When Setting Recertification Requirements
- It is important that the certifier be able to provide a logical rationale for each requirement, linking the requirement to the certifier’s ultimate goal of either enhancing or measuring continuing competence.
- Recertification program that allows certificants to earn points for a variety of occupational/professional development activities may require significant administrative support if each application must be checked to verify that the activities the certificant engaged in are acceptable and that the certificant assigned the proper number of points for each activity.
- Requirements may be challenging, but should not be unnecessarily onerous to fulfill. For example, expecting certificants to maintain a daily log of their work activities to confirm that they have relevant work experience would be an onerous requirement.
- How accessible are opportunities to fulfill the recertification requirements? Fairness dictates that consideration be given to timing (how frequently are the opportunities available), geographic location (how far must certificants travel), and cost (how reasonable are the fees for assessments, continuing education, etc. given the median salary for the occupation/profession).
- The “APPLE” Criteria “APPLE” criteria provide a convenient rule of thumb which encapsulates many of the above ideas. These criteria, developed by the National Board of Professional Teaching Standards (2002), specify that an assessment system should be: Administratively feasible; Publicly credible; Professionally acceptable; Legally defensible; and Economically affordable.

Summary
An active effort must be made to ensure competence throughout an individual’s working years. This realization has contributed to the acceptance of the concept of time-limited certification. Certifiers have come to understand that their role in defining and promoting occupational and professional competence extends beyond the initial awarding of the certification. There are many different methods and activities that certifiers use to enforce continuing competence requirements – mandatory continuing education being the most prevalent. The overall structure of the recertification may include written, oral, or performance-based examination, work products/samples, employer/peer review, consumer satisfaction surveys, and/or on-site performance review.

While there exists benchmarking data on the recertification methods used by certifiers and the frequency of recertification, it is important to recognize that every certification program is different— the demands of the occupation/profession differ, as does the speed with which information changes.
Future Trends in Certification

Institute for Credentialing Excellence

2009


Synopsis

We need to identify and understand challenges and opportunities for certifiers in the future. This can be done by understanding current and emerging trends and the effects of those trends on standards for certifiers and the accreditation process.

Key Findings

Success of certification programs depends on the environment in which they operate. There are seven broad-based trends that are anticipated to shape the future of certification programs for the next 5-10 years and beyond:

- Rapid pace of change in the workplace and the knowledge and skills required for competent performance;
- Globalization of society and the economy;
- An overworked workforce whose leisure time is diminishing;
- Retirement of aging baby boomers on a massive scale combined with a shortage of younger workers;
- Increased competition within the certification industry;
- Growing prevalence of security breaches and increasing magnitude of their damage;
- Growing influence of social and consumer-generated media.

Rapid Pace of Change

Workplaces are evolving to adapt to changes caused by globalization and advances in science and technology. Such rapid changes can affect services and products offered by organizations to consumers, processes used and structure of operations. The scope of knowledge and skills required of today’s workers is broader than their predecessors and continues to expand. Unlike in the past, knowledge and skill levels for today’s workforce to perform competently may last just a few years.

Half of certifiers believe that the rapid changes of knowledge and skills needed for competent job performances will have positive effect on certification programs, with more workers seeking certification and recertification. In order to stay relevant with the workforce and certification market, certifiers should ask the following questions:

- What is the pace of change in the occupation/field represented by our credential?
- What types of knowledge and skills within the occupation/field have the shortest life?
- What might be the positive effect of the pace of change on our certification program? The negative?
- What tools and metrics can we use to track changes?

Globalization

The impact of globalization on the certification market can be seen by the growth of certification programs outside traditional domestic markets. As more business is conducted in global markets, there is increased value for international credentials.

In the past certifiers merely accepted international candidates for certification, but did not actively pursue them. Now, certifiers are proactively reaching out to such candidates due to globalization, by establishing local test centers or developing mutual recognition agreements with other countries.

Looking to the future, certifiers should be aware of international markets and the national and global presence of other certifiers already established there. They should first understand the markets they wish to enter and evaluate
the impact globalization has on their domestic programs. This will allow them to appraise whether they have the ability to serve such markets. When reviewing the impacts of globalization, certifiers should ask the following questions:

- To what degree is occupational/professional practice similar across regions?
- Has the occupation/profession evolved at different rates across the globe? If so, do we target the credential to the highest or lowest level or somewhere in between?
- Is there a real need for our credential in other regions or are we just chasing volumes?
- If a credential is needed, why haven’t local organizations developed it?
- Will local stakeholders view our efforts as an enhancement?
- Is our credential “global” in name only?

**Overworked Workforce With Diminishing Leisure Time**

The increased use of technology in the workplace has cut into leisure time for individuals, making them carefully evaluate the cost and value of certification programs. Certifiers should keep the following questions in mind as they consider the certification needs of an overworked workforce:

- What opportunity costs are associated with preparing for certification and with maintaining it after it has been achieved?
- What can we do to increase the value of certification such that it sufficiently exceeds the associated costs (financial, loss of disposable time, etc.)?
- What can we do to make the process of preparing for certification and maintaining the credential more time-efficient for candidates and certificants?
- How can we make the concept of certification more appealing to an overworked workforce?

**Retirement of Baby Boomers and Shortage of Younger Workers**

Workforce demographics will change in the U.S. and across leading global economies as baby boomers retire with a smaller pool of less experienced, younger workers replacing them. Because there will be fewer qualified workers, the market for certification programs will be affected along with the staffing of such programs.

This generation of boomers views retirement as a transitional period, as most plan to work part-time. Certifiers need to examine ways to retain retiring certificants while attracting younger applicants. This will enable them to increase the length of time boomers keep their credential while gaining new certificants in what will be a younger, smaller market.

When thinking of the retirement of baby boomers, certifiers should keep in mind the following questions:

- How can we keep retiring certificants engaged in the certification program?
- What must we do to ensure a higher penetration of the smaller market of younger workers?
- How can we ensure ease of access to certification programs for older and retiring workers entering new careers?
- How will the loss of retiring boomers affect our revenue and what impact will this have on our operations?
- What can we do to ensure that the certification program continues to be staffed by qualified employees?

**Increased Competition**

There are many certification programs in existence, leading to more products and competition in the market. Direct competitors offer credentials in a similar area and indirect competitors offer professional development and services that compete for stakeholders’ attention. The following represent competition to certifiers:

- Other certification programs focused on identical knowledge and skills sets as their own programs;
- Certification programs focused on specialty or subspecialty areas within the profession/occupation targeted by the certifier’s credential;
• Assessment-based certificate programs (offered by professional and trade associations, educational institutions or for-profit companies), which award a certificate upon successful completion of both an educational/training component and an assessment process designed to evaluate whether participants have accomplished the intended learning outcomes of the education/training;
• In-house, training-based certificate programs developed by large employers for their employees;
• Certificates of attendance/participation granted by professional and trade associations, educational institutions or for-profit companies upon completion of a course or series of courses (with no required assessment);
• Degrees and executive education programs offered by academic institutions;
• Professional development programs offered by professional and trade associations, educational institutions or for-profit companies (e.g., Web-based courses, workshops offered at annual meetings); and
• Continuing education programs required for licensure, maintenance of membership status, etc.

This competition exists because of the increased demand for professional development and credentialing products, along with low market barriers. While nearly 40 percent of certifiers think competition will have a negative effect on their programs over the next five years, certifiers can distinguish themselves by serving as a comparison to differentiate their products and services. Good competitors do not pose severe long-term threats and can serve beneficial functions.

When viewing increased competition, certifiers should consider:
• How can we differentiate ourselves from our competitors in ways which are meaningful to our stakeholders?
• Are there opportunities to partner with our competitors?
• Who are our good competitors? Our bad competitors?

Growing Prevalence of Security Breaches
Security breaches and information damage has occurred in the certification market, resulting in the theft of assessment or examination questions. Such losses were caused either intentionally, by failing to follow security protocols or accidentally. These breaches also extend to certificants’ financial and personal information such as social security numbers and credit card numbers.

With the widespread use of technology that can lead to security breaches, certifiers should ask the following questions:
• What are our greatest vulnerabilities with respect to the security of intellectual property?
• What are our greatest vulnerabilities with respect to the security of personal and financial information?
• How can we better communicate the concepts of security and intellectual property to our candidates, staff, volunteers, suppliers/partners?

Growing Influence of Social and Consumer-Generated Media
In the past, traditional media outlets controlled marketing messages to consumers. Now, consumers have greater control of the message with the rise of social media, greatly influencing customer opinion. With the loss of trust in government, advertising, corporations and media, consumers have become the most credible source of information to one another.

As empowered customers seek to participate in the process of developing and improving products, certifiers examining the growing influence of social and consumer-generated media should ask the following questions:
• Where do our customers and stakeholders gather online?
• What social media tools can we use to actively engage our customers and stakeholders on an ongoing basis?
• Who are the influencers in our market? Who are our customer evangelists?
• What can we do to support our customer evangelists?
• How can we most effectively participate in, and facilitate, online conversations about our certification program?

Implications of These Trends for Certifiers
Each of the seven trends outlined above carry direct implications for certifiers, requiring a review of potential programs to address them.

Rapid Pace of Change
  • Prevalence of narrow scope and specialty certifications will increase

As knowledge and skills increase within a profession or occupation, such as medicine, workers evolve from generalists to specialists. Understanding this trend and its increasing pace, certifiers should plan ahead:
  • Making some hard choices when defining the scope of the credential. How much can individuals realistically be expected to master? Where is the line between “core” knowledge and skills and specialty knowledge and skills?
  • Monitoring changes in the field, such as the emergence of special interest groups or specialized professional/trade associations representing aspects of professional/occupational practice.
  • Exploring whether the organization can effectively serve micro-markets (smaller, more specialized markets). Typically, the markets for specialty or narrow scope certification are smaller than those for foundational or generalist certifications.
  • Evaluating the potential impact of narrow scope and specialty certifications on generalist or foundational certifications. Will these cannibalize the market for the certifier’s generalist credential? Can the generalist credential be positioned as a prerequisite to narrow scope and specialty certifications?
  • Continuous job/practice analyses will become more common

It may not be realistic for certifiers to expect certifications to last for several years because of rapid changes in the workplace and the constantly evolving body of knowledge. Continuous or rolling job/practice analyses can identify knowledge, skills and competencies annually or on an ongoing basis, enabling certifiers to update and supplement examination specifications.

  • A new form of certification may emerge

With the rapid pace of change, the need for “just-in-time” certifications may arise, enabling someone to be certified when targeted knowledge and skills are needed.

Globalization
  • Interest in competency-based assessments will grow

Competency-based assessments would focus on how applicants apply their knowledge and what they can do, in conjunction with real-life demands of the workplace.

  • Higher-fidelity assessments will become more common

Certifiers need to include assessments beyond multiple choice examinations, to increase the value and credibility of the certification process globally. Higher fidelity assessments test the type of behavior that would actually be required in professional practice.

  • Accreditation may be required for global recognition.

Certifiers seeking to expand geographically may discover that mutual recognition agreements may be viable alternatives than competing with existing credentials.
• Occupational/professional standards will be harmonized

The globalized economy has led to a globalized workforce, where individuals and companies perform work in other nations. This may lead to harmonizing professional/occupational standards on an international basis.

**Overworked Workforce With Diminishing Leisure Time**

• Certifiers will provide candidates with more preparation and study aids

As the disposable time for candidates diminishes, certifiers must make preparation convenient and efficient. This will clarify what content falls within the scope of the certification program and guide them more effectively in preparing for the assessment.

• Modular examination formats may be used more widely.

Modular assessment formats consist of a series of assessments focusing on different domain content, rather than one single exam. This may help candidates better prepare for certification, save them time and make the certification process much more manageable.

• Certifiers will develop more meaningful recertification processes

Certification will carry greater value if it provides meaningful professional development and could include self-assessments and resources to certificants.

**Retirement of Baby Boomers and Shortage of Younger Workers**

• Certificant volumes will decline

Lower volumes may result as certificants retire and labor and target markets shrink. With large numbers of baby boomers set to retire, certifiers can establish new roles for retirees to maintain their certification.

• Candidate volumes will decline

With a smaller pool of workers replacing baby boomers, certifiers will need to gain greater penetration of this shrinking labor force.

• Certifiers will experience an overall decline in revenue

To compensate for revenue loss, certifiers may expand in new markets or create new products and services.

• Certifiers will have difficulty staffing their programs

The retirement of baby boomers may lead to staffing shortages at certification programs. Certifiers need to engage in succession planning, or offer better mentorship programs, compensation and flexible work arrangements to attract workers.

**Increased Competition**

• Stakeholders will demand that certifiers prove the value of certification

Greater choice in the marketplace enables applicants to demand that certifiers prove the value of the credentials. Employers are more likely to support the certification process if the outcomes they desire result from certification,
i.e., enhanced employee efficiency; reduction in errors; higher employee retention rates; increased customer satisfaction; and industry-specific measures.

- Certifiers will need to actively create value

To achieve/maintain market leadership, certifiers must create and enhance the value of certification by:
- Implementing strategies to increase the recognition and prestige of the credential, particularly among employers and key influencers;
- Offering strategies to increase the recognition and prestige of the credential, particularly among employers and key influencers;
- Offering exclusive events and opportunities for certificants (providing certification value added); and
- Providing resources and tools that enhance professional development or help certificants succeed in their professional roles (e.g., ongoing self-assessment tools to identify strengths and weaknesses, mentoring programs for younger certificants, access to knowledge resources).

To enhance employer value, certifiers can:
- Encourage third-party entities to provide incentives or benefits to employers who have certified workers (e.g., insurance companies provide discounts to roofing contractors who employ certified roofing safety professionals);
- Institute recognition programs for employers with a high percentage of certified employees; and
- Help employers leverage their commitment to certification as a competitive advantage in their businesses (e.g., promotional materials highlighting the benefits of certification to the employers’ customers and clients; certification talking points to use in proposals to potential customers).

- Certifiers will be required to adopt a customer-centric approach

Certifiers will become more customer-centric, to ensure their needs are met during the certification process, rather than just focusing on their products.

- Certifiers will expand their product/service portfolio

As competition increases, certifiers must expand their portfolio of services and products, including into areas they may have avoided such as examination preparation products, professional development programs and certificate programs.

- Employer buy-in will be intensely courted by certifiers

Employer recognition and support creates value for the credential and is often a key driver for an individual to seek and maintain certification.

- Industries will develop their own certification standards

Where there are competing certifications, developing industry-specific guidelines and standards will ensure quality and consistency across disparate certification programs offered.

**Growing Prevalence of Security Breaches**

Preventing, detecting and legal action or prosecution will be key to reducing security breaches and minimizing their damage.

- More rigorous security procedures will be implemented.
The failure to follow security procedures and the unintentional release of assessments/questions are among the top factors contributing to security breaches. Certifiers must institute rigorous policies and procedures for handling, storing and accessing secure information.

- Certifiers will engage in more proactive monitoring
- Certifiers will be more proactive and vigilant in their efforts to detect existing and potential breaches.
- Defensive measures will be taken by certifiers
- Certifiers will take defensive measures to mitigate the possible security breaches such as maintaining larger item pools to prevent overexposure and enable the rapid development of alternate examinations forms if needed.
- Certifiers will be more aggressive in pursuing prosecution

Certifiers may aggressively pursue criminal prosecution of those responsible for breaches to deter future breaches.

Growing Influence of Social and Consumer-Generated Media

- Certifiers will utilize customers as marketers for their credentials
- Certifiers will leverage the power of word of mouth by providing customers with timely and useful information and a platform so they can communicate about the certification program.
- Stakeholders will demand greater transparency
- Certifiers will need to provide more information to empowered customers about the certification process to avoid being publicly criticized for not being transparent.
- A more customer-centric focus will be adopted by certifiers
- Certifiers will become more receptive to customers and responsive to their needs to maintain a positive reputation for the certification program.
- Certifiers will participate in and monitor conversations in the online community

Following social media conversations about certification programs will provide certifiers with insights into customers' perceptions and needs.

Implications of the Trends for NCCA and Other Relevant Standards
The certification industry must be flexible enough to accommodate change and meet future market needs while maintaining their high-quality professional certification programs for stakeholders.

Standards Will Need to be Current and Timely
Standards organizations should set outcome-based requirements for certification programs.

Access to Global Markets Will Drive Unification of Standards and Accreditation Systems
As certifiers seek to expand internationally, globally recognized standards for certification programs will be needed.

Increased Referencing of Accreditation in Regulations Will Drive Unification of Standards and Accreditation Systems
As recognition of the value of certification and accreditation within the regulatory community increases, it is likely that regulators will call upon certifiers whose credentials cover similar scopes to come together to work toward a common set of standards in an effort to reduce confusion and redundancy in regulatory efforts.
Standards Specific to an Industry or Occupation/Profession May Become More Common
Certifiers may develop national or international standards to provide a baseline to which all certifiers should conform in the administration of their programs and the development of their assessments in an effort to meet market needs.

The Focus of Certification Industry Standards Will Expand
Regulators, professional and trade associations, and consumers continue to recognize the value of professional certification. Stakeholders have become more knowledgeable about certification and will begin to demand more of industry standards, such as meeting specific customer needs.

Summary
Certifiers can best prepare for the future by recognizing and understanding trends impacting their markets and the field of professional certification in general. There are seven broad-based trends that are anticipated to shape the future of certification programs: the rapid pace of change in the workplace and required knowledge and skills; globalization; overworked workforce; impending workforce gaps of substantial magnitude; increased competition; growing prevalence and impact of security breaches; and the rise of social and consumer-generated media.

Standards organizations and accrediting bodies will be impacted in ways similar to certification programs, and adaptability is essential for future success.

The future anticipated in this chapter is mixed, presenting both challenges and opportunities for certifiers. Organizations that will survive and thrive in the next decade will begin their planning today.
Accuracy of Physicians Self-Assessment Compared with Observed Measures of Competence

Published by the Journal of the American Medical Association

2006


Synopsis

This systematic review determines how accurately physicians self-assess compared with external observations of their competence. Using electronic databases MEDLINE, EMBASE, CINAHL, PsycINFO, the Research and Development Resource base in CME and proprietary search engines, the review searched using terms related to self-directed learning, self-assessment and self-reflection. Studies compared physicians’ self-rated assessments with external observations, with a population of at least 50% practicing health professionals from the U.S., U.K., Canada, Australia and New Zealand.

The search yielded 725 articles, and of the 20 comparisons of self and external assessment, 13 demonstrate little, or no, inverse assessment and seven demonstrate positive associations. A number of studies showed the worst self-assessment was associated with physicians who were the least skilled and those who were most confident.

Self-assessment was defined as predictive, summative or concurrent, and was conducted in the studies by questionnaire, checklists or survey focused on learning needs. Studies compared self-ratings with stable external objectives such as OSCEs, standardized patients, simulations, performance on in-training or other evaluations, chart audits, or ability to explain concepts.

Key Findings

- Evidence suggests physicians have a limited ability to self-assess.
- The process to evaluate competence may need to come from external assessment.
- The review found that in a majority of relevant studies, physicians do not appear to accurately self-assess. Weak or no associations between physicians self-rated assessments and external assessments were observed.
- In the studies indicating poor or limited accuracy of self-assessment, this finding was independent of level of training, specialty, the domain of self-assessment or manner of comparison.

Conclusion

If it’s true that physicians perform poorly in this domain, new initiatives and formats are needed to assist the self-assessment process to assess broader domains of competence, such as lifelong learning. Ultimately, a more useful approach may be to focus on externally determined self-assessments in the use of educational and other activities designed to improve performance.

- Such measures might include the development of a more holistic continuing professional development process involving learning portfolios, documenting practice-based learning and improvement activities, creating less general and more detailed learning practice objectives and addressing the general competencies espoused by the Accreditation Council for Graduate Medical Education.
- Training may reduce the variation between self and external assessments by encouraging the internalization of objective measures or benchmark of performance.
- Methods such as multi-source evaluations may be a necessary next step, particularly when interpersonal skills, communication skills and professionalism need to be evaluated.
Practice

Systematic Review: the Relationship between Clinical Experience and Quality of Health Care

Niteesh K. Choudhry, MD; Robert H. Fletcher, MD, MSc; and Stephen B. Soumerai, ScD

2005


Synopsis

The purpose of this study was to systematically review studies relating medical knowledge and health care quality to years in practice and physician age.

Data sources included English-language articles in MEDLINE from 1966 to June 2004 and reference lists of retrieved articles. Studies were selected that provided empirical results about knowledge or a quality-of-care outcome and included years since graduation or physician age as explanatory variables.

Key Findings

Studies Evaluated

- Overall, 32 of the 62 (52%) evaluations reported decreasing performance with increasing years in practice for all outcomes assessed
- 13 (21%) reported decreasing performance with increasing experience for some outcomes but no association for others
- 2 (3%) reported that performance initially increased with increasing experience, peaked, and then decreased (concave relationship)
- 13 (21%) reported no association
- 1 (2%) reported increasing performance with increasing years in practice for some outcomes but no association for others
- 1 (2%) reported increasing performance with increasing years in practice for all outcomes

Conclusions

- This review of empirical studies suggests that physicians who have been in practice for more years and older physicians possess less factual knowledge, are less likely to adhere to appropriate standards of care, and may also have poorer patient outcomes.
- Therefore, this subgroup of physicians may need quality improvement interventions.
- The requirements that are imposed on physicians to keep up to date and to demonstrate continuing competence should be further considered.

Possible Explanations

- Physicians' "toolkits" are created during training and may not be updated regularly.
- Older physicians seem less likely to adopt newly proven therapies and may be less receptive to new standards of care.
- Practice innovations that involve theoretical shifts, such as the use of less aggressive surgical therapy for early-stage breast cancer or protocols for reducing length of stay, may be harder to incorporate into the practice of physicians who have trained long ago.
- Environmental changes in medicine over the past several decades:
  1. Evidence-based medicine has been widely adopted.
  2. Quality assurance techniques, such as disease management and performance evaluation, are frequently used.
3. More experienced physicians may have less familiarity with these strategies and may be less accepting of them.

Study Limitations
- Because of the lack of reliable search terms for physician experience, reports that provided relevant data may have been missed.
Continuing Education

Effectiveness of Continuing Medical Education

The Johns Hopkins University, Evidence-based Practice Center, Baltimore, MD

2007

Citation: Evidence Report/Technology Assessment Number 149 Effectiveness of Continuing Medical Education Prepared for: Agency for Healthcare Research and Quality, Department of Health and Human Services 540 Gaither Road Rockville, MD 20850 www.ahrq.gov Contract No. 290-02-0010 Prepared by: The Johns Hopkins University, Evidence-based Practice Center, Baltimore, MD

Synopsis

Prepared for the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Despite the broad range of CME offerings aimed at educating the nation’s practicing physicians through the provision of up-to-date clinical information, researchers have found that physicians commonly overuse, underuse, and misuse therapeutic and diagnostic interventions. Some medical educators have suggested that CME may not be effective enough to significantly narrow the gap between what is done in clinical practice and what should be done based on current evidence. Understanding what CME tools and techniques are most effective in disseminating and retaining medical knowledge is critical to improving the effectiveness of CME and thus diminishing the gap between evidence and practice.

**Purpose:** The purpose of this review was to comprehensively and systematically synthesize evidence regarding the effectiveness of continuing medical education (CME) and differing instructional designs in terms of knowledge, attitudes, skills, practice behavior and clinical practice outcomes.

**Methods:** Method used was specific questions prepared with input from external experts and representatives of the Agency for Healthcare Research and Quality (AHRQ) and the American College of Chest Physicians (ACCP). A systematic search of the literature incorporated specific eligibility criteria, hand searching of selected journals, and electronic databases. Each eligible article underwent double review for data abstraction and assessment of study quality.

**Key Questions**

1. Is there evidence that particular methods of delivering CME are more effective in: a) imparting knowledge to physicians, b) changing physician attitudes, c) acquiring skills, d) changing physician practice behavior, or e) changing clinical practice outcomes?
2. Do changes in knowledge, attitudes, skills, practice behavior, or clinical practice outcomes produced by CME persist over time (greater than or equal to 30 days)?
3. What is the evidence from systematic reviews about the effectiveness of simulation methods in medical education outside of CME?
4. Which characteristics of the audience by themselves or in combination with other characteristics influence the effectiveness of certain educational techniques?
5. Which external factors by themselves or in combination with other factors reinforce the effects of CME in changing behavior?
6. What is the reported validity and reliability of the methods that have been used for measuring the effects of CME in terms of: a) imparting knowledge, b) changing attitudes, c) acquiring skills, d) changing practice behavior, or e) changing clinical practice outcomes?

**Key Findings**

- Overall, the literature supported the concept that CME was effective, at least to some degree, in achieving and maintaining the objectives studied, including
1. Knowledge (22 of 28 studies)
2. Attitudes (22 of 26)
3. Skills (12 of 15)
4. Practice behavior (61 of 105)
5. Clinical practice outcomes (14 of 33)

- Common themes included:
  1. Live media was more effective than print
  2. Multimedia was more effective than single media interventions
  3. Multiple exposures were more effective than a single exposure

- In addition, interactive techniques seem to be more effective than non-interactive ones. Thus, the evidence supports consideration of these attributes of effective educational interventions when designing a CME course.

- The number of articles that addressed internal and/or external characteristics of CME activities was too small and the studies too heterogeneous to determine if any of these are crucial for CME success. Evidence was limited on the reliability and validity of the tools that have been used to assess CME effectiveness.

Conclusion

- Despite the low quality of the evidence, CME appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes.

- More research is needed to determine with any degree of certainty which types of media, techniques, and exposure volumes as well as what internal and external audience characteristics are associated with improvements in outcomes.
Redesigning Continuing Education in the Health Professions

Committee on Planning a Continuing Health Professional Education Institute; Institute of Medicine

2010


Synopsis

In this report, the committee examines continuing education (CE) for all health professionals, explores development of a national continuing education institute and offers guidance on the establishment and operation of such an institute. Literature reviewed: “Crossing the Quality Chasm: A New Health System for the 21st Century” and “Health Professions Education: A Bridgeton Quality” recommends that all clinicians possess five core competencies, which include being able to provide patient-centered care, work in interprofessional teams, employ evidence-based practice, apply quality improvement and utilize informatics.

Requirements that are based on credit hours rather than outcomes—and that vary by state and profession—are not conducive to teaching and maintaining these core competencies aimed at providing quality care. Improving the system for CE will therefore require changes that expand its conventional boundaries.

Continuing professional development (CPD), includes components of CE but has a broader focus, such as teaching how to identify problems and apply solutions, and allowing health professionals to tailor the learning process, setting, and curriculum to their needs.

Key Findings

Five broad messages

- There are major flaws in the way CE is conducted, financed, regulated and evaluated.
- The science underpinning CE for health professionals is fragmented and underdeveloped.
- Continuing education efforts should bring health professionals from various disciplines together in carefully tailored learning environments.
- A new, comprehensive vision of professional development is needed to replace the culture that now envelops continuing education in health care.
- Establishing a national interprofessional CE institute is a promising way to foster improvements in CE for health professionals.

The Institute

The Continuing Professional Development Institute (CPDI) should be an independent body with membership and financing from both the public and the private sectors. The federal government initially should oversee and coordinate the development of the CPDI, and a competency-based board should be appointed to lead the CPDI's activities. Upon decision of the institute’s board, the government’s responsibilities should be transferred back to CPD stakeholders.

Recommendations

1. The Secretary of the Department of Health and Human Services should commission a planning committee to develop a public-private institute for continuing health professional development that will improve CPDs among health professions.
2. To achieve the new vision of a continuing professional development system, the planning committee should design an institute that creates a new scientific foundation for CPD to enhance health professionals’ ability to provide better care; develops metrics, encourages use of health information technology and emerging electronic health databases, fosters interprofessional collaboration, improves the value and cost-effectiveness of CPD delivery.
3. The planning committee should design the Continuing Professional Development Institute to work with other entities whose purpose is to improve quality and patient safety by collaborating with data measurement, collection, cataloguing, and reporting agencies to evaluate changes in the performance of health professionals and the need for CPD in the improvement of patient care and safety.

4. The CPDI should lead efforts to improve the underlying scientific foundation of CPD to enhance the knowledge and performance of health professionals and patient outcomes.

5. The CPDI should enhance the collection of data that enable evaluation and assessment of CPD at the individual, team, organizational, system, and national levels.

6. The CPDI should work with stakeholders to develop national standards for regulation of CPD. The CPDI should set standards for regulatory bodies across the health professions for licensure, certification, credentialing and accreditation.

7. The CPDI should analyze the sources and adequacy of funding for CPD, develop a sustainable business model free from conflicts of interest, and promote the use of CPD to improve quality and patient safety.

8. The CPDI should identify, recognize, and foster models of CPD that build knowledge about interprofessional team learning and collaboration.

9. Supporting mobilization of research findings to advance health professional performance, federal agencies that support demonstration programs, should collaborate with the CPDI.

10. The CPDI should report annually to its public and private stakeholders.
Testing: Examination and Self Assessment

Unskilled and Unaware of It: How Difficulties in Recognizing One’s Own Incompetence Lead to Inflated Self-Assessments

Published by Justin Kruger and David Dunning, Cornell University

1991


Synopsis

Literature review of four psychological studies that tested subject’s overestimation of their abilities in many social and intellectual domains. The authors suggest that this overestimation occurs, in part, because people who are unskilled in these domains suffer a dual burden: Not only do these people reach erroneous conclusions and make unfortunate choices, but their incompetence robs them of the met cognitive ability to realize it.

Studies focus on the met cognitive skills of the incompetent to explain, in part, the fact that people seem to be so imperfect in appraising themselves and their abilities. An illustration of this tendency is the “above-average effect,” or the tendency of the average person to believe he or she is above average, a result that defies the logic of descriptive statistics. Studies focus on the metacognitive deficits of the unskilled that may help explain this overall tendency toward inflated self-appraisals.

Several lines of research are consistent with the notion that incompetent individuals lack the metacognitive skills necessary for accurate self-assessment. Work on the nature of expertise, for instance, has revealed that novices possess poorer metacognitive skills than do experts. These findings suggest that unaccomplished individuals do not possess the degree of metacognitive skills necessary for accurate self-assessment that their more accomplished counterparts possess.

Four studies presented participants (Cornell University undergraduates) with tests that assessed their ability in a domain in which knowledge, wisdom, or savvy was crucial: humor (Study 1), logical reasoning (Studies 2 and 4), and English grammar (Study 3). Through a series of questionnaires that had participants take a test in the study topic (humor, logical reasoning, grammar), participants then made three estimates about their performance and ability, then compared it with that of other students, then estimated how their score would compare with that of their classmates. Finally they estimated how many test questions they had answered correctly.

In the fourth study, participants were given a pre-training packet in logical reasoning, predicting that would provide them with the skills necessary to recognize the limitations of their ability, and to monitor which test problems they had answered correctly and which incorrectly.

Authors predicted that participants in general would overestimate their ability and performance relative to objective criteria. They also predicted that those who proved to be incompetent (i.e., those who scored in the bottom quarter of the distribution) would be unaware that they had performed poorly.

Key Findings

- Studies found that participants scoring in the bottom quartile on tests of humor, grammar, and logic grossly overestimated their test performance and ability.
- Although their test scores put them in the 12th percentile, they estimated themselves to be in the 62nd.
- Several analyses linked this misconceptions to deficits in metacognitive skill (the ability to know how well one is performing), or the capacity to distinguish accuracy from error.
- Improving the skills of participants, and thus increasing their metacognitive competence, helped them recognize the limitations of their abilities.
• Participants who received the training packet graded their own tests more accurately than did participants who did not receive the packet a difference even more pronounced when looking at bottom-quartile participants exclusively. In fact, the training packet was so successful that those who had originally scored in the bottom quartile were just as accurate in monitoring their test performance as were those who had initially scored in the top quartile.

**Conclusion**

The studies explored into why people tend to hold overly optimistic and miscalibrated views about themselves. The authors proposed that those with limited knowledge in a domain suffer a dual burden: Not only do they reach mistaken conclusions and make regrettable errors, but their incompetence robs them of the ability to realize it.

Study suggested that one way to make people recognize their incompetence is to make them competent. Once we taught bottom-quartile participants how to solve selection tasks correctly, they also gained the metacognitive skills to recognize the previous error of their ways. Once they gained the metacognitive skills to recognize their own incompetence, they were no longer incompetent.

Study showed that incompetent individuals may be unable to take full advantage of one particular kind of feedback: social comparison. One of the ways people gain insight into their own competence is by watching the behavior of others.

In order for the incompetent to overestimate themselves, they must satisfy a minimal threshold of knowledge, theory, or experience that suggests to themselves that they can generate correct answers. People are more miscalibrated when they face difficult tasks, ones for which they fail to possess the requisite knowledge, than they are for easy tasks, ones for which they do possess that knowledge (Lichtenstein & Fischhoff, 1977). Our work replicates this point not by looking at properties of the task but at properties of the person. Whether the task is difficult because of the nature of the task or because the person is unskilled, the end result is a large degree of overconfidence.
Continuing Education, Recertification, and Examination Anxiety

Eugene B. Feigelson, M.D.
William Frosch, M.D.

1977


Synopsis
A substantial majority of the 645 psychiatrists responding to a questionnaire survey favored mandatory continuing education and evidence of continuing education as a requirement for relicensure. The respondents’ overwhelming repudiation of recertification may be based on examination anxiety. The respondents recognized the value of continuing education, were even willing to document it in order to be relicensed, but did not wish to be examined. Those respondents who were younger, Board-certified, and had an academic appointment were more likely to favor continuing education requirements in order to be relicensed. Private practitioners were underrepresented among the respondents, highlighting the important role that APA and its district branches must play in developing meaningful continuing education opportunities for psychiatrists.

Key Findings

Respondents
- More of the respondents were Board-certified (67% versus 58%) had an academic appointment (70% versus 53%): and were principally involved in institutional and/or academic work (43% versus 20%) rather than private practice.
- Perhaps the most important finding is that full- and part-time private practitioners, who constituted the largest subgroup of questionnaire respondents (80%), were the slowest to respond to the survey.
- Younger members were more likely to support continuing medical education and recertification requirements.
- Psychiatrists who were Board-certified or who had an academic appointment were more likely to favor documentation of continuing medical education activity as a requirement for relicensure.
  1. They also are more likely to have educational experiences and quality control built into their work environment.
- Psychiatrists in private practice constitute the greatest reservoir or resistance to meeting any requirements, whether they are in continuing education or recertification, practice audit, or clinical competence exams.

Continuing Education and Recertification
- Respondents strongly favored mandatory continuing education in psychiatry (434 versus 151) and roundly repudiated mandatory recertification (475 versus 135).
- A surprising majority (325 versus 272) favored evidence of continuing educations a requirement for relicensure.

Examination Anxiety
- The overwhelming repudiation of recertification suggests examination anxiety as its basis.
- That only 47.1% of the 22,205 members of the APA were Board-certified in 1976, in contrast to much higher percentages for other specialties, may be further evidence of examination anxiety.
- Only 2% of the 1,062 psychiatrists responding to a survey in 1973 reported that they had ever been called upon to engage in a professional activity for which they felt ill-prepared.

Conclusion and Discussion
- Cognitive knowledge and clinical skills are both important, but are not necessarily related.
- There must be further study of what constitutes meaningful continuing education for psychiatrists.
Public

Recertification and Relicensure: A Consumer’s Viewpoint

Melvin A. Glasser

1981


Synopsis

The burgeoning of major research related to the effectiveness and appropriateness of clinical treatment methods as part of efforts to improve the quality of patient care provides added emphasis to consumer needs for certification and recertification. While there are multiple factors involved, the prime consumer question continues to be “How good is the physician and surgeon?” The combination of increased services delivered on an outpatient basis and in doctor’s offices gives added weight to the importance of peer-approved physician competence.

So, too, are the Health Care Financing Administration’s (HCFA) efforts to report on the quality of care in hospitals and its first reports on the quality of services in nursing homes. Research programs aimed at selecting preferred treatment methods are currently underway by a host of organizations, including the Rand Corporation and the American Medical Association, private sector insurers and agencies of the federal government. Almost all, however, ultimately depend on the competence of the individual physician to put into clinical practice the knowledge and standards of the developing new research.

Key Findings

Perennial Questions for Doctors

- Oliver Wendell Holmes, one of America’s most distinguished physicians and philosophers of medicine, posed the following questions:
  1. How does your knowledge stand today?
  2. What must you expect to forget?
  3. What remains for you yet to learn?

Health Care Costs

- There is an increasing awareness of the flood of new knowledge, which is offering improved tools for treatment of a variety of medical conditions.
- At the same time, there is mounting concern that costs of personal health services in the United States are substantially higher than in any other industrialized country.
  1. Wasteful and inefficient or ineffective treatment may be needlessly escalating costs.
- There has been so much emphasis in recent years on techniques to contain the extraordinary inflation in health care costs that regrettably too little time, attention, and funds have been committed to protecting and augmenting the quality of personal health services offered.

Consumer Concerns

- Currently at the core of the consumer’s concern in protecting their health and treating illness in their families is the education, training, and updated knowledge of their physicians.
- In most consumers’ minds, certification and recertification are related to the prime consideration: How good is the surgeon?
- In a survey of adults in the United States, Canada, and the United Kingdom, Americans were significantly less satisfied with their own physician’s care than either the Canadians or the British.
1. There is reason to be concerned about the increases in expenditures per enrollee in Medicare, the substantial increase in payments for orthopedic surgery, and what appears to be declining satisfaction with services.
   - Consumers are becoming more concerned about the added length of time required for subspecialization and the growing costs that hospitals and educational institutions are required to expend for such training.
   - There are reports of excessive numbers of general surgeons and other surgical specialists. To maintain an adequate patient base, these doctors are taking on increasing numbers of people who require primary care, for which many surgeons are ill prepared by formal education, updated knowledge, or experience.

Board Certification
- Board recertification attested to by professional peers offers specific evidence of peer review and verification of current competence.
  1. In 1986, a report from the U.S. Department of Health and Human Services said state licensing boards were not tough enough on errant doctors and that physicians tended to shield their inept colleagues from outside scrutiny.
  - The time for choice is at hand. If the specialty boards do not move forward with recertification, they will have far less cause to complain about government intervention in the process.

Physician Competence
- Updated physician competence, attested to by professional peers, will also increasingly be dependent on practice guidelines.
- Prescription drugs, for example, have long been established as requiring evaluation for safety and effectiveness before they are released for general use. But comparatively little has been done to evaluate procedures.

Conclusions
- Consumers should not have to wait until an accumulation of malpractice suits provides clues that a clinician's practice may be below standard.
- The combination of traditional, sound professional standards and the developing new knowledge about how to protect and advance quality medical care is at the core of consumer commitment to certification and recertification.
Measuring Continuing Competence of Health Care Practitioners: Where Are We Now – Where Are We Headed?

Proceedings of a Citizen Advocacy Center Conference

June 2000

Citation: CAC Measuring Continuing Competence

Synopsis

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. 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. 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 the Interprofessional Workgroup on Health Professions Regulation (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.

Key Finding

The major recommendation to emerge from the conference is to move deliberately toward convening an even more broadly-based, action-oriented national summit on continuing professional competence in 2002.

Primary Discussion Points – Barriers and Strategies for Overcoming Barriers

The group identified the following barriers to be overcome and produced the following outline of promising strategies for overcoming the identified barriers:

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<th>Barriers:</th>
<th>STRATEGY:</th>
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<td>All</td>
<td>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.</td>
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<tr>
<td>Need for Common Definitions and Terminology</td>
<td>Expand the IWHPR's ongoing definitions project to involve CAC and other stakeholders.</td>
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<td>Need for Agreement on What to Measure and How</td>
<td>Develop a research agenda and set priorities.</td>
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<td>Need for collaboration and cooperation among responsible parties and stakeholders</td>
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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.

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.

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.
Crossing the Quality Chasm - A New Health System for the 21st Century

Published by the Institute of Medicine’s Committee on Quality of Health Care in America

2001

Citation: Institute of Medicine “Crossing the Quality Chasm: A New Health Care System for the 21st Century.” Washington DC: National Academy Press. 2001. Executive Summary

Synopsis

Second and final report of the Committee on the Quality of Health Care in America, which was appointed in 1998 to identify strategies for achieving a substantial improvement in the quality of health care delivered to Americans. The report addresses quality-related issues more broadly, providing a strategic direction for redesigning the health care delivery system of the 21st century.

The committee proposed six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should. Health care should be:

- **Safe**—avoiding injuries to patients from the care that is intended to help them.
- **Effective**—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

To achieve the six aims proposed, additional skills may be required of health professionals—not just physicians, but all clinicians who care for patients.

Key Findings

- Although curriculum changes are essential in providing new skills to health professionals, they are not sufficient by themselves. It is also necessary to address how health professional education is approached, organized, and funded to better prepare students for real practice in an information rich environment. Two examples are teaching evidence-based practice and training in multidisciplinary teams.
- Much of the traditional emphasis in clinical education focused on the basic mechanisms of disease and pathophysiological principles. This approach should be expanded to teach how to manage knowledge and use effective tools that can support clinical decision making.
- As more care is provided by teams, more opportunities for multidisciplinary training should be offered. People should be trained in the kinds of teams in which they will provide care, starting with initial professional training and continuing through graduate training and ongoing professional development.
- Changing relationship between clinicians and their patients also calls for new skills in communication and support for patient self-management, especially for patients with chronic conditions.
- Although improved methods of training the next generation of clinicians are important, efforts must also be made to retool practicing clinicians. Traditional methods of continuing education for health professionals, such as formal conferences and dissemination of educational materials, have been shown to have little effect by themselves on changing clinician behaviors or health outcomes.
- There are implications for the training and development of nonclinical administrative and management personnel, as well as governance. By making budgetary and resource decisions for health care organizations, these groups, with input from and in collaboration with the clinical community, influence priorities and the pace at which they are implemented.
• The Internet can be a powerful tool for undergraduate, graduate, and continuing medical education for all types of health professionals. A variety of Internet-based educational programs have made their curricula and training materials available on the Web. There are also educational videos, lectures, virtual classrooms, and simulation programs to teach surgical skills.

Conclusion
Although quality assessment organizations, accreditation organizations, and government agencies are currently doing work to measure quality of care, most of this activity has begun during the past decade. The rapid development of the field is encouraging, but it is confined to organizations that cover specific sections of the country or restrict themselves to certain segments of the health care marketplace. But changes in the U.S. health care delivery system are occurring more rapidly than evaluations of them can be performed.

Much of the information concerning the relation between the organization of the health care system and quality of care is already outdated. There is no system that provides a comprehensive assessment of quality of care for the nation.

The United States cannot afford to let this situation continue. A systematic strategy for routine monitoring and reporting on quality, as well as the information systems needed to support such activities, will be essential if we are to preserve the best of the American health care system while striving to improve the efficiency with which high-quality services are provided. A strategy will need to cover the aspects of quality that patients, purchasers, and providers care about; it will need to collect data in a way that is manageable, reasonable, and affordable; and it will need to produce information in a format that is useful for making a variety of decisions.

The United States is capable of implementing a quality measurement system that can provide the multiple participants in the health care system with the information they need to ensure delivery of high-quality care. In light of the changes that the health care system has been experiencing, a strategy to measure and consequently to improve quality is needed now.
Maintaining and Improving Health Professional Competence

The Citizen Advocacy Center

2004

Citation: CAC (2004) Maintaining and Improving Health Professional Competence

Synopsis

In this report, the Citizen Advocacy Center (CAC) offers a road map to get from where we are now to a national program for assessing and assuring competence. It is an action plan that recognizes and builds upon the diverse initiatives already undertaken by public and private oversight agencies. The final destination, which may take as long as a decade to reach, is the institutionalization of meaningful, periodic continuing competency assessment and assurance for all health care professionals.

The primary beneficiaries will be health care consumers. Health care systems and the existing oversight programs of licensure and certification agencies will be helped significantly in meeting their obligation to assure the public of the safety and quality of health care. And health care professionals themselves will be supported in their efforts to be lifelong learners, remaining current and proficient as the science base for medicine continues to evolve and become more complex.

Patients have every right to assume that a health care provider’s license to practice is the government’s assurance of his or her current professional competence, and clinicians themselves would like assurance that those with whom they practice are current and fully competent. Unfortunately, this is not currently the case.

Key Findings

Institute of Medicine Findings

- Among the systemic changes the Institute of Medicine (IOM) recommends are that regulatory and oversight bodies begin to assess and ensure the ongoing competence of all practitioners throughout their careers.
- Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies, among other requirements.

Principles Underlying the CAC Road Map

- **Most Important**: Valid, reliable continuing competency assessment and assurance requirements should be mandated by regulatory boards.
- **Collaborate**: A broadly based collaboration of stakeholders is absolutely essential to design and implement effective continuing competency assessment programs that are accepted by the health professions.
- **Quality is the Purpose**: Continuing competency assessment and assurance are not designed for finding “bad apples” among practitioners.
- **An Evidence-Based Approach is Essential**: More research needs to be initiated.
- **Build Upon What Works**: Build upon and learn from competency assessment and remediation programs that are already up and running.
- **Mandating is Key**: There is general, but not unanimous agreement that routine continued competency assessment and assurance must be mandated to be successful.
- **Clinician Responsibility is Key**: Programs should be designed so professionals view competency assessment and assurance as a positive in the development.

The CAC Road Map
CAC envisions its roadmap leading within the next decade to a destination where all health care professionals periodically demonstrate their competence through one of a variety of acceptable methodologies.

Its purpose is to enable clinicians to practice safe, quality health care and to support their efforts as lifelong learners, not to punish or burden professional practice.

Five steps:
1. Routine Periodic Assessment
2. Develop a Personal Plan
3. Implement the Personal Plan
4. Documentation
5. Demonstrate/evaluate Competence

Six major action areas:
1. Conduct Research - test, validate, and compare competency assessment and assurance methodologies
2. Seek Enabling Legislation – new laws are necessary to direct licensing boards to develop pilot projects and set new standards based on the results
3. Develop Evidence-Based Standards - Data generated by the pilot projects will enable licensing boards to establish standards for assessing knowledge and clinical performance
4. Change Expectations During Initial Education – instill in students that there is an expectation that they will be required periodically to demonstrate their continuing competence
5. Use Fees to Pay For Competency Assurance - just as state licensing and discipline programs are financed by professional licensing fees
6. Reform Continuing Education - ensure that courses are evidence-based and require enrollees to demonstrate that the course has improved their knowledge base, skills, and/or practice management

Twelve distinct interest groups share some responsibility for making progress along the road map:
1. Accreditation bodies
2. Voluntary certifying board
3. Consumer groups
4. Continuing education providers
5. Employers
6. Health care professionals
7. Health care professional associations
8. Educational institutions
9. Independent researchers
10. Licensing boards,
11. State legislatures
12. National Conference of State Legislatures
Implementing Continuing Competency Requirements for Health Care Practitioners

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

2006

Citation: Swankin, D., LeBuhn, R.A., & Morrison, R. (2006). Implementing continuing competency requirements for health care practitioners. AARP.

Synopsis

The Institute of Medicine notes that quality problems in the health care field occur for many reasons, including 1) the growing complexity of science and knowledge; 2) an increase in chronic conditions; 3) poorly organized health delivery systems; and 4) not adopting health information technologies that could foster quality improvement.

This study seeks to understand how to address regular assessment of clinicians to ensure continuing competency as consumers recognize the importance of assessing physician performance to improve quality.

The 24-member boards of the American Board of Medical Specialties, a nonprofit organization whose members issue 37 general and 92 subspecialty certificates, have all agreed to issue time-limited certificates that require recertification within specified time frames and to maintain certification programs that involve continuous processes of assessing competence.

Background

- Health care authorities have recommended that state professional licensing boards address the continuing competence of health care practitioners the same way they examine the qualifications of candidates for initial licensing due to evidence of widespread preventable medical errors and other problems with health care quality.

- This report presents recommendations for implementing state-based requirements for continuing competency assessment and assurance as a prerequisite for licensure renewal based on four assumptions:
  1. Problems exist with both patient safety and health care quality
  2. Practitioner competence is as important as system safety
  3. Regulators and certifiers do not currently assure the continuing competence of health care professionals
  4. State licensure boards are the logical entity to be charged with assuring continuing professional competence

Purpose

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

Key Findings

- New laws are required to demonstrate competency, with state professional licensing boards being the logical entity to assess competency and quality. This new model must go beyond continuing education courses and require some form of a five-step model that includes periodic assessment of knowledge, skills, and clinical performance; development, execution, and documentation of an improvement plan based on the assessment; and periodic demonstration of current competence.

- There are five “core” competencies all health care professionals should possess throughout their careers:
1. **Provide patient-centered care**—identify, respect, and care about patients’ differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

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

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

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

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

   The Institute of Medicine recognizes six stages of lifelong learning: novice, advanced beginner, competent, proficient, expert, and master. There appears to be a growing consensus that measurement of continuing competence should target a health care professional’s current practice and should measure both cognitive knowledge and clinical skills.

   The authors recommend a five-step framework for assessing and demonstrating continuing professional competence:
   1. Routine Periodic Assessment
   2. Development of a Personal Improvement Plan
   3. Implementation of the Improvement Plan
   4. Documentation
   5. Demonstration of Competence based on steps 1 through 4

**Recommendations**

- Eliminate continuing education requirements
- Mandate that as a condition of relicensure, licensees participate in continuing professional development programs approved by their respective health care boards
- Mandate that continuing professional development programs include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence
- Provide licensure boards with the flexibility to try different approaches to foster continued competence
- Ensure that the boards’ assessments of continuing competence address the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual’s practice at the time of relicensure
- Require that boards evaluate their approaches to gathering evidence on the effectiveness of methods used for periodic assessment
- Authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards

Significant challenges must be overcome to implement effective systems for continuing competency assessment and assurance. Progress is likely to be incremental and may be slow. To promulgate broad-based continuing competency programs that enhance patient safety and health care, the authors propose the following recommendations:

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

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

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

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

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

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

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

RECOMMENDATION 8: The board should inform the public whether a licensee has been successful in demonstrating his or her continuing competence.
Improving the Quality and Safety of Health Care for Virginians: Assessment & Evaluation of Licensed Health Care Practitioners

AARP

2007

Citation: CAC AARP Virginia Competency Evaluation (PDF)

Key Findings

- 98,000 to 195,000 deaths each year from preventable medical error
- Quality of care varies widely by area, income and by type of service
- The public expects they will receive proper care
- Current U.S. health licensure system was created for a different era
- There is a movement toward recommending state licensing boards require periodic assessment and demonstration of competencies as a condition to renew licenses
- Board Certified Physicians are rapidly moving to require demonstrations of competency
- Other providers such as nurses, dentists, pharmacists and dietitians are also reviewing demonstrations of competency
- AARP Virginia created a health care reform task force to research consumers' views on health care quality, engage in dialogue with providers on the best ways for them to demonstrate continued competency, and have legislation introduced to require demonstrations of competency to get relicensed
- When researching consumers' views, AARP Virginia discovered that:
  1. 68% believe that being licensed meant the provider underwent periodic evaluation & assessment
  2. 98% felt it was important for health professionals to periodically demonstrate current competency
  3. 30% reported they or a family member had experienced a medical error
- AARP Virginia seeks to commission a study, followed by a report on how health professional licensing boards can best implement such a policy
- Each licensing board would base its requirements on the characteristics of the professions it regulates
- Methods for demonstrating current competencies include:
  1. Peer review
  2. Consumer satisfaction surveys
  3. Records/chart reviews
  4. Written/oral examinations
  5. Performance evaluation
  6. Program portfolios
  7. Continuing education based on needs assessment and tests to verify grasp of the material
Strategies to Improve Health Care Quality in Virginia: Survey of Residents Age 50+

AARP

2007

Citation: CAC AARP Virginia Strategies to Improve Health Care (PDF)

Synopsis

AARP commissioned Woolfei Research, Inc. (WRI) to conduct a telephone survey of residents age 50 and older in Virginia. A total of 800 interviews were completed. The survey was pretested on October 27, 2006 and interviewing was completed November 29, 2006. The sample was drawn using random digit dialing (RDD) methodology.

Key Findings

- More than 95 percent of Virginians in an AARP study believe that health care professionals should be required to show they have up-to-date knowledge and skills to provide quality care as a condition of retaining their license. Ninety percent of respondents indicated it is at the least very important for health care professionals to periodically be re-evaluated to show they are currently competent to practice safely.
- More than 68 percent of respondents incorrectly believed that currently “health care professionals are required to demonstrate they have up-to-date knowledge and skills needed to provide quality care.” Health care professionals do not need to provide an evaluation and assessment of their knowledge and skills to become re-licensed.
- AARP Virginia will support legislation in the 2008 General Assembly session to study incorporating competency requirements into the licensing process for health care professionals in the state.
- Almost one-third of the respondents (30 percent) reported they or a family member had experienced a medical error in Virginia. At the same time, 87 percent said they were satisfied with the quality of health care they receive.
- Ninety percent of respondents were in favor of the following policies to reduce medical errors:
  1. Require hospitals to report all serious medical errors to a state agency (97 percent)
  2. Require hospitals to have quality control systems designed to reduce medical errors (96 percent)
  3. Require doctors, nurses, pharmacists, and other medical professionals to show periodically they are currently competent (95 percent) - AARP sponsored research has found progress in this area – American Board of Medical Specialties (ABMS) requires that all of its 24-member specialty certification boards have strong maintenance of competence programs in place as of March, 2007. These programs cover about 90 percent of medical doctors.
  4. Suspend the license of a health care professional who has a pattern of committing medical errors (95 percent)
  5. Have better training for health care professionals (93 percent)
  6. Limit the work hours of residents or trainees to avoid fatigue (93 percent)
  7. Use only health care professionals specially training in intensive care medicine in intensive care units (91 percent)
Continuing Professional Development - Step One: Meaningful Assessment

Published by Citizen Advocacy Center (CAC)

2011

Citation: CAC Meaningful Assessment of Competence (PDF)

Synopsis

Proceedings from the June 2011 CAC conference discussing the 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 current competence.

Self-assessment appears to be 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.

Third-party assessment is by definition more objective and more accountable, but more expensive than self-assessment and potentially more disruptive to practice. 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.

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.

Key Discussions

Is Self-Assessment Reliable?

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

- For most professions, declarative knowledge is what the licensing exam assesses. By and large, exams don’t get at the delivery of services.
- 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.
- 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.

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

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

- 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.

The Assessment Program of the Commission on Dietetic Registration
Grady Barnhill, Director of Recertification and Professional Assessment, Commission on Dietetic Registration

- 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.
- 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 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.

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

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

The Assessment Program of the North Carolina Board of Nursing
Linda Burbans, 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, 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 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.
- 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 re licensure.

The Assessment Program of the National Certification Corporation
Fran Byrd, Director, Strategic Initiatives, National Certification Corporation
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.

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

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.

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.

Discussion: Points to Consider When Developing an Assessment Program
Cynthia Miller Murphy, Executive Director, Oncology Nursing Certification Corporation

In 2010, we initiated a discussion about “How should ONCC implement a more rigorous process for the measurement of continued competency?” Asked four questions:

- 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. Half the nurses have their initial certification paid for by employers, but only 38% have their recertification paid for by their employers.

- 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.

- 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.
The Future of Regulation

Mark Lane, Vice President of Professional Standards and Assessment, Federation of State Boards of Physical Therapy

Citizen Advocacy Center Annual Meeting Keynote

2010

Citation: CAC The Future of Regulation

Synopsis

Continuing competence is a longstanding priority for the Citizen Advocacy Center (CAC). They have been pleased to see recommendations from several prestigious Institute of Medicine committees that advocate more meaningful assessment and demonstration of current competence as a condition of re-licensure and recertification. One such recommendation reads:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care, as defined by the five competencies in this report, through direct measure of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods.

This keynote presentation addresses regulation in general – what it is, where are we headed, and what can we do about it. Certainly, scope of practice and continuing competence issues play a significant role in the future of regulation.

Key Findings

What is licensure?

- A public policy exercise of the state’s police powers
- A system of standards for entry into a profession
  1. This raises questions about continued competence.
- A system of standards for continued practice in the profession
- A system for removing impaired or incompetent providers from practice
- A legal way to deter entry into a profession
- A mechanism to protect licensees from competition
- A means to gain access to third-party reimbursement
- A means to establish and enhance the prestige of the profession
  1. Many professions are trying to obtain licensure for status reasons, even when there is no evidence of potential harm to the public.
- A means to create a market for new academic disciplines

Environmental factors influencing the future of regulation

- Limited access to healthcare is creating many problems
- Decreasing state budgets which force distorted prioritization by regulators because there aren’t the funds to discipline everyone who should be disciplined
- Increasing deficits that force states to cut costs One way to cut costs is to eliminate licensing boards
- Economic recession, which is helping to drive regulation
- The aging population
- Technology, which changes the ways care is delivered
- Professional associations, which promote their particular agendas and lobby the legislatures
- The public
- National healthcare reform
Current state of professional regulation

- Quote from David Montgomery, Nebraska Department of Health
  “Our present professional regulatory system is a patchwork resulting from centuries of unsystematic legislation, band-aid fixes, and ad hoc changes. It is marginally effective, but also inefficient, needlessly expensive, inconsistent, and confusing to the public.”
- Lane posited that if we want things to change positively, we can’t keep doing the things we have always done. If want things to get worse, we can sit back and let it happen.

What will happen if we stay on the current regulatory path?
- Continuing scope of practice battles
- Reactive regulation
  1. The system is currently complaint-based. Shouldn’t our approach be to promote good practice so we don’t have complaints coming in?
- Discipline-based regulation.
- Unenforceable and ineffective regulations.
- Little assurance of ongoing clinical competence
  1. We are at the tip of the iceberg in dealing with continued competence. We are just moving from continuing education to thinking about competence.
- Protection and promotion of the profession
- Regulation based on assumptions vs. evidence
- Restriction of mobility
- Lack of collaboration between disciplines

What might happen if we do not change our regulatory path?
- Scope of practice decisions would no longer be made by the professions
- Boards will be deemed ineffective and be eliminated
- Continued competence will be mandated and it won’t necessarily be a good system
- Licensure requirements will be reduced
- There will be a mandated focus on outcomes
- There will be stricter requirements for sunset review
- There will be an increase in public members and fewer licensee members
- There will be forced licensure compacts to improve mobility within the United States and globally
- Elimination of licensure altogether

If regulators change the face of regulation
- Interdisciplinary scope of practice decisions
- Proactive rather than reactive regulation
- Just culture, which recognizes that people make honest mistakes
- Education and promotion of quality, as opposed to just trying to prevent bad care
- Peer Review
- Continuing competence
- Encourage good practice rather than simply punishing bad practice

How do we get there?
- Collect the data
  1. Regulators should have the capacity to do data analysis of licensees to find out what the issues are.
- Collaborate
  1. Professions and boards need to work together.
  2. Change the framework from a punitive reactive system to a prevention system
  3. Expand regulators’ perspective
  4. Become inventors

The following leadership competencies would enable regulators to change the face of regulation
• External awareness
• Strategic thinking
• Innovation
• Entrepreneurship
• Leading transformation
• Leadership vs. management

Conclusion
• Lane closed with a quote from Margaret Wheatley
  "To be responsible inventors and discoverers, we need the courage to let go of the old world, to
  relinquish most of what we have cherished, to abandon our interpretations of what does and what
does not work. We must see the world anew."
• That is our challenge as we deal with scope of practice and continued competence. We need to get out of
  our comfort zones and start changing the regulatory future.
Grandfathering

The Changing Locus of Decision Making in the Health Care Sector

Clark C. Havighurst, Duke University

1986


Synopsis

In the 1970s, the health policy debate focused on whether government or the medical profession should control the health care system. This article asserts that that struggle between two forms of centralized control was both less promising and less consequential than the devolution of decision-making authority upon consumers and their agents that is occurring today and that seems likely to continue as competitive forces become stronger and opportunities for meaningful consumer choice increase. What we are witnessing is the simultaneous deprofessionalization and depoliticization of important decisions affecting health care, a decentralization and diversification of the system that is opening new possibilities for translating diverse consumer desires into provider performance. Although covering much familiar ground, this article links a variety of seemingly discrete issues under the decentralization theme. Its object in developing this theme is to escape some of the sterility of the competition-versus-regulation debate and to show the historical and ethical significance of the major changes that are under way in the health care sector.

Key Findings

Grandfathering

- When increasing specialization by physicians first began to impress upon consumers that all physicians were not necessarily alike in skill, the profession sponsored the creation of medical specialty boards to standardize each field, thus reestablishing within each specialty the homogeneity previously fostered for the profession as a whole.
- By periodically lengthening the period of training required by new applicants and "grandfathering" those certified under earlier standards, the medical specialty boards not only increase the costs of market entry to new practitioners but also create an appearance of greater homogeneity within the board-certified ranks than in fact exists.
  1. Consumers are thus induced to underestimate the differences between physicians, and physicians are limited in the ways they can differentiate themselves from their competitors.
- Antitrust theories are also available to attach the medical profession’s domination of accrediting and credentialing in the allied health occupations, the practice of grandfathering (obscuring relevant differences among practitioners) by medical specialty boards, and the division of the market for credentialing services that has occurred under the auspices of the American Board of Medical Specialties.

Decentralization: The emergence of consumer choice

- Although the nation is generally content to have other goods and services supplied through competitive markets, many observers balk at using market forces—even with public subsidies to assist those who cannot pay—to allocate resources to personal health care.
- The current era is seeing both a significant shift of power from public to private hands and a notable decline in the power of private professional interests to control industry developments.
- Government regulation and professional self-regulation were the only alternatives generally recognized in health policy debates until late in the 1970s.
- Long before the debates over regulation in the 1970s, health care was already centrally controlled, not so much by government as by professional interests.
In the 1970s, in order to overcome the costly inefficiencies tolerated by the dominant system of regulation, the nation experimented with government regulation as a substitute for the control systems already in place. But the government never quite got its regulatory program organized, as legislatures—particularly a Congress in an increasingly deregulatory mood—refused to adopt comprehensive cost controls applicable to the private sector as well as to public programs.

A crucial event in establishing a market-oriented policy and making it credible was the Supreme Court's Goldfarb decision in 1975.

1. By interpreting the federal antitrust laws to mandate competition in the provision of professional services, the court change de facto federal policy toward the health care sector and undermined numerous industry-sponsored barriers to competition.

2. Since about 1979, as a result of government's refusal to accept an encompassing regulatory role and its pressing of the antitrust attack, decision-making power has begun to devolve upon consumers and private entities accountable to them in the competitive marketplace.

Limiting consumer choice of health care personnel

- Professional licensure laws have long made the provision of most personal health services the exclusive province of physicians.
  1. Obviously, such regulation limits consumers' options by forcing them to use highly trained, expensive personnel when other types might serve quite well.

- State licensing requirements enabled the profession both to influence the number of physicians trained and to standardize medical education so that its products were highly homogeneous.

Limiting consumer access to corporate agents

- The medical profession has long exerted a powerful influence over the various corporate participants in healthcare markets. In particular, hospitals and health insurers, both of which occupy strategic positions from which they might have exerted substantial influence over physicians, were prevented from acting as agents of consumers in organizing the delivery of care and imposing appropriate constraints on health care spending.

Public acquiescence in professional control

- The medical profession was viewed as a single entity striving to solve purely scientific problems, and medical practitioners were seen as primarily engaged in applying received technical knowledge.

- Believing that there is a single right way, or sometimes a narrow range of acceptable ways, to diagnose and treat human disease, the public naturally accepted professional hegemony over all technical questions and even acquiesced in the view that cost considerations were undesirable impediments to the pursuit of professional objectives.

- The view that decision making on all vital points should be centralized and largely entrusted to the medical profession as an entity dominated most thinking about health policy well into the 1970s. Indeed, this idea remains widespread today even as traditional patterns are being broken and pluralistic influences are creeping in. Nevertheless, it should be clear from the history summarized here that the stage was set for major change.

Recent developments

- The federal government began to concentrate its efforts solely on controlling the costs of its own programs: Medicare and Medicaid.

- In doing so, it moved to phase-out the strategy of directly challenging provider-incurred costs and to substitute payment system based on retrospectively determined costs but on price.

- Other payers, both public and private, have begun to follow the federal government's lead toward more aggressive buying.

Outlines of a choice-driven system

- In general, cost-conscious selectivity by middlemen acting as consumer agents is an important key to making the market translate consumer preferences into provider behavior.
Improving the flow of information

- Data sharing now under way is helping bulk purchasers make sensible choices, and progress is being made in developing measures of health care quality that can facilitate comparative evaluations of providers by consumers and overcome the claims of government and professional interests that they alone possess the secret key to quality assessment.
- In the past, public policy has generally accepted JACH accreditation and profession-sponsored educational accreditation as adequate substitutes for direct government regulation, without recognizing the opportunities that exist for philosophical biases and conflicts of interests to affect accreditors’ judgments.

Antitrust initiatives to enhance the role of corporate middlemen

- One important antitrust goal should be to clarify that independent corporate middlemen and procompetitive joint ventures enjoy fairly wide discretion in excluding providers from desirable market opportunities as long as they stand in a vertical rather than a horizontal market relationship to the provider in question or have a satisfactory business justification for their actions.
  1. Thus, a hospital should be free to deny admitting privileges to a physician or other practitioner on any rational basis and with only minimal accountability to an antitrust court as long as it acts independently (though perhaps with the advice of its medical staff) and does not simply delegate decision-making responsibility to its physicians.

Reducing governmental and judicial limitations on consumer choice

- As the potential for private cost containment is realized and as it is recognized that private plans freely chosen by consumers may have a comparative advantage in economizing over politically sensitive public programs, interest in such “voucherization” should increase, especially if adverse selection problems prove manageable.
- Only if privately negotiated arrangements are not viewed by the legal system as an invitation to litigate their validity, can the benefits of decentralized decision making be fully realized.

The ethical virtues of expanded choice

- Because choice has always been given lip service in the system, the real policy issue is not whether there shall be any choice at all but how much of the discretion that goes into designing and operating the system shall in fact be exercised by consumers and how extensively certain choices shall be subsidized.
- This article has argued that the U.S. system has in the past assiduously limited the range of consumer choice, controlled the flow of information, denied the consumer corporate allies, and resisted letting price or cost considerations influence choices.
- In addition to the many protections against over economizing and mistaken individual choices that the law supplies, the marketplace offers consumers numerous opportunities to make their health care choices collectively rather than individually, thereby overcoming the difficulty of becoming personally informed concerning the available options.
- To the author’s mind, consumer choice, under cost constraints, is an ethically attractive way to deal with the difficult value questions that pervade the provision of health services.
- A preeminent advantage of competitive markets is that they serve minority tastes and interests and, unlike political institutions, given special weight to the preferences of the majority.
Recertification in Advanced Practice Nursing: General Trends and Current Practices

Published by Promissor, a Pearson VUE Business

2007

Citation: Recertification in Advanced Practice Nursing: General Trends and Current Practices (PDF)

Synopsis

Literature review of certification requirements of advanced practice nursing certification organizations.

In 1996, the IOM launched the Health Care Quality Initiative, which set out to assess the quality of healthcare in the United States. The IOM recommended a four-tier approach that included "Raising performance standards and expectations for improvement in safety through the actions of oversight organizations, professional groups, and group purchasers of health care." This report evoked a strong reaction and commitment for change across the United States.

The IOM issued a report, Health Professions Education: A Bridge to Quality, that focused on the education and training of health professionals. They provided five core competencies that education programs should embrace: provide patient-centered care, work in interdisciplinary teams, employ evidence-based practice, apply quality improvement and utilize informatics. Their review found that nearly all certifying bodies required some type of continued competence. Most required continuing education or retaking the initial certification examination, but other methods are being introduced.

The NCSBN Advanced Practice Task Force set a certification maintenance program five-year cycle minimum requirement. In a 2006 vision paper other methods to measure continued competence are mentioned, such as portfolios, examinations, and practice evaluations.

The study summarizes the recertification practices used in advanced practice nursing and other medical professionals analogous to nurse anesthetists. Only long-term recertification programs are presented. The certifying organizations presented were the American Association of Critical-Care Nurses, Pediatric Nursing Certification Board, American Board on Anesthesiology, National Commission on Certification of Physician Assistants, American Academy of Nurse Practitioners, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties, American Association of Critical-Care Nurses, Oncology Nursing Certification Corporation, Oncology Nursing Certification Corporation, American Nurses Credentialing Center, American Nurses Credentialing Center and American Midwifery Certification Board.

Key Findings

Current Certification Practices

- **Certified Nurses Midwives:** The American Midwifery Certification Board (AMCB) issues a CNM certificate. Nurses certified after 1995 are automatically enrolled in the Certificate Maintenance Program (CMP), which requires recertification every eight years.
- **Nurse Practitioners:** Nurses recertify every five years either by passing an examination or completing 1000 clinical practice hours in their specialization area and 75 hours of continuing education. The National Certification Corporation (NCC) for the Obstetric, Gynecologic, and Neonatal Nursing Specialties has awarded over 65,000 certifications, which must be maintained every three years through the Certification Maintenance Program. The Pediatric Nursing Certification Board (PNCB) offers two NP certifications, the Certified Pediatric Nurse Practitioner for Acute Care (CPNP-AC) and the Certified Pediatric Nurse Practitioner for Primary Care (CPNP-PN). Both recertification cycles, as well as the dual recertification
program offered to NPs certified in both areas, are seven years. The ANCC (American Nurses Credentialing Center) and the Oncology Nursing Certification Corporation (ONCC) also have NP recertification programs, which are similar to the CNS program and described later in the paper.

- **Clinical Nurse Specialists**: The AACN (American Association of Critical-Care Nurses) certifies CNSs in adult, neonatal, and pediatric acute and critical care, which varies from the AACN NP program mentioned previously. To be eligible to renew certification, nurses must have a minimum of 2000 practice hours, with at least 400 hours in the last year. For renewal, which is every four years,

- **Other Nursing Programs**: ANCC (American Nurses Credentialing Center) is the largest nursing credentialing organization in the United States, The Oncology Nursing Certification Corporation (ONCC) currently provides certification to 24,000 nurses, including 20,757 Oncology Certified Nurses (OCNs), 371 Advanced Oncology Certified Nurse Practitioners (AOCNPs), and 151 Advanced Oncology Certified Clinical Nurse Specialists (AOCNSs). Certifications need to be renewed every four years.

**Analysis**

- The two certifications requiring examinations were the only non-APRN certifications surveyed (for MDs & PAs); they also were the only examinations that were different than the original certification examination.
- Of the eight certifications offering the initial certification examination as an option, six had required activities in addition to the optional activities and two featured only the optional activities.
- Of the eight certifications offering the initial certification examination as an option, six had required activities in addition to the optional activities and two featured only the optional activities.
- Of the two certifications without requirements, the option to either complete professional development/practice hour activities or take an examination was given.
- Of the six certifications with requirements in addition to optional activities involving examination, three required practice hours with an option of either professional development or examination (two of which were offered by the same organization); two required professional development with an option of either practice hours or examination (both were offered by the same organization); and one required professional development with an option of further professional development.
- Of the ten total examinations offered, five were entirely computer-based and five had a paper-and-pencil option but encouraged the computer-based examination.

**Conclusion**

The recertification movement has seen two major shifts over the past several decades as a result of research findings and government policies: a shift from a one-time certification model to a recertification method that primarily uses continuing education, and then a shift to a continued competence or maintenance of certification approach, which recognizes that good clinicians should be committed to and proactively involved in lifelong professional development.

Although specific assessments still are debated, this approach emphasizes a wide range of evidence-based assessments, including measuring medical knowledge and skills in clinical settings. Current recertification practices primarily offer candidates at least two methods for recertification, typically involving the option to retake the original certification examination along with either professional development activities or clinical practice hours.

Major studies are currently being conducted by the IOM, NCsBN, and other organizations to further identify what specific recertification methods and combinations most effectively contribute to the performance of healthcare workers to eventually raise the overall quality of healthcare in the United States.
Recertification Practice Analysis

National Board on Certification and Recertification of Nurse Anesthetists

2008

Citation: NBCRNA Report on the Recertification Practice Analysis.

Synopsis

One of the primary purposes of the NBCRNA is to formulate, adopt, and continuously evaluate the criteria for recertification of Certified Registered Nurse Anesthetists.

As part of a strategy for evaluating the reasonableness of recertification requirements and long-range planning, the NBCRNA Council on Recertification conducted an analysis of the practice of nurse anesthesia specific to recertification—that is, at a level of practice that is higher than the entry-level assumptions for initial certification in the specialty.

The study identified the importance, criticality, and frequency of domains (major elements of practice), tasks, and knowledge and skills as well as pain management techniques for the recertification of nurse anesthetists.

A Recertification Task Force comprised of Certified Registered Nurse Anesthetists from throughout the United States was convened on February 4 – 6, 2008 and, through facilitated discussion, reached consensus on three performance domains for nurse anesthetists:

- Clinical Practice
- Practice Evaluation and Improvement
- Professional Responsibility

Domains were validated using scales for importance, criticality, and frequency. Tasks and knowledge and skill statements were also validated using scales for criticality and frequency. The importance scale offered insight into how essential the domain is for the recertified nurse anesthetist. Criticality (potential for harm) and frequency (how often) scales also supplied support for decision making about the practice analysis, which should be considered when making decisions about recertification program development.

In May – June, 2008 all active certified nurse anesthetists were asked to participate in the validation survey component of the project, and 6,650 (23.5%) provided qualified, usable responses. Responses to items in the demographic portion of the survey support the conclusion that participants constituted a reasonable sample of certificants across a variety of practice settings.

Survey respondent data provide strong evidence of validity for the three performance domains and for all tasks except for “Support research activities."

Key Findings

Demographics

- Over one-third of the respondents were employed in hospitals. About 20% were employed in a physician group
- The largest group of respondents reported their age as being between 50 and 59
- Many respondents reported being between 40 and 49 and between 30 and 39
- Concerning race/ethnicity, over 90% classified themselves as Caucasian
- More than 20% had earned a certificate in anesthesia and most respondents have earned at least a Bachelor’s degree in anesthesia
- In addition to the degree in anesthesia, more than sixty percent had earned a Master’s degree
- Just over half of the respondents were female
• Although all regions of the United States were represented in the respondent group, the southeastern part of the country (Zip code beginning with 3) predominated

**Respondent Practice Data**

• The vast majority of respondents’ work was devoted to direct clinical patient care
• Just over half of respondents’ time was spent working with adults, and an additional third of respondents’ time was devoted to the elderly

**Education specific to an institution**

• The vast majority of respondents were required to complete mandatory education specific to an institution
  1. The most common among the topics for the mandatory education were fire safety, patient confidentiality, and transmission precautions: blood and body fluids.
  2. For respondents reporting that mandatory education is required, nearly half indicate that an examination is included

**Domains and Tasks**

• Clinical Practice
  1. Tasks within Clinical Practice were given relatively high criticality and are performed very often
• Practice Evaluation and Improvement
  1. Tasks within practice evaluation and improvement were seen as moderately critical and performed about once per month
• Professional Responsibility
  1. Tasks in professional responsibility are less critical although they are performed about once per month to once per week
Effect of Board Certification on Antihypertensive Treatment Intensification in Patients with Diabetes

Alexander Turchin, Maria Shubina, Anna H. Chodos, Jonathan S. Einbinder and Merri L. Pendergrass

2008


Synopsis

Since 2006, all 24 specialty boards of the American Board of Medical Specialties issue time-limited certificates that require physicians to retake the examination within 6 to 10 years to maintain certification. However, quantitative studies that offer evidence in support of recertification are lacking.

This study was carried out to determine whether the frequency of antihypertensive treatment intensification for diabetic patients changes with time since their physicians’ last board certification.

The authors developed and validated a technique that allowed them to computationally analyze the text of physician notes in the electronic medical record to identify documentation of antihypertensive treatment intensification. Frequency of treatment intensification when faced with an abnormal finding (e.g., elevated blood pressure or blood glucose level) is an emerging measure of quality of care that has been promoted as “tightly linked” to outcomes of care.

Key Findings

- Physician intensification of pharmacological therapy for blood pressure levels above the recommended treatment goals decreases with time since the last board certification. This finding supports the current policy of mandatory recertification.
- Frequency of treatment intensification decreased from 26.7% for physicians who were board certified the previous year to 6.9% for physicians who were board certified 31 years before the visit.
- Treatment intensification rate was 22.5% for physicians certified 10 or fewer years ago versus 16.9% for physicians last certified more than 10 years ago ($P < 0.0001$).
- For every decade since the physician’s last board certification, the probability of treatment intensification decreased by 21.3%.
- Independently from the patient’s blood pressure during the visit and other patient and visit characteristics, the probability of treatment intensification progressively decreased nearly 4-fold as the number of years since the physician’s last board certification increased.
- Neither physician age nor the time since medical school graduation was significantly associated with the probability of treatment intensification in multivariable analysis.

Possible Explanations

- A likely reason for the relationship between the time since board certification and the frequency of treatment intensification is the educational efforts many physicians engage in before taking the examination.
- Because current treatment goals for patients with diabetes mellitus are included in the examination curriculum, it is likely that they are reviewed during the preparation for the examination and are then adopted in clinical practice.

Study Limitations

- Study was restricted in scope to the patients of internists affiliated with academic hospitals in eastern Massachusetts. This could limit its generalizability to the patient and physician populations.
• This retrospective study relied on documentation of relevant findings in the electronic medical record. If the accuracy of this documentation varied with the rate of treatment intensification, the study findings could be biased.
• Many diabetic patients did not have sufficient information in the electronic medical record (primarily notes) to be included in the study.
Assessment of Specialists In Cardiovascular Practice

Kamran Ahmed, Hutan Ashrafian, George B. Hanna, Ara Darzi and Thanos Athanasiou

2009


Synopsis

Assessment of medical specialists was introduced to ensure patient safety and to maintain professional knowledge. Cardiovascular specialist assessment is challenging, as the ongoing development of new technologies is associated with increased requirements for up-to-date training and acquisition of new skills. The cardiovascular specialties include cardiology, vascular interventional radiology, cardiac surgery and vascular surgery. Assessment within these disciplines involves evaluation of knowledge in addition to technical and nontechnical skills, a process that is termed recertification or maintenance of certification. Increasingly, there is a demand for professional accountability through recertification because of concerns about professional negligence and increased awareness of medical errors. In this article we describe the process of recertification in different geographical regions and discuss the role of current tools used to recertify cardiovascular specialists and, in particular, how their use can contribute to the requirements of patient care.

Key Findings

- As with other medical specialties, the outcomes of cardiovascular services are under widespread scrutiny by both the media and the public.
  1. Reports such as the Bristol Inquiry in the UK and the publication of To Err is Human by the Institute of Medicine in the US, have further contributed to the general loss of public trust in the health services.
- Recertification is a fundamental quality assurance process aimed at achieving excellence in patient care and protecting patients from specialists who perform poorly.
- The cardiovascular specialties require system that considers continuing education in innovative technologies while objectively assessing competence and performance.
- Although the current state of recertification for specialists is still developing, a step towards the amalgamation of CME and assessment has been taken.

Recertification in Different Regions

The US: maintenance of certification

- Introduced in 2006
- Based on core competencies, which are established by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties
- Carried out by the appropriate member boards for each specialty
- Guided by four principles:
  1. professional standing (ensured by a valid and unrestricted medical license from a state or a jurisdiction)
  2. lifelong learning and self-assessment (ensured by completion of CME programs that meet specialty-specific standards set by the respective member board)
  3. Cognitive expertise (ensured by testing the fundamental, practice-related and practice-environment-related knowledge)
  4. Practice performance assessment (ensured by comparing the quality of individual care against national benchmarks along with application of the best evidence or consensus to achieve excellence of care)

Canada: maintenance of certification
• Introduced in 2000
• Depends on the autonomous regulatory decisions of each provincial College of Physicians and surgeons
• 5-year cycle during which practitioners must show evidence of their continuing professional development through their record of CME exercises and self-evaluation documents.
• Objective assessment of specialists is not a part of the process
  1. Based on a framework of core competencies. These roles include:
     - Medical expert
     - Communicator
     - Collaborator
     - Health advocate
     - Manager
     - Scholar
     - Professional

The UK: revalidation
• Mandatory for all specialist practitioners after 2009
• Two components:
  1. Recertification – equivalent to MOC in the US
  2. Relicensing - British specialists will be required to renew their license to practice every 5 years, along with their recertification. Relicensing is based on the ‘Good Medical Practice’ document and is coordinated centrally by the General Medical Council

Tools of Recertification

Patient Safety

• Regular audits of practice
• Reporting of any adverse events
• Reporting of participation in quality assurance and quality improvement programs

Professionalism

• References from peers
• Unrestricted license from state governing bodies
• Volunteer work
• Teaching or participation in the emergency department call rotation

Communication Skills

• 360-degree feedback (multisource feedback), in the form of peer or patient checklists, devised by various medical boards and the royal colleges
  1. Opportunity for individuals to compare their self-assessment with evaluation from their colleagues and patients

Medical knowledge

• CME

Situation awareness and decision making

• The Nontechnical Skills for Surgeons (NOTSS)
• Observational Teamwork Assessment for Surgery (OTAS)
• The Nontechnical Skills (NOTECHS) Scale
• Anesthetists’ Nontechnical Skills (ANTS)

Technical skills

• Individual practitioner logbooks
• Case load
• Data on patient morbidity and mortality
• Observation of performance by an independent assessor
The Future of Continuing Medical Education

Mary Martin Lowe, PhD; Alejandro Aparicio, MD; Robert Galbraith, MD; Todd Dorman, MD; and Edwin Dellert, RN, MBA

2009


Synopsis

To ensure that continuing medical education (CME) continues to evolve so that it offers educational activities that are relevant to physicians in keeping with the definition of CME, CME providers must respond to and prepare for emerging expectations. This article puts into context the impact of the current emphasis on lifelong learning in medicine, particularly the requirement for maintenance of certification and licensure, on CME. Further, the effect of changing needs assessments and the impact of the integration of new technology in CME is included. Finally, a discussion of the emerging unique needs of CME providers and organizations related to these changes are addressed in the following four broad categories: CME as a value center, resources in support of CME, research to further advance the field, and leadership to guide the profession.

Key Findings

- Expectations and required performance changes will influence CME significantly.
- Self-assessments will spotlight learning needs that are not only unique and physician specific, but also critical for a physician to fulfill. This type of individualized self-assessment will create motivated learners who will want to become involved in a learning process that supports desired changes.
- Just as physicians are working with more informed patients, CME providers will target engaged physicians who have increased expectations for CME.

Environmental factors that likely will influence the future of CME

Expectations

- Expectations for physicians to meet licensure and certification requirements and to provide current, patient-focused, evidenced-based care will shape the future of CME.
- Today, the Maintenance of Certification (MOC) program of the American Board of Medical Specialties is the standard.
  1. An important impact of MOC on CME is the requirement of lifelong learning and self-assessment, creating a direct link between MOC and CME.

Performance Measures

- Performance measures will be critical in determining needs assessment

Technology

- Newer types of technologies offer flexibility to CME providers to support physicians’ “just in time” learning. These types of encounters often relate directly to a question in a physician’s practice, which is a desirable component of CME for licensure and MOC.
- As CME providers deliver their products and services to newly graduating physicians who may use technologies in different ways than their older counterparts, it will be important for CME providers to assess not only the content of learning, but also the needs related to format and methodology.
Health Information Systems and Physician Quality: Role of the American Board of Pediatrics Maintenance of Certification in Improving Children's Health Care

Paul Miles

2009


Synopsis

A second revolution in quality is occurring in US health care, as profound as the Flexner revolution almost 100 years ago. Systems issues are the basis for most of the concern, but physician quality and professional development are also important. Specialty board certification and maintenance of certification are key drivers of professional development and improvement of care. Physicians are now required to document that they can assess and improve quality of care. Functional health information systems are essential for this process.

Key Findings

- The American Board of Pediatrics (ABP) and other boards are creating MOC programs that help physicians close the quality gap.
- As the standard for MOC part 4, the ABP is requiring diplomates to demonstrate with data the quality of the care they deliver, to compare their quality with peer results and benchmarks, and, where gaps exist, to improve care systematically over time.

Meeting ABP Requirements

- Two options:
  1. Internet-based improvement modules, such as the Electronic Quality Improvement in Pediatric Practice program developed by the American Academy of Pediatrics and the Patient Safety Improvement Program developed by the ABMS.
     - These modules guide pediatricians through the basic process of measuring and improving quality of care for a small sample of patients from their clinical practice, using evidence-based guidelines.
  2. Receive credit for participating in an ABP-approved, established, quality improvement project.
     - The ABP has developed standards to enable established quality improvement projects to meet the requirements for MOC part 4, as well as standards for what constitutes valid participation by a pediatrician for MOC credit.
Maintenance of Certification in Anesthesiology (MOCA®)

*The American Board of Anesthesiology*

2009

Citation: ABA MOCA Slide Presentation.

Synopsis

Slide show presentation on details of the Maintenance of Certification (MOCA) exam.

Maintenance of Certification (MOCA)

- Mandatory for those who received their initial certification in 2000 or later
- Certification lasts at most 10 years - at the end of 10 years, if all requirements are not met, no longer ABA certified
- Emphasis on lifelong learning, ongoing evaluation of practice
- Cognitive examination small part of the process
- Four components:
  1. Professional standing
  2. Lifelong learning and self-assessment
  3. Cognitive examination
  4. Practice performance assessment and improvement
- Credits: 350/10 years, 200 before cognitive examination, 250 credits must be Category 1
- Diplomates who enter MOCA after January 1, 2008, are required to complete the following once during their 10-year MOCA cycle: 60 Category 1 credits of either the American Society of Anesthesiologists’ (ASA) Self-Education and Evaluation (SEE) program or the ASA’s Anesthesiology Continuing Education (ACE) program and 20 Category 1 credits of Patient Safety CME
- Self-reported CME subject to audit
- Cognitive exam on “walking around” knowledge to be completed between seven to ten years in MOCA cycle
- Case evaluation: collect data, compare practice data to approved standards, develop plan, reassess individual or group practice

Recertification Exam

- Only for diplomates certified before 2000
- 2010 and thereafter – MOCA is only option

How are the two exams similar and different?

- Similar: professional standing, attestation of minimum clinical activity and practice assessment and improvement
- Different: MOCA has an explicit LLSA/CME requirement, specific Part IV requirements and is ongoing; episodic

How to change programs

- Recertification to MOCA: first, write ABA to withdraw Recertification Application, then, enroll in MOCA at [www.theABA.org](http://www.theABA.org)
- From MOCA to Recertification: first, write ABA to de-enroll from MOCA, then, apply for Recertification at [www.theABA.org](http://www.theABA.org)

Subcertification

- Pain and Critical Care are time-limited - 10 years
- Recertification is only option. The transition from recertification to MOCA-SUBS begins in 2010.
- Can maintain subspecialty certification even if anesthesiology certification expires, using the SAME CME, Patient Safety CME, and simulation-based training.
- Will require separate exams and Part IV case evaluations certificate
NBRC Continued Competency Program - Introduction to the Continuing Competency Program (CCP)

Published by National Board for Respiratory Care

2009

Synopsis

Overview of the NBRC’s CCP and benefits of being credentialed. Nurses who get certified demonstrate a level of excellence in professional achievement indicating their knowledge in respiratory therapy and pulmonary function technology, and enhance and maintain that level of knowledge as a key component to one’s professional development and career advancement.

Individuals participating in the Continuing Competency Program are required to provide evidence they are continuing to meet current standards of practice and have successfully renewed their national credentials issued by the NBRC. Individuals may confirm they meet active status requirements and renew their annual dues through our website, www.nbrc.org. Through implementation of the Continuing Competency Program, the NBRC further demonstrates its compliance with the accreditation standards of the National Commission for Certifying Agencies (NCCA).

Key Findings

Three renewal options

- Option 1 – Provide proof of completion of a minimum of 30 hours of Category I Continuing Education (CE) acceptable to the NBRC.
  - 1. Includes any one of the following: lecture, panel, workshop, seminar, symposium, distance education
- Option 2 – Retake and pass the respective examination for the highest credential held.
- Option 3 – Pass an NBRC credentialing examination not previously completed.

Continuing Education Documentation

Practitioners completing the Continuing Competency Program requirement by Continuing Education (CE) are required to submit the Continuing Competency Program information prior to their credential expiration date. Individuals may complete the application process and pay fees online at www.nbrc.org. Failure to comply by the deadline may result in the expiration of an individual’s credential. Contact hours may be obtained from accredited providers on continuing education in respiratory care approved by the American Association for Respiratory Care (AARC). All AARC-approved providers and those accepted by state agencies regulating the respiratory care profession will be accepted by the NBRC.

Program Fees

- Individuals who renew their active status in each of the four consecutive years following their exempt period pay $0 for the CCP Program
- Individuals who do NOT renew their active status in any of the four consecutive years following their exempt period pay $25 per inactive renewal period during five years of the credential term
- Individuals who fail to apply for the program or who fail the examination and do not complete one of the other options for renewal pay $150 plus current examination fee

Notification procedures

The NBRC will provide general information about the Continuing Competency Program to credentialed practitioners each year through the annual renewal process. One year before the expiration date of the individual’s credential, a reminder notice will be sent directly to the individual at the last known address, including information on documenting requirements for the CE option of the CPC. Six months before the expiration date, a follow-up notice will be sent. A final reminder notice will be sent 90 days before the expiration date.
Verification of Compliance
The NBRC will audit a random sample of CCP compliance documentation and will confirm the validity of all submitted information with the appropriate parties. Cases in which it appears false information may have been provided will be referred to the NBRC’s Judicial and Ethics Committee for investigation and possible disciplinary action according to the committee’s Operating Policies and Procedures.
ABA Announces Changes to MOCA Exam

The American Board of Anesthesiology

2010

Citation: ABA MOCA 062110 one page update.

Synopsis

Announcement of changes in MOCA certification process.

Key Findings

- As of January 2010, the (ABA) recertification exam is no longer available
- Only the American Board of Anesthesiology (ABA) Maintenance of Certification in Anesthesiology (MOCA) exam is part of the MOCA process
- Previously, examinees had to answer 150 out of 200 questions of the recertification exam. Now, they are required to answer all 200
- The MOCA exam tests clinical issues, broad-based clinical anesthesiology knowledge
- The exam will not ask questions related to highly subspecialized knowledge
- 92.7 percent of ABA diplomates who took the January 2010 exam passed
- ABA encourages diplomats to take the exam early in their MOCA cycle earlier (seven to eight years) rather than later (nine to ten years), allowing more than one opportunity to pass the exam prior to expiration
NBCRNA in Motion

Published by the NBCRNA

2011

Citation: NBCRNA CPC Slide Presentation (PDF)

Synopsis

Slide show presentation overview of the National Board on Certification and Recertification Of Nurse Anesthetists (NBCRNA), and their proposed CPC Program.

Vision

- To be recognized as the leader in advanced practice nurse credentialing to protect and enhance the value of the CRNA credential
- To promote patient health and safety through credentialing programs that support lifelong learning

Roles of NBCRNA vs. American Association of Nurse Anesthetists (AANA)

- NBCRNA’s mission is public protection
- AANA’s is CRNA advocacy.
- Accreditors and regulators require a separation between membership organization and the credentialing body
- NBCRNA incorporated to provide the best governance model for nurse anesthesia credentialing.

Proposed CPC Program

- Addresses ever-evolving changes in the practice of anesthesia
- Responds to public, governmental and other stakeholders desire for assurance of ongoing assessment of minimum competence
- Focuses on ongoing growth and development of competency throughout your career
- Incorporates the latest thinking related to learning and credentialing

Proposed Program Components

Recertification cycle every 4 years and practice-focused recertification examination every 8 years

- 35 continuing education credits per year; some with an assessment component
  1. 15 credits require some type of assessment of learning
  2. 20 credits do not require assessment
- Work/practice requirement
- Evidence-based self-study on the four core competencies
- Content outline related to the knowledge and skill for everyday practice

Four Core Competencies

- Airway management techniques
- Applied clinical pharmacology
- Human physiology and pathophysiology
- Anesthesia technology

Evidence Supporting Change

- Physician certification processes that include testing are significantly correlated with superior patient outcomes
- Self-assessment of performance correlates poorly with a provider’s actual competence
- Health care agencies should not rely solely on continuing education to maintain competency
- Periodic demonstration of knowledge, skills and judgment are critical to public safety
- Increased formal education and training leads to improved test scores
- All health care provider organizations should have periodic provider recertification with measurable demonstration of continuing competency. Testing is one method of a measurable assessment of knowledge.

**Program Benefits**
- CONFIDENCE that the credential will provide evidence based ongoing learning that exceeds current standards
- ASSURANCE of the highest quality standard for your practice - now and in the future
- CONFIRMATION that you are up-to-date with leading practices, technologies and pharmacology
- OBJECTIVE VALIDATION of your individual competency for credentialing required by external agencies such as JCAHO & CMS
- SENSE OF ACHIEVEMENT you gain from demonstrating your commitment to lifelong professional growth
- CONTRIBUTION to your ongoing career advancement
- BUILT-IN FLEXIBILITY for you to choose from multiple methods for continuing education and demonstrated competency

**Next Steps**
- Public Comment Period: September 6 through November 14, 2011 ([www.nbcrnacpc.com](http://www.nbcrnacpc.com))
- Program Refinement: November 2011 – January 2012
- Board Discussion and Decision: January 2012 NBCRNA Board Meeting
Developing the Clinical Licensure Examination for Nurse Practitioners in British Columbia

Marie Napolitano, PhD, RN, FNP; Alison Roots, PhD(c), RN, MHSM; Christine Hoyle, DNP, ARNP, FNP; and Cynthia Johansen, SA

2011

Citation: Developing Clinical LIC Exam

Synopsis

The College of Registered Nurses of British Columbia adopted an objective structured clinical exam (OSCE) in 2004 as part of its licensure process for nurse practitioners (NPs). A rigorous and successful process was developed to create a fair, effective OSCE that ensured public safety. From July 2005 through January 2011, 217 NPs completed the OSCE, which is offered twice a year. NPs in British Columbia have expressed a great sense of pride and accomplishment after passing the OSCE, and they have stated that the recognition and credibility from colleagues have been the most beneficial outcomes.

Key Findings

In 2004, College of Registered Nurses of British Columbia (CRNBC) adopted an OSCE as part of the licensure process for (NPs). CRNBC initiated an extensive stakeholder consultation process to develop the competencies, determine the number and type of registration categories for NPs, and establish initial registration requirements and continuing competence and quality assurance requirements. Stakeholders said that safe NP practice would be better addressed by substantive regulatory requirements implemented by CRNBC than by having the provincial government set narrow limitations on practice.

The framework for the initial registration of NPs includes the following three requirements:

- Current registration or eligibility as an RN in British Columbia
- Graduation from a CRNB-recognized NP program or establishment of equivalency through a competence assessment process
- Passing scores on written and clinical NP examinations

Several components of an OSCE require the highest level of expertise in development, evaluation and revision to ensure a reliable process. CRNBC OSCE has the following components:

- **Patient scenarios enacted by trained standardized patients** - These cover the required age categories, body systems, and functions (history taking, physical examinations, diagnosis, management, education, and counseling). For each scenario, a systematic format was identified for a specific clinical health problem or need, the indicators of expected NP practice for the scenario, and the appropriate level of complexity required for the NP scope of practice. An examination content committee oversaw the work of the authors and reviewed the scenarios for entry-level, evidence-based practice. Scenarios were also reviewed for precise, uncomplicated presentation and information. New scenarios were regularly added to the case bank, which currently contains more than 50 scenarios that have been used at least once. Based on scenario performance, new information, and examiner and candidate feedback, scenarios have been updated and revised.

- **Standardized scenario checklists, written questions, and a global assessment scoring (GAS) process to assess the performance of NP candidates in the scenarios** - Authors of the clinical scenarios created checklists for the scenarios. The checklists consist of identified items or observable behaviors that are assessed during the scenarios and that relate to the required tasks of history taking, physical examination, development of management plans, or counseling. The checklist items reflect the minimum level of skill an entry-level NP must demonstrate. The content committee reviewed the checklists for completeness, safety, evidence-based best practice, and groundedness in nursing. An OSCE uses 600
to 700 checklist items to assess NP candidates. About half of the scenarios have written questions that follow a 5-minute patient interaction. An average of two or three questions, also called post-encounter probes, per scenario is used in accordance with research findings demonstrating higher levels of reliability with two or three questions per case. The NPs on the content committee created these questions to test the candidates in areas that are difficult to test by observing a clinical interaction with a patient. The questions target differential diagnoses, samples of documentation, referral-letter content, management plans, and diagnostic tests. The areas for each written question reflect the requirements of the examination blueprint and the most appropriate areas for the particular clinical scenario. Answers are identified using Canadian best practices, highest level of evidence, and NP expertise. Points are assigned based on the importance of the answer. A GAS instrument was designed to measure the comprehensive enactment of the NP role. It specifically addresses the competencies of relationship development and clinical knowledge and competence through the demonstration of in-depth nursing knowledge and skill. This instrument assesses candidates in five areas:

- Engagement in a partnership with the patient
- Negotiation of priorities with the patient
- Demonstration of clinical decision-making abilities and an in-depth knowledge base
- Demonstration of safe, organized, and appropriate clinical practice
- Ability to counsel and provide appropriate information to address wellness care, health promotion, and prevention needs.

**Identification of critical performance incidents by examiners** - Critical incidents on the OSCE are clinical and professional actions that harm or have serious negative consequences for the patient. The content committee reviewed each scenario for possible candidate behaviors that would be critical incidents. These behaviors are noted on the scenario checklist. The confidentiality of the OSCE prohibits descriptions of specific examples of critical incidents here. Examiners are required to note if a candidate demonstrated a critical incident or any other unsafe behavior by marking the checklist and writing a detailed description of the incident. Candidates are informed of critical incidents in their clinical-exam notification letters.

**Processes for selecting and orienting examiners** - NP examination committee, whose members are appointed by CRNBC board, is charged with overseeing the examination. This committee is responsible for ensuring that all examination content is consistent with entry-level competencies for NPs and represents safe practice. The committee approves test materials and rating scores, establishes the pass mark, ensures the appropriate selection of examiners, and determines the final scoring of the OSCE. NP examination committee appoints a chief examiner to oversee the examiners, make examination-day determinations regarding scenarios and scoring, and submit a written summary report to the committee. The exam coordinator oversees all the support staff assisting with the OSCE on test day. Usually, one examiner assesses performance for each scenario. Examiners must be master’s-prepared NPs, have experience as an NP educator or preceptor, and have at least 3 years of experience in NP practice. The examiner observes the candidate and marks items completed on the scenario checklist. After the candidate leaves the room, the examiner completes the GAS instrument. The number of examiners needed depends on the number of scenarios used on test day, the number of candidates, and the administrative configuration of the scenario. For example, a 16-scenario OSCE with 40 candidates would require 18 or 19 examiners.

**Processes for candidate orientation and examination administration** - About two months before the examination, orientation and examination preparation materials are provided to every candidate. Candidates receive a guidebook that introduces them to the examination process and procedures and provides advice on how to study and prepare for the OSCE cases. A reference list of documents and books that can aid candidates’ preparation is available. An orientation DVD on the administrative processes of test day is provided to candidates and is available on the CRNBC website. An orientation session on
registration procedures, the written examination, and the OSCE is conducted at each British Columbia university and again a few weeks before the examination.

- **Post-examination scoring of checklists and written questions** - OSCE is scored using a criterion-referenced system, a cut-off based on a minimum number of scenarios passed, and a demonstrated level of safe and appropriate professional practice. An overall pass requires the following:
  1. A passing score on a minimum number of scenarios in the clinical interaction and written-question sections
  2. A minimum overall competency score for the examination
  3. No critical incidents serious enough to warrant failure on the examination

If the candidate does not pass the OSCE, he or she may take it two more times. If still unsuccessful, the candidate may appeal to the CRNBC board, requesting another opportunity. If necessary, the candidate may repeat this appeal, but no candidate has had to appeal more than once. Two NPs independently mark the written answers. If discrepancies exist between the two markers, a third NP reviews the answers. The three markers discuss any discrepancies and reach agreement. All candidate responses are reviewed for their worthiness, and any acceptable answers are added to the master answer key with corresponding points.

On test day, NP OSCE consists of 15 or 16 scenarios, depending on the extent of the scope of practice for the registration category (family, adult, or pediatric). Each interactive scenario uses standardized patients to provide real-life interactions with the candidate. During the OSCE, the NP examiner is in the room to complete the checklist and GAS.

On test day, the scenarios are set up in a facility with a large number of clinical examination rooms. All staff members, examiners, standardized patients, and candidates must check in and receive a badge to enter the testing area. Candidates may bring only their stethoscope and lab coat into the testing area. They receive a blank notebook that must be returned at the end of the testing day. At the specified time, the candidates are escorted to the testing area and their assigned first scenario station. At the sound of the buzzer, the candidates begin the exam. Instructions regarding case specifics and the expectations for the candidates are posted at each station. Staff hall monitors disbursed throughout the hallways maintain security and answer questions from candidates, examiners, and standardized patients. Security is maintained at all times during the testing period.

After analysis of the examination's performance and examiners' feedback, the materials were revised, as needed. The most common changes involved clarifying instructions to candidates, simplifying information in the scenarios for entry-level NPs, and eliminating nonessential items on the checklists.

These changes were followed on subsequent examinations to determine whether performance or feedback improved. At the onset of the OSCE process, low scores by more than 50% of candidates on certain scenarios indicated a lack of attention to the topic area in NP educational programs. After the CRNBC provided feedback to the programs, performance improved on these scenarios.

Reliability and consistency were addressed to ensure consistency in the performance of examiners and the standardized-patient enactments of scenarios. To ensure a high level of internal consistency and inter-rater reliability, all examiners had to participate in a group orientation before each OSCE. Orientation included viewing two patient scenarios and scoring checklists for them. The chief and deputy chief examiners led discussions on examiners' markings for each checklist item and the GAS rating. Consistency in marking across candidates was stressed.

Standardized patients were trained by experienced trainers. The OSCE consultant viewed each enacted scenario for accuracy before the OSCE, and needed changes were made. Testing days were carefully monitored for consistent performances by the standardized patients, and checklists were reviewed to ensure all items were completed.
The total number of candidates who completed OSCE through January 2011 is 217. Of those, 192 were family NP candidates; 17 were adult NP candidates; and 8 were pediatric NP candidates. Of the 217 candidates, 62 were educated outside British Columbia.

Beginning in 2006, an annual university performance report was provided to every program with more than five students taking the OSCE. To preserve candidate confidentiality, information could not be provided to programs with fewer than five students. This report provides individual university programs with their performance in the blueprint categories of practice, lifespan, and body systems, and it compares their performance with the overall ratings for all candidates taking the OSCE. To ensure candidate confidentiality, information is provided only in percentages and, in some cases, percentile ranges.

**Conclusion**

NPs gained a broader scope of practice at the onset of their new role in BC partly because of an expectation that an assessment process comparable to the process used for medical candidates would be a component of their licensure. A rigorous process was developed to create a fair, effective OSCE that ensures public safety with purposeful attention to reliability and validity. Through seven offerings, the OSCE and its implementation have been measured as successful.

NPs have expressed a great sense of pride and accomplishment upon passing the OSCE. Many NPs have commented on the hard work to prepare for the exam and the anxiety inherent in the process; however, the endpoint was worth the effort and emotions. With time, most NPs have come to accept the OSCE as just another component of the licensure process rather than an obstacle that should be eliminated.

The most beneficial outcome has been recognition by colleagues. Examples of NP comments include the following:

> Having done an OSCE and being successful definitely provided credibility to physicians I work with and those outside of my workplace. They see doing an OSCE as a gold standard for determining whether a practitioner is safe to practice. An OSCE allays any fears that an NP does not have the skills and knowledge to provide primary care.

Although NPs experience varying degrees of acceptance by their professional colleagues, the OSCE has been acknowledged as helping NPs gain support and acceptance more rapidly than they would have without the OSCE.

Using nationally-based NP OSCE would more closely align the competence assessment process of NPs with their professional colleagues in medicine, pharmacy and physiotherapy. CRNBC OSCE could easily be adapted for use at the national level.
Appendix F: Updated References 2011-2014

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Physician

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Comparison of Professions


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- Self-Assessment in Continuing Professional Development. Robert A Brown, PhD, ABPP; Catherine Yarrow, PhD. Association of State and Provincial Psychology Boards
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