Board of Behavioral Sciences

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MEETING NOTICE

Continuing Education Provider Review Committee
October 4, 2012

Department of Consumer Affairs
El Dorado Room
1625 North Market Blvd., #N220
Sacramento, CA 95834

TELECONFERENCE LOCATION
288 Fascination Drive
Mammoth Lakes, CA 93546

1:00 p.m. to 4:00 p.m.

I. Introductions

II. Discussion and Possible Recommendations for Action Regarding Revising the Board's Continuing Education Provider Program

III. Discussion Regarding Continuing Competency

IV. Public Comment for Items Not on the Agenda

V. Suggestions for Future Agenda Items

VI. Future Meeting Dates

VII. Adjournment

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times are approximate and subject to change. Action may be taken on any item listed on the Agenda.

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT www.bbs.ca.gov.

NOTICE: The meeting is accessible to persons with disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Christina Kitamura at (916) 574-7835 or send a written request to Board of Behavioral Sciences, 1625 N. Market Blvd., Suite S-200, Sacramento, CA 95834. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Governor
Edmund G. Brown Jr.
State of California
State and Consumer Services Agency
Department of Consumer Affairs

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Board of Behavioral Sciences

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Memo

To: Continuing Education Program Review Committee **Date:** October 4, 2012

From: Steve Sodergren
Assistant Executive Officer **Telephone:** (916) 574-7847

Subject: **Discussion and Possible Recommendations for Action Regarding Revising the Board's Continuing Education Provider Program**

Background

Currently the law gives the Board authority to revoke or deny a continuing education (CE) provider approval based on a review of course content and instructor qualifications submitted in an initial application process or through a subsequent audit. Once the provider is approved, they are not required to submit any forms concerning their course content or instructor qualifications during the biennial renewal. Approved CE Providers are also not required to inform the Board of any changes in the courses offered, new courses added or changes to instructors. The Board does not review course content or instructor qualifications after the initial approval of a CE provider. This current process lacks the authority to ensure the legislative intent that licensees continuously improve their competence and obtain continuing education related to their profession or scope of practice.

Suggested Language Change

To address the weaknesses in the current CE provider approval process, the suggested language will remove the Board's authority to directly approve and license providers. This language will also establish the Board's authority to accept CE credits from providers who have been approved or registered by a Board recognized "approval agency" or by an organization, institution, association or entity that has been recognized by the Board as a continuing education provider. Essentially, this change in the regulation will entrust the review and approval of continuing education providers, coursework and instructors to professional associations and other entities recognized by the Board.

The Board recognized "approval agencies" named in the suggested language have establish stringent requirements for CE provider applicants, including administrative and financial accountability, program development and implementation criteria, and established performance measures for determining program effectiveness. Many of these accrediting entities also perform periodic reviews of approved "sponsor" or providers. By accepting CE from "approval agencies" and accrediting entities, the Board will not be involved in the approval or maintenance of the CE providers. Rather, the Board will rely on the accrediting entities standards to ensure quality of CE provided to licensees.

While the Board will not be directly approving CE providers, the suggested language will give the Board authority to audit coursework and providers. The approving agency and the provider must be able to deliver the specific coursework and provider material when requested by the Board. This language will also give the Board authority to revoke the approving agencies Board recognition if they fail to ensure that the providers that they approve meet the requirements of the Board.

Staff believes that the suggested language addresses six of the eight CE Provider Issues that were identified in June of 2012: current scope of approval authority, review of coursework/content; expired provider approval; cite and fine for CE providers; CE credit for examination development; CE provider approval through an accrediting body. The only issues that have not been fully addressed in the language are the definition of self-study versus online learning and continued competency.

Recommendation

Staff recommends that the Committee conducts an open discussion as to whether the proposed language for the Board's Continuing Education program addresses the issue previously determined in June 2012. Specifically, discussion should include:

- Direction on the Board transitioning to an accreditation model in which the Board accepts CE from providers that are approved or registered by a Board recognized "approval agency";
- Agreement on the Board recognized "approval agencies" that have been named;
- Agreement on the definition of the term "best practices";
- Direction on additional activities that may be accepted for CE credit;
- Agreement or revision of the proposed language for Continuing Education Course Content, Board Recognized Approval Agencies and Continuing Education Provider Responsibilities;
- Agreement on the Board recognized continuing education providers that have been named.
- Initial discussion on further defining self-study and online learning.

Attachment

Attachment A: Suggested Language

ATTACHMENT A

Suggested Language for Continuing Education Requirements (Added language is in italics and deleted language is strikethrough)

ARTICLE 8. CONTINUING EDUCATION REQUIREMENTS FOR MARRIAGE AND FAMILY THERAPISTS, LICENSED CLINICAL SOCIAL WORKERS, LICENSED EDUCATIONAL PSYCHOLOGISTS, AND LICENSED PROFESSIONAL CLINICAL COUNSELORS

§1887. DEFINITIONS

As used in this article:

(a) A continuing education "course" means a form of systematic learning at least one hour in length including, but not limited to, academic studies, extension studies, lectures, conferences, seminars, workshops, viewing of videotapes or film instruction, viewing or participating in other audiovisual activities including interactive video instruction and activities electronically transmitted from another location which has been verified and approved by the continuing education provider, and self-study courses.

(b) A "self-study course" means a form of systematic learning performed at a licensee's residence, office, or other private location including, but not limited to, listening to audiotapes or participating in self-assessment testing (open-book tests that are completed by the member, submitted to the provider, graded, and returned to the member with correct answers and an explanation of why the answer chosen by the provider was the correct answer).

(c) A continuing education "provider" means an accredited or approved school, or an association, health facility, governmental entity, educational institution, individual, or other organization that offers continuing education courses and meets the requirements contained in this article.

(d) An “initial renewal period” means the period from issuance of an initial license to the license’s first expiration date.

(e) A “renewal period” means the two-year period which spans from a license’s expiration date to the license’s next expiration date.

(f) A board recognized “approval agency” for continuing education means any of the following entities:

(1) National Association of Social Workers (NASW)
(2) Association of Social Work Boards (ASWB)
(3) National Board of Certified Counselors (NBCC)
(4) National Association of School Psychologist (NASP)
(5) American Psychological Association (APA)

(g) "Best practices" means clinical, practical, and educational and/or research services based on appropriately documented and accountable professional and scientific materials. Services provided within the context of a defined professional role and within the boundaries of competence based on education, training, and appropriate professional experience/licensure.

Note: Authority Cited: Sections 4980.60, 4989.34, 4999.76 and 4990.20, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76 Business and Professions Code.

§1887.1. LICENSE RENEWAL REQUIREMENTS

(a) Except as provided in Section 1887.2, a licensee shall certify in writing, when applying for license renewal, by signing a statement under penalty of perjury that during the preceding renewal period the licensee has completed thirty-six (36) hours of continuing education credit as set forth in Sections 4980.54**,** 4989.34,-4996.22, and 4999.76 of the Code.

(b) A licensee who falsifies or makes a material misrepresentation of fact when applying for license renewal or who cannot verify completion of continuing education by producing a record of course completion, upon request by the board, is subject to disciplinary action under Sections 4982(b), 4989.54 (b), 4992.3(b), and 4999.90(b) of the Code.

(c) Licensed educational psychologists shall be subject to the license renewal requirements of this section as specified:

(1) Beginning January 1, 2012 and through December 31, 2012 licensees shall certify in writing, when applying for license renewal, by signing a statement under penalty of perjury that during the preceding renewal period the licensee has completed eighteen (18) hours of continuing education.

(2) On and after January 1, 2013 licensees shall meet all of the requirements of subdivisions (a) and (b).

Note: Authority Cited: Sections 4980.60, 4989.34 4990.20, and 4999.76 Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22 and 4999.90 Business and Professions Code.

§1887.2. EXCEPTIONS FROM CONTINUING EDUCATION REQUIREMENTS

(a) A licensee in his or her initial renewal period shall complete at least eighteen (18) hours of continuing education, of which no more than nine (9) hours may be earned through self-study courses, prior to his or her first license renewal.

(b) A licensed educational psychologist that renews his or her license beginning January 1, 2012 and through December 31, 2012 shall complete at least eighteen (18) hours of continuing education prior to his or her license renewal.

(c) A licensee is exempt from the continuing education requirement if his or her license is inactive pursuant to Sections 4984.8**,** 4989.44, 4997 or 4999.112 of the Code.

(d) A licensee may submit a written request for exception from, or reasonable accommodation for, the continuing education requirement, on a form entitled "Request for Continuing Education Exception – Licensee Application," Form No. 1800 37A-635 (Rev 3/10), hereby incorporated by reference, for any of the reasons listed below. The request must be submitted to the board at least sixty (60) days prior to the expiration date of the license. The board will notify the licensee, within thirty (30) working days after receipt of the request for exception or reasonable accommodation, whether the exception or accommodation was granted. If the request for exception or accommodation is denied, the licensee is responsible for completing the full amount of continuing education required for license renewal. If the request for exception or accommodation is approved, it shall be valid for one renewal period.

(1) The Board shall grant an exception if the licensee can provide evidence, satisfactory to the board that:

(A) For at least one year during the licensee's previous license renewal period the licensee was absent from California due to military service;

(B) For at least one year during the licensee's previous license renewal period the licensee resided in another country; or

(2) The board may grant a reasonable accommodation if, for at least one year during the licensee's previous license renewal period, the licensee or an immediate family member, including a domestic partner, where the licensee is the primary caregiver for that family member, had a physical or mental disability or medical condition as defined in Section 12926 of the Government Code. The physical or mental disability or medical condition must be verified by a licensed physician or psychologist with expertise in the area of the physical or mental disability or medical condition. Verification of the physical or mental disability or medical condition must be submitted by the licensee on a form entitled "Request for Continuing Education Exception – Verification of Disability or Medical Condition," Form No. 1800 37A-636 (New 03/10), hereby incorporated by reference.

Note: Authority Cited: Sections 4980.54, 4980.60, 4989.34, 4990.20(a), 4996.22 and 4999.76, Business and Professions Code; Sections 12944 and 12926, Government Code. Reference: Sections 4980.54, 4989.34, 4996.22 4999.76, Business and Professions Code.

§1887.3. CONTINUING EDUCATION COURSE REQUIREMENTS

(a) During each renewal period, a licensee shall accrue at least thirty-six (36) hours of continuing education coursework as defined in Section 1887.4. A licensee may accrue no more than eighteen (18) hours of continuing education earned through self-study courses during each renewal period.

(b) A marriage and family therapist and clinical social worker licensee who started graduate study prior to January 1, 1986, shall take a continuing education course in the detection and treatment of alcohol and other chemical substance dependency during their first renewal

period after the adoption of these regulations. The course shall be at least seven (7) hours in length and its content shall comply with the requirements of Section 29 of the Code. This is a one-time requirement for those licensees specified above. Equivalent alcohol and other chemical substance dependency courses taken prior to the adoption of these regulations, or proof of equivalent teaching or practice experience, may be submitted to the board upon request in lieu of this requirement; however, this coursework or experience shall not be credited as hours towards the continuing education requirements.

(c) Pursuant to Section 32 of the Code, a marriage and family therapist and clinical social worker licensee shall take a continuing education course in the characteristics and methods of assessment and treatment of people living with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) during their first renewal period after the adoption of these regulations. The course shall be at least seven (7) hours in length and its content shall comply with the requirements of Section 32 of the Code. This is a one-time requirement for all licensees. Equivalent HIV and AIDS courses taken prior to the adoption of these regulations, or proof of equivalent teaching or practice experience, may be submitted to the board upon request in lieu of this requirement; however, this coursework or experience shall not be credited as hours towards the continuing education requirements.

(d) Any person renewing his or her license ~~on and after January 1, 2004~~ shall complete a minimum of six (6) hours of continuing education in the subject of law and ethics for each renewal period. The six (6) hours shall be considered part of the thirty-six (36) hour continuing education requirement.

(e) If a licensee teaches a course, the licensee may claim credit for the course only one time during a single renewal period, receiving the same amount of hours of continuing education credit as a licensee who attended the course.

(f) A licensee may not claim the same course more than once during a single renewal period for hours of continuing education credit.

(g) A licensee who takes a course as a condition of probation resulting from disciplinary action by the board may not apply the course as credit towards the continuing education requirement.

(h) A licensee who attends the board enforcement case review training may be awarded up to six hours of continuing education every renewal cycle.

(i) A licensee who acts as a board subject matter expert (SME) for an enforcement case review may be awarded six hours of continuing education per renewal cycle. The continuing education hours earned by acting as a board enforcement case SME may be used to satisfy the law and ethics requirement.

(j) A licensee who participates in a board examination development workshop may be awarded six hours of continuing education every renewal period.

(k) Provisions of this section shall apply to licensed educational psychologists as follows:

(1) Beginning January 1, 2012 and through December 31, 2012 licensees shall complete at least eighteen (18) hours of continuing education prior to his or her license renewal, in accordance with subdivision (d) through (g).

(2) On and after January 1, 2013, licensees shall meet the requirements of subdivision (a) through (g).

Note: Authority Cited: Sections 4980.60**,** 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 29, 32, 4980.54, 4989.34, 4996.22 and 4999.76 Business and Professions Code.

§1887.4. CONTINUING EDUCATION COURSE CONTENT

(a) A provider shall ensure that the content of a course shall be relevant to the practice of marriage and family therapy, educational psychology, professional clinical counsel*ing*, or clinical social work and meet the requirements set forth in Sections 4980.54, 4989.34 4996.22, and 4999.76 of the Code. The content of a course shall also be related to direct or indirect patient/client care.

(1) Direct patient/client care courses cover specialty areas of therapy (e.g., theoretical frameworks for clinical practice; intervention techniques with individuals, couples, or groups).

(2) Indirect patient/client care courses cover pragmatic aspects of clinical practice (e.g., legal or ethical issues, consultation, recordkeeping, office management, insurance risks and benefits, managed care issues, research obligations, supervision training).

(b) A provider shall ensure that a course has specific objectives that are measurable.

(c) Upon completion of a course, a licensee shall evaluate the course through some type of evaluation mechanism.

(d) Courses shall have a syllabus which provides a general outline of the course. The syllabus shall contain at a minimum, the learning objectives for each course and a summary containing the main points for each topic.

(e) Courses shall include a mechanism that allows all participants to assess their achievement in accordance with the program's learning objectives.

(h) Each course shall have written educational goals and specific learning objectives which are measurable and which serve as a basis for an evaluation of the effectiveness of the course.

(i) Continuing education shall not reflect the commercial views of the provider or any person giving financial assistance to the provider.

(j) Courses must be pertinent and reflect best practices of marriage and family therapy, educational psychology, professional clinical counselor, or clinical social work.

Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4996.22, 4989.34, and 4999.76, Business and Professions Code.

§1887.41~~10~~. COURSE INSTRUCTOR QUALIFICATIONS

(a) A provider shall ensure that an instructor teaching a course has at least two of the following minimum qualifications:

(1) a license, registration, or certificate in an area related to the subject matter of the course. The license, registration, or certificate shall be current, valid, and free from restrictions due to disciplinary action by this board or any other health care regulatory agency;
(2) a master's or higher degree from an educational institution in an area related to the subject matter of the course;
(3) training, certification, or experience in teaching subject matter related to the subject matter of the course; or
(4) at least two years' experience in an area related to the subject matter of the course.

(b) During the period of time that any instructor has a healing arts license that is restricted pursuant to a disciplinary action in California or in any other state or territory, that instructor shall notify all approved continuing education providers for whom he or she provides instruction of such discipline before instruction begins or immediately upon notice of the decision, whichever occurs first.

Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4982.15, 4989.34, 4996.22 and 4999.76, Business and Professions Code.

§1887.5. HOURS OF CONTINUING EDUCATION CREDIT

(a) One hour of instruction is equal to one hour of continuing education credit.

(b) One academic quarter unit is equal to ten (10) hours of continuing education credit.

(c) One academic semester unit is equal to fifteen (15) hours of continuing education credit.

Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20, and 4999.76, Business and Professions Code. Reference: Sections 4980.54**,** 4989.34, 4996.22, and 4999.76, Business and Professions Code.

1887.51 BOARD RECOGNIZED APPROVAL AGENCIES

(a) The following are board recognized approval agencies:

(1) National Association of Social Workers (NASW)
(2) Association of Social Work Board (ASWB)
(3) National Board of Certified Counselors (NBCC)
(4) National Association of School Psychologist (NASP)
(5) American Psychological Association (APA)

(b) Approval agencies shall:

(1) Evaluate each continuing education provider seeking approval in accordance with the provider's ability to comply with the requirements of section 1187.7 of this Section.

(2) Maintain a list of the name and addresses of persons responsible for the provider's continuing education program. The approval agency shall require that any change in the responsible person's identity shall be reported to the approval agency within 15 days of the effective date of the change.

(3) Provide the Board with the names, addresses and responsible party of each provider upon request.

(4) Respond to complaints from the Board, providers or from licensees concerning activities of any of its approved providers or their courses.

(5) Review at least one course per year offered by each provider approved by the agency for compliance with the agency's requirements and requirements of the Board and, on request, report the findings of such reviews to the Board.

(6) Take action as is necessary to assure that the continuing education coursework offered by its providers meets the continuing education requirements of the Board; and

(7) Establish a procedure for reconsideration of its decision that a provider or a provider's course does not meet statutory or regulatory criteria.

(c) Substantial failure of a recognized approval agency to substantially comply with the provisions as set forth in this article shall constitute cause for revocation of recognition by the board. Recognition can be revoked only by a formal board action, after notice and hearing, and for good cause.

~~§1887.6 RECOGNIZED CONTINUING EDUCATION PROVIDERS~~

~~A continuing education course shall be taken from:~~

~~*(a) an accredited or approved postsecondary institution that meets the requirements set forth in Sections 4980.54(f)(1), 4989.34, 4996.22(d)(1), or 4999.76(d) of the Code; or*~~

~~(b) a board-approved provider with a valid, current approval as provided in Section 1887.7.~~

~~Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22 and 4999.76, Business and Professions Code.~~

§1887.7 CONTINUING EDUCATION PROVIDER RESPONSIBILITIES

~~(a) A continuing education provider must meet the board's course content and instructor qualifications criteria, as provided under this article, to qualify to become a board-approved provider.~~

(a) Persons or entities that provide continuing education shall be;

(1) an accredited or approved postsecondary institution that meets the requirements set forth in Sections 4980.54(f)(1), 4989.34, 4996.22(d)(1), or 4999.76(d) of the Code; or

(2) a continuing education provider that has been approved or registered by a board recognized approval agency for continuing education; or

(3) an organization, institution, association, or other entity that is recognized by the board as a continuing education provider. The following organizations are recognized by the board as continuing education providers:

a. American Association for Marriage and Family Therapists (AAMFT)
b. California Association for Licensed Professional Clinical Counselors (CALPCC)
c. California Association of Marriage and Family Therapists (CAMFT)
d. National Association of Social Workers (NASW)
e. Society for Clinical Social Work (SCSW)

(b) Providers shall ensure that each continuing education course complies with the requirements of Section 1887.4

(c) Providers shall furnish each licensee a record of course completion as defined in Section 1887.11.

(d) Each provider shall notify the approval agency in advance of the first time each new continuing education course is offered or presented.

(e) Providers shall maintain records of completion of their continuing education courses for four years.

(f) Providers shall have written procedures for determining the credit hours awarded for the completion of continuing education courses.

(g) Providers shall not discriminate against any individual or group with respect to any service, program or activity on the basis of gender, race, creed, national origin, sexual orientation, religion, or age, or other prohibited basis. Providers shall not require counselors/attendees to adhere to any particular religion or creed in order to participate in training, and shall not imply that those not adhering to the tenets presented in the training are mentally ill, deviant, or unacceptable in any fashion.

(h) Providers must be able to demonstrate that their programs train licensees to treat any client in an ethical and clinically sound manner consistent with:

(1) the code of ethics of their accrediting agency, approval agency or professional association; and

(2) the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(3) Providers must have written policies and procedures for grievance resolution and must respond to grievances form course attendees, regulatory boards, or their governing accreditation agency in a timely manner.

(4) Providers are responsible for meeting all applicable local, state and federal standards which

include, but are not limited to, the Americans with Disabilities Act.

(5) Upon written request from the approval agency or the board, relating to an audit of course material, each approved provider shall submit such materials as are required by the approval agency or the board.

~~(b) A continuing education provider shall submit a completed Continuing Education Provider Application (Form no. 1800 37A-633, Rev. 03/10), hereby incorporated by reference, remit the appropriate fees, and obtain a continuing education provider number from the board to become a board-approved provider.~~

~~(c) A provider may not apply for a new provider approval number within one year of an existing approval's expiration unless the provider has undergone a change of ownership.~~

~~(d) A provider approval issued under this section shall expire on the last day of the twenty-fourth month after the approval issue date. To renew an unexpired provider approval, the provider shall, on or before the expiration date of the approval, pay the two-year renewal fee set forth in Section 1816 of these regulations.~~

~~(e) When a provider's approval is expired, the provider may not present a course for continuing education credits for licensees of the Board of Behavioral Sciences.~~

~~(f) Board-approved provider numbers are non-transferable.~~

~~(g) The Board shall send a renewal notice, at least thirty (30) days prior to the expiration, to any continuing education provider approved by the Board, to the address of record for such provider.~~

~~Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76, Business and Professions Code.~~

~~§1887.8. REVOCATION AND DENIAL OF BOARD-APPROVED PROVIDER STATUS~~

~~(a) The board may revoke its approval of a provider or deny a provider application for good cause. Good cause includes, but is not limited to, the following:~~

~~(1) a provider is convicted of a felony or misdemeanor offense substantially related to the activities of a board-approved provider;~~

~~(2) a provider, who is a licensee of the board, fails to comply with any provisions of Chapters 13, 13.5, 14 and 16 of the Business and Professions Code or Title 16, Division 18 of the California Code of Regulations; or~~

~~(3) a provider makes a material misrepresentation of fact in information submitted to the board.~~

~~(b) After a thorough case review, should the board decide to revoke or deny its approval of a provider, it shall give the provider written notice setting forth its reasons for revocation or denial. The provider may appeal the revocation or denial in writing, within fifteen (15) days after receipt of the revocation or denial notice, and request a hearing with the board's designee. The revocation is stayed at this point. Should the board's designee decide to uphold the revocation or denial, the provider may appeal the decision of the board's designee in writing, within seven (7) days after receipt of the decision of the board's designee, and request a hearing with a~~

~~continuing education appeals committee appointed by the board chairperson. The hearing will take place at the next regularly scheduled board meeting, provided the appeal is received before the meeting is noticed to the public. It is at the discretion of the board's designee whether to stay the revocation further.~~

~~The continuing education appeals committee shall contain three board members, one public member and two members representing two of the three license types regulated by the board. The decision of the continuing education appeals committee is final.~~

~~Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76, Business and Professions Code.~~

§1887.9. COURSE ADVERTISEMENTS

A provider shall ensure that information publicizing a continuing education course is accurate and includes the following:

(a) the provider's name;
(b) the provider number, ~~if a board-approved provider~~;
(c) the statement "Course meets the qualifications for _____ hours of continuing education credit for LMFTs, LPCCs, LEPs and/or LCSWs as required by the California Board of Behavioral Sciences";
(d) the provider's policy on refunds in cases of non-attendance by the registrant; and
(e) a clear, concise description of the course content and objectives.

Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76, Business and Professions Code.

~~**§1887.10. COURSE INSTRUCTOR QUALIFICATIONS**~~

~~(a) A provider shall ensure that an instructor teaching a course has at least two of the following minimum qualifications:~~

~~(1) a license, registration, or certificate in an area related to the subject matter of the course. The license, registration, or certificate shall be current, valid, and free from restrictions due to disciplinary action by this board or any other health care regulatory agency;~~
~~(2) a master's or higher degree from an educational institution in an area related to the subject matter of the course;~~
~~(3) training, certification, or experience in teaching subject matter related to the subject matter of the course; or~~
~~(4) at least two years' experience in an area related to the subject matter of the course.~~

~~(b) During the period of time that any instructor has a healing arts license that is restricted pursuant to a disciplinary action in California or in any other state or territory, that instructor shall notify all approved continuing education providers for whom he or she provides instruction of such discipline before instruction begins or immediately upon notice of the decision, whichever occurs first.~~

~~Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4982.15, 4989.34, 4996.22 and 4999.76, Business and Professions Code.~~

§1887.11. RECORDS OF COURSE COMPLETION

Upon completion of a course, a provider shall issue a record of course completion to a licensee (e.g., letters of verification of attendance, certificates, gradeslips, transcripts) containing the following information:

(a) name of licensee and license number or other identification number;
(b) course title *and course number if applicable*;
(c) provider name and address;
(d) provider number, ~~if a board-approved provider~~;
(e) date of course;
(f) number of hours of continuing education credit; and
(g) signature of course instructor, provider, or provider designee.

Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76, Business and Professions Code.

§1887.12. LICENSEE AND PROVIDER COURSE RECORDS

(a) A licensee shall maintain records of course completion for a period of at least two (2) years from the date of license renewal for which the course was completed.

(b) A provider shall maintain records related to continuing education courses for a period of at least four (4) years. Records shall include:

(1) syllabi for all courses;
(2) the time and location of all courses;
(3) course advertisements;
(4) course instructors' vitaes or resumes;
(5) attendance rosters with the names and license numbers of licensees who attended the courses;
(6) sign-in sheets; and
(7) records of course completion issued to licensees who attended the courses.

(c) The board may audit the course records of a provider to ensure compliance with the board's continuing education requirements.

Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34,-4996.22 and 4999.76, Business and Professions Code.

~~1887.13 RENEWAL OF EXPIRED APPROVAL~~

~~A provider approval that has expired may be renewed at any time within one (1) year after its expiration upon all of the following:~~

~~(a) Filing an application for renewal on a form prescribed by the board.~~

~~(b) Payment of the renewal fee in effect on the last regular renewal date.~~

~~(c) Payment of the delinquency fee in effect on the last regular renewal date.~~

~~(d) Submission of a letter stating that no courses were presented while the provider's approval status was expired. If a course was presented during that time, the letter shall state that all participants have been notified that the provider's approval status at the time of completion of the continuing education was expired and that continuing education hours will not be disallowed by the Board if the provider renews within one (1) year after its expiration.~~

~~Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20, and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76, Business and Professions Code.~~

~~1887.14 TIME LIMIT FOR RENEWAL OF APPROVAL AFTER EXPIRATION; NEW APPROVAL~~

~~A provider approval that is not renewed within one year of its expiration date may not be renewed, reinstated, or reissued thereafter, but the provider may apply for and obtain a new approval if:~~

~~(a) No fact, circumstance, or condition exists that, if the approval were issued, would justify its revocation; and~~

~~(b) The applicant pays the fees that would be required if applying for approval for the first time.~~

~~Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22 and 4999.76, Business and Professions Code.~~

Board of Behavioral Sciences

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Memo

To: Continuing Education Program Review Committee **Date:** October 4, 2012

From: Kim Madsen, Executive Officer **Telephone:** (916) 574-7841

Subject: **Discussion Regarding Continuing Competency**

Background

Historically, as a condition of renewal, licensees have sought out coursework or training to satisfy continuing education requirements. It is thought that completion of the required coursework or training provides assurance of a competent practitioner. Yet, in recent years the discussion regarding the value of continuing education versus continuing competency has emerged.

A continuing education model is measured by time spent attending the course. The commonly used measurement is one hour of class instruction equals one continuing education unit (CEU). CEUs may be obtained either in person, through an online method, or through a self study method.

A continuing competency model calls for valuing activities on a variety of factors beyond time. Examples of measurement in a competency model include periodic examinations, assessment tools, or recertification by a specialty board. Proponents of the continuing competency model assert this model improves patient safety and outcomes.

Department of Consumer Affairs Healing Arts Boards

A majority of the boards within the Department of Consumer Affairs (DCA) use a continuing education model. Some of these boards may refer to the required hours as professional development units, continuing education, or continued competency. However, the gaining of these hours is similar to the continuing education model and also incorporates alternative methods to gain CEUs such as the publication of an article.

In January 1999, the Board of Podiatric Medicine implemented a continuing competency model by requiring its licensees to complete a specific competency in addition to continuing education hours. Doctors of Podiatric Medicine must complete 50 hours of approved medical education and one of the following competencies.

The Board of Podiatric Medicine attributes the decline in complaints to the implementation of the continuing competency model. In fiscal year 1999/2000 the Board of Podiatric Medicine received 195 complaints. In fiscal year 2010/2011 the Board received 90 complaints.

Other States

Effective January 1, 2011, Colorado required its behavioral health professionals to maintain continuing professional competency in order to renew or reinstate a license or certificate to practice in Colorado. The affected professionals include Licensed Marriage and Family Therapists, Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Social Workers, Licensed Addiction Counselors or Level II or Level II Certified Addiction Counselors. Prior to January 1, 2011, Colorado did not require continuing education or continuing competency for these behavioral health professionals.

Colorado's Continuing Professional Development Program (CPD) requires its licenses to complete a self-assessment survey and a learning plan. The learning plan is based upon the licensee's survey results. Throughout the renewal period the licensee engages and completes activities identified in the learning plan.

Upon renewal, the licensee submits documentation to demonstrate compliance with the CPD program. The documentation submitted is intended to be confidential and is not subject to discovery in a civil action against a licensee. However, the documentation may be used by the Board to determine if a licensee is maintaining continuing professional competency to engage in the profession.

Nevada requires its licensees to complete 40 hours of continuing education every two years. Oregon requires 40 hours of continuing education (six must be in law and ethics) every two years. Additionally, Oregon permits its licensees to earn continuing education in alternative methods such as supervision and professional publications.

Arizona requires its licensees to complete 30 hours of continuing education activities. In addition to attending courses, a licensee may claim continuing education for presentations (first time), attendance at board or committee meetings where the licensee does not address the board or committee, service on a board or committee, association activities, publishing activities, or in-service training.

Studies on Implementing a Continuing Competency Model

Studies related to the implementation of a continuing competency model have been ongoing since at least 2000. The Citizen's Advocacy Center (CAC) is one organization that has actively engaged in the discussion regarding continuing competency versus continuing education. Throughout the CAC's discussions five steps have emerged as steps that are the foundation to a continuing competency model. These steps are as follows.

1. Routine Periodic Assessment
2. Develop a Personal Plan
3. Implement the Personal Plan
4. Documentation
5. Demonstrate/evaluate Competence

Several questions within each of these steps emerge.

- Should the assessment be conducted by a third party or is a self assessment sufficient?
- What competencies need to be assessed; knowledge or clinical practice?
- Does the personal plan require approval prior to implementation?
- Will self certification demonstrate competency is additional documentation required?
- What will the Board do with the information?
- What information will be available to consumers?

One important consideration is the work setting of the Board's licensees. Review of the studies related to continuing competency centers around the medical professional such as nurses and doctors. The medical professional's work setting differs from the mental health professional setting. The medical professional work setting affords these professionals increased opportunities for activities that can be measured. For example, privileges in hospital or health care facility.

Often the mental health practice is independent and does not include close proximity of colleagues or supervisors to observe the mental health practitioner or provide feedback on their work. Thus, identifying activities that can be measured and are accessible to Board licensees would be a vital component to a continuing competency program for the Board. Potential activities that could be measured for a mental health professional may include the following.

- Supervision of an intern or associate
- Presentation or instruction of course related to the licensee's scope of practice or profession
- Participation on a professional ethics committee
- Passage of the law and ethics examination
- Completion of a course (other than a continuing education course) related to their profession
- Publication of an article or book
- Participation as a Subject Matter Expert for the Board (examination and/or enforcement)

Recommendation

Although the studies seem to focus on the medical profession, there appears to be some components of a continuing competency model that could be considered for the Board's CE program. The committee and stakeholders should conduct an open discussion regarding continuing competency. The committee and stakeholders should consider the following questions during the discussion.

1. Does the committee desire a continuing competency model?
2. Is it appropriate to eliminate the Board's traditional continuing education model and implement a continuing competency model?
3. Is it appropriate to consider incorporating components of the continuing competency model in addition to requiring continuing education (e.g. a hybrid model)?
4. If a hybrid model is appropriate, what activity or activities must the licensee complete in addition to the traditional continuing education model?

Attachments

A. Continuing Competence – Continuing Debate
B. Colorado Bill
C. MFT Workbook – Colorado
D. CAC Continuing Competence Proceedings 2011
E. CAC Implementing Continuing Competence
F. Board of Podiatric Continuing Competence Requirements

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CONTINUING COMPETENCE--*CONTINUING DEBATE*

"Currently no state medical board requires physicians to demonstrate their continuing competence to practice, and efforts to strengthen the requirements for relicensing physicians have been successfully opposed by professional organizations. As a result, many physicians continue for decades to practice medicine with little change from what they learned in medical school and hospital residency. States are stricter in testing the skills of motor vehicle drivers."

--Thomas H. Meikle Jr., MD, President, Josiah Macy Jr. Foundation, "States Must Act to Reform Medical Education," *The Journal of American Health Policy*, March/April 1992, Vol. 2, No. 2

"The issue of continuing competency assessment is gaining political force. . . . Boards, as the bodies responsible for licensing physicians, are increasingly going to have to respond to this concern. Or others will!"

--Mark R. Yessian, PhD, "How Can State Medical Boards Compete in the Quality Assurance Marketplace?," *Federation Bulletin*, Federation of State Medical Boards, Vol. 81, No. 2, 1994

"States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals. . . . The evidence that continuing education cannot guarantee continuing competence is sobering."

--*Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, December 1995, Pew Health Professions Commission

"What is the role of boards in ensuring continuing professional competence? Should boards regulate continuing education providers, or should this be the function of educational organizations and oversight bodies?"

--Kathleen Hamilton, Director, California Department of Consumer Affairs, speaking at Citizen Advocacy Center annual meeting, San Francisco, November 13, 2002 [*News & Views*, Citizen Advocacy Center, Fourth Quarter, 2002. Vol. 14, No. 4]

"It was more than 30 years ago, in the pages of the *Federation Bulletin*, that Robert C. Derbyshire, MD, wrote ' . . . whenever the subject of recertification or re-examination was brought up in almost any medical gathering it was greeted by an uncomfortable silence or open hostility.' I regret to say that during the past three decades the prevailing attitude in the profession toward a physician having to prove his continuing competency has changed little."

--Ronald C. Agresta, MD, FSMB President, "Maintenance of Competency: An Old Emerging Issue," *Journal of Medical Licensure and Discipline*, Federation of State Medical Boards, Vol. 89, No.1, 2003

"It's hard to say when the board will feel that they have gathered enough information and are ready to move ahead. . . . There always is something new that we need to learn about and consider before making a proposal."

--Neal Kohatsu, MD, Medical Director, Medical Board of California, "Maintenance of Competence: The Debate Heats Up," *Journal of Medical Licensure and Discipline*, Federation of State Medical Boards, Vol. 89, No. 1, 2003

"I have given a *lot* of thought to this and brought my staff, faculty (including the former CEO of the American Board of Medical Specialties), our faculty in podiatric medicine, and our colleagues at the National Board of Medical Examiners into the discussion. . . .

"First, you will never know how much we respect the California Board of Podiatric Medicine for being the first Board of any discipline, to our knowledge, to have made a true Maintenance of Competence requirement a legal requirement of licensure. The medical profession is many years away from attaining this enlightenment, if it ever happens at all. We are not aware of any State or country, anywhere in the world, where this is the law. Your Board has done the right thing, and we congratulate you. Your Board will be recounted as heroes in the history books, and I mean this honestly and literally."

--William A. Norcross, M.D., Clinical Professor of Family Medicine, and Director of the Physician Assessment and Clinical Education (PACE) Program, University of California at San Diego, April 2, 2010

HB09-1086 Continuing Competency for Behavioral Health Professionals Pro/Con

For the Health District of Northern Larimer County Board of Directors
February 24, 2009

Bill Title:	Continuing Professional Competency
Issue Summary:	The bill creates a requirement that certain behavioral health professionals regularly update their professional competency
Bill History:	01/08/2009 Introduced In House - Assigned to Health and Human Services + Appropriations 01/29/2009 House Committee on Health and Human Services Refer Amended to Appropriations
Date of Analysis:	February 18, 2009
Prepared by:	Jill Golke and Carrie Cortiglio

BILL SUMMARY

HB 1086 would require licensed clinical social workers, licensed social workers, licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, and Level II or Level III Certified Addiction counselors to maintain continuing professional competency in order to renew or reinstate a license or certificate to practice in Colorado. The bill is effective January 1, 2011. The bill authorizes the governing body that regulates each profession to develop "a continuing professional competency program that assesses the licensee's ongoing ability to learn, integrate, and apply the knowledge, skill and judgment necessary to practice the profession according to generally accepted industry standards and professional ethical standards." The bill directs the board of each profession to establish a continuing professional competency program that includes the following elements:

1) A self-assessment of the knowledge and skills of a professional seeking to renew or reinstate a license
2) Development, execution, and documentation of a learning plan based on the assessment
3) Periodic demonstration of knowledge and skills necessary to ensure a minimal ability to safely practice the profession

BACKGROUND

In Colorado, licensing for all mental health and substance abuse professionals is managed by the state's Department of Regulatory Agencies (DORA). DORA manages licensing for many professions, including pharmacists, dentists, and accountants. For mental health professionals, DORA currently oversees the process by which behavioral health practitioners obtain their original license to practice or have a license reinstated. For professions that have a continuing education requirement, DORA conducts audits of a set percentage of professionals to ensure those continuing education requirements are being met.

HB 1086 requires a demonstration of continuing competencies rather than continuing education. While continuing education requirements are typically a certain number of training hours per year, continuing competency requires professionals to create a learning plan to address areas that need improvement as indicated by their self-assessment. The goal of the plan is to be able to demonstrate a set outcome. The professional may attend continuing education trainings, receive supervision, and attend a course or workshops as part of their learning plan. The demonstration of competency may be teaching a course, providing a workshop, completing a report or achieving some other tangible outcome. The purpose of continuing competencies is to have a way to objectively demonstrate that the professional has met a goal of improving a skill area. Compliance with the new competency regulation would be monitored by DORA through random audits of learning plans at the time of licensure renewal or reinstatement. DORA would also review learning plans if there is a grievance against the licensed professional. The bill delineates that there will not be any retesting of the professional as a way to demonstrate competency. The bill also ensures that continuing competency plans are not subject to discovery in connection with a civil action against a professional. The records and documents could only be used by the DORA to determine whether a professional is maintaining continuing professional competency.

Colorado has no continuing education requirement of any kind for behavioral health professionals. In 2008, Governor Ritter asked DORA to consider a competency model for all professions regulated by DORA. The National Association of Social Workers Colorado Chapter , along with the Colorado Society for Clinical Social Work, Licensed Marriage and

Family therapists, Licensed Professional Counselors, Licensed Addiction Counselors, worked with DORA to draft a bill. All of the organizations who would be regulated by the bill testified in support of HB 1086 when it was heard by the House Health and Human Services Committee.

The National Association of Social Workers Colorado Chapter states that the bill would raise licensure fees to cover the cost of oversight by DORA. After the bill would be enacted, there would be an initial $15 at the first licensing renewal and then a $10 increase for subsequent renewals. The current renewal fees range from $160 - $200 depending on the license.

WHY IS THIS ISSUE IMPORTANT?

Colorado, along with New York and Hawaii, is one of three states that does not require continuing education for mental health professionals. Illinois, New Jersey and Connecticut do not require continuing education for psychologists, but do require it for other mental health professionals. The Community Mental Health and Substance Abuse Partnership Policy Committee has identified the lack of any continuing education requirement as a priority to be addressed. Like the medical field, which has long required continuing education, the field of behavioral health is rapidly evolving and the training providers receive when they are first granted licensure may quickly become outdated. As evidence-based practices become more widely disseminated, it is important that all providers have access to information on the latest treatments to better serve their clients and patients. For example, the Community Mental Health and Substance Abuse Partnership identified the need for providers to be able to competently treat people with co-occurring mental health and substance abuse disorders. Through the Partnership, many local providers have been trained on the best practices for treating these co-occurring disorders. The trainings have led to changes in policies, services offered, and practice approaches. Without partnering agencies educating themselves and requiring staff to participate in trainings, our community would not be as effective in treating these disorders.

REASONS TO SUPPORT BILL:

- Although some professionals may elect to pursue continued education on their own, not every member of the profession can be counted on to do so. This bill would ensure that all behavioral health professionals covered under the bill seek out continued training. As the field develops more evidence-based practices it is essential that all professionals remain current and competent in those practices.
- Continuing competencies can provide some consumer protection. By requiring ongoing learning, consumers will get some assurance that the behavioral health professional has at least worked on improving his/her skills. Most consumers might not think to ask if a clinician has been updating his or her training and this bill ensures that every member of the profession will be engaged in ongoing training of some type.
- Although there is not high quality research demonstrating a clear connection between better outcomes and continuing education, research on continuing medical education provides guidance on the efficacy of continuing education. The Agency for Healthcare Research and Quality reviewed the effectiveness of continuing medical education (CME). The review found that overall, CME was effective in achieving and maintaining an increase in knowledge, changing attitudes, improving skills, changing practice behavior and improving clinical outcomes. Effective approaches were live media, multimedia and multiple exposures to information.
- Requiring continuing competencies is the first step to improving the skills of professionals in Colorado. By using a competency model, professionals will need to assess their own skills, develop a plan for improvement and demonstrate competency in that area. While the correlation between ongoing training and changes in practice is imperfect, this process ensures that clinicians give some attention to updating their knowledge and skills. This is better than the current system of relying on professionals to improve skills on their own. While some professionals will certainly continue to train, not every member of the profession can be relied on to do so.

REASONS TO OPPOSE BILL:

- Opponents of the bill might question the efficacy of continuing education because there are not studies that robustly demonstrate that continuing education or competencies improves a mental health clinician's skills.
- Opponents of the bill might argue that mandatory competency requirements are unnecessary. Responsible practitioners will seek out additional training on their own. Clients can then decide for themselves if they want to seek services from a practitioner with additional training or continuing education.

- Concerns have been raised about the cost and time burden the bill might place on mental health providers. Clinicians will have to perform the self-assessment, cover the cost of any training and keep track of their progress on the competency areas identified. However, the bill is structured so that clinicians have a variety of means to choose from, including some fairly low cost options like keeping up with appropriate journals, in order to meet the competency requirements.

About this Analysis
This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. Analyses are based on bills or issues at the time of their consideration by the Board and are accurate to the best of staff knowledge. It is suggested that people check to see that a bill has not changed during the course of a legislative session by visiting the Colorado General Assembly web page at www.state.co.us/gov_dir/stateleg.html. To see whether the Health District Board of Directors took a position on this or other policy issues, please visit www.healthdistrict.org/policy.

About the Health District
The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves.

For more information about this analysis or the Health District, please contact Carrie Cortiglio, Policy Coordinator, at (970) 224-5209, or e-mail at ccortiglio@healthdistrict.org

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Dora

Department of Regulatory Agencies

Continuing Professional Development Workbook

Marriage and Family Therapists

Consumer Protection

Version 5/20/11

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Download the CPD Portfolio too! www.dora.state.co.us/mental-health/cc

FREQUENTLY ASKED QUESTIONS

Why is Continuing Professional Development being required?

In 2009 the Colorado State Legislature passed HB09-1086 entitled "Concerning Continuing Professional Competency of Certain Mental Health Professionals." This bill was introduced by four mental health professions (Addiction Counselors, Marriage and Family Therapists, Professional Counselors and Social Workers) and supported by DORA (DORA supports continuing professional development as a whole). Prior to the introduction of the bill, the mental health professional associations met to discuss support for this bill.

Who is required to participate?

Certified Addiction Counselors II and III
Licensed Addiction Counselors
Licensed Marriage and Family Therapists
Licensed Professional Counselors
Licensed Social Workers
Licensed Clinical Social Workers

Continuing Professional Competence *is* Professional Development. Many of the activities you are already doing on a day-to-day basis will count as credit.

When does the Continuing Professional Development program go into effect?

The Colorado Legislature mandated that the Continuing Professional Development program begin on January 1, 2011. This means participation will be required for the renewal cycle ending on August 31, 2011. Because the program starts during the current renewal cycle, the Board will allow licensees to complete the program requirements in two parts. The Self-Assessment, Practice Survey and drafting of the Learning Plan (Steps 1 – 2) must be completed before August 31, 2011. The implementation of the Learning Plan and all Professional Development Activities as well as their required documentation must be completed during September 1, 2011 to August 31, 2013. During a normal renewal cycle, Steps 1 - 5 would all be completed during the term of the cycle. For example, licensees will be required to complete Steps 1 – 5 during the renewal cycle that runs from September 1, 2013 to August 31, 2015.

How often do I need to participate in the Continuing Professional Development program?

You will need to attest upon each renewal that you have complied with the Continuing Professional Development program requirements. The Continuing Professional Development cycle coincides with the existing license cycle. You have the full timeframe between two renewal cycles to complete your Professional Practice Survey, Self-Assessment, Learning Plan, Professional Development Activities, Documentation, and Self-Evaluation. Typically the two-year timeframe begins and ends on odd numbered years.

How do I know that the Board won't evaluate me based on how I rate myself on the Professional Practice Survey or by the PDAs on my Learning Plan?

The purpose of the Continuing Professional Development program is consumer protection achieved by promoting high standards and quality assurance with respect to the Marriage and Family Therapy profession. The intent of the program is one of enrichment rather than remediation. The Board's objective is not to police the profession to discover the "bad apples."

The CPD program is based upon the assumption that both internal factors (interest, job promotions, etc.) and external factors (new technology, law, etc.) offer the opportunity to further develop knowledge and skill. Professional Development Activities develop your professional skill and must be directly relevant to your competence in the Marriage and Family Therapy field. PDAs provide new knowledge, skills or attitudes and sharpen or expand existing skills. Within these guidelines, you should be the judge of your learning goals and achievement. The Board will verify that you have completed the requirements of the CPD program by ensuring you have finished the Professional Practice Survey, Learning Plan, and the 40 PDH required each renewal cycle. In the event of an audit, the Board will also require you to submit documentation of the PDAs on your Learning Plan.

Is the information I submit through the Continuing Professional Development program confidential?

By statute, all the records of assessments or other documentation developed or submitted in connection with the CPD program are intended to be confidential and not subject to inspection by the public or discoverable in connection with a civil action against an LMFT unless specifically ordered by a Court. However, the records of assessments or other documentation developed or submitted in connection with the CPD program may be used by the Board for the purposes of determining whether an LMFT is maintaining continuing professional competency to engage in the profession.

Marriage and Family Therapists should be aware however there may be circumstances where information regarding your failure to participate in the program and any subsequent disciplinary action may be reported to the public or other inquiring parties. For the full statute text, refer to §12-43-506(2)(a), C.R.S.

DO NOT SEND YOUR PROFESSIONAL PRACTICE SURVEY, SELF-ASSESSMENT, SMART GOALS, OR SELF-EVALUATION TO THE BOARD.

These tools are provided to help you develop a meaningful Learning Plan. It is not necessary to share the details of these documents with the Board or DORA.

Can I share my Continuing Professional Development materials with my employer?

You may find it beneficial to use the CPD program as the basis of employee reviews and performance planning. You may choose to print, share or otherwise disclose this information at your will and discretion. Employers may not require you to disclose any CPD materials or make such disclosure a condition of employment. By statute, all the records of assessments or other documentation developed or submitted in connection with the CPD program are intended to be confidential and not subject to inspection by the public or discoverable in connection with a civil action against an LMFT unless specifically ordered by a Court. For the full text refer to §12-43-506(2)(a), C.R.S.

Why should I complete the Self-Assessment? I'm already competent.

Continuing Competency is an ongoing process. By completing the Professional Practice Survey and Self-Assessment you will be able to assess your strengths and identify the areas that you can enhance. This will enable you to develop a Learning Plan based on your personal learning needs. By developing your own Learning Plan, you have a greater chance of attaining the goals you have set for yourself.

How soon do I need to start my Learning Plan?

The Board recommends you draft your Learning Plan immediately after taking the Survey and Self-Assessment. The reason for this is that you are probably already focused on professional development and actively thinking about your

interests. Planning early is important to help you accomplish your goals. By starting early, you will also assure there is ample time to change your Plan if something comes up.

Can I change my Learning Plan?

Yes! Your Learning Plan is open to changes or updates during the licensure cycle. Your Learning Plan may not always be open to changes though. There are two events that may cause your Learning Plan to close after which you may not make changes or updates.

1. Once you renew your license, your Learning Plan will be locked. You will not be able to make changes to your previous Learning Plan. Because Continuing Professional Development is a requirement to renew your license, you must complete the Survey, Learning Plan and Documentation prior to renewing your license. When you renew your license, your Learning Plan will become subject to an audit for compliance.

2. All open Learning Plans will be closed to further changes or updates the day after the grace period ends for licensure renewal. That day falls on November 1 of odd numbered years.

The last day to change your Learning Plan for the current cycle is November 1, 2013 *or* the day you renew your license, whichever comes first.

How long should I keep my Documentation forms?

Board rule requires you keep your Documentation materials which may include certificates, programs, letters, presentations or copies, for at least 5 years after the expiration of your license (for example, if your license expired on August 31, 2013, you should retain your documentation demonstrating your CPD compliance until August 31, 2018). Because audits are rolling, this documentation may be required of you either before or after your renewal period. An audit of your participation in the Continuing Professional Development program occurring before your renewal date for which you are accruing credit will take into account the possibility that all professional development hours may not be completed at the time of the audit.

Can I take Continuing Education courses?

Yes, Continuing Education coursework can be counted toward your Professional Development Hours. In fact, you can use several types of coursework to accrue PDH. This includes academic coursework, attending conferences, lectures, and seminars. For a full list of eligible coursework activities, please refer to the PDA guidelines on page 10 of the Portfolio.

I have more than one role. Do I need to complete the Survey for each role I occupy?

No. It is only necessary to complete one section of the Survey. If you occupy more than one role, you do not need to take all respective sections of the Survey. Choose one of your roles to focus on for this CPD cycle. The choice of which role you will assess is based upon your sole discretion. You may choose a role that you do not currently occupy but which you would like to develop and achieve for promotion or professional development reasons. For example:
Sally works as a Professor as well as a Direct Service Provider at the clinic at the University. She does not need to take both the Educator and Direct Service Provider sections of the Survey. Sally decides to assess herself on the Direct Service Provider role as this is the area that most interests her.

If I am under stipulation or a Final Agency Order that requires me to complete continuing education coursework, can I count those hours towards my PDH accrual and CPD compliance?

No. Stipulations and Final Agency Orders utilize continuing education to remediate sub-standard practice or other practice act violations. This type of discipline is strictly separate from the requirement to demonstrate continuing professional development through the accrual of PDH. If you are under Stipulation or a Final Agency Order which requires you to complete continuing education coursework, you must do so *in addition to* the CPD program requirements.

What do I submit to DORA?

Not all CPD materials need to be submitted to DORA. Many are supplemental tools and for your private records. Use the list below to help navigate the program requirements:

1. Professional Practice Survey: Complete online through your user account at www.dora.state.co.us/mental-health/cc. DORA will track your completion of the Survey. Results will be compiled aggregately by license type. For this reason, you will not be able to access your results after you have completed the Survey. If you have not completed the Survey, you will not be able to renew your license.
2. Self-Assessment: Complete the Self-Assessment Worksheet provided for you in the CPD Workbook (page 7). Do not send your Self-Assessment to DORA or the Board. Retain your results for your personal records. The Self-Assessment is ***not*** subject to an audit of CPD compliance.
3. SMART Goals: Complete the SMART Goals Worksheet provided for you in the CPD Workbook (page 9). Do not send your SMART Goals Worksheet to DORA or the Board. Retain your results for your personal records. The SMART Goals Worksheet is ***not*** subject to an audit of CPD compliance.
4. Learning Plan: Complete the Learning Plan online through your user account. Your Learning Plan is subject to an audit to verify your participation in the CPD program. Completion of the Learning Plan is required in order to renew your license. If you have not completed your Learning Plan, you will not be able to renew your license.
5. Documentation: Retain the proper documentation of your PDAs according to the guidelines found on page 10 - 12 of the CPD Portfolio. It is suggested you complete the corresponding documentation after completing each PDA on your Learning Plan and save them in a file. Should you be selected for an audit, you will be notified at which point this documentation will be required for submission to DORA. Your documentation should match the details on your Learning Plan by the time you renew your license.
6. Self-Evaluation: Complete the Self-Evaluation Worksheet provided for you in the CPD Workbook (page 13). Do not send your Self-Evaluation Worksheet to DORA or the Board. Retain your answers for your personal records. The Self-Evaluation Worksheet is ***not*** subject to an audit of CPD compliance.

CPD Step:	Submit to DORA?	Where can I find it?	Subject to Audit?
Professional Practice Survey	Yes	Online User Account	No
Self-Assessment	No	CPD Workbook	No
SMART Goals	No	CPD Workbook	No
Learning Plan	Yes	Online User Account	Yes
Documentation	Yes (if selected for audit)	Retain according to Portfolio Guidelines on pages 10 –12.	Yes
Self-Evaluation	No	CPD Workbook	No

LMFTs should be aware however there may be circumstances where information regarding your failure to participate in the program and any subsequent disciplinary action may be reported to the public or other inquiring parties.

By statute, all the records of assessments or other documentation developed or submitted in connection with the CPD program are intended to be confidential and not subject to inspection by the public or discoverable in connection with a civil action against an LMFT unless specifically ordered by a Court. However, the records of assessments or other documentation developed or submitted in connection with the CPD may be used by the Board for the purposes of determining whether an LMFT is maintaining continuing professional competency to engage in the profession. For the full statute text refer to §12-43-506(2)(a), C.R.S.

Self-Assessment

Scope of Practice:

1. What other providers do you interact with regularly?

2. Describe the interaction(s):

Population Demographics:

3. What is the age range of the population in your practice?

4. What common therapeutic issues do you encounter?

5. Describe the diversity of the population in your practice (e.g. socioeconomic, cultural, ethnic, gender, religious, etc.)

Professional Strengths and Opportunities for Development:

6. Describe a work related situation from the past two years in which you felt confident or competent:

7. What skills contributed to the success of this situation? (You may want to create a learning goal to further develop this skill/strength.)

8. Describe a work related situation from the past two years that made you feel unsure or uncomfortable, or for which you were dissatisfied with the outcome:

9. What skills would you want to develop to better manage similar situations in the future?

10. If you are engaged in non-direct client care activities, describe your work:

11. Describe your record keeping practices:

12. What new developments in the profession are likely to impact my practice? Are there new techniques, technologies or skills I would like to add to my practice?

13. What new factors or developments in the social, psychological, governmental or environmental landscape are likely to impact my professional practice? What additional information might I need about these factors? (e.g., healthcare reform, Hurricane Katrina, the aging population, changes in insurance/reimbursement, increasing competition from similar professionals, etc.)

SMART GOALS

A professional development goal is a statement or question that describes what you want to learn. Your objective should follow the SMART Principle. Recording SMART Goals is not a requirement of the CPD program. It is a useful practice however, and may help you to achieve your professional objectives more quickly. Your professional development goals are always subject to your personal discretion.

Your SMART Goal may not be clinically based. You may discover that your learning needs are related to management, business, administrative or communication issues that are also an important part of your practice.

SMART Goals are **Specific**, **Measurable**, **Achievable**, **Relevant** and **Timed**. This doesn't mean they are unchanging! You may have established a SMART Goal at the beginning of the licensure cycle, but find your interest has changed and the objective is no longer "Relevant" to your practice. Or a family emergency may come up that means your goal is no longer "Timed" or "Achievable" during this cycle. Unforeseen circumstances, whether they are internally motivated or externally imposed, are a part of life. You should feel comfortable changing your goals as is appropriate for your circumstance both personally and professionally.

A common error is to formulate a Learning Goal that is too broad. When vague words or methods are used, the goal is left open-ended. For example, a broad Learning Goal may be "*Learn more about bullying*." In this case, it is unclear what the learner means by the statement "*learn more*." How will they know when they have reached their goal and what level must be achieved to "*learn more*"? This type of statement creates a vague Learning Goal that won't be easily assessed when the goal is achieved. If the Learning Goal is more focused, such as "*What are the primary differences in therapeutic approaches between boys and girls when addressing bullying and how can I apply them to my practice within 6 months*?" the learner will be able to determine when they have accomplished the goal by when they can successfully answer the question.

Vague Learning Statements	"SMART" Learning Statements
Learn more about bullying.	What are the primary differences in therapeutic approaches between boys and girls when addressing bullying and how can I apply them to my practice within 6 months?
Learn more about supervising and managing.	Within 12 months, identify 3 "best practice" approaches to managing licensed clinical social workers working in End of Life care settings.
Develop a lecture for marriage and family therapists on a martial stressor of older couples.	Within 12 months, develop a 2 hour lecture for marriage and family therapists regarding the effects Parkinson's Disease has on couples and their primary care givers.

SMART Goals

Specific:	Measurable:	Achievable:	Relevant:	Timed:
Your Learning Goal should present a clear picture of what knowledge or skill is desired. Consider stating your goal in the form of a question; this will help you identify a clear objective.	You should be able to determine when you have met your learning objective. Ensure your goal is not too vague or you won't know when you have achieved it.	Be realistic – ensure that you are able to complete your goal taking time, cost and support into consideration. Consider breaking a lofty goal into smaller steps so that it is not so overwhelming.	Your Learning Goal should be relevant to your learning needs and the needs of your practice.	Set realistic deadlines to achieve your goal. Begin by setting start and end dates. Time management is critical so it is important to focus on the activities of higher priority that will have a greater impact on your practice.

Identify your SMART Goals for this renewal cycle. Remember that a learning activity is something that you *DO* (i.e. *attend a Bullying workshop*). A SMART Goal is something you hope to achieve as a result of completing the learning activity (i.e. *identify the top 5 tips to give elementary students dealing with a bully*).

Goal 1:

Learning Activity:

Goal 2:

Learning Activity:

Goal 3:

Learning Activity:

*See the *PDA Chart* on in the CPD Portfolio.

Continuing Professional Development Learning Plan

Name:		**License Number:**	
License Type:	**LMFT**	**Address:**	
Role:	**DSP CS R E A/M**		
Version:	**01/01/2011 - 11/01/2013**	**Phone:**	
Completed:	**Yes / No**	**Email:**	

	Activity	Applied Hours	Total Hours	Planned Start	Planned End	Actual Start	Actual End	Documentation*
☐	Volunteer Service							☐ Yes
☐	Mentoring							☐ Yes
☐	Presenting							☐ Yes
☐	Supervision							☐ Yes
☐	Publishing							☐ Yes
☐	Coursework							☐ Yes
☐	Independent Learning							☐ Yes
☐	Group Learning							☐ Yes
	Plan Totals							

**Please note that several activities require you retain documentation of your activity completion (e.g. copy of presentation, syllabus, certificate of completion, etc.). Please be sure to review these documentation requirements and keep them on file for 5 years. In the event of an audit, these verification documents will be requested. By checking "Yes" I verify that I have retained the appropriate documentation per the guidelines in the current Continuing Professional Development Portfolio for my license type.*

The CPD Program is being implemented in stages for individuals who are licensed on or prior to April 30, 2011. Prior to the date you renew your license expiring August 31, 2011, you need to draft a Learning Plan. This initial Learning Plan is a simple draft of the Professional Development Activities (PDA) you may want to participate in during the next renewal period (running from September 1, 2011 to August 31, 2013). All licensees must update their Learning Plan prior to licensure renewal in 2013. At that time, the Learning Plan should reflect the Professional Development Activities the licensee actually undertook and all fields in the Learning Plan should be completed. Accordingly, the Learning Plan fields that ***are not*** required for renewal in 2011 are shaded in grey. These grey fields must be completed prior to renewal in 2013. You may begin accruing hours on or after July 1, 2011.

Glossary:

Activity: Indicate which Professional Development Activities (PDA) you undertook this renewal cycle by checking the box to the left of the Activity name. *Required field for renewal in 2011.*

Actual Start: The date you began that Professional Development Activity. This date may not occur in the future or prior to July 1, 2011. Please confirm that you have started the activity by adding the "Actual Start" date *on or after* the day you actually begin that activity. *Not a required field for renewal in 2011.*

Actual End: The date you completed that Professional Development Activity. This date may not occur in the future or prior to July 1, 2011. Please confirm that you have completed the activity by adding the "Actual End" date *on or after* the day you actually complete that activity. *Not a required field for renewal in 2011.*

Applied Hours: The number of hours you are applying to the CPD program requirement of 40 hours per two-year renewal cycle. Applied Hours must consider the 20 hour maximum accrual in a single activity. Your Total Hours may exceed the Applied Hours and may document more than 20 hours in a single activity. A total of 40 Applied Hours is required each two-year renewal cycle for the Learning Plan to be considered complete. *Not a required field for renewal in 2011.*

Documentation: Completed Professional Development Activities must be documented according to the guidelines set forth in the CPD Portfolio. A Learning Plan is not considered complete until the licensee has verified they have retained and can produce documentation of their activities if required to do so by the Board. *Not a required field for renewal in 2011.*

Planned Start: The date you plan to start that Professional Development Activity. This date must occur on or after July 1, 2011. *Required field for renewal in 2011.*

Planned End: The date you plan to complete that Professional Development Activity. This date must occur on or after July 1, 2011. *Required field for renewal in 2011.*

Total Hours: The number of hours you accrued in that activity. This may exceed the 20 hour maximum allowed during a given 2-year renewal cycle. Likewise, the sum of your Total Hours may exceed the 40 hours required each two year renewal cycle. This field is provided for those licensees that would like to track all the professional development they do that exceeds the Board requirement. *Required field for renewal in 2011.*

INDEPENDENT/GROUP LEARNING FORM

NAME:_____

Date	Resource	Topic Area	Summary of Activity

** Depending on which PDA you choose, your documentation guidelines may be different. The Independent/Group Learning Form only applies to the Independent or Group Learning PDAs. If you selected a different PDA, this form is not necessary for you to complete. Please refer to documentation Guidelines in the CPD Portfolio.*

Self-Evaluation

Evaluate the Professional Development Activity by considering the questions below. You may find it useful to evaluate each PDA after completing the activity as well as at the end of the CPD cycle, after completing all the activities on your Learning Plan.

How have your PDAs impacted your professional practice?

How will you apply any new knowledge?

** Do not submit your Self-Evaluation to the Board or DORA.*

Continuing Professional Development

Step One: Meaningful Assessment

Proceedings from a Citizen Advocacy Center Conference

June 22, 2011

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

Introduction

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

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

> Periodic assessment is the key to tailoring lifelong learning programs to the needs of individual healthcare professionals and to demonstrating continuing competence over the course of one's career. Assessment pinpoints the knowledge gaps that can be filled by continuing education or other professional development mechanisms. Assessment also is used to determine whether a practitioner competently applies his or her knowledge and skills in clinical situations….
>
> There are two key questions that have to be answered about assessment: who should be assessed and who should do the assessing…. The question of who should do the assessing is more difficult to answer. Self- assessment is the option many voluntary credentialing organizations and some regulatory agencies have written into their emerging competency or professional development programs. This approach is likely to be more acceptable to many professionals than third-party assessment. It appears to be, therefore, a comparatively painless way to introduce periodic assessment into the routines of professional careers.
>
> But, critics of self-assessment point out that it does not provide the same degree of public accountability afforded by third-party assessment. They also wonder about relying on a professional's judgments about their own strengths and weaknesses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

During the debate, these questions came up:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Assessment Program of the Commission on Dietetic Registration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What we learned from all this is

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

Where should we go from here?

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

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

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

Question: Have you considered making this mandatory for recertification?

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

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

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

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

Question: Have you analyzed the user population?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Assessment Program of the North Carolina Board of Nursing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question: What is your definition of "active practice?"

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

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

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

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

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

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

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

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

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

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

The Assessment Program of the National Certification Corporation

Fran Byrd, Director, Strategic Initiatives, National Certification Corporation

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

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

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

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

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

The assessment is a125-item multiple-choice computer-delivered tool based on the knowledge competencies for each specialty. The items are co-related with the competency categories on the certification exam and they are weighted to equal 50 hours of CE across all categories. The competency categories are different for each specialty, such as inpatient obstetric nursing, neonatal intensive care nursing, and the women's health care nurse practitioner specialty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As of May 2011, CSEC has examined 229.091 candidates with 2,749,092 standardized patients. We have five centers in Atlanta, Chicago, Houston, Los Angeles, and Philadelphia that run 5-6 days a week. We have 2 – 3,000 examinees a month, which is about 24 per day at each center. It costs about $1,100.00 per examinee.

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

We build our blueprint to relate to system, gender, age, and acuity. Every exam involves 12 encounters, which take 25 minutes apiece – up to15 minutes with the standardized patient and 10 minutes to write a patient note.

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

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

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

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

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

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

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

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

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

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

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

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

Question: Please say something more about assessing practice teams.

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

Question: What do you think about assessment using simulations?

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

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

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

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

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

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

Discussion: Points to Consider When Developing an Assessment Program

Cynthia Miller Murphy, Executive Director, Oncology Nursing Certification Corporation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question: What percent of oncology nurses are certified?

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

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

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

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

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

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

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

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

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July 2006

Implementing Continuing Competency Requirements for Health Care Practitioners

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

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

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FOREWORD

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

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

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

Joyce Dubow
AARP Public Policy Institute
July 2006

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

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

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EXECUTIVE SUMMARY

I. BACKGROUND

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

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

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

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

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

II. PURPOSE

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

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

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

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

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

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

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

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

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

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

III. METHODOLOGY

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

That foundation is supplemented with:

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

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

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

IV. FINDINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

- Eliminate continuing education requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In support of these two recommendations, the IOM stated:

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

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

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

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

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[21]Ibid, 111.

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

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

II. PURPOSE

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

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

- What current methodologies and techniques assess and document continuing professional competence?
- Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?
- How frequently should licensees be required to demonstrate their competence?
- Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?
- How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of private specialty certification boards? Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?
- How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?
- Who should pay the costs of continuing competency assurance? Licensees? The state?

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

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

III. METHODOLOGY

Overview

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

That foundation is supplemented with:

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

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

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

Literature Review

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

Personal Communications, Internet Web Sites, and Sponsored Sources

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

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

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

IV. FINDINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Professions Develop Self-Assessment Tools

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[46]www.nabp.org.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[55] www.abpath.org.

[56] www.abns.org.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[66] www.abns.org.

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

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

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

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

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

- State boards retain full authority to enforce all regulatory requirements.
- Reliance on deemed status is subject to full and open public comment.

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[67] www.nursecredentialing.org.

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

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

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

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

- Surveys conducted by deemed status organizations are validated periodically.

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

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

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

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

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

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

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

[71]Conversations with FSMB staff.

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

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

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

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

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

[74]Conversation with Diane Marshburn.

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

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

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

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

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

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

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

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

[78]See www.NABP.net.

[79]See www.ABIM.org.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

- Eliminate continuing education requirements.

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

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

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

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

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

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

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

> **RECOMMENDATION 1: State laws and implementing rules and regulations should require that, as a condition of relicensure, licensees participate in continuing professional development (CPD) programs approved by their respective boards. CPD programs must include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence. Licensees should be permitted to demonstrate continuing competence through a variety of legally defensible, psychometrically sound, evidence-based methods.**
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> **RECOMMENDATION 2: Demonstrations of continuing competence should cover the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure**.

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

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

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

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

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

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

APPENDIX I

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

The expert panel comprised the following individuals:

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

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

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

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

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

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

APPENDIX II

ANNOTATED BIBLIOGRAPHY
CITIZEN ADVOCACY CENTER PUBLICATIONS
CONTINUED COMPETENCY ASSESSMENT AND ASSURANCE

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

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

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

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

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

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

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

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

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Information on Continuing Competence

The Law

Section 2496 of the State Medical Practice Act specifies the continuing competence requirements for doctors of podiatric medicine (DPMs) and authorizes the Board of Podiatric Medicine to adopt regulations to ensure the "continuing competence of persons licensed to practice podiatric medicine":

At each renewal, a DPM must certify compliance with one of the following under penalty of perjury, subject to audit.

1. passage of an exam administered by the board (within past 10 years).
2. passage of an exam administered by an approved specialty board (past 10 years).
3. current diplomate, eligible, or qualified status with an approved specialty board (past 10 years).
4. recertification by an approved specialty board (past 10 years).
5. completion of an approved residency/fellowship (past 10 years).
6. granting/renewing health care facility privileges (past 5 years).
7. completion of an extended course of study approved by the Board (past 5 years).
8. passage of Part III exam administered by the National Boards (past 10 years).

The board's regulations require each licensee to complete at least fifty units of approved continuing medical education during each 2-year license period. At least twelve units must be in subjects related to the lower extremity muscular skeletal system. ***All courses must be scientific in content, and relate directly to patient care.***

Licensees must maintain records of continuing education course attendance for a minimum of 4 years, in case of an audit.

What Courses Are Acceptable for Credit?

The following courses are approved for continuing medical education credit, providing they are scientific in content and relate directly to patient care:

1. Programs approved by the California Podiatric Medical Association or the American Podiatric Medical Association and their affiliated organizations
2. Programs approved for Category 1 credit of the American Medical Association, the California Medical Association, or their affiliated organizations, and programs approved by the American Osteopathic Association, Osteopathic Physicians and Surgeons of California, or their affiliated organizations;
3. Programs offered by approved colleges or schools of podiatric medicine, medicine, and osteopathic medicine;
4. Completion of an approved residency or fellowship program (credited for 50 hours of continuing medical education).

Programs not included under items 1-4 above may be approved by the Board of Podiatric Medicine following an application and review process. Courses approved by application to the board must meet several criteria, including documentation that the course material is scientific in

content and directly related to patient care. ***Courses in other subjects such as investments, tax planning, practice management, and risk management are not approved for credit.***

Note: A maximum of one-third of continuing education hours may be satisfied by teaching courses offered by an approved continuing education provider.

Waivers

The board may temporarily waive these requirements. A waiver may be granted **only** for reasons of health, military service, or undue hardship. A waiver must be applied for on a form provided by the board, and must be approved prior to issuance of the license renewal.

A temporary waiver permits an additional two-year license period for completion of deficient requirements, which must be documented at the following license renewal. If these are not completed, a license renewal will not be granted.

Any licensee granted a temporary waiver may not be granted another temporary waiver at the next license renewal. (California Code of Regulations Section 1399.678(e))

Random Audit

The Board of Podiatric Medicine annually audits a random sample of DPMs for compliance. Licensees selected for audit must provide documentation of compliance. Licensees must maintain records of continuing education course attendance for a minimum of 4 years, in case of audit.