



Assisting public members and the health professional oversight bodies on which they serve

This document contains Friday's proceedings from our 2010 annual meeting, held on Thursday and Friday, November 11 – 12, 2010, in Washington, D.C. Although this is not a verbatim transcript of the speakers' remarks and the question and answer sessions, it is a faithful rendition of what occurred.

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CONTINUING COMPETENCE

INTRODUCTION

Continuing competence is another longstanding priority for CAC. We have been pleased to see recommendations from several prestigious Institute of Medicine committees that advocate more meaningful assessment and demonstration of current competence as a condition of re-licensure and recertification. One such recommendation reads:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care, as defined by the five competencies in this report, through direct measure of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods.

Other committees have critiqued reliance on mandatory continuing education and recommended significant changes in the way it is delivered. One report we will hear about later this morning is entitled, *Redesigning Continuing Education in the Health Professions*. Part of the justification for this report's recommendations reads:

Licensure and certification processes should reward successful demonstration of maintenance of competence. Additionally, certification should require a minimum standard of practice-based learning to promote the identification and solution of practice-based needs. Licensure should require demonstrated use of learning portfolios with documented needs assessment.

This is not just learning portfolios, but portfolios tailored to an individual's skills, practice and learning needs.

Keynote: The Future of Regulation

Mark Lane, Vice President of Professional Standards and Assessment, Federation of State Boards of Physical Therapy

I'm not going to talk specifically about scope of practice or continued competence, but about regulation in general – what it is, where are we headed, and what can we do about it. Certainly, scope of practice and continuing competence issues play a significant role in the future of regulation.

In order to understand where licensure is heading, we need to understand what licensure is. Here are some things licensure may be:

- **A public policy exercise of the state's police powers.** Is licensure designed to protect the public? Does it protect the public? Or, is it designed to do something entirely different? Is licensure a legalized monopoly to practice a profession? That certainly is an aspect of what licensure is.
- **A system of standards for entry into a profession.**
- **A system of standards for continued practice in the profession.** This raises questions about continued competence.
- **A system for removing impaired or incompetent providers from practice.** How do we identify whom to remove and decide how they should be removed?
- **A legal way to deter entry into a profession.** We may not like it, but licensure does deter entry.
- **A mechanism to protect licensees from competition.** We may not like it, but licensure does do that.
- **A means to gain access to third-party reimbursement.**
- **A means to establish and enhance the prestige of the profession.** We have many professions trying to obtain licensure for status reasons, even when there is no evidence of potential harm to the public.
- **A means to create a market for new academic disciplines.**

There are environmental factors that are influencing the future of regulation:

- **Limited access to healthcare is creating many problems.**
- **Decreasing state budgets which force distorted prioritization by regulators because there aren't the funds to discipline everyone who should be disciplined.**
- **Increasing deficits that force states to cut costs. One way to cut costs is to eliminate licensing boards.**
- **Economic recession, which is helping to drive regulation.**
- **The aging population.**
- **Technology, which changes the ways care is delivered.**

- **Professional associations, which promote their particular agendas and lobby the legislatures.**
- **The public.**
- **National healthcare reform.**

These and other environmental factors compete with each other and regulators are pulled in many different directions. Whoever wins the tug of war will direct the future of regulation.

David Montgomery of the Nebraska Department of Health made a comment I'd like to repeat here:

Our present professional regulatory system is a patchwork resulting from centuries of unsystematic legislation, band-aid fixes, and ad hoc changes. It is marginally effective, but also inefficient, needlessly expensive, inconsistent, and confusing to the public.

Do you agree? Is this true in your experience? If yes, we need to do something about the system. "The best way to predict the future is to invent it," according to Alan Kay, one of the pioneers in computer science. It says we own the future. Our tendency as regulators is to sit back and let things happen to us, but we need to invent the future.

What does it mean to be an inventor? First, we have to change the way we regulate. If we want things to change positively, we can't keep doing the things we have always done. If want things to get worse, we can sit back and let it happen.

If we are inventors as regulators, what qualities do we need to have?

- **Creativity.** Are we thinking outside the box?
- **Open-mindedness.**
- **Ability to listen.**
- **Willingness to change.**
- **Ability to learn from our mistakes.**
- **Proactivity, rather than reactivity.**
- **Perseverance.**
- **Willingness to question assumptions.**
- **Ability to buck the norm, to ask questions.**

We can all demonstrate these qualities of inventors. We can invent a regulatory future. Public members, licensee members and administrators alike need to stir the pot, to ask questions.

We have two choices. One is to continue on the current regulatory path, allowing things to happen to us. The alternative is to change the face of regulation and be inventors of the future.

What will happen if we stay on the current regulatory path?

- **Continuing scope of practice battles,** where it is the public who loses because decisions aren't based on data. They are based on economics and politics and influence.
- **Reactive regulation.** Should we be regulating in reaction to events, creating a hodge-podge of laws that aren't a cohesive guideline to good practice? Our system is currently complaint-based. This shouldn't be the only determinant of good practice. Moreover,

the complaint system waits until the harm has been done. Shouldn't our approach be to promote good practice so we don't have complaints coming in?

- **Discipline-based regulation.** Does punishment change behavior? Does it work in the public interest?
- **Unenforceable and ineffective regulations.** As an example, most jurisdictions have a supervision ratio for physical therapists vs. physical therapy assistants. The ratio varies from jurisdiction to jurisdiction. It doesn't make sense. What if I am supervising two physical therapy assistants and I get sick or go on vacation? Does that mean the patients cannot get treatment? It's all arbitrary and not based on any evidence. The real concern is whether the physical therapist is a good supervisor, not the ratio. Are our regulations really promoting good care and preventing harm, or are they arbitrary?
- **Little assurance of ongoing clinical competence.** We are at the tip of the iceberg in dealing with continued competence. We are just moving from continuing education to thinking about competence. We are far from impacting and demonstrating competence and influencing patient care.
- **Protection and promotion of the profession.** I hear members of licensing boards and professional associations talk about the battles they are fighting with one or more groups. Why are we talking about battles? Shouldn't we be concerned about the patient and creating a system of regulation and service that is in the best interest of the patient? We need to change the dynamic.
- **Regulation based on assumptions vs. evidence.** Oftentimes our regulations inhibit good practice and may contribute to problems with access.
- **Restriction of mobility.**
- **Lack of collaboration between disciplines.**

What might happen if we do not change our regulatory path?

- **Scope of practice decisions would no longer be made by the professions.** The ideal would be an impartial commission that decides based on what would be best for the public.
- **Boards will be deemed ineffective and be eliminated.** They may be combined, stripped of authority, or nationalized.
- **Continued competence will be mandated and it won't necessarily be a good system.**
- **Licensure requirements will be reduced.**
- **There will be a mandated focus on outcomes.**
- **There will be stricter requirements for sunset review.**
- **There will be an increase in public members and fewer licensee members.**
- **There will be forced licensure compacts to improve mobility within the United States and globally.**
- **Elimination of licensure altogether** if we cannot justify what we are going.

What might happen if we change the face of regulation?

- Interdisciplinary scope of practice decisions.
- Proactive rather than reactive regulation.
- Just Culture, which recognizes that people make honest mistakes.
- Education and promotion of quality, as opposed to just trying to prevent bad care.
- Peer Review.
- Continuing Competence.
- Encourage good practice rather than simply punishing bad practice.

Effective regulation does not inhibit good practice. It is evidence-based. It involves collaboration between disciplines for the greater good. It is proactive. Regulators play an active role in promotion of quality and remediation. Effective continued competence measures are in place. Regulation is part of the solution *vis a vis* access to quality healthcare.

How do we get there?

- **Collect the data.** We are doing a bad job now. We should have the capacity to do data analysis of our licensees to find out what the issues are.
- **Collaborate.** Professions and boards need to work together.
- **Change the framework** from a punitive reactive system to a prevention system.
- **Expand our perspective.**
- **Become inventors.**

Our choices are to continue on our current regulatory path, or to change the face of regulation. I suggest that we work together to do the latter. What leadership competencies would allow us to do this?

- External awareness
- Strategic thinking
- Innovation
- Entrepreneurship
- Leading transformation
- Leadership vs. management

Not everyone on a licensing board will have all these skills. That's why you are a team. Here is another quote from David Montgomery:

As part of healthcare reform, a major national conversation is needed over the effectiveness and efficiency of this system, including licensing, private certification, and enforcement. Such a conversation could lead to reforms that would streamline and modernize licensing practices. At present, there is no sign that this will occur.

It is up to us to change the face of regulation. Invention involves creativity, open-mindedness, willingness to change, learning from our mistakes, being active rather than passive, and perseverance. These are the qualities you need to have on your board to be inventors of the future of regulation.

Is your board made up of inventors? Do your board meetings facilitate invention and the creation of a new future, or do they deal only with the agenda?

I challenge you to create an environment where you help create the future of regulation. We can work together to do that. As Margaret Wheatley wrote,

To be responsible inventors and discoverers, we need the courage to let go of the old world, to relinquish most of what we have cherished, to abandon our interpretations of what does and what does not work. We must see the world anew.

That is our challenge as we deal with scope of practice and continued competence. We need to get out of our comfort zones and start changing the regulatory future.

Comment: There is a provision in the healthcare reform bill saying if a professional gets recertified every two years, he or she is exempt from some data collection.

Comment: In my observation, one of the distinguishing characteristics of effective boards embedded in effective organizations is that there is time set aside for reflective discussion at every board meeting. They challenge the way they do business as a board and the way they do business as an organization. In other words, they exhibit and foster many of the characteristics you mentioned.

How Will the Institute of Medicine’s Report “*Redesigning Continuing Education in the Health Professions*” Impact Health Professional Regulatory Boards?

Lucinda Maine, Executive Vice President and CEO, American Association of Colleges of Pharmacy

The work of the IOM Committee on Planning a Continuing Health Care Professional Education Institute needs to be considered together with the work of three other entities. The first of these was research funded by the Macy Foundation. Two key priorities for the Macy Foundation are (1) inter-professional education and (2) maintaining practitioner competence to care for people throughout their professional lifespan. The Macy researchers concluded that the current reliance on continuing education (CE) is insufficient to achieve the second priority. They were particularly concerned about CE in medicine because of what they perceived as commercial biases in its design and delivery. That study group recommended the creation of the IOM committee on which I served and the Macy Foundation provided support.

The Macy Foundation also supported two other pieces of work. One was a study by the Association of American Medical Colleges and the Association of Colleges of Nursing that looked at CE and professional development in those two professions. The fourth piece of work was an economic analysis of the enterprise of CE and continuing professional development.

The IOM committee I served on was charged to review CE of healthcare professionals and to consider specifically a recommendation arising from the first analysis of nursing and medicine to create a national inter-professional continuing education institute to advance the science and the practice of CE.

The committee worked for approximately a year and involved three face-to-face meetings of a very diverse panel. There were two public workshops, extensive literature reviews, and external review of the report and its recommendations.

The committee acknowledged the importance of CE across the lifespan to help professionals stay up-to-date. There was agreement that quality care of the future depends upon the functioning of inter-professional teams. Those teams are going to have different compositions based on practice site and patient needs, but that is the wave of the future. However, we now do uni-rather than multi-professional licensure and certification.

The committee agreed with many others that there are flaws in the way we are currently financing, regulating, conducting and evaluating CE. We agreed that current regulatory requirements are insufficient. There is room for conflicts of interest and bias in the financing CE, but a lot has been done to address this problem.

We talked about the research that is needed to move the enterprise forward. Even though we can draw on the literature on CE and the professions, and we know that the didactic learning method is not optimal for adult learners, we don't know a lot about what more effective models might be, especially for teams of practitioners. We are not currently anywhere near team-based learning at the point of care.

Self-assessment and selecting the right CE program is a very immature science.

The committee embraced continuing professional development as the philosophy and the practice underpinning a better system for keeping our professionals at the cutting edge of their clinical care abilities. The current system is too disaggregated and there is no leverage for change.

We evaluated different scenarios about what could create a better system. One alternative considered was to create a federal agency. Another was a purely private entity composed of professional associations. We considered a coalition involving quality improvement organizations.

Ultimately, we recommended creating a public-private professional development institute that would bring all stakeholders together in support of a nationally coordinated system for professional development. We recommend some initial federal investment, but recognized the need to build a financial model that involves financial support from a variety of sources. The institute would have a board and a structure, but there would also be a variety of councils and ad hoc committees to do the work.

So, our first recommendation was that the Secretary of HHS should commission a planning committee to develop a plan for a public-private continuing professional development institute. This recommendation was made a couple of months before the passage of national healthcare reform, which calls for the creation of multiple offices, agencies and commissions. Our IOM recommendation is likely to take a back seat, but the National Health Workforce Commission called for in the Affordable Care Act could potentially address some of the recommendations in the IOM report.

The institute should help advance what we know about continuing professional development, help to guide and influence regulation across jurisdictions, and professions, address issues associated with financing CE and continuing professional development. The original Macy Foundation report recommending an institute documented the financing of medical CE, but there is little data for other professions. There is also a need for research into the science of CE and professional development.

The goals of the institute include creating a stronger scientific foundation for CE and continuing professional development. This means collecting and analyzing data, or creating a framework for other organizations to conduct data collection, analysis and measurement. Research is needed to identify meaningful measures of practice performance and quality. Electronic health records may facilitate the meaningful measurement of quality in ways we haven't be able to do before.

The committee believed that the institute could help inform regulation nationally, even if regulation continues to be state-based. In pharmacy, there is already a National Association of Boards of Pharmacy and a model pharmacy practice act.

How would continuing professional development be funded? Perhaps employers and practitioners themselves will need to bear more of the expense. Responsibility should be shared by all of the stakeholders.

One of the principal rationales for a national public-private institute is that we are committed to changing the model of patient care to an inter-professional model. Educators have a responsibility to educate future clinicians to work effectively in teams. Early in 2011, pharmacy, medicine, nursing, dentistry and public health will release a set of core competencies for inter-professional education involving these disciplines.

It may be productive to host an annual symposium, perhaps with a partner such as CAC, to synthesize the learning across professionals and energize and advance the enterprise. This would benefit of licensing boards and certifying bodies by assembling a collection of best practices that accelerate learning and improve the delivery of education, the regulation of practice, and the delivery of patient care.

Questioner: I am a public member in the state of Pennsylvania. I am surprised you said there is little research into educational methods other than didactic. Looking at how people on the cutting edge are trained now, some of the techniques are simulation, partial-task training, human patient simulators, gaming, triage scenarios for trauma, virtual reality, joystick-controlled learning, smart phone applications that offer just-in-time training, scenario-based cases, team ratings, video replay, cognitive task analysis, mentoring, and rotating skill stations.

Maine: We talked about everyone of those except the smart phone application, but not in any level of detail. The general consensus was that there is good evidence that there are a variety of different approaches. According to the Department of Education, blended learning appears to be the most effective – i.e., some didactic and some active learning via the tools you mention. Also, online learning appears to be more effective than the traditional model of sitting in a lecture hall and being lectured to. A complicating factor is that many entities that provide active learning are not approved by state regulatory boards so wouldn't satisfy regulatory requirements.

Questioner: There are continuing professional development activities underway within some specialty societies. This is the driver of continuing professional development within the medical professions. There has been a lot of attention paid to the various modalities of CE and other professional development and measurement activities that are part of maintenance of competence. This will undoubtedly be the primary way physicians will demonstrate to licensing authorities and others that they are maintaining their professional competence.

Maine: Maintenance of certification in medicine was on the table as an extremely important model. The problem is that only about three percent of pharmacists are board-certified, so we can't use maintenance of certification the way medicine is using it, and that is true in other disciplines also.

Questioner: Professional development must take place in the practice setting and not in a lecture hall. Mandatory CE is a big source of resort and cruise business in the US. Boards are asking people for contact hours, with little attention to the content of those hours. Did the committee address the role of licensing boards as the demand structures to drive the desired change?

Maine: It was clearly understood that state mandates for CE units are the leading driver of practitioner behavior today. Most licensed professionals have those requirements. Nobody knows what would happen if they went away and nobody is recommending that the requirements and the regulatory oversight go away. But, we did talk about the probability that workplace learning is the most effective model.

Questioner: Please elaborate on the topic of funding by private sources, particularly with respect to pharmaceutical companies, which I think are pernicious when I see their ads on television. What circumstances would make it okay for pharmaceutical companies to be funding CE?

Maine: I agree. There is a difference between marketing activities, which are regulated by the FDA (including all the pernicious advertising on TV) and continuing education grant support. I administered CE

earlier in my career and AACCP offers CE credits at our annual meetings. I think the point made by the economist on the IOM committee was that there is absolutely potential for wrongdoing and ample evidence of it occurring, but if the accreditation framework for the providers of CE and the regulatory framework for the consumers of the CE have adequate safeguards, then wrongdoing shouldn't occur. The situation has improved and many providers have left the business. There has been some creative thinking, for example, finding ways to demonstrate that what is learned in CE is applied to patient care.

Comment: I am the current President of the National Board for the Certification of Hospice and Palliative Care Nurses and the President of the Alliance of Hospice and Palliative Nursing. My comment goes to the recommendation related to inter-professional models. We are very proud that the American Academy of Hospice and Palliative Physicians and the Hospice and Palliative Nurses Association have a combined conference every year. The conference includes social workers, physicians, registered nurses, administrators, nursing assistants, and advanced practice nurses. They not only attend, they are also presenters. All the professions benefit from the presentations and the networking that goes on.

Maine: The Society of Critical Care Medicine is another organization that is moving in that same direction. We need to foster this kind of collaboration and to find ways to make the documentation of CE as inter-disciplinary and user-friendly as possible.

Comment: I am a public member of a medical board and a public member of the Accreditation Council for Continuing Medical Education (ACCME). As a sociologist, I am very skeptical about pharmaceutical companies and am suspicious of the research they fund. However, one of the things that ACCME has done is to require in its accreditation standards at least a symbolic separation between pharmaceutical company funding and what is actually taught in CE courses and the faculty who does the teaching. ACCME is also working with nursing organizations to permit both physicians and nurses to earn CE credit for some of the same courses. The proposed institute seems a great way to encourage more of this kind of collaboration.

Comment: I am with the Wyoming State Board of Nursing. We have been struggling with competence for initial licensure for entry-level nurses. We approve education programs and approve many online programs because of the rural nature of the state. Our requirement for practical clinical experience for initial licensure has provoked a lot of political pushback against online programs. We rely heavily on the National Council of State Boards of Nursing's research, which shows that practical experience with a preceptor in an educational setting must supplement online learning.

Continuing Competence Initiatives by Licensing Board Associations

Martin Crane, Immediate Past Chair, Federation of State Medical Boards Board of Directors

The goal of the maintenance of licensure initiative at the Federation of State Medical Boards (FSMB) is to assure the continued competence of licensed physicians. This effort has moved forward in a deliberate and thoughtful fashion for about six or seven years.

Maintenance of licensure is a sea change in the licensure and license renewal process for physicians. It will mean that, as a condition of licensure renewal, physicians must demonstrate participation in a continuous professional development program of life-long learning that is objective, practice-relevant, and results in demonstrable practice improvement over time. It is the kind of change that the Institute of Medicine (IOM) has been recommending.

Why do it? Because state medical boards are mandated to protect the public and guarantee that licensed physicians are competent. It is implied authority in every medical practice act. For physicians, it is a commitment to their patients. For the public, it is an assurance that they have access to the highest quality care. I believe it will give the public confidence in a self-regulatory system and the medical profession. We are preparing to launch the initiative in a few states in the near future and expect full implementation in five to ten years.

Assuring that physicians maintain their competence throughout their careers is an absolute expectation by the public. Most surveys show that the public already believes that physicians are periodically evaluated for competence and quality of care.

The initial licensing process takes into account education, training, experience, examination, and other factors. The re-licensure process to date has been mainly administrative. I agree with the previous speaker that mandatory continuing education leaves a lot to be desired, at least the continuing education system we have now.

There is definitely a cultural and paradigm shift underway in medicine and some other professions away from the reactive, complaint-driven approach to a proactive approach of prevention and improvement. This is not about finding bad apples. It is about making good practitioners better by encouraging continuing professional development.

We paid attention to the IOM reports (*To Err is Human, The Quality Chasm*, etc.), the Pew Commission recommendations, the patient safety and error reduction movements and recognized that the accountability of the regulatory system was being challenged. We did not want to be part of the problem and felt that we could change and be part of the solution.

We created a special committee, which included representatives of the public, the IOM and other stakeholders in addition to medicine. The core statement of this effort is that medical boards have an obligation to the public to ensure the ongoing competence of physicians seeking license renewal. This is the same as their obligation to assess people seeking initial licensure.

An important point about the recommendations coming from the committee is that current competence needs to be demonstrated within the scope of one's daily professional practice. We began with the core competencies of the Accreditation Council for Graduate Medical Education (ACGME), which encompass most of the practice of medicine and pay attention to system-based and team approaches to practice. This is a non-punitive, non-burdensome system for physicians and does not create undue expectations by the public.

The guiding principle is lifelong learning to facilitate improvement in practice. State boards establish the requirements, but they don't have the resources and funding to do everything, so they will collaborate with other organizations, such as assessment certification organizations and third-party attestations, just as the CE process does now. The system should not compromise care nor create barriers to physician practice. It needs to balance transparency and privacy.

We created an advisory group in 2009 to look at the impact FSMB has on boards, on the public, on physicians, to review the FSMB's reports, to predict the challenges in the future, and to decide whether the maintenance of licensure initiative is a value-added endeavor. The advisory group represented regulators, licensees, legislators, assessment certification bodies, and the public. It endorsed the concept that licensees must participate in a professional development program based on the ACGME competencies.

There are three components to implementation: Objective self-assessment of knowledge and skills; performance improvement plans, measurement of the resulting improvements. Licensees may choose from several options to satisfy these three requirements.

One option is to maintain specialty certification, which itself requires continuing professional development and continuous practice improvement. About seventy percent of physicians are board-certified. That leaves at least thirty percent who cannot maintain their licenses through that route.

There are also physicians who are grandfathered by their specialty certification boards, which means they are exempt from maintenance of certification requirements. Depending on the specialty, anywhere from 29 – 40 percent of physicians are grandfathered. There are also physicians who choose not to re-certify – 29 percent of generalists.

So, more than half physicians cannot participate in maintenance of certification as a surrogate for maintenance of licensure.

The system needs to be verifiable and satisfy the public that the profession means business. It needs to cover physicians who are in non-clinical roles because they may want to re-enter practice in the future.

In April, FSMB approved a framework for maintenance of licensure and a template for state board implementation. This will be exposed for public comment, submitted to the board in February and to the FSMB delegate assembly in April 2011.

The startup plan allows boards to build on programs they already have, so long as they are consistent with continuing professional development and lifelong learning, and do not rely exclusively on CE. We anticipate that the program will evolve with time. Self-assessment will drive educational opportunities and improvement plans will drive practice changes. We will start with a renewal cycle of 5-10 years

Challenges remain. One is that we are still developing programs like this in silos. We still don't fully know how we will deal with non-clinically active physicians.

We don't want to push out physicians who are at the end of their careers. Reciprocity and portability among states is important. Remediation programs must be created for those whose self-assessment identifies deficiencies.

FSMB is happy to share what we are doing as a model for other professions.

William Rafferty, Immediate Past President, Association of Regulatory Boards of Optometry

I am here on behalf of the Association of Regulatory Boards of Optometry (ARBO), but I am presenting as myself today because I don't know whether my board would support everything I say.

Regulatory boards are charged with responsibility for ensuring the competence of licensees. Currently continuing education is the modality optometry uses. I think we all know that is insufficient.

ARBO formulated a plan based on common sense, which looks a lot like what the FSMB is doing. It is a work in progress. Our continuing education program (COPE) categorizes continuing education into subject areas and creates a framework states can use. It includes an accreditation process and a tracking system for every optometrist in the country. We also have a national mobility program providing a national uniform high standard for mobility. It has not been adopted by many states.

We have been working on competency since the 1960s, when we developed our CE system. Recently, we have had conferences on the topic. In 2009 we conducted a survey, which asked whether general board certification and continued competence are the same. Seventy-three percent of respondents said they are not the same. We asked whether there is a need for track education programs with post-assessment. Most respondents thought so. We asked them to name the highest priority for regulatory boards at this time. More than 50 percent said continued competence. This gave us the momentum to pass a resolution supporting the development of an improved system for demonstrating continued competency for the benefit of the public. In 2010, we presented the outline of our competency program to the membership. It was fairly well received.

Yesterday, our board considered increasing the number of CE hours and adding a test at the end. I said I thought that would be doing more of the same and expecting a different outcome. That approach would still not identify the practitioner's weaknesses and it would not demonstrate the practitioner's competence to the public. I believe those are the two objectives we must try to accomplish. Hopefully, we will modify our approach in North Carolina.

People ask why bother to have a continuing competence program? Healthcare consumers have a right to expect their practitioner is competent. Our maintenance of licensure concept was not designed for third parties; it is designed to protect the public. However, we recognize that in some professions, competence will be demonstrated through certification and in others through licensure.

Our plan uses the competency, accreditation, and tracking programs I mentioned earlier. It involves self-assessment. It involves putting a framework around both continuing education and continuing professional development to address the results of self-assessment. It includes a post-assessment component to monitor what happens in step two and identify changes that affect practice performance. We want to see long-term changes in practice.

The self-assessment is computer-based. It can be self-or testing center-administered. It is not a test, but a self-assessment module. It directs education and remediation to an individual's weaknesses, not their strengths. Practitioners will be provided feedback about strengths and weaknesses.

The curriculum attempts to establish a dynamic, well-rounded, long-term learning process. Because optometry is a specialized area, it is possible to break down the learning process according to sections of the eye. There can be required areas and elective areas and general requirements related to ethics and medical errors, and so on.

Continuing professional development includes accredited and non-accredited learning activities, self-assessment programs, structural learning, degree programs, chart review, teaching, research, and so on. The post-assessment component is designed to determine the effectiveness of the educational and professional development activities. We are thinking of a five-year framework for pre- and post-assessment.

This program could fit well in most states without statutory modifications. It is designed for boards that want to enhance their current programs. The program is feasible for ARBO because it builds on existing programs, such as the data tracking.

Questioner: Please talk a bit about the concepts of “legally defensible and psychometrically sound.” These are often raised as stumbling blocks in the way of continued competence programs.

Crane: The American Board of Medical Specialties first called its program “maintenance of competence.” Early on, they learned that they would not be indemnified if they gave someone a certificate of competence, so they changed the name to maintenance of certification. FSMB researched this and learned that we are indemnified and can use the word competence. The legal concerns you raise vary from jurisdiction to jurisdiction.

Rafferty: Our plan is to start small, with two or three states, to see what problems we run into. We are fortunate to have an exceptional psychometrically sound testing agency, which will be used for self-assessment and post-assessment, so it will be legally defensible.

Questioner: The Accreditation Council for Pharmacy Education accredits providers of continuing education. Quality improvement in CE is part of our strategic plan. Dr. Crane, you mentioned that non-clinically active physicians and physicians with inactive licenses will have to comply. Please explain how that will work.

You also referred to maintenance of competence programs in other countries, which have moved toward a continuing professional development model. In pharmacy, most of these countries have a split register. They have different requirements for maintenance of licensure for pharmacists who are clinically active and those who are not. Please comment on this, given the objective of having a competency system that relates to what practitioners do on a daily basis.

Crane: There is a difference between having an active license and being an active physician. Anyone with an active license has to go through an administrative renewal process currently. Some of the licensees are not in clinical practice. They may be in administrative roles. There is a movement to create an administrative license, which would not authorize an individual to practice, but would enable him or her to be a medical director of an HMO or hospital.

Those with inactive licenses must now demonstrate something to a medical board in order to gain an active license. In the future, anyone who decides to re-enter practice will have to satisfy the maintenance of licensure requirements.

We were sure from the start that what we were talking about was an individual's current daily practice. We are now looking into the idea of "mapping a practice," as is currently done in hospitals. Most of medicine is now practiced outside hospitals.

Questioner: Do you have a system worked out for monitoring compliance with your program?

Rafferty: The program could be voluntary initially, but we are hoping state boards will adopt the program for re-licensure. In North Carolina, we monitor 100 percent of CE compliance currently, and could monitor a new program the same way.

Crane: Currently, medical boards randomly monitor CMEs. So, we don't really know much about compliance right now. We thought we would start with an attestation system because boards don't have the resources to monitor. Ultimately, in order to be credible, the system has to be verifiable. I am hoping that we will incentivize participation with changes in the reimbursement process.