Certification – The Public Perspective

Remarks by David A. Swankin, Esq., President and CEO, Citizen Advocacy Center, at the certification luncheon sponsored by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN), Thursday, March 4, 2010, in Boston, Massachusetts.

Good Afternoon!

It is my honor and pleasure to be with you today. I greatly respect and admire the good and important work performed by nurses, doctors, and other health professionals who deliver palliative care. Like so many others, I have had personal experiences with one type of palliative care – hospice care – in my own family, and based on my personal experience, I hold all of you in this room in my highest esteem.

Today, I will begin by telling you a little about the Citizen Advocacy Center, then a little about my own experience as a public member of a large certification organization, then I will get to the subject of this address, "A Public Perspective of Certification."

The Citizen Advocacy Center (CAC) is a small non-profit entity based in Washington, DC. Since 1987, CAC has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. We offer training, research and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve.

Created as a support program for the thousands of public members serving on health professional boards as representatives of the consumer interest, CAC soon became a resource for the health professional boards themselves.

CAC's products and services include:

- A quarterly publication entitled CAC News & Views;
- Research reports on public policy issues and topics of current and practical concern to board members;
- An annual meeting and periodic conferences on public policy matters;
- Website design assistance; and
- Tailored training seminars on current health issues.

OUR MISSION

To increase the accountability and effectiveness of health care regulatory, credentialing, oversight and governing boards by:

- Advocating for the significant numbers of public members;
- Improving the training and effectiveness of public and other board members;
- Developing and advancing positions on relevant administrative and policy issues;
- Providing training and discussion forums; and,
- Performing needed clearinghouse functions for public members and other interested parties.

OUR CORE VALUES

- *Transparency* - Maximum possible openness of the policy-making process and its results;
- *Oversight and Accountability* - As a necessary component of patient protection and the regulatory process;
- *Collaboration* - Between consumers, health care providers, payers, regulators, and oversight organizations to support the delivery of ethical, safe, accessible quality health care;
- *Meaningful consumer representation and participation* - As essential to a system that serves the public interest.

I currently serve as a public board member on one of your sister organizations, the Certification Board of the American Association of Critical Care Nurses (AACN). When I was recruited to take that position, I asked the board chair, the other board members, and the board's executive director and senior staff, "Are you SURE you want me on your board? You may not be too happy with some of the new directions I will try to 'nudge' you towards pursuing." I will be talking today about those "new journeys" that are as relevant to NBCHPN as they are to AACN, and I will be interested in your reactions to them.

A few years ago, one of CAC's founding board members was appointed as a public member of a nurse certification board. He shared with me his first presentation to his colleagues at his first board meeting. He said:

> My challenge as your public representative will be to examine every issue considered by the Board from the viewpoint of the health care consumer. My job also includes bringing public issues and problems to the attention of the Board, especially when specialty certification may offer a part of the solution to the problem.

> I want to be convinced that specialty certification is in the public interest as well as the interest of nurses who choose to be certified. How, exactly, does the public benefit from certification? For example, can certification be demonstrated to improve health care outcomes? If it can, I intend to carry that message to the public – to employers, Accreditors, insurers, consumer organizations and the media. If it cannot, then we should look at ways to modify the program so that it can and does.

I share this with you because, from a public perspective, a certification program is only meaningful if it, in fact, differentiates the market. In other words, certification must be a quality assurance indicator.

I look at organizations that certify health care professionals the same way that I look at organizations that certify products. The grand-daddy of all product certification organizations is Underwriter Laboratories, or UL for short. For more than a century, the public has relied on the UL mark as an indication of product safety. I remember when I was a little boy, my folks would never even think of buying a toaster or a vacuum cleaner that did not carry the UL label. To me, it is the epitome of what a certification should stand for.

Granted, it is in many ways easier for UL and similar organizations to carry out their responsibilities and make certain that their quality mark does indeed indicate that the product bearing their mark is safe. They accomplish that end by a rigorous review of a product's design and assurances that the product is indeed manufactured to the approved specifications. Then they devote considerable resources to monitoring the marketplace to assure that the integrity of their label is not compromised.

As I said, in many ways the product certifiers have an easier job conducting a <u>product</u> certification program than organizations such as yours are faced with in conducting a <u>people</u> certification program. As my colleague asked, "Can certification be demonstrated to improve health outcomes?" No easy task to do that! I know how many hours the certification organization on which I sit, AACN, struggles to answer that question. We all want to believe that it does. Our gut tells us that it does. But what about hard evidence to prove it?

The American Board of Nursing Specialties (ABNS), a group I admire and respect, has published a position statement on the value of specialty nursing certification. It says:

> ABNS believes that the increasingly complex patient/client needs within the current healthcare delivery system are best met when registered nurses, certified in specialty practice, provide nursing care.

> The first specialty nursing certification program in the United States was established in 1945. According to the 2002 American Association of Critical Care Nurses (AACN) report, "Safeguarding the Patient and the Profession," more than 67 certifying organizations exist, representing 134 specialties.
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> Numerous studies have demonstrated the positive benefits of nursing certification. In 2000, the Nursing Credentialing Research Coalition studied the relationship between certified nurses and patient care quality. In 2002, an ABNS survey of nurse managers demonstrated that nearly 90% of respondents clearly prefer hiring certified nurses over non-certified nurses. Furthermore, 58% stated that they see a positive performance difference in certified nurses. Additionally, an AACN study in 2002 demonstrated that certification has a significant positive impact on patient care and patient safety.

ABNS goes on to state:

> Specialty nursing certification is an objective measure of knowledge which validates that a nurse is qualified to provide specialized nursing care.

That language is positive and uplifting, and the footnotes that are imbedded in the quote I just read cite studies by AACN, the organization on which I serve as a public member. But we cannot fool ourselves – we really don't yet have outcomes data that shows that the outcomes are better when the nursing care services are delivered by certified, as opposed to non-certified, nurses. It is one of the reasons that many nurse credentialing organizations are nowhere near achieving recruitment targets approaching 90 or 100% of eligible nurses – as you all know, often times 25% of the universe is a more realistic percentage. Would outcomes data change that equation? I believe that it would.

While we are a long way from developing outcomes data for individual certified nurses, and comparing the data with outcomes for non-certified nurses, we are much further along the road of being able to demonstrate outcomes of units and of teams. I think that certification organizations should ride this wave more than I think they now do. The phrases "Team practice" and "Collaborative practice" are in vogue these days. Virtually all prestigious policy bodies, including the Institute of Medicine, have been singing the praises of collaborative practice for well over a decade.

If collaborative teams include health professionals from a variety of health disciplines, and if the doctors, nurses, and pharmacists on these teams are certified, and if the teams have good outcomes, then I think it appropriate to draw the link back to certification of individual

practitioners. Admittedly, it is easier for physicians, since 85 or 90% of them are board certified. But nurses need to do all in their power to address the outcomes linkage.

I want to devote the rest of my time today to what I believe is the greatest challenge to nurse certification organizations if they are to meet public expectations.

Here's the issue from a public perspective: Does certification mean that the certificant is currently competent? Not competent when they were initially licensed, and not competent when they were initially certified, but competent now?

In other words, is the certification organization's recertification program designed to address current competence?

Unfortunately, in most cases with regard to nurse certification boards the answer is no. That needs to change, and the sooner, the better!

About 3 or 4 years ago, the Virginia branch of AARP conducted a major survey of persons over 50 years of age in that state, both members and non-members. The survey asked whether health professionals should be required to demonstrate their current competence. It was not a big surprise that the overwhelming majority of citizens thought that this was a good idea. But the survey also showed that a sizeable majority believed that this was already the case. In other words, most people believed that those pieces of paper hanging on their health care providers' walls were indications of current competence. And, of course, that is not the case.

Those of you who flew to Boston on a commercial airline may be aware that all of the pilots and co-pilots are required to demonstrate their current competence every year; more and more school systems are requiring teachers to demonstrate their current competence. But for the most part, health professionals are not subject to current competence requirements. What both licensing bodies and certification organizations require is mandatory continuing education hours and an occasional specified number of practice hours as a condition of maintaining their license and certification.

That fact is well known to the health professions, but is a well-kept secret from the public. If the public knew that current competence is not required, they would be up in arms.

The major exception is for board-certified doctors. Both the American Board of Medical Specialties (ABMS) and their counterpart for osteopathic physicians have rigorous requirements in place regarding current competence. Except for those board-certified members who have been grandfathered (the price the ABMS leadership had to pay to get the program accepted),

board-certified doctors now must periodically demonstrate their current competence as a condition of recertification. Because the great majority of physicians are, in fact, board-certified, medicine is well along the pathway towards giving the public what they believe they already have: doctors who demonstrate their current competence. It is time for nurse credentialing organizations to set out on this same journey.

We've known about the problem for well over 50 years. In the early 1960s, the U.S. Department of Health and Human Services (then known as HEW – the Department of Health, Education, and Welfare), convened a 2-day meeting on the issue. The attendees agreed that the public has a right to know that the health professionals from whom they receive services are currently competent. During the 1990s, the PEW Health Professions Commission, under the chairmanship of Senator George Mitchell, called on both state licensing boards and health professional certifying agencies to put in place continuing competence programs as a condition of maintaining license and certification. The Institute of Medicine (IOM) in both its 1999 report, "To Err is Human" and in its 2001 report, "Crossing the Quality Chasm – A New Health System for the 21st Century" echoed the PEW Commission recommendations. The IOM, 2 years later in 2003, in its report, "Health Professions Education: A Bridge to Quality", had this specific recommendation directed to health professional certification organizations:

> Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies, among other requirements. (Recommendation #5: Those competencies include evidence-based practice, interdisciplinary teams, informatics, and quality improvement.)

In spite of all this, both licensing boards and certification agencies cling to the discredited notion that mandatory continuing education requirements are the equivalent of current competence requirements. Earlier in this talk, I quoted from a position paper from the American Board of Nursing Specialties (ABNS). Let me read again the last sentence one more time:

> Specialty nursing certification is an objective measure of knowledge which validates that a nurse is qualified to provide specialized nursing care.

That statement would benefit from a major revision. Current competence is much more than an objective measure of knowledge. It is not enough to know something; it is also

essential to apply that knowledge in practice. In other words, one needs to both know it and do it.

Don't get me wrong. Good continuing education programs are important, and are critical to keeping health professions up to date. But continuing education is a tool, not an end. Our licensing bodies and our certification organizations have got it backwards – they have made continuing education the end.

Perhaps that will all change in response to yet another Institute of Medicine report, "Redesigning Continuing Education in the Health Professions." Released just this winter, the very first paragraph in the report's preface, written by committee chair Gail Warden, states:

> Continuing education (CE) is the process by which health professionals keep up to date with the latest knowledge and advances in health care. However, the CE "system," as it is structured today, is so deeply flawed that it cannot properly support the development of health professionals. CE has become structured around health professional participation instead of performance improvement. This has left health professionals unprepared to perform at the highest levels consistently, putting into question whether the public is receiving care of the highest possible quality and safety.

The report calls for CE to be replaced by a system of continuing professional development:

> An emerging concept, called continuing professional development (CPD), includes components of CE but has a broader focus, such as teaching how to identify problems and apply solutions, and allowing health professionals to tailor the learning process, setting, and curriculum to their needs. The principles of CPD already have been adopted in numerous other countries, including the United Kingdom and other members of the European Union, Canada, and New Zealand. Some groups in the United States, including the American Medical Association and the Accreditation Council for Pharmacy Education, also have recognized the broader learning opportunities that CPD offers and have adopted the concept as a guide. In line with such examples, the committee adopted the term CPD to signal the importance of multifaceted, lifelong learning in the lives of all health professionals.
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> In this new vision, a CPD system takes a holistic view of health professionals' learning, with learning opportunities stretching from the classroom to the point of care. It shifts control of learning to individual health practitioners and has the flexibility to adapt to the learning needs of individual clinicians, enabling them to be the architects of their

> own learning. The system bases its education methods on research theory and findings from a variety of fields, and embraces information technologies to provide professionals with greater opportunities to learn effectively.
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> If coordinated nationally and across the health professions, a CPD system offers the promise of advancing evidence-based, interprofessional, team-based learning; engendering coordination and collaboration among the professions; providing higher quality for a given amount of resources; and leading to improvements in patient health and safety.

I looked up the recertification requirements for the various certifications offered by NBCHPN. (I had done the same thing when I went on the board of AACN as their public member.) The web page explaining the Certified Hospice and Palliative Nurse (CHPN) program states:

> Renewal of Certification can be accomplished by exam or by RN Hospice and Palliative Alternative Recertification, a portfolio that confers points for CES and other professional activities.

Recent surveys of recertification programs offered by health certification bodies shows that often one option is to retake the initial certification exam, and in most cases that option is infrequently chosen. The portfolio idea is on the right track, but portfolios and good lifelong learning programs should begin with a needs assessment as a first step. Assessment (either self-assessment or third party assessment) is missing from most recertification programs. Until that changes, we'll be stuck with CE programs as they have developed in the past. The new IOM report devotes considerable space to making the case for improving the CE process, both in terms of course content and methods of delivery. And the report is heavy in recommending interdisciplinary CE. I think one thing the American Academy of Hospice and Palliative Medicine can be justifiably proud of is its commitment to interdisciplinary, team practice.

It is significant that the certifying boards under the American Board of Medical Specialties have established themselves as champions of patient quality and safety through their maintenance of competence programs. The ABMS boards are light years ahead of the state medical licensing boards. Nurse certification organizations are in a position to do the same thing, and win over the public by so doing. For its part, CAC, my own organization, has recommended that licensing boards grant "Deemed Status" to continuing competence

programs administered by voluntary credentialing and specialty boards, when these programs meet high standards.

I know there is considerable push back by health care professionals and their associations in opposition to moving away from traditional CE programs. But current competence programs are coming, and one day will be required for re-licensure. I am absolutely certain that a majority of certified health care professionals would rather engage in maintenance of competence programs offered by their voluntary certification boards than have to “prove” their current competence to their state licensing board. So here is your opportunity to get out ahead of the curve, do a real service to your certificate holders, and, in keeping with the theme of this talk, meet the public’s expectations!

There are two other thoughts I’d like to share with you before I close: Earlier in this talk, I mentioned how Underwriters Lab (UL) devotes significant resources to monitoring the marketplace to assure that the UL mark is not, in fact, being abused. They do this to protect their integrity. I believe certification boards would be wise to devote time and resources to monitoring the actual performance of those whom they certify. Is the certificate holder’s practice ethical? Conducted competently? Some argue that those are matters for the licensing boards to address, not the certification agencies. I couldn’t disagree more. One’s reputation and integrity are too important to be ignored. I think that certification organizations should welcome complaints and other feedback from employees, and from patients and their families. I think that certification organizations need to have fair, efficient, and well-advertised complaint programs in place. Ask Toyota if they have learned that lesson the hard way!

Finally, especially in your case, I think your Websites should be looked at carefully to determine the extent to which they are, or could become user-friendly. Many Websites have lots of good information within them, but not all of them have a prominent and easily navigated section devoted to consumer information and education about the meaning of certification and the mission and services performed by your organization. Sometimes you really do need to toot your own horn!

Thank you!