News & Views

Citizen Advocacy Center

Fourth Quarter, 2015 – Health Care Public Policy Forum – Volume 27 Number 4

Announcement

Our 2016 annual meeting will be held in Portland Oregon on Saturday afternoon and all day Sunday, September 17 and 18, 2016. The meeting will be co-sponsored by CLEAR. The theme will be "Modernizing the Regulatory Framework for Telehealthcare Delivery." It will take place immediately following the CLEAR meeting, which ends at noon on Saturday.

Proceedings of Citizen Advocacy Center's Annual Meeting November 12-13, 2015, in Washington, DC.

Demonstrating Current Competence: How Far Have We Come? Where Are We Headed?

Editorial Note: The following proceedings are not a verbatim transcript, but they are faithful to the speaker's remarks. Please visit www.cacenter.org to find copies of the speakers' PowerPoint presentations, which you may want to consult as you read these proceedings.

Opening Remarks: Rebecca LeBuhn, Board Chair Citizen Advocacy Center

The call to this meeting said we are returning to a familiar theme. We do this because we think it is time to assess where we are in terms of assuring and demonstrating continuing competence and to take a look at some promising ideas and trends that will influence how healthcare professions will measure and demonstrate competence in the near future.

This truly is a familiar theme for CAC. We've been researching and advocating on this topic almost since the creation of the organization. I looked back at just a few of our publications. In 1995, we published a resource guide entitled *The Role of Licensing in Assuring the Continuing Competence of Health Care Professionals.* In it, we quoted CAC's first Board Chair, Ben Shimberg:

> It's amazing how little board members know about their licensees once that precious piece of paper has been mailed out…. Has the licensee kept up with the field? Does he or she practice at the state-of-the-art level? Do the services he or she delivers to the public meet the minimum standards of competence set by the board?

We quoted NOCA, then the National Organization for Competency Assurance (now the Institute for Credentialing Excellence). Several of our speakers today and tomorrow are affiliated with that organization. Their 1981 *Guidelines on Continuing Competence* said:

> Continuing competence assurance is necessary … health care technology is advancing too fast for a certificate of competence earned at the beginning of one's career to constitute proof of competence many years later. Demonstrations of continuing competence are as reasonable and necessary as are required demonstrations of entry-level competence.

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We quoted the Pew Health Professions Commission:

> Assessing the continuing competence of practitioners, a much more difficult task at which many professional licensing bodies have done very little, other than requiring attendance at continuing education courses. There should be more attention to assessing the actual practice performance of licensees using quality assurance techniques and evaluation of consumer and professional criticisms about licensees.

We quoted Virginia's Department of Health Professions, which wrote in 1985:

> Continuing competence is one of the dominant issues in professional regulation. Regulatory boards are careful to ensure that candidates for licensure are competent, but it is possible to practice for a lifetime without being required to demonstrate continuing competency… the community of regulators acknowledges the need for prevention and agrees that some system for monitoring the continuous acquisition of knowledge, skills, and ability by health practitioners is a warranted use of State regulatory powers.

In 1997, CAC published proceedings from a conference we called *Continuing Professional Competence: Can We Assure it?* At that conference, we posed the same question we pose here today: Where have we been and where are we going? Ben Shimberg opened the conference by identifying several challenges:

- When we evaluate competence, are we concerned with cognitive knowledge or with functioning and judgment?
- Which is a better indicator of continuing competence: general, entry-level knowledge or the knowledge and skills needed in the professional's current setting?
- Is it important to evaluate the continuing competence of everyone in the profession, or only those who give reason to suspect there may be a need for evaluation and remediation?
- When it comes to assuring continuing competence, what is the appropriate division of responsibility between the regulatory system and private credentialing bodies?

Another set of conference proceedings published by CAC in 2001 explored barriers to advancing continuing competence requirements and suggested strategies for overcoming them. The barriers had to do with

- a need for common terms and definitions
- a need for research and information to validate methodologies and approaches, including what to measure and how to relate competence assessment to patient outcomes, and
- a need for collaboration and cooperation among agencies, and between public and private sectors.

In 2004, CAC published a *Roadmap to Continuing Competence Assurance*. The route included research, legislative and regulatory mandates, utilization of evidence-based methods to demonstrate competence, and reforming continuing education.

In 2006, CAC joined with AARP's Public Policy Institute in a publication entitled, *Implementing Continuing Competency Requirements for Health Care Practitioners* (http://www.cacenter.org/files/ImplementingContinuingCompetencyRequirements.pdf). We convened another meeting conference on continuing competence in 2011 (http://www.cacenter.org/files/ContinuingCompetenceProceedings2011.pdf). And now, here we are again.

This brief recollection makes it clear that regulators, certifiers, and organizations like CAC have long recognized the need for demonstrating current competence. We have known what questions need answers. But the will to act and the science for assessing and demonstrating competence in practice have been slow to emerge.

At CAC, we think we are slowing turning the corner. The Institute for Credentialing Excellence held its annual meeting two weeks ago. There were no fewer than six sessions on continuing competence, recertification, or reflective practice. The American Board of Medical Specialties is moving along a bumpy road toward implementing Maintenance of Certification programs within its member boards. Many health care professions are talking seriously about ways they might require demonstrations of competence as a condition of re-licensure. CE is changing – with assessment based courses and CE in the work setting. Advancements in psychometrics make it possible to assess reasoning power as well as book learning. Organizations are making a serious effort to overcome resistance among licensees and credential holders to new requirements around re-licensure and re-certification. A clarification in terminology enables us to distinguish between *competence*, meaning a potential ability or capability to function in a given situation, and *competency*, which focuses on actual performance in a given situation.

In the next day and a half, we will hear about public expectations regarding the current competence of licensees and credential holders. They think licensing boards and certifying bodies are taking care of the situation. Should we strive harder to meet those public expectations? Or, do we need to disappoint them the news that their confidence is misplaced?

We will hear about innovations in CE and psychometrics and performance testing. We'll hear about how some organizations have tried to overcome resistance within the profession to continuing competence and competency requirements.

Many of these innovations come from certifying organizations. They encounter the same challenges as licensure boards, but since they are private, voluntary organizations, they can be more nimble about experimenting with new approaches and changing the rules of the game.

The concluding panel is comprised of representatives from the world of licensing. We'll hear from them about what their professions are doing to assess continuing competence and, significantly, how their professions might integrate some of the innovations described during the conference into their approach to licensure renewal.

At lunch today, we are pleased to honor Lisa McGiffert with the Ben Shimberg public service award and to hear her speak.

Part I – What Do Consumers Expect?

AARP Survey - Ed Susank, Public Member, National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)

I am going to tell you about a study of consumer opinion in Virginia conducted by AARP a little over eight years ago. Let me speak first about the context in which the study came about.

The dictionary definitions of "competence" run the gamut from the legal aspects to the reproductive aspects. For our purposes, the key definition is "capable of performing an allotted function." As a consumer, it is not enough for me to assured that my healthcare provider *knows* how to do something. That is certainly a prerequisite. I want to know that they can *perform*. It is the doing that counts.

The Commission on Medical Education was formed during the Hoover administration at the suggestion of the American Association of Medical Colleges. In 1932, the Commission predicted that at some point every physician might be required to take courses to ensure that his or her practice would be kept up to date. Fifteen years later, the American Academy of General Practice was the first group to require continuing education as a condition for membership. Twenty years later, the Department of Health Education and Welfare went a step further by recommending that physicians undergo periodic reexamination over the course of a career. As many of you know, the Citizen Advocacy began looking at this issue in the early 1990's and joined a few other voices to question whether coursework alone is enough to assure competence over the course of a career. In 1995, CAC published a resource guide on how licensing boards could assure continuing competence of the healthcare professionals they regulate and their entire annual meeting in 1996 was devoted to this topic.

In 1995, the Pew Commission issued its seminal report, *Reforming Healthcare Workforce Regulation*. That report focused on how the approximately ten and half million healthcare workers in the United States were affecting the cost, quality and accessibility of healthcare. One of the ten policy objectives the Commission suggested was that states should require licensing boards to develop, implement, and evaluate requirements that would assure the continuing competence of their healthcare professionals.

In March 1998, the American Board of Medical Specialties (ABMS) commissioned a task force on competence. One of its stated goals was to improve the quality of healthcare. The ABMS leadership knew it was not enough to simply maintain quality – there had to be continuous improvement. They noted that a written examination alone was probably not enough to document competence in real world clinical practice. The ABMS task force developed a list of six general competencies that physicians in training would have to demonstrate - the *doing*, not just the *knowing*. That was a clarion call to the twenty-four ABMS member boards for maintenance of certification (MOC) built around the six general competencies.

In April 2003, the Institute of Medicine (IOM) issued a report recommending that all licensed professionals be required to periodically demonstrate their competence. It challenged licensing and certification boards to start moving toward such a requirement. It also recommended that these boards simultaneously evaluate the various assessment techniques they were using and modify them as necessary, incorporating the feedback loop that is so important to any ongoing process improvement.

As things were progressing at a national level, related activities were taking place in the Commonwealth of Virginia. Concerns were raised in the 1996 session of the Virginia General Assembly that some healthcare professionals might not be maintaining current knowledge of practice modalities and ethical issues. The Joint Legislative and Review Commission introduced two study resolutions. One of the studies found that the Virginia Board of Medicine was not adequately protecting the public from substandard care by physicians. This prompted the legislature to study the entire Bureau of Health Professions, which oversees and provides staff for thirteen different health professional licensing boards. There had also been some collaboration between AARP's Public Policy Institute and CAC on a document called *Implementing Continuing Competency Requirements for Healthcare Practitioners.* Also, AARP's State Director strongly supported the concept and decided to focus on Virginia as a place to explore legislation to require periodic measurements of competence as a condition of license renewal.

AARP is a data-driven organization. It was clear that the experts had weighed in on the importance of re-testing. AARP recognized that what was missing was solid data from consumers themselves. In 2006, AARP commissioned a research organization to gather the views of Virginia residents aged 50 and older.

The statisticians tell us that the survey had a sampling error of plus or minus 3.78%. AARP staff developed most of the questions, drawing upon questions used in other surveys, including the Kaiser Family Foundation and the American Board of Internal Medicine Foundation. In April 2007, AARP released the survey results in a report entitled *Strategies to Improve Healthcare Quality in Virginia: A Survey of Residents 50 and Over*. That report is available on the AARP website.

The survey focused on consumer impressions and included questions that probed the respondent's understanding of what it means to be licensed as a healthcare professional in the Commonwealth of Virginia. What did they know about the requirements for licensing? How do respondents assess the qualifications of a particular professional? How might they compare one professional with another? Respondents were asked how effective various techniques would be in controlling healthcare cost and reducing medical errors. They were asked whether they or a family member had experienced a medical error. Three of ten said yes. Despite that finding, 87% of respondents indicated at least some level of satisfaction with the quality of their healthcare. Thirty-nine percent were very satisfied, 33% were somewhat satisfied, and 15% were extremely satisfied. Only 13% expressed some level of dissatisfaction.

The survey asked people what they thought was required to practice medicine in Virginia. Nearly everyone correctly answered that practitioners had to be licensed and thought they must have completed some specified level of training and passed a written examination of their medical knowledge. More than two out of three respondents (68%) incorrectly thought that healthcare professionals are required to periodically demonstrate that they have up-to-date knowledge and deliver quality care. In fact, the Commonwealth of Virginia, like most other states, has no such requirements. People don't have to demonstrate their knowledge and skills. All that most states require is that people sit through some minimum hours of continuing education. If you go back to some of the earlier questions, it is probably not unreasonable to suggest that the disconnect we saw regarding satisfaction with healthcare may be based on these incorrect assumptions as to what standards were in place.

Respondents were asked their opinion about whether certain actions would ensure quality healthcare. Ninety percent of respondents said it is either extremely or very important for healthcare professionals to be periodically reevaluated to show they are currently competent to practice. But, regular ongoing assessments are *not* required to renew the licenses of healthcare professionals today, although as you are going to hear in this meeting, that is gradually changing. Eighty-eight percent of respondents thought it was very important that practitioners have high success rates for the diseases and conditions that they treat most often. Eighty-one percent wanted healthcare practitioners to pass written tests of their medical knowledge. Seventy-three percent wanted them to get high ratings from their patients. Seventy percent thought it important to get high ratings from other professionals.

Respondents were eager for information that would help them compare physicians. Nine out of ten said they'd like information on whether a physician communicates well with patients. Almost as many said it would be useful to know whether a doctor (or other healthcare professional) is board certified. Despite this finding, only 35% had investigated whether their own physician was board-certified. (On this point, we have often thought licensing boards should set standards for how professionals are allowed to advertise themselves.)

Respondents were asked to evaluate actions that might help reduce medical errors. Considered most important was having adequate numbers of nurses. Other items that ranked very high were better reporting of serious medical errors, quality control systems in hospitals, and requiring healthcare professionals to periodically demonstrate their current competence.

The findings of the AARP Virginia study closely parallel other studies done at about the same time by the Kaiser Family Foundation and the American Board of Internal Medicine. More recent surveys reflect changes in the healthcare environment – the Affordable Care Act, the increasing use of electronic media -- which have changed people's expectations.

NBCRNA / CAC Survey - Karen Plaus, Executive Director, National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)

NBCRNA's mission is to promote patient safety through credentialing programs that support lifelong learning. We want to be recognized as one of the leaders in credentialing in the anesthesia community.

The first national certification examination was introduced in 1945 as a requirement for membership in the national organization. In 1969, the professional association began awarding certificates of professional excellence to members who completed a certain number of CE requirements every five years. In 1975, the responsibility for certification of nurse anesthetists was transferred to the council for certification. This was in response to recommendations from the Pew Commission and others that credentialing should be separate from the member organization. Continuing education became a requirement for recertification of nurse anesthetists in 1976 – 40 credits every two years with no examination. In 1978 the responsibility was transferred to an autonomous council on recertification. Between 2005 and 2007, the two councils merged to become NBCRNA.

We conducted a national benchmark study of what other organizations were doing in relation to continuing competency. We consulted the AARP study and Institute of Medicine reports on redesigning continuing education and multiple articles and reports on continuing competency. We held focus sessions with students, practitioners, educators, and other leaders. We did a recertification practice analysis to establish the knowledge and skills to be assessed in a practice examination. We wanted an examination that was different from entry to practice and demonstrated continued learning and growth.

In August 2011, we introduced an ideal continued professional recertification program, including a test every eight years, no grandfathering, completion of continuing education, and the opportunity to earn CE credit for involvement in professional activities. But, nurse anesthetists, like many other professions, had concerns about taking a test and prohibiting grandfathering. It was clear we couldn't adopt the ideal program.

We wanted to create parity with other providers, including anesthesiologists and anesthesia assistants, who are our competitors and our colleagues. They both required some type of examination and ongoing continuing education. The American Society of Anesthesiologists compared anesthesiology assistants and nurse anesthetists and faulted us for having a less a rigorous program. Our certificants faced challenges with reimbursement, scope of practice, and other issues because of the differences in our recertification programs.

In 2011-12, we realized it would be valuable to get the public perspective, and patient expectations. So, NBCRNA embarked on a public opinion poll about continuing competence and recertification. We partnered with a leading national polling firm and with CAC to add credibility to the survey results.

We asked whether individuals should be examined on their profession-specific knowledge. Did they need to attend educational programs throughout their careers? Should there be an independent body to evaluate their knowledge and skills v. self-evaluation?

The survey started with an explanation of the purpose and functioning of professional certification programs. Then we asked a series of questions to assess consumer expectations about periodic examinations, CE, etc. We asked if consumers thought professionals should be excused from certain education and evaluation requirements, including passing an exam, periodically demonstrating qualifications, and attending CE programs. We asked what kind of training and / or evaluation consumers thought professionals should be expected to complete related to their current practice.

Ninety-one percent of the 2,000 respondents think it is important for clinicians to pass periodic examinations. Seventy-four percent think healthcare providers should not be excused from lifelong learning, regardless of their years of practice. Eighty-nine percent think healthcare providers should attend educational programs throughout their careers. The majority disagrees with the concept of grandfathering.

Our media release was picked up by many publications, including the Wall Street Journal, the Boston Globe, the Miami Herald, Minneapolis St Paul Tribune, Sacramento Bee, Columbus Dispatch, and more. We had more than 113 million media hits as a result of the press release.

We found that the public's perspective is aligned with many of the best practices in certification and recertification. In addition, we concluded that our recertification program aligns with patient expectations.

We made four major program modifications in the recertification program initially introduced in 2011. The program that will launch August 2016 is an eight-year program consisting of two four-year cycles. Individuals will take 60 Class-A assessed CE requirements in the first cycle. We award Class-B activities, such as teaching. We introduced the concept of voluntary core modules – evidence-based review of content related to four areas identified in our practice analysis that every nurse anesthetist has to know. In the second four-year cycle, the same Class-A and Class-B activities are required in addition to an examination based on the practice analysis. Individuals from 2020-2024 will be required to meet a performance standard, or complete additional activities. Starting with the 2028-2032 cycle, the examination will have a passing standard.

We know continuing competence requires a commitment to lifelong learning. We know we need to educate nurse anesthetists and other stakeholders about continuing competence and the need to represent competence to the patients and public we serve. We created a discovery series to educate stakeholders, dispel the misperceptions associated with the program and reach those stakeholders who have not familiarized themselves with the coming requirements.

I would like to thank the Citizen Advocacy Center for its assistance in gathering the public perspective and helping to message the importance of the public perspective in evaluating and changing continuing competence requirements for certification organizations.

Question – What happened after AARP's survey results were released?

Susank - AARP recognized the importance of legislation to require some type of ongoing competency testing as a condition of licensure renewal. The boards of medicine and nursing supported the legislation that was introduced, but some of the smaller boards were concerned because they didn't have the resources to implement continuing competency requirements. The smaller boards were able to convince legislators that this was too complicated for Virginia to take on. But, the survey is still cited by many organizations as an indicator of consumer expectations.

Comment – Consumers Union has done several national polls that include questions related to physician oversight.

Question – In my experience as a high school teacher, continuing education offerings are varied. Are you going to direct your certificants to certain subject areas? How do you assess vendors and their offerings?

Plaus - Some CE vendors already include an assessment as part of their courses. Our national membership organization is helping us try to effect this change in CE offerings.

Question - Will the modules you described as voluntary eventually become mandatory?

Plaus - The modules are developed by external CE vendors and then evaluated by us against the domain areas in our professional practice analysis and recognized by us. Certificants are concerned about the additional cost of recertification if these modules were made mandatory. We will be studying the value of the core modules before making a decision about whether they should be required for the second four-year cycle.

Question - Do you require individuals to take general modules, or modules related to their actual practice?

Plaus – The four modules are the same as the content modules on our exam. They take general modules, no matter what their area of practice.

Comment - My comment is about requirements imposed in response to a disciplinary matter involving problems that come up in practice. I don't think we always specify closely enough exactly what remedial CE is appropriate in a given case.

Comment - In the dental field, disciplined practitioners may be referred to educational opportunities and examinations to improve their performance.

Question – Did publicizing the results of your survey help overcome certificants' resistance to the new recertification requirements?

Plaus - Yes for those who bought into the need for change. No for those who opposed change no matter what information we sent to them.

Question - Do you have plans in place to periodically monitor consumer expectations and adjust to any changes that occur?

Plaus – We expect to adapt to changes in consumer expectations, to attitudes within the profession, and to changes in the state-of-the art in assessing continuing competence. Evaluation is a critical piece of the effort.

Part II – Innovative Programs to Meet Consumer Expectations

Innovations in Continuing Education – Graham McMahon, President and Executive Director, Accreditation Council for Continuing Medical Education (ACCME)

I come to this topic as a physician and an educator. I have worked hard at thinking about teaching and learning and how we generate meaningful engagement, health awareness, performance improvements and change. ACCME's role as an accreditor is to bring the various elements of the CME provider community to play advancing best practices in improving patient outcomes and care. We are fortunate to be in a system where health professionals are intrinsically motivated to do the right thing. Our job is to provide them the nourishment to continue to grow and improve in ways they know are right for them. Our job is to steer the entire profession in a positive direction and support the growth and improvement of the profession as we serve our patients.

We are committed to providing the infrastructure to deliver education to clinicians. Our role is to give the clinicians the confidence that the activities we accredit provide unbiased, independent information that is evaluated appropriately and is relevant to their needs, not the needs of a marketing or commercial interest.

Unlike our colleagues in Europe we do provider-based accreditation. We accredit 2,000 organizations nationally – hospitals, healthcare systems, medical schools, and the like – to provide high quality education to learners of all types. Because we develop a relationship with those providers, and encourage, sustain, and regulate them, we are able to develop systems that are able to flexibly meet the needs of the learners they interact with.

Europe has an activity-based accreditation system, where every time a provider wants to put on a program, give a lecture, bring a group of people together to learn, it needs to get permission from the accreditor by sending them materials in advance and weeks later getting approval. That is obviously a chaotic, inflexible and problematic system.

CME is a lot more than a series of lectures. The new model is to attend to the individual and personalized needs of learners. This is challenging because unlike in medical school, individual practice is incredibly diverse in a residency. Mandatory education for everyone on specified topics doesn't meet individual needs and results in box-checking behavior that results in almost no behavior change. We have to be very careful about the balance between regulation and mandatory requirements and the carrots and incentives that bolster professional self-confidence and self-determination and respects diversity of our practicing audience.

Even in that context, all activities need to be relevant to individual's needs, independent of commercial influence, evidence-based, and evaluated for outcomes. In some respects, we've been pretty successful. We have a uniform system of provider accreditation. We have systems for activity management. We have a working system of disclosure of conflict management, which many organizations we work with have adopted. There is an expectation that activities are based on needs and appropriately chosen for pedagogy. Whether it is a course, a performance assessment, or a skill-based program, it is evaluated and integrated into a longitudinal program of performance improvements where participation is tracked and managed appropriately.

But, we have major challenges above and beyond the diversity of our learners and the difficulty of leveraging a relatively small number of providers to meet that broad need. We have challenges related to funding CME providers because our health system leaders often consider continuing education to be about points and credits and not about the actual behaviors and performance improvement that really drive educational quality. It makes me furious when I ask a group, "What is CME?" and they say it is credit. It is not about credit. It is about performance improvement, learning, knowledge, skills, and attitude.

Traditionally, some clinicians chose programs based on convenience and ease and sometimes many of these activities are promotional marketing masquerading as high quality continuing education. Two additional problems are worth mentioning. One is the tradition of relatively constant educational approaches –a speaker on stage, a dark room, people reading newspapers in the back, searching their iPads, whatever it is. This is an ineffective approach to actually generating change. The reason it has stayed this way is that many of our clinicians are acculturated and accustomed to learning that way. Often, learning isn't happening. It is difficult for the community to adapt to different techniques, such as collective problem solving. Shifting the culture toward active, participatory, effective, and efficient education is difficult.

Our work as accreditors is to encourage providers to adopt educational approaches that actually work. This means approaches that engage people, make them more self-aware, able to evaluate themselves against their peers, and so on. Clinicians have to actually participate to learn and grow; it doesn't work to be passive.

We also have to accommodate our learners' evolving expectation. Our younger learners expect a very different educational environment than our more senior and seasoned learners do. This challenges educational providers because producing apps and technologically sophisticated adaptive solutions is expensive. We are working to address

confusing and diverse systems for awarding credit. When learners provide feedback to the CE providers, the providers can deliver better value to the health system by investing in a system that supports the competency improvement that we are all looking for.

Our 2,000 providers offer about 150,000 activities annually resulting in about 25 million interactions with the healthcare community. Our growth is not with physician learners. Our high quality educational activities draw learners from multiple professions to in-person and Internet based education across the country.

The vast majority of providers are eager to demonstrate their ability to use best practices and do the right thing. Providers are required to engage in continuous quality improvement and their activities are required to evolve and adapt to the changing needs of learners. We like to think of ourselves as coaches rather than cops, so we work with providers to hold them account, and help them to improve. We try to move the community forward by commending CME providers who demonstrate their ability to engage in educational best practices.

The area of greatest difficulty is managing and resolving conflicts of interest. Many of the best speakers and teachers have completely appropriate and necessary relationships with the industries in which they work. You want to have those people be able to present and engage audiences at events. But, they have to do so without any promotional marketing and the have to disclose their relationships so learners can make their own judgments about any bias. Most of the problems involve errors in interpretation and what appear to be honest mistakes.

In our evaluations, we look for evidence that providers are doing exactly what we know works best for educational quality and for generating those types of behavior modification we know are important. About half of our providers achieve accreditation commendation. We do sometimes have to put providers on probation when they make meaningful errors in the way in which they manage their educational activities, or even eject them from the system.

In addition to courses and Internet-based activities, CME providers offer a wide variety of other types of learning and improvement activities. This speaks to the evolution of the educational system. We have learned to adapt to time constraints. Gone is the day when we can access hours of a clinician's time for education. We have to meet learners where they are – with apps, in small conferences, in their clinics, via problem-solving cases that engage them in active learning, and multiple other ways.

One of the common misconceptions about the CME system is that it has been corrupted by commercial investment. To the contrary, the reassuring news is that only about 11% of activities are funded in any way by a commercial organization like a pharmaceutical company. Eighty-nine percent are funded either by a professional society meeting or by a health system putting on grand rounds or an educational activity.

The vast majority of activities are designed for knowledge improvement, but over half are designed to change actual skills. About one-third of activities are designed to change patient level outcomes. About 89 percent are measuring knowledge outcomes; just under

half are measuring for performance outcomes; 13 percent are measuring patient outcomes. This may seem small, but consider the difficulty of what they are measuring. Accreditation standards are encouraging providers to move in this direction and design activities to meet community needs.

We promote additional research to evaluate how to be more effective in communicating the message to healthcare systems that accredited CME can be a powerful resource to generate performance improvement. There is evidence that several organizations that have made meaningful investments in educational activities for their health systems can demonstrate meaningful improvement in quality and efficiencies.

ACCME is evolving in response to the changing needs and expectations of the community, such as engagement of patients and patient representatives in the planning and delivery of continuing education for physicians. Organizations will now be rewarded for appointing patient representatives to communicate patient perspectives and values to healthcare providers. Other expectations drive creativity and innovation, research, engaging leadership, working collaboratively with other community based organizations, measuring actual skill and ability, measuring and demonstrating the effect on patient outcomes, engaging students in the planning and delivery of educational activity, doing more inter-professional work, team based activities and measuring outcomes based on team performance, engaging health informatics and using data to improve performance.

We are also working with other organizations, such as the American Board of Internal Medicine. ABIM's diplomates have been frustrated over the years over the mismatch between expectations of the board and the availability of educational activities that meet those expectations. We told ABIM that our providers are able to reach learners where they work, where they practice, and where they live and deliver a high quality diverse array of educational resources to meet their needs. ABIM has agreed to let accredited CME providers issue Maintenance of Certification points based on a much broader view of what counts for high quality education. They are willing to trust our educational providers without requiring activity review, which they traditionally have done.

We are working with colleagues in pharmacy and nursing to offer something called joint accreditation, where interdisciplinary credits are issued appropriately. We can work together and can create alignment because our values are similar. This is an affirmative sign of the growth of true appreciation for teamwork.

We have an infrastructure that is trustworthy and reliable and is doing remarkable work. The accreditation system is evolving to meet the expectations of the community and increase the engagement between CME providers and the healthcare community in planning and delivering continuing education.

Question - How do you recognize targeted learning as opposed to seat time?

McMahon - We worry that mandating CME in certain areas will just create box-checking behavior, cynicism and lack of engagement. Individualizing the target is much

more likely to be effective. Providing data that is interesting and useful to an individual provider, such as comparing his or her performance with that of peers, is compelling information that they value.

Question - Is there any way of evaluating the comparative effectiveness of the variety of activities that are different from course work?

McMahon - The challenge is that it depends on what you are trying to achieve. If you are trying to develop skills, the type of educational intervention you need is very different than if you are trying to improve a clinician's receptivity to patients of a different racial or ethnic group. It is true that people can learn. Our job is to determine which intervention is more effective and more efficient to achieve the outcome you are looking for.

Innovations in Demonstrating Competence in Practice – Jim Henderson, Executive Vice President, Castle Worldwide

As other speakers have noted, not much has changed in the way we talk about continuing competence. But, things are beginning to happen. We have a sense of traction and progress being made. Medicine led the way with the research done in connection with Maintenance of Certification programs adopted by the American Board of Medical Specialties. Progress is apparent in many other certification and licensure areas.

The traction is in response to the ever-accelerating pace of change in healthcare practice, new technologies, and enhanced expectations. Consumers have access to more information about their conditions and the services they need. Much of that information is of high quality. This puts the onus on credentialed providers to stay ahead of the curve and be prepared.

Most credentialing bodies have no idea about the proficiency of the people they have credentialed after they award the initial credential. Yet, consumers assume that current competence has been verified in one way or another through recertification or re-licensure. That's a faulty assumption. In many cases, state laws don't provide the regulatory body with the authority to require it. So, in order for a state to verify that a person has maintained proficiency, they have to open up their practice acts and there is a lot of resistance to doing that. When certifications augment licenses, regulatory bodies often look to the national certification process as a means of getting at continuing competence through endorsement.

How do we go about assessing continuing competence? The first thing is to articulate the organization's beliefs about continuing competence. Think about the stakes that are associated with the profession or the practice of the discipline. Determine what implications those stakes have for public safety. Consider the pace of change in the profession. These are variables in the creation of a framework for assessing continuing competence.

You also need to think about specialization that occurs. The examination that qualifies an individual to achieve the initial credential is broad ranging across the entire discipline.

But with the very first job, practitioners begin to specialize in the kinds of patients they see and the kinds of problems they work with. That specialization creates an opportunity for deep on-the-job learning in that area and an opportunity to forget those things relevant to other settings. You need to consider to what degree natural specialization occurs and how you are going to deal with the problem that surfaces if a person working in a subspecialty wants to change jobs and work in a different specialized area. They may have lost some of the core competence they need to draw on to work in the new area. To what degree does natural specialization occur and how will the continuing competence program address that. Then, you can develop a consensus statement that provides clear direction for assessing continuing competence.

This is one of the points that the Institute for Credentialing Excellence has addressed so well in two really good documents. *Methods for Ensuring Continuing Competence Part I, and Part II.* The second one in particular talks about defining the construct of what continuing competence means in the discipline a credential is focused on. It is only after defining the construct that you can design a meaningful assessment of competence.

Assessment should be the bedrock at the beginning, middle, and end of a renewal cycle to verify that the requirements for proficiency have been met. At the beginning of the cycle, self-assessment to define career objectives can be accomplished online or through a structured process where the practitioner considers areas of current practice where he or she may want to enhance proficiency. One method of self-assessment is self-report based on reflection. The problem with this method is that self-assessment is unreliable.

Assessments are important in the middle of the renewal cycle. Continuing education without an assessment has little value. When there is an assessment component, people aren't as likely to read the newspaper during a CE activity. End of activity assessments don't need to have the same degree of reliability as a high stakes assessment needs to have. Their value is not so much in the score report as it is in motivating the person to pay attention and learn.

Assessments at the end of the renewal cycle may be higher stakes and therefore require higher reliability. These assessments must cover some core competencies and allow the individual to select components relevant to his or her own current practice and anticipated future practice.

There are a variety of commonly used measures, many of which were identified in a 2009 ICE publication on benchmarking the renewal activities of certification and licensure bodies around the country. These include guided reflection on practice. This occurs when an individual encounters a new situation or problem that resembles something similar encountered in the past and instantly makes that connection and grows professionally. We want to teach people to do this better and also guide them through a process they can use to set goals for their renewal cycle.

Self-assessments can be informal or formal. Academic course work is often used as a measure that a person is maintaining or building competence. Engaging in research leading to publication or presentations often earns continuing professional development credit. Participation in professional meetings and activities could include writing

questions for an examination. Active employment indicates that the individual is performing well enough to satisfy his or her employer. It also indicates that the individual is keeping up with technological developments via on-the-job training.

Periodic examination is not necessarily required, depending on the nature of the profession and the public's expectations. Continuing education is much better with an assessment at the end. Most of what I have talked about has to do with assessing a level of knowledge. However, peer review gets at performance in a way that other assessments don't do. Portfolios, where an individual submits documentation of elements of his or her practice can provide standardized review.

The best programs involve a multi-step approach, the utilization of a variety of tools, and an iterative process. It isn't enough to do it once or to use only one tool.

Larry Fabrey, Senior Vice President, Applied Measurement Professionals (AMP)

We psychometricians live by the standards of the American Educational Research Association, the American Psychological Association and the National Council on Measurement Education. There has been no mention of recertification in any of the versions of those standards since 1966. The National Commission for Health Certifying Agencies made no mention of recertification or continuing competence in 1977. In the 2002 standards adopted by the National Commission on Certifying Agencies (NCCA), there were for the first time two standards related to recertification. They essentially said there has to be a requirement for periodic recertification, a statement of basis and purpose (basically to measure or enhance competence), and a rationale for the time interval. These standards weren't very vigorously enforced. International standard ISO 17024 also mentions recertification. It requires documentation that the credential confirms continued competence and there have to be adequate activities to ensure an impartial assessment to confirm continued competence.

The current version of NCCA's accreditation standards effective in January 2016 has more definition about what maintaining certification has to involve. This could apply also to licensing. The essential elements are:

- statement of purpose,
- definition of continuing competence,
- time-limited ...supported by a rationale,
- periodic recertification,
- mechanism to verify that certificants have met the requirements,
- publicly available policies and procedures.

I suspect that these new standards will result in a little more rigid adherence to compliance. The commentary related to standards identifies different mechanisms that could be used to conform to the standard. There is guidance for what various tools should include. For example, if an organization uses a test for recertification, the test has to have the same properties of validity and reliability that any other test should have. If

an organization uses continuing education, it has to make sure it is as meaningful as possible. Since the concept of recertification standards was introduced in 2002, the momentum has grown. Now we are well past the tipping point.

I want to ask questions today rather than provide answers. For example, is there a difference between *competence* and *continuing competence* in practice? If your answer is no, it seems to me that if the test you give to new applicants is what your organization requires to provide evidence of competence, then the same test would measure continuing competence. Suppose a person gets certified or licensed today as an xyz professional, what assurance does the public have about the meaning of that credential five years hence? What is the meaning of your credential over time? If it is okay with you that the meaning of the credential can change, that's fine. The idea is to set the goal, identify what the goal is, and don't concentrate on the tools.

That said, here are some innovative assessment tools in alphabetical order:

- Audio
- Branching simulations
- Case studies
- Drag and drop
- Essay
- Fill-in-the-blank
- Graphics
- Hotspot …

Many of these are not new techniques, although they have been enhanced by technology. There is new flexibility in administration. For example, there are ways to do a superficial computer-based evaluation of an essay exam. Written simulation is a tool that used to be administered in paper format, using invisible ink. Now it is possible to incorporate all sorts of audio and video in a computer-based environment.

The bottom line is that there are tools. But, don't start with the tools. Think first about what you want to convey to members of the public about the meaning of the credential. Identify the goal. Then develop the tool that will meet the goal you have set for your continuing competency program. If an organization asserts that the credential holder has demonstrated knowledge and skills, the assessment must show both. If the organization mentions only knowledge of a defined content area, the assessment is less complex. In a similar vein, what does the organization want assert about credential holders five, ten or fifteen years after initial certification or licensure? Start with the goal, not the tool.

Question - Licensing boards are complaint-driven. So, we often don't get feedback about competence until someone has been harmed. Is there any way to develop a system that would bring hospital peer review into the system so they can review competence on a regular basis?

Fabrey - Most of you are familiar with 360-degree evaluations, which include patient feedback. You can go online now and get patient opinion. The issue I have from a psychometric perspective is that this is a self-selected group of people choosing to

participate, which raises questions about reliability. As to peer review, it is human nature to not want to report about one's colleagues.

Question - Dentistry has a three-part definition of competency: skill, knowledge and values. You have to be able to do the right thing, know why you are doing it, and value doing well. We have a hard time measuring values.

Fabrey - Simulated patients is one way to get at values, although at one point in time. The answer may lie in some kind of continuous evaluation with patients involved.

Henderson – Peer review is a great tool for assessing things like values. Like Larry, I value reliability, but when it comes to certain things, I am willing to live with a less formal process. Peer review consisting of observation followed by a discussion with the individual to get at nuances can be a valuable way to learn and to get at the values that undergird professionalism.

Fabrey - Going back to my question about whether continued competence is different from initial competence, I think the answer probably should be yes. If you are thinking yes, what we are talking about now may be a good part of the meaning of continued competence.

Comment - Some places in the country send questionnaires to their patients, whose responses are made publicly available.

Question - As a public member, I have an expectation that every healthcare provider is competent today. As a regulator, my dilemma is how do I meet that expectation? Today, you could be a pediatric nurse and tomorrow you could be a geriatric nurse and next year someone else. How do we assess 150,000 licensees with a small budget?

Fabrey - Solve your dilemma by changing your expectation. People aren't perfect. There will be errors. There will be disciplinary actions. The solution may be to get multiple sources of input involved.

Question - Most of us are licensure based. I see private sector practices that do data analysis, evaluate their practitioners and improve performance.

Fabrey - That is a good point. Licensing boards can imitate successful models from other sectors.

Kim Edward LeBlanc, Executive Director, Clinical Skills Evaluation Collaboration (CSEC)

The Clinical Skills Evaluation Collaboration (CSEC) is an endeavor of the Educational Commission for Foreign Medical Graduates (ECFMG), which credentials foreign medical graduates to allow them to come to the US for training, and the National Board

of Medical Examiners (NBME), which administers many different examinations to assess the competency of physicians and other professionals. CSEC was begun to administer the clinical skills exam. The collaboration began in 2003.

The mission of the two organizations is to be sure that anyone practicing medicine in the US has a minimal level of competency required to enter training programs. It doesn't mean they are ready to practice medicine, per se, but it allows them to train to practice medicine. It is really a licensing exam. Medical boards use the USMLE program to assess someone's qualifications to be granted a license.

There are more than 900,000 licensed physicians in the US. Slightly fewer than 23% are foreign medical graduates. In any given year, about .51 % will be sanctioned by a licensing board, or about 4,500 individuals.

There are three steps in the USMLE process. Step one is weighted toward foundational science. Step two has two parts: clinical knowledge assessment and clinical skills assessment and is usually taken during a student's senior year. Step three is an assessment of clinical skills after one year of residency.

Prior to 2004, there was no assessment of clinical skills in the US. The precursor to the current exam was only for foreign graduates and was heavily weighted toward English proficiency. When the collaboration was formed in 2003, everyone wanting to practice medicine in the US was required to take the clinical skills evaluation. Shockingly, prior to that, nearly a third of medical students completed medical school without ever having been witnessed examining a patient. Since then, every medical school in the US has a clinical skills program.

Are the assessment results predictive? Canadian research shows that failing the clinical skills exam was a predictor for getting in trouble with medical boards, particularly with patient-physician communication and clinical decision-making. Many other studies confirm this. The three most common reasons physicians get in trouble with licensing boards are communication, communication, communication.

We know what is good and what is bad professional behavior. We know what is safe and what is not safe. The problem is that it is not always obvious when a clinician crosses the line.

We have tested over 380,000 examinees as of the end of last month. We have more than 4.5 million standardized patient encounters.

The clinical skills exam takes a whole day. There are twelve encounters with standardized patients, which is enough to have a valid and reliable exam. During the encounters, the examinees have 15 minutes with a patient. They are given a fairly common clinical scenario developed in collaboration with subject matter experts. They take a history and do an appropriate physical examination. They have to communicate and show empathy. After the encounter, examinees have a maximum of ten minutes to type patient notes.

This year we will test more than 35,500 examinees. About 21,000 will be US graduates and the remainder foreign graduates. How well do these students perform? Prior to 2013, the fail rate was around 2%. The exam has changed significantly so the failure rates went up to 4.9% for US graduates. The fail rate is now declining again.

The exam has three components: interpersonal skills; spoken English proficiency; and the Integrated Clinical Encounter, which includes history taking, physical, diagnosis and treatment plan.

What happens if someone fails? They take remedial studies and try again. The USMLE limits individuals to six attempts for any one exam. Many state medical boards' limit is 3 or 4 re-takes.

Question – Medicine has residencies. Do you think a skills assessment would be appropriate in other professions that don't have residencies?

LeBlanc – In my opinion, no licensed professional should have qualms about being tested. We can teach all we like, but we also need to assess someone's ability.

Question – Do you really need 12 encounters??

LeBlanc - For scoring purposes, we have 12 encounters and at least 11 are scored. We have ad hoc stations where we pre-test items.

Question - Can you visualize a clinical skills test being used as part an assessment of current competence for license renewal purposes?

LeBlanc - Yes. We have been asked by an organization to do this for them, particularly for individuals who want to re-enter practice. I don't know that we could do it for every physician seeking licensure renewal. It would overwhelm our system. But, licensing boards need to decide whether they would like to see that happen.

Question – My board sees nurses fired when the problem is really a team problem. I hear a lot about assessment for individuals, but how about assessing the team and the environment and the system?

LeBlanc - I agree. We are looking at adopting a team-based approach in the future. Clearly, there is always a scapegoat, but is that the right person?

Question - Please talk about how students responded to the requirement that they take this assessment.

LeBlanc - The resistance continues. Some of it is cultural. We survey everyone who completes the exam and they often comment that the exam in unnecessary because they have been assessed at school. True, but CSEC is standardized.

Comment – A system is only as strong as its weakest link. So, improving individuals contributes to improving teams.

Performance Testing – Tom Granatir, Senior Vice President, Policy and External Relations, American Board of Medical Specialties (ABMS)

I will talk about the political backlash ABMS is experiencing in opposition to Maintenance of Competence MOC requirements. There is also a sad story on the science because our ambition to measure performance exceeds our ability to do it. It is a reality we have to face.

When physicians say MOC didn't make me a better doctor, didn't have any effect on patient care, and it's invalid and never been proven, the may be right. We heard Dr. McMahon say a person can attend an educational event and get nothing out of it. In the minds of doctors and hospitals, both CME and the certification process are all about checking boxes and not about meaningful engagement to make things better.

Both of us would like to try to create a system that is innovative about assessing and improving. Dr. Fabrey asked earlier what a credentialing organization wants to assert about its credential. This is actually a tough question. It is probably not what was suggested earlier that everybody is able to perform competently in a given domain. That is not something that any certifying body can actually attest.

ABMS has 24 independent member boards that certify physicians to practice in a specialty. We are a strange kind of trade organization because we don't get to choose our members and our members don't get to choose us. The boards emerged from a joint initiative by AMA and ABMS. They decide whether it is appropriate to create a new specialty. When they do, residency programs have to be in place to provide training in that specialty. ABMS certification is very intimately linked to the creation of training programs. There are many other certification programs, many of which have strong tests, but they may not have the direct involvement in creating training in specialties.

Part of what ABMS boards do is create the standards for training and part of what they do is create an assessment at the end of training to make sure people have learned from the training and are confident they can practice in the specialty. This is not a judgment about whether they do practice well, but a judgment about whether they are capable of practicing well. That is a big distinction.

The first board (ophthalmology) was created in 1917 amidst a movement to look at the quality of medical care. The American College of Surgeons adopted the first standards for hospitals in 1917. This was part of the progressive movement in the early 20th century, which included standardizing training and evaluation of medical practice. The profession decided to separate the assessment function from the guild function. The AMA did not control the boards; they were independent from the very beginning. Four more boards were created during the next 15 years and ABMS was created as the umbrella in 1943. Now there are 24 boards. The boards set standards for themselves in the sense of establishing expectations.

Initial certification follows residency training. About 800,000 physicians are certified in a specialty. Maintenance of Certification (MOC) was approved in 2000, implemented in 2006 and revised in 2009 and 2014. About 500,000 physicians are participating in MOC. That number increases by about 50,000 a year.

At the time MOC was introduced, a decision was made for legal and political reasons to "grandfather" physicians who had been issued lifetime certifications. Research shows that skills decline over time, so two boards created in the 1960's (Family Medicine and Emergency Medicine) decided to have no grandfathering. During the next twenty years, all the other boards moved toward the recertification requirement. Still, in the backlash we are now experiencing toward MOC, there are physicians who say they don't want to take an MOC examination.

There isn't any evidence that medical specialists are better doctors, but there is science to show that skills decline. There is also evidence that people can't assess themselves. They tend to ignore what they are bad at and overestimate what they are good at.

In 1999, the boards adopted a competency framework for medical training along with the Accreditation Council for Graduate Medical Education (ACGME), which sets standards for training. There are six core competencies: professionalism, knowledge, practice and procedural skill, lifelong learning and improvement, interpersonal communication, and system-based practice. These competencies can be observed during training, but once people are out in practice it is more difficult to observe. MOC implies a philosophical shift from "Are you ready to practice?" to "How are you practicing?" This is a much harder question to answer. Interested parties all over the world are researching what it means to make care better and what at the qualities it takes to do so.

Because MOC affects people already in practice, it is not only about knowing, it is also about learning and doing and improving. There are four elements: professionalism and professional standing; lifelong learning and self-assessment; external assessment of knowledge, judgment and skills; and improvement in medical practice. There were few models for assessing improvement in medical practice so we have been developing measures – multiple measures for some specialties and sub-specialties.

The boards have taken various approaches to what the improvement in medical practice element is. Is it about measuring actual performance? A lot of the backlash we are hearing is that this is tedious work that physicians don't feel they ought to be doing. Some of the boards (pediatrics, for example) are emphasizing participating in learning collaboratives and learning how to use data to become a better doctor. The surgeons and anesthesiologists tend to focus on more technical matters, so they have simulations and patient outcomes in terms of functional results. Other boards (obstetrics and gynecology) are focusing on making sure people are practicing according to the latest evidence. Some boards are developing registries to collect data. We don't have a good understanding of what practice-based learning means. If physicians have to stop practice to assess themselves, that probably does not qualify as practice-based learning. The ultimate idea of an integrated system of assessment and learning that happens in practice is something we would like to see happen, but don't know how to do it.

Meanwhile there have been some papers on the topic, including *Achieving the Potential of Health Care Performance Measures* by Robert A. Berenson, Peter J. Pronovost, and Harland M. Krumholz. These authors evaluated the kind of measures we use – process measures, outcome measures. There are limitations to both. Are outcomes attributable to

a particular physician or to a system? When we look for something, we find more of it. On the process side, was the care appropriate? Was the diagnosis right? We measure whether a physician is doing something well, but we aren't measuring whether it was the right thing to do. We don't have a way to measure that.

Their recommendations at the end of the paper are to

- Move to outcomes
- Use other QI approaches
- Measure at the organization level, not the clinician level
- Measure patient experience of care and patient-reported outcomes as ends in themselves
- Promote a rapid-learning health system
- Invest in measurement science
- Create an entity to set standards for measuring and reporting quality and cost data.

One of their recommendations is to measure at the organization level, not the individual level. But under the ACA, physicians are now going to be held accountable for a quality score computed on their participation in quality activities, quality measures, resource use metrics, and so on. The payment system is entirely dependent on being able to measure something that I'm pretty sure we can't measure.

Meanwhile, one of the things the board has been concerned about is the 10-year exam interval. We also think that studying for a test is not the best way to retain knowledge. So the boards are looking for different approaches. One option is more frequent tests with feedback; remote testing at the test-takers convenience; a more practice-relevant system; and using new technologies such as videos and simulations.

The Board of Internal Medicine, the largest board, convened its own group of experts to look at the science and make recommendations about what it is important for an internist to be able to do and whether there is a way of assessing it. They concluded the ten-year cycle should be replaced by more frequent assessments focusing on cognitive knowledge because we don't have reliable tools to assess the other competencies.

So, the science isn't great. We don't have the tools to measure all the things we think are important. Physicians are purists and are pushing back ferociously against us. They are forming alternative boards that will confuse the public about what certification actually means. We are spending a lot more of our time dealing with that than figuring out how to upgrade the science.

Simulation is attracting a lot of interest among medical educators. Family Medicine is looking at how to use data from electronic medical records to create a profile of physician performance.

One question is whether we actually need to assess every doctor. Are there ways to figure out how to look at the population and have more interventions with the people who need it the most? Computer assisted testing and predictive modeling can help us figure out where to target interventions and individualize testing requirements and their

frequency. Other boards are looking at reporting on certain "tracer" conditions, registries of variables such as certain kinds of imaging, and physician engagement in safety programs and organizational quality improvement.

Do we need different ways of evaluating physicians? What are the qualities that can be assessed locally – in context? How can we engage physicians in a positive way? We need the support of the patient community to keep pushing us to improve our tools. We need consumers to tell us what they expect.

We confront practical challenges:

- How can we reduce the data collection burden?
- Can we develop relevant measure for everybody?
- How do we capture the "non-technical" competencies?
- What qualities are best assessed locally?
- Do we need different approaches for different specialties?
- What is the best way to help physicians improve care?

There are additional philosophical challenges:

- Should we focus more on improvement science than measurement science?
- How do we focus on organizational improvement and still meaningfully assess the performance of individuals?
- How do we reconcile our focus on capabilities in a world that wants measures of actual performance?
- Should MOC assess general competence in the specialty or focus on what physicians do in practice?

Question - Do you see any concepts that licensing boards use for risk-based assessment not tied to the disciplinary process? Licensing boards have access to data about prescribing patterns, for example, but no outright authority unless there is a disciplinary complaint and investigation.

Granatir – The ABMS boards have a close relationship with state medical boards and get data about actions that have been taken. They rely heavily on state boards to do their job of identifying professional issues. A risk-based assessment that could be used as a screener is a very good idea.

Question - Please speak more about portfolio improvement. Do the doctors choose the cases to include in their portfolios?

Granatir - The intention is to get physicians meaningfully engaged in an improvement process inside their hospital. There are also community collaboratives and group practices participating in this. We are looking for organizations that have strong safety and quality enforcement and have demonstrated they can do quality improvement. They apply to sponsor the program and choose the things they want to work on inside the hospital. It started at Mayo and now there are fifty-five sponsors. We are looking for an infrastructure of quality improvement support that physicians can become engaged in.

Grady Barnhill, Director of Examination Programs, National Commission on Certification of Physician Assistants (NCCPA)

This is an exciting time to be at a conference on this topic. I agree with other speakers that we are finally getting some traction in things we have been talking about for a long time. There are lots of reasons why continuing competence is important. For example, a 2015 study of anesthesiologists found that 124 out of 277 operations included a medication error or adverse drug event.

In the mid-90's, CAC came up with the five-step model for a continuing competence program: 1) routine periodic assessment; 2) personal improvement plan; 3) implement improvement plan; 4) documentation; 5) demonstration of competence. My talk will focus on two of those steps: routine periodic assessment and demonstration of competence. Some of us feel these two might be merged, one occurs at the beginning of a renewal cycle and the other at the end. Those two points in time are not very far apart.

Looking at trends in continuing competence, we see advances around the globe. We are seeing more emphasis on reflection and on targeted assessment. The physicians and surgeons of Ontario, for example, mandate practice audits for practitioners who are 70 and older. More attention is being paid to non-technical skills, such as communication. Communication was found in one survey to be a primary factor in 43% of errors made during surgery.

Competency includes skills and attitudes, but because of push back from members of the profession and because skills and attitudes and other non-technical skills are more difficult to assess than knowledge, there is a tendency to rely heavily on multiple-choice tests of knowledge. Self-assessment, we seem to agree, is unreliable. More of an effort is being directed at approaches that are evidence-based and supported by data. The New Zealand pharmacists have a four-step program with the fourth step being evaluation and documentation of the outcomes of learning.

Some organizations are giving more points for higher quality CE. The Royal College of Physicians and Surgeons in Toronto, for example, rewards such high quality activities as accredited self-assessment and practice review and appraisal. Pharmacists in New Zealand earn a different number of points per activity depending on its quality. For example, demonstrating practice improvement earns five times more points than attending CE with no assessment.

What kinds of assessments are in use? The Pharmacy Examining Boards of Canada have for some years used objective structured clinical exams (OSCE), or standardized patients. The American Board of Anesthesiology is using a novel online assessment called the MOCA Minute. A single question is sent to every certificant's home every week with one minute to respond. The system gives feedback and direction to resources to promote learning. Answering a certain number of questions over a year is the equivalent of taking a test.

Practice reviews are increasingly in use. The National Board for Certification in Occupational Therapy (NBCOT) incorporates virtual reality in its new assessments. Some of us are using practice exams, which provide detailed feedback to the test-takers.

Should self-assessment be voluntary or mandatory? Voluntary assessments tend to be under-utilized and may work best for those who need them least.

What about length of time in practice? Research shows that knowledge is not permanent. Those in practice for longer times tend to perform less well on examinations and have poorer outcomes. A study based on a literature search published in 2005 in the Annals of Internal Medicine documented many studies showing poorer outcomes over time.
Another study implies that one reason for declining performance may be that practitioners focus on a narrow specialty while the exams they are taking are general in nature.

What is new in assessments? One example is the anesthesia crisis resource management simulator. Another is the virtual standardized patient, which can be used to take blood pressure, perform a physical, and more. The Standard Patient Hospital used in the University of Southern California assesses communication. The system can create a variety of personalities, including "average, sullen, loquacious, uncertain, reserved, and erratic." Medical sonographers can use simulators to improve the quality of their images. A test of virtual reality skills training of professionals in alcohol screening produced this conclusion: "The technology tested in this trial is the first virtual reality simulation to demonstrate an increase in the alcohol screening and brief intervention skills of health care professionals." Simulations used for high stakes surgery, endoscopy, and other skills are also working pretty well. The Food and Drug Administration is requiring completion of simulation training for some procedures, such as carotid stenting. Data mining of E-pelvis simulator assessments with 41 expert and 41 novice practitioners found that 92% performed correctly.

Turning to my organization and physician assistants (PAs), this is traditionally a broad-based generalist credential. Yet, our numbers are changing and now over 70% of our practitioners are specialists. How should we address the generalist vs. specialist conundrum? PAs want practice mobility among specialties, but also want to be assessed by what they do.

Is it a waste of time for a specialist to study for and pass a broad-based exam? For public protection, you want to be testing people on what they are doing, which is an argument for focusing more on testing by specialty.

For our practice analysis, we looked at PA practice over time and by specialty. We found that practice doesn't change much over time. But, how different is specialized versus general primary care practice? We interviewed 72 different practitioners in eleven different specialty areas about knowledge, skills and abilities. We had seventeen come in to talk about the general credential. We designed a large survey of more than 93,000 PAs to address all these issues. We looked at what practitioners do and what diseases and disorders they encounter in practices. We had about a 17 % participation rate.

We compared practitioners with 6 or fewer years of practice with those having more than 6 years of experience. The younger ones are more inclined to use informatics. Those with more experience spend more time negotiating contracts. The new folks more frequently recognize professional and clinical limitations. All the practitioners tend to encounter the same diseases and disorders over time. Then we compared emergency medicine with primary care (family medicine, general internal medicine, and pediatrics) and found greater variations in knowledge and skills and in the frequency of encountering conditions. The bottom line is that specialty PA practice appears to be different from general primary care practice.

We are envisioning a general primary care assessment component as an online summative / formative assessment. We will also have practice-focused modules, probably in such fields as family medicine, pediatrics, more rigorous emergency medicine, orthopedic surgery, hospital medicine, cardiology, dermatology, and so on. We are probably five years out for implementation. The worst part is that we will put this out for public comment, but what we hope is that the practitioners who are complaining bitterly about having to take this test will be more amenable to a test that is more like real life. We will, for example, let them take the assessment at home and, for some questions, consult outside resources just as they would in practice.

Question – You commented that communication is a competence issue. There is a bridge between certification organizations and regulators. Typically, regulators see a lot of issues with communication. How can we bridge on this particular competency issue?

Barnhill - Our exam is used as a de facto licensing exam and 27 states require continued certification with us for continued licensure. So it is very high stakes. One thing we have found is that "if you test it, they will teach it." I think the best thing a certifying body can do, which would in turn impact licensing bodies, is to test communications. This has to be done through patient questionnaires or 360 behavior- based interviews, or maybe in a virtual context.

Question – My dental school teaches students that they must practice only within their current level of competency. This makes self-assessment a serious matter.

Barnhill – Your point is well taken. It has been found that self-assessments improve when practitioners are given feedback. Perhaps by providing objective information, we can improve the capacity to self-assess more accurately.

Part III – Innovations in Overcoming Stakeholder Resistance

Making Continuing Competence Fun – Paul Grace, President and Executive Director, National Board for Certification in Occupational Therapy

We started looking at continuing competency three years ago. We had a very traditional certification renewal requirement where individuals had to satisfy a predetermined number of continuing education units during a three-year cycle. Most states have licensure renewal requirements of two to three years, so we adopted a three-year cycle to

be consistent. This has been beneficial for our certificants because many of the states allow the units that individuals submit to us to be credited towards their licensure renewals.

We are accredited by the National Commission for Certifying Agencies and conform to the ISO 17024 standard. ISO and NCCA have standards related to continuing competence. We held a series of focus groups throughout the U.S. composed of certificants, educators, employers, and state regulators. A consensus emerged that we didn't want another one-size-fits-all test. Unlike the entry-level people coming out of school or finishing a training program, older individuals don't like testing. Based on the focus groups, we developed our "vary audacious goal," and I think we have met it. Our goal was to provide a virtual platform for certificants to engage in continuing competency programs. We got the idea from a session at ATP about how games are used in education. We translated that into putting serious gaming into assessment. So, we created an innovative and dynamic delivery platform for games.

Many thought our program duplicated the state licensing requirements, but our accreditation requires a certification renewal program. Also health systems were becoming interstate or regional and they wanted their therapists to be held to a national standard. That is one of the reasons we reached out to employers to determine what kind of program would fit within their business model and also support our certificants and their assistants in their jobs.

The IOM's report on continuing competency of the 21st century workforce identified major areas where healthcare, particularly allied healthcare, workers should be able to: provide client-centered care, work in professional teams, employ evidence-based practice, apply quality management, utilize informatics, and demonstrate professional responsibility. We used these as the major domain areas of our practice analysis. Then we brought together regulators, academics, certificants, and employers and did a typical practice analysis for a high-stakes certification examination.

We wanted the program to have validity so every part of the game is linked back to some aspect of the practice analysis. We identified the knowledge associated with each of IOM's domains and those knowledge areas are assessed in the game at some level. Our study did not focus exclusively on OT because we hoped the tool would be useful for other professions if it focused on knowledge that is essential for practice. (Employers have been enthusiastic about the study because they may be able to use it for professional development scenarios for their staff.) Then we assembled subject matter experts and gaming company employees to develop the games.

We wanted the games to be accessible and engaging. We also wanted to make the games generational. Millennials learn differently than Gen-Xs and Baby Boomers. So, we wanted a gaming platform adaptable to all these populations. The sweet spot was 25 to 45-year-old therapists who comprise the bulk of our population. Those individuals like the more traditional multiple-choice way of assessment. As they get younger, gaming is more attractive.

We didn't want one-size-fits-all. We didn't want gaming to interfere with actual assessment. We wanted clear and consistent graphics. We paid attention to

incorporating appropriate sound. We wanted to provide needed instruction and meaningful feedback. In addition to games, we had to develop a platform to deliver the games. They can be played on a computer or a tablet.

We know that students have an abundance of evidence at their fingertips. When they graduate, the evidence is no longer accessible unless their workplace provides it. Our board adopted a policy to provide a free subscription to the ProQuest and Refworks evidence-based database to our certificants.

There is little research about using serious games in assessment. We are sponsoring a post-doctoral student at the University of Florida who will follow up with OTs and their patients to determine whether this program makes a difference in practice. So we hope over time we will have enough data to be able to report about the effectiveness of our games.

We called our program the Navigator because we hope it guides users to the place they want to be. The game begins with a self-reflective computer-based questionnaire. Individuals enter their current practice area and the computer selects the appropriate case simulations, multiple-choice quizzes, and match play games accordingly. It is possible to override the computer and select additional games if, for example, someone is considering transitioning to another specialty area. The multiple choice mini-practice quizzes are developed with references and reading lists to enable certificants to learn more about the topic areas. The match games include one developed by a group of organizational psychologists to teach people who have not attended graduate school how to locate and use evidence in practice. There are also common self-assessment tools. Certificants earn professional development units (PDUs) by completing the games. Seventeen stares currently recognize the PDUs obtained this way. They also get feedback showing where they fall within the cohort of people who have played the same games.

Where are we today? We did a soft launch of the program in early June. As of two weeks ago, 16,341 games had been played by more than 6,000 occupational therapists. The feedback has been positive. Academics have asked to incorporate the program into their curriculums. Employers are interested because the games not only support a therapist's continuing education but also reveal the areas where continuing education is especially needed.

Editorial Note: Much of Mr. Grace's presentation was video taken from the recertification link on the NBCOT website, which can be found here: http://www.nbcot.org/certification-renewal.

Question – Is it safe to say that as a therapist's scores improve, their patient outcomes improve?

Grace - The research initiative we are supporting will give us some insight into that. Based on the feedback we are getting we are fairly confident the program is improving patient care.

Question - Are the games required?

Grace – No, this is one option for earning PDUs.

Question - How do you plan to update the content?

Grace – We have a development team and an ongoing practice team. Some of the original games are already being reviewed for modification. We re-check the references annually to be sure they are up-to-date. It is very expensive. Other certifiers have asked if we can make the platform available. We haven't decided about that. We make the games available to certificants free of charge because we think it is a value proposition to our certificants. We wanted a product that meets our accreditation needs and is attractive to certificants.

Deeming to Avoid Duplicative Requirements – David Swankin, President and CEO, Citizen Advocacy Center, CAC

My remarks are derived from excerpts from a report that Becky LeBuhn, Richard Morrison and I wrote and AARP published in July 2006 entitled *Implementing Continuing Competency Requirements for Healthcare Practitioners*. (http://www.cacenter.org/files/ImplementingContinuingCompetencyRequirements.pdf).

The report contained a number of recommendations, including:

> Licensing boards should grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards or by hospitals and other healthcare 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 continuing competence through board-administered continuing competence programs.

This recommendation assumes that boards have programs that can serve as benchmarks and that they can measure the effectiveness of credentialing organization programs against the benchmarks. Most boards don't meet those assumptions, but they could evaluate outside private programs against a standard. This is how we explained our rationale for the recommendation.

We raised two questions: How should state legislatures take into account the relationship between continuing competence requirements of licensing boards and those of specialty certification boards? Should current board certification satisfy a licensing board when a licensee again demonstrated his or her competence? This was our answer:

> State legislatures need to provide guidance to licensing boards on implementing a continuing competence 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 by which licensees can demonstrate their continuing competence. For example, boards might be

> authorized to recognize (deem) outside organizations as the boards' agents in enforcing 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.

On that point, Ed spoke yesterday about our efforts in Virginia to get legislation passed and he mentioned that there was not overt opposition by the medical society or the nurse's association, but we don't know what went on behind the scenes because no one voted for the legislation. Since 90% of physicians in Virginia are board-certified, the board would have to concern itself with only 10% of the physicians licensed in the state. That stopped the conversation for a while. Medicine has the highest percentage of board-certified licensees, so this fix won't work as well for other professions. Back to the publication:

> To be consistent with current regulatory practice, for a licensing board to recognize a credential awarded by a private entity, for example, a specialty certification board, a professional association, a hospital credentialing committee, as evidence that a licensee has demonstrated continuing competence. Many boards already deem that individuals meet education and 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 they be satisfied by completing courses that meet the standards of an independent accrediting agency. Legislatures and boards would have to identify the criteria that outside organizations would be required to meet in order to earn deemed status. Several acceptable approaches are possible. Legislators could choose to legislate some or all of the criteria for granting deemed status to private organizations. They could direct licensing boards to establish the deeming criteria via rules and regulations. Or, the legislatures could establish the criteria in broad policy terms and allow the boards to fill in the specifics by rulemaking. Whatever the approach, it is essential that any program for evaluating current competence be equivalent in terms of public protection to the program a licensing board establishes on its own for periodically evaluating and verifying the continued competence of its licensees.
>
> Private voluntary specialty certification boards will likely seek deemed status from their professional 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 under their laws. 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 of those licensees who choose to earn a specialty certification. However, no licensee

should be put in danger of having their license taken away or legally restricted unless they fail to meet 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% of all licensed physicians are certified by specialty board. The American Board of Nursing Specialties has 26 member boards in the United States (as of 2006), one of which is the American Nurses Credentialing Center, an ANA-sponsored organization that certifies 135.000 nurses in more than 50 specialties. It is estimated that only about four percent of pharmacists are board certified. In other health professions, there are no specialty certification boards at all. Some specialty certification boards have recertification programs requiring maintenance of competence, ongoing lifelong learning based on assessment and demonstrations of continuing competence. The most developed of these is the American Board of Medical Specialties program.

In addition, all certification programs accredited by the National Commission on 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 in a variety of health professions and found that at that time, 95% of the forty-four responding boards require practicing certificants to demonstrate their competence periodically, 86% of them allowed their certificants to meet their continued competence requirements by taking approved CE not based on assessment. This is changing rapidly.

Before granting deemed status, licensing boards need to evaluate and assess the specific requirements of each voluntary certification board against the licensing board's own requirements. Certification bodies that allow their certificants to fulfill recertification requirements simply by taking continuing education courses should be found inadequate. Likewise, portfolio requirements based solely on self-reflection and continuing professional development programs that contain only competence improvement steps also would not have the necessary rigor in our view.

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,
- The public has ready access to deemed status organization's standards and measures,
- Information about individuals, including their qualifications and affiliations, who conduct reviews on behalf of the deemed status organizations are made public,
- Surveys conducted by deemed status organizations are validated periodically,

- The results of deemed status organization's review process are public, and
- Deemed status organizations have no conflicts of interest with, and are independent of those entities they approve or accredit.

Turning to another document from the Credentialing Resources Center Daily published in August 18, 2015 and entitled*, The Medical Staff's Guide to Overcoming Competence Assessment Challenges*:

> After a practitioner completes his or her initial focused professional practice evaluation, the (hospital) medical staff is responsible for monitoring his or her competence on an ongoing basis. The following excerpt from the Medical Staff Guide to Outcome Competence Assessment Challenges describes what data needs to be tracked to ensure a practitioner is currently competent…. Often, negligent credentialing claims are based on allegations that the organization failed to ensure that a practitioner was competent to provide specified care, treatment, or services. Organizations should ensure that they have done their due diligence to not only verify initial competence but to also establish a comprehensive process to monitor and review practitioners' ongoing competence.
>
> Monitoring a practitioner's overall performance is a comprehensive, data-driven process. Most organizations collate these data into a central department for tracking and trending and/or use commercially available databases to help streamline the process. Performance data that should be monitored on an ongoing basis include but are not limited to the following:
>
> - Department-specific quality metrics
> - Quality metrics identified by the organization that can be tracked and measured for each practitioner (e.g., average length of patient stay as noted in the example above, unplanned returns to the emergency department or ICU, timely patient discharge, etc.)
> - Compliance with medical record documentation requirements (e.g., countersignatures; appropriate documentation of verbal orders; thorough, accurate, and timely documentation; etc.)
> - Medication reconciliation compliance (e.g., review any discrepancies noted by the pharmacy or error rates attributed to the practitioner)
> - Complaints or grievances reported from patients/families
> - Performance concerns documented by the department chair (e.g., collegiality, meeting attendance, feedback from medical students/residents, etc.)
> - Peer review data (e.g., clinical or behavioral concerns, policy or compliance violations, etc.)
> - Maintenance of current credentials (e.g., number of times practitioner allowed license, Drug Enforcement Administration, insurance, or other credentials to expire, resulting in automatic suspension)
> - Ongoing monitoring of state medical board investigations/sanctions, National Practitioner Data Bank (NPDB) updates, and Office of Inspector

General (OIG) queries to ensure the practitioner is not on the excluded parties list
- Complaints or concerns reported from employees, the compliance department, or peers
- Overall compliance with hospital policies, code of conduct, medical staff bylaws, and rules and regulations
- Data from patient/family satisfaction surveys
- Any other data identified by the organization as being meaningful and measurable performance data. (Source: http://www.credentialingresourcecenter.com/news/assessing-ongoing-competence)

CAC is aware of a study of peer review in California. The study showed that some hospitals used peer review as a vehicle for improving quality. Others didn't. If a licensing board set standards for peer review it would have to have the staff, the will and the resources to implement the standards. It is hard to see how a board in a large state with many hospitals would be able to evaluate them all. It is a wonderful idea, but it would be difficult to implement unless the board used third parties, such as accrediting organizations. Or, boards could rule that all magnet hospitals could have deemed status. If boards had their own program for requiring demonstrations of continuing competence as a condition of re-licensure, it would be easier to measure an outside program against the board's program.

Netia Miles, Licensing Manager, Oregon Medical Board

I am here to talk about how the Oregon Medical Board assesses current competence. The Oregon Board recognizes that continuing medical education credits and courses relevant to one's practice are just one important element used for competence assessment during a medical career. Given that, there are four competency assessment areas in which physicians earn continuing medical education (CME) credits: licensure renewal, re-entry to practice, license status change and investigative process resulting in board orders.

We license about 21,000 practitioners, the largest group being physicians and physician assistants. The average professional with no identified issues or problems may participate in maintenance of certification. For those who don't participate in maintenance of certification, we require 60 hours of CME every two years for physicians and physician assistants and 30 hours of CME every two years for acupuncturists. The CME credits must be relevant to the licensee's practice.

The board requires any licensed physician who has been out of practice for two years or more to design a re-entry plan. The re-entry plan is influenced by a number of factors, including the number of years of active practice before the hiatus, the number of years out of practice, and the number of years of specialization. A re-entry plan may include supplemental training or mentorship, CME, re-certification, or passing a national exam. In some circumstances, the board may require a licensee to pass a standardized and validated competency assessment. They also may be required to engage in computer-

bases simulations or undergo evaluation by third-party assessor or board-approved clinician.

The reason for documenting license status is that it enhances patient safety and allows the board to know who is practicing in our state and that they are practicing at the appropriate capacity. For the sake of time I will discuss only two categories: active and inactive. Active status means actively practicing in the state at a current Oregon practice address. A practitioner who changes to out-of-state practice is subject to being changed to inactive. Some licensees who remain in state but choose to cease practice still want to maintain a licensed status. They can have an inactive status.

Those who want to change from inactive to active status go through a reactivation process, which is an abridged version of the application process. It allows us to review what the individual has been doing while out of practice. If they have been practicing in another state, the board would initiate a license verification to establish that they are in good standing. If they have not been in practice for at least two or more years, the re-licensure process comes into play. We establish competency and ask for a background check.

The last situation in which continuing competency is assessed is when licensees go through the investigatory process. The investigatory committee interviews every licensee who has an open investigation. The committee has the power to evaluate competency and request an evaluation of the licensee's practice. The committee can send the licensee for targeted CME and/or call in a consultant for specialized case reviews.

In 2014, we closed 730 investigative cases. Approximately 9% (64 licensees) of those resulted in board orders. As a condition of these orders, a compliance officer travels around the state and makes random visits to do competency assessments, records reviews, and the like. We might send physicians to outside organizations, such as CPEP or substance abuse programs. The licensee also can be subject to random review and interview by the board and assignment to CME.

Question – I'm intrigued by deemed status. I think it opens up a lot of possibilities. My question is when there is a problem down the road related to an organization that has been approved for deemed status? Can the board view that organization's records?

Miles – If we start an investigation we look for any and all records, so I believe we would have access to the records of an organization with deemed status.

Swankin – If the board accepts a licensee's demonstration of competence through another organization's program, the licensee would waive any personal right to keep records confidential.

Question - You said there are two routes for licensure renewal. Approximately what percentage of licensees renews through the MOC program vs. the CME program? Do

you accept certifications from entities other than ABMS? Also, do you collect any data comparing outcomes for the two groups?

Miles - Currently, we are considering whether to accept other certification organizations in addition to ABMS. We audit 10% of licensees for compliance every renewal year. I can't give you percentages, but the number of people complying via MOC is definitely increasing.

Comment – In Washington State, the pharmacy commission recognizes CE approved by the American College of Pharmaceutical Education, which has a large CE approval mission. We also deem CE approved by other boards of pharmacy. We also have a process whereby the commission can approve a provider of CE for a two-year period. We can pre-approve programs or post-approve at the request of a pharmacist. We don't have deeming of hospitals. I don't know what the rules would look like if we did.

Comment – Washington State's Nursing Commission is overwhelmed with applications for CE because there are schools popping up everywhere, including remote and virtual CE sites and we have to review them all. Also, there is a term used in a previous law because we didn't have enough nurses. The law says "non-traditional" schools can apply to certify nurses to come into our state to practice. We could use some help from CAC to clarify the meaning of "non-traditional." To us, it means the students do not have to have clinical oversight by an RN or LPN. This is a huge gap, so we are trying to repeal the law.

Question – When the compliance officer does a site visit, does he or she interview anyone in addition to the licensee in question?

Miles – It depends on the circumstance. We can interview colleagues. The complainant and family members may also be interviewed.

Comment – The Maryland Board of Pharmacy enacted regulations allowing it to excuse a certified pharmacist from some of our mandates for CE or competency assessment. We will seek statutory authority next year.

Rewarding Good Marks in Self- Evaluation – Cyndi Miller Murphy, Executive Director, Oncology Nursing Certification Corporation (ONCC)

ONCC was founded in 1984. We now have eight certifications in various roles and subspecialties in oncology nursing. We are NCCA accredited. We currently have more than 37,000 certificants.

We have a four-year recertification cycle. For the first ten years we required re-testing, which was not popular. Our renewal rate was only about 59% for the basic exam and about 70% for the advanced exam. In 2000, we moved into something we call the "oncology nursing points renewal option" (ONPRO). This raised our recertification rate to about 75% for the basic exam. This benchmarks well against other nursing

certification organizations. All nurses need to get either 100 or 125 points, depending on whether they are at the basic or advanced level. In 2013, we began moving toward the "individual learning needs assessment (ILNA) approach. It will be phased in during 2016. In developing this approach, we sought input from oncology nurses, employers, educators, and the public. We looked closely at what other organizations are doing and what seems to be working. We patterned the ILNA program after NCC, but we are not as far along.

Let me say some more about the current system because I want to contrast it with the new system. ONPRO is used by about 95% of the candidates for renewal. Other options include taking the test, and several hundred candidates do. Eligibility criteria include an unencumbered RN or APRN license and active practice in nursing and a specialty. Nurses not in active practice take the test and meet the ONPRO requirements.

We have a four-year cycle. Holders of the basic credential must accrue 100 points during the four years. One point equals one hour of CE or CNE, presentations, publishing, or taking academic courses in an oncology specialty. Twenty percent of the points can be volunteer service or precepting students.

The ILNA is a better approach because it is individualized. Everyone has his or her own requirements based on their learning needs identified through assessment. It is not self-assessment, but one ONCC administers. We think this is better because it doesn't allow people to choose courses simply because they are convenient, free, fun, or about something they are already good at. We want to make sure certificants are closing gaps in knowledge rather than reinforcing their strengths.

ILNA is an option. The same eligibility criteria apply. The cycle remains four years. The main difference is the number and content of points, which are based on how an individual performs on the assessment. The assessment is based on our content outline, just like the examination is. We give them a diagnostic score report which tells them the categories in which they need to earn points. I think the majority of nurses continue to use CNE, but we still accept the other types of professional development we do for ONPRO, except volunteer service and precepting because that can't be categorized into specific content areas.

We decided to move forward with ILNA in 2011 and to phase it in over four years. People need to know what is coming and adjust to change. Our first cohort is people who certified or renewed in 2012. We did lots of communication. We have a video on our website fully explaining the process. We sent out emails and paper mail, did presentations at every opportunity.

The first cohort of candidates certifying for the first time in 2012 got their diagnostics when they took their test. Those renewing went online to take the assessment and get a diagnostic report to guide them for the next four years. So, in 2016, that first cohort will submit their points accrued under the new system.

Point accrual is tracked through the Learning Builder platform. We needed an online system to track the individual needs and development activities. The diagnostic report and corresponding learning plan is online, accessible by the certificant and ONCC. Certificants document their points in this personalized file.

The assessment itself begins with a survey where the candidate rates his or her knowledge. So far, the data shows people are not good at identifying their learning needs. The second part is a tutorial showing them how to use the assessment. It is similar to the exam, but in a low-key environment. They can take it online at home or at work.

The items are like items on the exam. It is weighted the same way. There are alternate items types that are not on the exam. There is no fee to take the assessment. We did not want cost to be a barrier.

Security measures include access only to those with a profile, randomized items, a required agreement not to share items, and so on. The assessment must be completed in two hours and no re-entry is allowed.

The diagnostic report indicates scores according to content areas. The points required for each area depend on the weighting of the category in the test blueprint. The minimum number of required points is 25, no matter how well the candidate does on the assessment.

So, the system is pretty simple and many nurses will need fewer points than before. We thought certificants would be happy about this, and many more them are. However, many perceive this as a test, which they don't see why they have to take. People resist change. We've received negative feedback, often based on a lack of understanding despite our efforts to communicate. I wish we could come up with a better term than "assessment."

We expected increased workload and costs for ONCC. We didn't anticipate the degree to which certificants would need help using the system. Many don't understand they must take the assessment before doing CE. Nor did we anticipate a lack of vendor understanding. We didn't expect to be accused of using this as a revenue stream for ONCC, since it doesn't cost the certificants anything and most end up paying less for CE. They are having difficulty matching continuing professional development activities with the needed learning content.

So far, 67% of the cohort renewing in 2016 have taken the assessment. Fifty-one percent of those renewing in 2017 and 41% of those renewing in 2018 have taken the assessment. The average number of points needed after the assessment is about a third of the 100 needed under ONPRO. Candidate feedback is improving gradually. In 2013, 72% found the assessment results useful in guiding professional development. That number was 84% in 2015. Similarly, 70% were satisfied with the process in 2013; 78% in 2015. We feel it will take 3 or 4 certification cycles for the necessary culture change and no more resistance.

Fran Byrd, Director Strategic Initiatives, National Certification Corporation (NCC)

The National Certification Corporation (NCC) is a private not-for-profit certification organization that has since 1975 awarded over 120,000 credentials to APRNs in the fields of inpatient obstetrics, neonatology, and women's health. All eight of our programs are NCCA accredited.

Our evolution into a continuing competency initiative has been a long process. The board followed the reports of the Pew Health Professions Commission, of the Institute of Medicine, and of CAC's wonderful resources and reports. In 2007 NCC did its own study with a group of certified women's health care nurses, letting them self-assess what they felt were their knowledge gaps and giving them a 100-item exam to see how well they assessed themselves. As you have heard multiple times, professionals do not appropriately self-assess their knowledge needs. So, the board decided it was time to move forward toward a third party process.

What do our certificants think they are gaining from this program? Notable benefits to them are that it does provide a third party mechanism to align their knowledge competency with their certification maintenance activities. It tailors their CE requirement for certification maintenance to their individual knowledge gaps based on their personal assessment results. The results are a personalized continuing education plan, which may well have fewer requirements than the prior one size fits all shotgun approach. The assessment approach does not threaten their certification status because it is just one available alternative.

There is no increase in the maximum number of CE hours required. Under the current program, 50 hours is the standard. We give them 5 hours of CE for taking the assessment. There is no mandate to take NCC CE modules. There are multiple acceptable accredited resources for CE. There is no increase in the recertification fee.

The major components of the specialty assessment process began with an orientation phase in which we encouraged certificants to just try it out. The second phase was a binding program beginning with the 2014 maintenance cycle. It involves a 125-item assessment with content and distribution reflective of the core certification exams. We recommend completion as early in the maintenance cycle as possible. We offer an early-taker option. The critical point is that no CE credits are acceptable before taking the assessment.

The assessment is available on demand from any computer, tablet or phone, except at locations that have maximum firewalls and spam filters. It does provide individual feedback using a customized education plan. Results for each competency area are tabulated in an index rating from one to ten. The board determined that for ratings of 7.5 or higher, NCC would not expect CE in that maintenance area. This gives them the option of being able to opt out of directed CE in a particular area. Individuals that have 7.5 ratings still have to do a baseline of fifteen hours of CE in categories of their choice

as long as they are obviously related to their specialty. They can earn baseline credits in some of the alternate ways, such as academic credits, presenting at an accredited CE conference, precepting, and so on.

Upon completion of the assessment, an individualized development plan populates the certificants personal online account. It tells them their index rating and the CE hours required. The report doesn't focus on items, but on those general areas within their core knowledge competency where they could use more work. This is to make it easier for those certificants who have doubts about the system or how it works. The individual codes and enters CE hours in their online account as they are accrued.

NCC's program began before ONCC's, so we are probably past the peak of the wave of alarm and opposition to change. During the orientation phase over 42,000 availed themselves of that opportunity. As a three weeks ago 54,369 of those who are due to renew in 2016 had completed their assessments or had locked in an alternative maintenance plan. This is 76% of the 71,147 who are due to take the assessment. This demonstrates that push back is gradually decreasing.

One of the best resources we provide is a CE coding catalogue for each one of our specialties. And, we are working with larger membership organizations to help them code their annual conferences.

I have been on the receiving end of emails from our certificants who are unhappy about this program, but I really feel the trend is getting more positive. In 2010 the general response was push back. Certificants were convinced we did this solely to make money. Now people are less hostile, even enthusiastic about it.

Looking back, what would we change? The orientation phase really threw people off. They thought they had already done it, so they didn't do it again when it went live. We probably should have let them use the orientation phase results for their first cycle. Looking forward, certificants will get different forms in different years. In the next cycle, individuals may get a repeat of the first form they received because we want to see if they are retaining anything.

Yesterday, I heard many speakers say we really don't have the scientific evidence we need. I think you sometimes have to go with your gut and we feel this is the right thing to do.

Question – Do other specialized certificates do this type of competency assessment?

Miller-Murphy – I don't know how many other similar programs there are.

Question – Is it a challenge to come up with enough items for multiple specialty areas?

Miller-Murphy - Yes, some of the categories are small and it is a challenge to come up with items. That is why we want to collapse some of the categories.

Question – I really like the idea of doing an assessment that drives professional development plans. It seems to me the success of the program is based on the quality of the assessment. Could you talk some more about how you develop the assessment tools? How different are they than the initial exam?

Byrd – Every specialty has its own assessment, which is developed by the same process that the certification exam was developed by the content team. They review every form of the assessment before it is posted. The distribution and weighting of the assessment is based on the content outline and distribution of the existing certification examination to keep it current.

Question – Do you take into account differences between what entry-level people are expected to know and what a seasoned practitioner should know?

Byrd - We have two advanced practice certifications. Our certification exams for advanced practice are at entry into practice level because many states use them as the qualification to practice. Our other six core exams are specialty, meaning certificants have approximately two years in the field and are voluntarily coming to take the exam. The assessment is more in line with the current certification exam, which is updated with current developments in the field.

Question - Do you have security in place to verify that the assessment takers are who they say they are?

Miller-Murphy – It is an honor system. I think the two-hour timing prohibits some security breaches.

Byrd – Certificants can only access the assessment through the link into their personal account. People who want to can find a way around it.

Part IV – Reactions from The Health Profession Regulators

Moderator: Rebecca LeBuhn

Panelists:

Marianne Alexander, National Council of State Boards of Nursing

David Jones, Maryland Board of Pharmacy

Mary Jo Monahan, Association of State Social Work Boards

Netia Miles, Oregon Board of Medicine

Kathy O'Dwyer-Armey, North Carolina Board of Physical Therapy Examiner

Carol Webb, Association of State and Provincial Psychology Boards

LeBuhn – This concluding panel is composed of representatives from six health care professional regulatory bodies. They will share their observations about what they have learned in the last day and a half and how they think is applicable to fulfilling their responsibilities as regulators. I will begin by asking each panelist to tell us who you represent, and how your professions approach continuing competence in the context of re-licensure.

Jones – I'm the long-term care commissioner for the Maryland State Board of Pharmacy. I will also have some comments from the Maryland Society of Pharmacists, which deals with long-term care and geriatric patients. The most complex competency scored by the board is the one around sterile compounding, where in legislation and regulation we reference USP 797 and we expect any pharmacy and pharmacist who is doing sterile compounding to be fully compliant. Our inspectors love what they are doing they look at procedures and cleanliness. We recently had a demonstration of what inspection can do. We inspected a pharmacy where the pharmacist had completed the required CE, but on inspection we found eleven deficiencies in compliance and competence. We are working with that practitioner to strengthen his competencies.

There are separate competencies around pharmacists who wish to do immunizations. Competencies get more complex as we add more and more things that those pharmacists can do. There are competencies about the techniques of administration, competencies about explaining the risks and benefits to patients. We can add competencies about patient privacy and cultural and education sensitivities.

Recent legislation in Maryland allows pharmacists to actually administer drugs as part of the teaching process for self-administering drugs. If a patient came in with an order for insulin, for example, that pharmacist could teach the patient how to self-administer. There we had to evaluate this competency, just as we did with immunization. If the pharmacy is doing immunizations as part of routine practice there are requirements for them to maintain competencies in their policy and procedure manual, which our inspectors will look at. We keep hearing more and more requests that pharmacists have provider status where they can do more in terms of education. As we get closer to that, we added some competencies. The board recently did a survey of pharmacists and pharmacy technicians, the schools of pharmacy and some public organizations. We found some issues with pharmacists understanding what was required for medication error risk management. There were some issues around communicating those risks to prescribers and to patients. We are working on an interactive module with which pharmacists so they can demonstrate those competencies on an ongoing basis around licensure.

Armey – I represent two perspectives. I am a member of the Federation of State Boards of Physical Therapy, where I currently chair the continuing competence committee. I am also a physical therapist licensee and staff deputy director of the physical therapy board in North Carolina.

The Federation's continuing competence committee started its work by looking at the Institute of Medicine and Pew Commission reports and other studies, looking for a basis for validating a continuing competency model that they hoped all the jurisdictions would adopt. To give you some flavor for what the model currently includes, it is sort of the triangulation model discussed by Dr. Henderson where practitioners can complete a variety of types of activities in order to demonstrate competencies every two years. The Federation has a rigorous tool called Procert through which activities can be certified. As a licensee, I took the orthopedics tool and I thought it was outstanding. It included case scenarios in a multiple-choice format. Because it is voluntary, not many people are taking it. I was nervous about taking the test, but I came out with a valuable gap analysis. It is based on both time and value-added activities. Conferences, continuing education, exams, residencies and fellowships fit under the certified category. Approved activities include study groups, research, and mentoring. I don't know that the Federation is yet utilizing the data to determine the extent to which practitioners are getting the education needed to fill the identified gaps. Certainly, today has emphasized the need for better data and data analysis.

North Carolina came late to requiring anything related to continuing competence for license renewal. In 2006, the legislature did authorize us to establish mechanisms for assessing continuing competence. That phrase "assessing continuing competence" did not require high stakes testing. The intent is that the practitioner engages in some analysis to inform the continuing development plan. Is that really happening in practice? I don't think so. I still see a lot of what's fast, what's cheap, what's convenient. Our model looks similar to the Federation's but everything is self-directed except one point has to be related to jurisprudence. I have felt the needle has to move and this conference has provided a lot of information about how to do periodic assessment and get closer to being able to really assure the public that we have a legitimate basis when we say a practitioner is competent.

Miles – The Oregon Health Authority took a bill to the legislature that will mandate cultural competency for our practitioners. This will apply to active practitioners under current renewal.

Alexander – I represent the National Council of State Boards of Nursing. We have explored this topic since the early 1980's, and our goal is to find a model that is evidence-based. We regulate three types of nurses: RN, LPNs and APRNs. For RNs and LPNS, continuing competence is handled at the state level, so requirements vary across the country. APRNs are required to be nationally certified, so they take the certifying organizations' exams and meet their recertification requirements. I commend the national certifying organizations for the work they are doing. They have made real progress. I think we have entered a new era of assessments that are focused toward individuals and will help them focus on their education and bring in an element of engagement.

Some nursing boards are experimenting continuing competency assessment. The Arizona Board of Nursing, for example, developed a structured simulation assessment to examine licensees who have been reported for competency issues. The nursing boards have been looking at continuing competence from a multi-dimensional standpoint.

One of the questions I would ask is, "Where are the employers in this process?" That is something we are looking at very closely because you can have great assessment tools, but as we all know, the bottom line is practice. People can pass tests and do CE, but it doesn't mean they are ethical or careful or free of gaps in their knowledge. We have developed a tool called the adverse events decision pathway that helps employers analyze an adverse event using Just Culture principles. It helps them decide what type of remediation is needed and whether the individual needs to be reported to the board of nursing. We are hoping that working more closely with employers will help make nursing safer.

Monahan - I am the CEO at the Association of Social Work Boards (ASWB). We serve 64 jurisdictions throughout North America. Currently there are over 500,000 licensed social workers. Clinical social work is regulated in all 50 states. Masters level social work is regulated in 46 states. And Bachelors level in 40 states. Requirements for licensure are education, experience and an exam. We develop and administer the exam for all social workers.

All jurisdictions require some form of continuing education. This ranges from 50 credits every two years to ten credits. ASWB offers the Approved Continuing Education (ACE) program. We approve providers and our jurisdictions accept our approved providers. New Jersey requires a review of individual courses, and we provide that service for them. Some states specify certain CE courses that must be taken, for example ethics, medical errors, cultural competence, and domestic violence.

Some jurisdictions require social workers moving into the state to re-take the exam if they haven't taken it in five years. Some states require retaking the test if the license has lapsed for more than two years. Retesting may be part of a discipline requirement.

In summary, I would say that we are concerned about the efficacy of continuing education to satisfy what the public wants. Are we really protecting the public if we are not recertifying in some manner? I have just hired a second full-time person in the continuing education department and we are taking a look at going beyond continuing education to continuing competency of social workers.

Webb - I am Carol Webb, the COO for the Association of State and Provincial Psychology Boards (ASPPB). Our members are the licensing boards in 50 states and ten Canadian provinces and four U.S. Territories. We develop the national licensing exam for psychology and offer a lot of other services to our member boards. I am a psychologist and served on the Georgia board for ten years.

Several years ago ASPPB appointed a task force to look at continuing competence and make recommendations to our member boards about how to assess continuing competence. Our website has links to Guidelines for Continuing Professional Development and a Maintenance of Competence for Licensure white paper. I chaired those committees.

The Continuing Professional Development Guidelines identify the areas of activities psychologists could use to demonstrate that they are continuing their professional development (CPD). Among the activities we feel the research supports include activities that have shown over time to improve outcomes and activities that have formal feedback.

Not all states require CE or CPD for renewal. We are encouraging all states to do so. Jurisdictions have begun to adopt our guidelines. Some have experienced no resistance from psychologists in the state, but others have withstood a huge backlash from licensees about the kinds of activities that are recommended. Mind you, this doesn't include any assessment. It just requires activities in addition to CE.

I've made many presentations to psychologists about this subject in recent years. I believe boards need to assure the public that licensees maintain their competence. Our boards are complaint-driven. What we are saying is that boards have a responsibility to do more than respond to complaints and more than just require CE to ensure in an evidence-based way that our licensees maintain their competence. We are working hard, making presentations, and trying to help the boards evolve.

LeBuhn – What have you learned in the last day and a half that you plan to take home and try to apply within your various professions? Let's revisit the various themes touched on in the agenda. We began yesterday talking about consumer expectations. Each of you has implied that consumer expectations have been the motivator for professions to take a more serious look at continuing competency requirements now than, say, five years ago.

Webb – In our discussions with our boards, the AARP data was one of the things they took most seriously. Now we have other data from the nurse anesthetists that we can present as well. Public expectation is a powerful argument and rationale for the need for a demonstration of continuing competence.

Monahan - Social workers pride themselves on starting where the client is, so I talk to social workers about licensure as a social justice issue. Providing competent, ethical and safe care is important and this needs to apply not just to initial licensure, but also throughout one's career. Everyone, including social workers, educators, students, and regulars, needs to be concerned about these topics.

Alexander – I think the presentation that hit home to me was about the use of gaming. It is saying is that we have a new generation of millennials who learn in different ways and

we have to recognize the ways they learn and determine the best way to assess their knowledge.

Miles – In terms of public feedback and public protection, we are looking at what we can do to improve public awareness of who we are and what we do. Back in 2012, we worked hard to revamp our website to make it more user friendly and simple to use.

Armey – As with so many things, perception is reality. If what the public really believes is that a current license means the practitioner is competent, even if that isn't the board's definition, we need to be reaching toward meeting the public's perception so we are meeting our public protection mission. The fact that they believe that periodic reassessment is happening as part of assuring continuing competence is something I will be taking home to the organizations I am a part of.

Jones – In follow-up to the AARP data we heard yesterday, our board of pharmacy is looking at stresses in the lives of pharmacists and pharmacy technicians that may lead to a risk of medication errors. Every pharmacy reports when a patient experiences a medication error. We did a survey and found that over the course of time 32% or respondents had experienced a medication error and almost a third of them had an adverse event secondary to that medication error. When we looked at other responses, we found that almost two-thirds of pharmacists did not consider an error found before the medication was dispensed to be a true medication error so there was no follow-up whatsoever. Most scary of all, sixty-one percent of the pharmacists who responded felt we have a punitive culture, so even errors that caused patient harm were not brought to the attention of the board. We are going to convene a task force representing all the stakeholders to look at how we can create interactive modules pharmacists and technicians can use to assess the risk of medication errors.

LeBuhn - All of you mentioned continuing education. Many of you said that you are trying to expand upon CE so it is just one of many tools used to assess and demonstrate continuing competence. What did you take away from the presentations yesterday about improving continuing education, such as focusing on active rather than passive learning, approving only accredited providers, requiring licensees to pass a pre-assessment so their choice of activities addresses gaps in their knowledge and skills?

Jones – With the growth in the number of competencies pharmacists are expected to have, continuing education needs to cover the multiple competencies expected of pharmacists. We are looking at cultural competence and we were asked to recommend that this be part of CE requirements. We put resources related to this competency on our website. For those pharmacists who do specialty care, such as geriatric cares, there are available modules teaching how to do a better job of monitoring patient care, reducing overall meds, and better stewardship to avoid placing those patients at risk.

Armey - Physical therapy jurisdictions have wide variation in re-licensure requirements. Some require only CE; some use the phrase continuing competence but include elements of continuing education. I think boards have huge variation in their resources, their structure, and their operations. So the things that I think may be possible to implement are a pre-assessment based on a practice analysis and targeted professional development

activities. The Federation is re-examining its model and the concept of best practices is attractive. The breadth of activities described at this conference is impressive and the deeming aspect is really important. I think we could explore some of these things. We need to take it beyond continuing education.

Alexander – I agree with what has been said. The concept of an assessment prior to continuing education allowing the individual to focus on their needs has not been new to us, but we are glad to see that others are using it. It certainly does seem to be the trend and something that will help individuals become more competent.

Monahan – I'm taking a lot back because I feel we have a lot of work to do. One of the easier things is to prepare a mission statement and define what continuing competence really is. We can develop that at ASWB and disseminate it to our members and then engage in a more informed dialogue. I also think we can make the CE providers appreciate how they are connected to regulation and how their offerings need to be higher quality and better related to competency in practice. I am also struck by new ways of learning. Most of the CE we currently approve is a little boring. It is not interactive engaging education that people can get excited about.

Webb - A lot of the information these two days is really important and will be used by ASPPB. Our various committees came up with a pretty clear conclusion that traditional CE without an evaluation component really doesn't demonstrate continuing competence. I like self-assessment assisted by some kind of peer review or formal feedback. I find that older practitioners really oppose any kind of assessment, but the younger ones are used to being evaluated over time and they don't push back so hard. We should be aiming our programs to this younger cohort.

Question – As several speakers have said the public perception is that this is happening. When I became a public member of the board of nursing, I was surprised to see that it is not happening. What is a public member to do? What is our best approach to persuade our boards to do what the public thinks we are doing? Should we go back and work on the state level? It seems to be a lot more efficient to get the national organizations to do something. They have more influence, more power, and more money to develop some of these things. What is the best use of the public members' time and energy?

Alexander – It is a challenge we have been working on it since the early 1980's. One obstacle is the huge investment, not only for the national association and the state boards and also the licensees. It is something that will potentially determine whether they renew their licenses. We want to get it right. We have been involved in a lot of research, data analysis and evaluation of various methods.

Once we decide on the right approach, we will do a national study to evaluate whether the method distinguishes among practitioners and is predictive. These are hard to measure when somebody's license and livelihood is on the line. We did a small-scale

pilot study where we looked at various types of continuing competence to see what is predictive, what might have an association with what the manager perceived as an individual competency level. We found out that there was no association. We did find that individuals told us they like being assessed and they want to learn what their learning needs are. We are building on that pilot study and looking at how regulators can use an assessment. It is a complicated process.

Miles – As a public member, you are a liaison to the public. We hold rulemakings all the time. We need to see members of the public come in to participate in our rulemaking process. I encourage public members to find ways to get citizens to come to board rulemaking proceedings.

Webb - You have a unique perspective and licensee board members should listen to that. I do think action has to occur at the national level because they have the resources and can help bring jurisdictions together.

Jones – Bring all the public muscle you can to board meetings. Have the public contact their legislators. Have the public show up en masse at hearings. Last year, a constituent complained about care, brought it to her legislator, who held a hearing at which the board of pharmacy was represented. The public speaks loudest of all because you vote.

LeBuhn – Having been a public member and having worked over the years with CAC, I know that change may take years and years of repetition. You have to keep the subject on the agenda. You've heard the litany of publications CAC has issued over the years and we honestly think we have had an impact. We know we are not the only people who influenced the progression of thought on the subject, but we have certainly contributed. We know how difficult it is to get the public to appear at board meetings. One idea CAC is promoting is that licensing boards assemble public advisory panels comprised of various stakeholders in the community to give the licensing board advice on various subjects including the need for more meaningful continuing competency requirements for re-licensure. Associations of licensing boards could write model acts. Consumer organizations can participate in the lobbying at the state level to get model acts enacted.

Jones – Speak to the boards about remote access for the public. The board of pharmacy in Maryland will soon begin interactive webinars to include people from all over the state.

Question – I am a public member. My question is addressed to the national association representatives. Have you reached out to national consumer organizations to get their input to find out their expectations relating to competency?

Alexander – NCSBN did a Gallup poll to ascertain consumer expectations. We got the same results at the AARP study. We know what the public wants. The challenge is to do it. Public members have an important role. Our data shows that 30% of the individuals we discipline have previously been disciplined by an employer. They are passed along from institution to institution and they do not come to the attention of the board of

nursing until some huge event occurs or somebody gets fed up. You should be actively working on getting people who are unsafe and unethical reported to the board so we can improve their competence before they continue their chain of unsafe practice.

Monahan – As the head of one of the national organizations, I appreciate the focus on the consumer. We have one consumer member on our board and plan to add another one. I really appreciate the suggestion about involving consumer organizations in our work.

Comment - This has been a wonderful learning experience. Every member of every licensure board is a public member. There are many who have a secondary role. Next year, I'd like to see a much bigger room and more attendance.

Comment - I am the executive director of a national certifying organization and am here representing the Institute for Credentialing Excellence (ICE). I heard someone ask, what is the public member to do. I think this is very important. ICE has a public member on its board and certifying bodies must have a public member to be accredited by NCCA. This has been a very informative meeting.

Comment - My board relies heavily on our public members and their input. We don't get involvement from the general public unless there is a problem. When we have a disciplinary case, we don't discipline on best practice. We discipline on basic practice. So, we have to have employers and professional organizations and all of us working together to make best practice a reality.