

**MAINTAINING AND IMPROVING  
HEALTH PROFESSIONAL COMPETENCE:**

**The Citizen Advocacy Center  
Road Map to Continuing Competency Assurance**

**April 2004**

The Citizen Advocacy Center (CAC) is a unique support center for the thousands of public members who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory and other health policy boards, or selected by private sector institutions and agencies to serve on boards or advisory panels, public members are typically in the minority and are usually without the resources and technical support available to their counterparts from professional and business communities. CAC is a not-for-profit 501 (c)(3) organization created to serve the public interest by providing research, training, technical support, and networking opportunities to help public members make their contributions informed, effective, and significant.

© Copyright 2004 Citizen Advocacy Center  
1400 16<sup>th</sup> Street NW, Suite 330  
Washington, DC 20036  
Telephone (202) 462-1174 Fax (202) 265-6564  
[www.cacenter.org](http://www.cacenter.org)

## TABLE OF CONTENTS

Executive Summary.....	i
Preface.....	1
The Challenge.....	1
The Urgency.....	3
The Solution .....	4
The Collaboration That Led Us to Here.....	6
Principles Underpinning CAC’s Road Map.....	6
The Destination.....	9
The Five Step Model.....	9
How Do We Get There? .....	12
The Road Map.....	16

## EXECUTIVE SUMMARY

America's health care system is in crisis. Recent and reliable policy studies point to an unacceptable level of preventable medical errors and serious problems in quality of care. Assuring the continuing competence of health care practitioners is an essential element in any program to improve patient safety and health care quality. Recommendations for assuring continuing competence have been on the table for nearly fifty years. It is time to act!

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

CAC appeals to all those with a stake in the quality and safety of health care to join us in realizing the vision outlined in this road map. The primary beneficiaries will be health care consumers. Health care systems and the existing oversight programs of licensure and certification agencies will be helped significantly in meeting their obligation to assure the public of the safety and quality of health care. And, finally, health care professionals themselves will be supported in their efforts to be lifelong learners, remaining current and proficient as the science base for medicine continues to evolve and become more complex.

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

We have experienced a revolution in health care delivery, but there has been little corresponding change in the oversight of individual members of the health care occupations and professions and inadequate support to help clinicians stay up to date. Despite a fast-evolving, high intensity practice environment, the oversight system makes no meaningful demands on professionals to demonstrate that they are maintaining and improving their knowledge, skills and performance.

Among the systemic changes the Institute of Medicine (IOM) recommends are that regulatory and oversight bodies begin to assess and ensure the ongoing competence of all practitioners throughout their careers. The IOM's April 2003 report, ***Health Professions Education - A Bridge to Quality***, made the following two recommendations:

All health professions' boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care—as

defined by the five competencies identified by the committee<sup>1</sup> – through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods.

Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies, among other requirements.

A number of principles underlie the vision CAC presents here, the most important of which is that valid, reliable continuing competency assessment and assurance requirements mandated by regulatory boards (acting alone or in concert with other public or private entities) can change practitioner performance for the better and result in safer and higher quality health care for the public. Other principles include:

- **Collaborate** – A broadly based collaboration of stakeholders is absolutely essential to design and implement effective continuing competency assessment programs that are accepted by the health professions. There appears to be a growing consensus in support of experimenting with various approaches to continuing competency assessment and assurance and general agreement that each stakeholder group has something to contribute. There is virtually universal agreement that no one stakeholder group can drive through a successful program on its own.
- **Quality is the Purpose** – A basic underpinning of any effort to assure patient safety and improve the quality of health care practice are systems that assure continued clinician competence and which are routine in every professional’s practice life. Continuing competency assessment and assurance are not designed for finding “bad apples” among practitioners.
- **An Evidence-Based Approach is Essential** – Research should be initiated that focuses on examining the link between periodic continuing competency assessment and assurance and changes in behavior that lead to improved clinical outcomes.
- **Build Upon What Works** – It is both prudent and more efficient to build upon and learn from competency assessment and remediation programs that are already up and running.

---

<sup>1</sup> The authors of this IOM report believe all health care professionals should be educated to deliver **patient centered care**, as members of an **interdisciplinary team**, emphasizing **evidence-based practice**, **quality improvement** approaches, and **informatics**. They conceive of these as five "core" competencies all health care providers need to possess.

These include professional development and self-assessment programs presently administered by certification agencies and professional associations.

- **Mandating is Key** – There is general, but not unanimous agreement that routine continued competency assessment and assurance must be mandated to be successful. CAC is among those that believe this must be mandated.
- **Clinician Responsibility is Key** – Programs should be designed so professionals view competency assessment and assurance as a positive in the development of their own careers, not as an unwanted intrusion or punitive burden.

CAC envisions its roadmap leading within the next decade to a destination where all health care professionals periodically demonstrate their competence through one of a variety of acceptable methodologies. The final parameters of these methodologies will be shaped by the research and experimentation conducted along the way, and will likely evolve in response to the lessons of future experience.

CAC adopts a five step model, already incorporated into some continuing competency and professional development initiatives as the conceptual framework by which all health care professionals prepare themselves periodically to demonstrate their continuing professional competence. Its purpose is to *enable* clinicians to practice safe, quality health care and to support their efforts as lifelong learners, not to punish or burden professional practice. The steps are:

***Step One: Routine Periodic Assessment***

***Step Two: Develop a Personal Plan***

***Step Three: Implement the Personal Plan***

***Step Four: Documentation***

***Step Five: Demonstrate/evaluate Competence***

The road map describes six major action areas and assigns responsibility for accomplishing them during the coming decade. The road map is presented in two phases. The first relies heavily on pilot programs. The second phase benefits from evidence gathered during the pilot programs and related research and, as the evidence proves its value, from the commitment to the program by a growing number of stakeholder groups.

The six action areas are:

- **Conduct Research** – Research is needed to test, validate, and compare competency assessment and assurance methodologies and document the impact of competency assurance on patient outcomes.

- **Seek Enabling Legislation** – New laws are necessary to direct licensing boards to (1) develop and implement a series of pilot projects to gather data comparing the validity, reliability, and affordability of various methodologies and techniques for competency assessment and assurance, and (2) based on the results of these pilot projects, set standards for effective, valid, and reliable continuing competency assessment and assurance programs. Boards should be encouraged to recognize acceptable private sector programs and to allow a variety of pathways for demonstrating continuing competence.

Just as it is important not to reinvent continuing competency assurance 50 times over for every profession, it would be an unnecessary expenditure of scarce resources to conduct duplicative pilot projects in more states than required for a valid research finding. Rather, states can share research data and emulate best practices.

- **Develop Evidence-Based Standards** – Utilize evidence-based methods for demonstrating continuing competence. Data generated by the pilot projects will enable licensing boards to establish standards for assessing knowledge and clinical performance and for recognizing those programs operated by voluntary credentialing agencies, professional associations, employers, and others that meet such standards.
- **Change Expectations During Initial Education** – Change educational programs to instill in students enrolled in health professional and occupational education and training the expectation that they will be required periodically to demonstrate their continuing competence.
- **Use Fees to Pay For Competency Assurance** – Licensing board operated continuing competency programs should be financed through the imposition of fees, just as state licensing and discipline programs are financed by professional licensing fees. Private sector agencies that operate continuing competency programs approved by the board should be encouraged to bear some of the cost of competency maintenance.
- **Reform Continuing Education** – Reform continuing education programs to ensure that courses are evidence-based and require enrollees to demonstrate that the course has improved their knowledge base, skills, and/or practice management.

At least twelve distinct interest groups share some responsibility for making progress along the road map. From the private sector are: accreditation bodies, voluntary credentialing boards, consumer groups, continuing education providers, employers, health care professionals and their associations, educational institutions, and independent researchers. Governmental stakeholders include licensing boards, state legislatures, and the National Conference of State Legislatures.

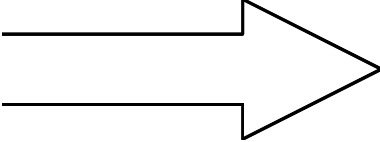
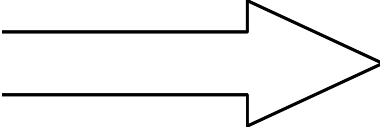
CAC will take it upon itself to “jump start” movement along the road map by calling a national conference of opinion leaders from the stakeholder groups and researchers with the following agenda:

- 1) Agree on a national definition of competence across all health care professions.

- 2) Pull together existing evidence of the impact of competence and continuing competency assurance on patient outcomes and develop a future research agenda.
- 3) Sketch out the parameters and objectives for state-based continuing competency assessment and assurance pilot projects for various professions and develop legislative language to make them happen.
- 4) Develop a business plan for funding road map activities.
- 5) Appoint task forces or some other mechanism to follow up on each aspect.



# THE ROAD MAP

<u><i>ACTION AREAS</i></u>	<u><i>PHASE I</i></u>	<u><i>PHASE II</i></u>
Conduct Research	<ul style="list-style-type: none"> <li>• Convene a national meeting to establish a prioritized research agenda (All)</li> <li>• Conduct research (IR)</li> </ul>	<ul style="list-style-type: none"> <li>• Analyze results of research and feedback to all interest groups, and continuously adjust continuing competence programs to take into account research results (IR, All)</li> </ul>
Seek Legislative and Regulatory Mandates	<ul style="list-style-type: none"> <li>• Draft, introduce and enact state laws requiring all health care practitioners periodically to demonstrate their continuing competence (All)</li> <li>• Authorize licensing boards to launch pilots in each state (SL), and launch pilots in each state (LB)</li> </ul>	<ul style="list-style-type: none"> <li>• Based on lessons learned in pilot projects, move from pilot programs to state wide mandated programs (LB)</li> </ul>
Utilize Evidence-Based Methods to Demonstrate Continuing Competence	<ul style="list-style-type: none"> <li>• Design pilot programs collect evidence of reliability, validity and accuracy of various assessment and assurance methods (All)</li> <li>• Analyze results (IR)</li> </ul>	<ul style="list-style-type: none"> <li>• Based on results in Phase I, develop and implement regulations setting standards for acceptable methodologies, including assessment methodologies (LB) (CB)</li> </ul>
Change Educational Programs	<ul style="list-style-type: none"> <li>• Add to health professional education curricula the message that periodic demonstration of continuing competence will be required throughout their careers (SCH)</li> </ul>	
Finance Continuing Competence Programs	<ul style="list-style-type: none"> <li>• Seek financing support for funding pilot projects and for carrying out research agenda (All)</li> </ul>	
Reform Continuing Education Programs	<ul style="list-style-type: none"> <li>• Urge CE providers to adopt Institute of Medicine (IOM) recommendations that courses be evidence-based and require students to pass a test to earn credit (PASSN, CEP, CB, LB)</li> </ul>	<ul style="list-style-type: none"> <li>• Require, as a condition of accreditation, that all CE courses (1) are evidence-based, and (2) conclude with a test of each student's mastery of the course material (CEP)</li> </ul>

# **MAINTAINING AND IMPROVING HEALTH PROFESSIONAL COMPETENCE:**

## **The Citizen Advocacy Center Road Map to Continuing Competency Assurance**

### **Preface**

America's health care system is in crisis. Recent and reliable policy studies point to an unacceptable level of preventable medical errors and serious problems in quality of care. Assuring the continuing competence of health care practitioners is an essential element in any program to improve patient safety and health care quality. Recommendations for assuring continuing competence have been on the table for nearly fifty years. It is time to act!

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

CAC appeals to all those with a stake in the quality and safety of health care to join us in realizing the vision outlined in this road map. The primary beneficiaries will be health care consumers. Health care systems and the existing oversight programs of licensure and certification agencies will be helped significantly in meeting their obligation to assure the public of the safety and quality of health care. And, finally, health professionals themselves will be supported in their efforts to be lifelong learners, remaining current and proficient as the science base for medicine continues to evolve and become more complex.

### **The Challenge**

Patients have every right to assume that every health care provider's license to practice is the government's assurance of his or her *current* professional competence. Unfortunately, that is not the case. Clinicians also have a right to assume that those with whom they work are fully proficient professionals. Instead, our state-based system grants licenses to any candidate who graduates from an accredited school and passes a standardized test demonstrating minimal competence to practice. The license remains good for the rest of the licensee's career – unless he or she does something so egregious that the licensing board is compelled to limit it or take the license away.

This century-old approach to professional regulation and oversight was devised in simpler times, when a diploma and a passing test grade may well have sufficed as indicators of initial competence, and reliance on professional associations to provide postgraduate education to keep their members up-to-date was adequate public protection.

However, since the mid-1900's, we have experienced a revolution in health care financing and delivery, with little corresponding change in the oversight of individual members of the health care occupations and professions and inadequate support to help clinicians stay up to date. Today's practitioners must keep up with accelerating advances in technology, and a proliferation of prescription drugs. Care givers face mounting pressures caused by limited resources, workforce shortages, employer demands, and heightened patient expectations. They work longer hours, change jobs more often, and postpone their retirement, causing a "graying" of the health care workforce. Despite this fast-evolving, high intensity environment, the oversight system largely fails to make meaningful demands on professionals to demonstrate that they are maintaining and improving their knowledge, skills and performance.

Ben Shimberg<sup>1</sup> described these lapses in safety and quality assurance years ago. There has been little change since.

The fact is that state governments, through health professional licensing systems, do not impose specific requirements on licensed professionals to demonstrate their continuing competence. Many state boards do require licensees to take continuing education courses to maintain their licenses. However, with some significant exceptions, these requirements ask only that a licensee show that he or she has attended approved courses. Whether the chosen courses are relevant to the licensee's specific practice, or whether the information presented in the course has been understood, is not subject to regulatory review. Private certification and specialty boards have paid much more attention to the continuing competence of health professionals than have state health licensing boards. More and more observers concerned about continuing competence are asking the licensing system to reassess its responsibilities in this area.

As Shimberg observed, continuing education (CE) requirements imposed without prior competency assessment, the tailoring of coursework to address demonstrated deficiencies, and rigorous testing to assure that the desired competencies have been assimilated into practice do little to guarantee the public that the health care they receive is safe and of acceptable quality. This fact is affirmed by many authoritative critiques. Most recently, the Institute of Medicine (IOM) in its 2003 report, *Health Care Education - A Bridge to Quality*, challenges health care oversight agencies (licensing boards and certifying agencies) to abandon reliance on continuing education in favor of a more systematic approach requiring that each practitioner's competence be assessed, that interventions be targeted to specific deficiencies, and that each care giver be tested to ensure that the desired competencies have been acquired and incorporated into practice.

---

<sup>1</sup>Ben Shimberg, a renowned expert in professional licensing, was the first chair of the board of the Citizen Advocacy Center (CAC), and honorary chair emeritus until his death in September 2003.

By abnegating its responsibility to require all health care clinicians to show that they continue to be safe, competent practitioners, the oversight system has lost out on a major opportunity for quality assurance in health care delivery and thereby failed the public.

## **The Urgency**

That quality problems and patient safety issues permeate the U.S. health care system is no longer at issue. The Institute of Medicine (IOM) estimated in its 1999 report, *To Err is Human: Building a Safer Health System*, that between 44,000 and 98,000 *die* each year from preventable medical errors. The RAND Corporation estimates that only half of all patients receive therapies that medical science knows to be appropriate -- things as simple and inexpensive as giving an aspirin after a heart attack. Experts say there is an average lag of 17 years between the discovery of more effective forms of treatment and their incorporation into routine patient care.

The IOM took a broader look at quality issues in its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, concluding that medical errors are the tip of the iceberg in terms of quality problems and asserting that "(t)he American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

The public and private sectors have reacted to the challenges presented in these and other authoritative critiques of contemporary health care by concentrating primarily on changes that can be made in the *system* of health care delivery. Positive changes are occurring as a result of the focus on system safety. Some involve safeguards aimed at reducing the frequency of medication errors, others require multiple sign-offs to prevent wrong site or wrong patient surgeries, and others incorporate information technology into clinical routines.

Nothing but good comes from system changes that help expose errors, identify their causes via meaningful root cause analyses, and institute fail-safe procedures to prevent their recurrence. What we need to do in addition is put in place systems for the periodic assessment and verification of the continuing competence of all health care professionals. Individual competence is every bit as much a systems issue as is error prevention. Not all medical errors and poor quality care can be explained solely by flaws in systems. Human failings and human errors by individual practitioners play a significant role. To address these problems, programs that assure the competence of all practitioners are urgently needed.

As the evidence base continues to burgeon and the range and number of therapeutic interventions grows exponentially, such programs can support clinicians in assessing where they need to enhance their practices and help to inform educators about where they need to focus their efforts. Most importantly, such efforts can help assure consumers and health care institutions that clinicians maintain their professional edge.

## The Solution

Among the systemic changes the IOM recommends are that regulatory and oversight bodies begin to assess and ensure the ongoing competence of all practitioners throughout their careers. *To Err is Human* overlooked neither individual practitioner accountability for patient safety and quality of care, nor the pivotal role of regulatory agencies. The report recommended that health professional licensing bodies should:

- (1) implement periodic reexamination and relicensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices; and
- (2) work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

IOM argued that professional associations should assist oversight agencies by making a "visible commitment" to patient safety through curriculum development, information dissemination, promotion of practice guidelines and standards, and other forms of professional development and competency enhancement. But the bottom line was that only governmental licensing boards have the authority to effect universal change. As voluntary organizations, professional associations are not empowered to effect universal competency assurance for all practitioners.

Comparable recommendations were stated more powerfully in yet another IOM report issued in April, 2003, *Health Professions Education - A Bridge to Quality*. Again, the task of professional competency assurance was viewed as the shared responsibility of the public and private sectors:

All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care—as defined by the five competencies identified by the committee<sup>2</sup> – through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods.

Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating

---

<sup>2</sup> The authors of this IOM report believe all health care professionals should be educated to deliver **patient centered care**, as members of an **interdisciplinary team**, emphasizing **evidence-based practice**, **quality improvement** approaches, and **informatics**. They conceive of these as five "core" competencies all health care providers need to possess. The Pew report said professional competence is comprised of "**knowledge, judgment, technical skills**, and **interpersonal skills** relevant to their jobs throughout their career." The Pew Commission later enumerated "Twenty-one Competencies for the Twenty-First Century," which essentially flesh out the IOM's five core competencies.

their ability to deliver patient care that reflects the five competencies, among other requirements.

The IOM is but one of many entities to draw attention to the need for regulatory boards and other oversight bodies to demand evidence of ongoing competence. The U.S. Department of Health and Human Services (then known as the Department of Health Education and Welfare) advocated competency assurance back in the 1960ies. Three decades later, in 1995, the Pew Health Professions Commission reasserted that "(s)tates should require each board to develop, implement, and evaluate continuing competency requirements to assure the continuing competence of regulated health care professions." Many of the Pew Commission's recommendations caused alarm within the health care establishment, but its approach to continuing competence was widely accepted and applauded.

After so many decades of talking and writing about the need for assuring continuing competence, little has happened.<sup>3</sup> It appears an inescapable conclusion that short of state governments mandating periodic competency assessment and assurance as a condition of continued licensure, little will change.

The Pew Commission recommendation implicitly recognized the role legislatures play in determining the authorities of regulatory boards. On this subject the Commission wrote:

Legislatures have not allowed or required regulatory boards to play a role in requiring continuing competence demonstrations of their licensees throughout their careers. The private sector has been far more active in this arena. Voluntary professional associations and private certification and credentialing boards have established and continue to perfect standards, goals and evaluation measurements to meet the demands for competence throughout one's professional practice. These models are good starting points but will need additional development. In addition, the role of the private sector can only go so far. Practitioners whose credentials are not routinely reviewed by private systems may fall through the cracks without attention by the states.

Conceding that presently regulation is "a dense patchwork that is slow to adapt to change," as well as, "inconsistent, contradictory, and duplicative" from state to state, the authors of the *Quality Chasm* report nevertheless conclude that regulation may be a necessary ingredient in order to realize the kind of 21st century health care system the report envisions. "Properly

---

<sup>3</sup> CAC and others have studied and written about competency assurance for many years. Several institutions -- mostly non-governmental -- have initiated programs to make competency assessment and assurance a reality. In medicine, for example, the America Board of Medical Specialties' (ABMS) 24 member boards are committed to developing "life-long learning" programs that will require periodic re-demonstrations of competence. Experimentation with self-assessment and professional development programs in dietetics, nursing, occupational and respiratory therapy, pharmacy, and other professions are significant steps in the direction of competency assurance, particularly in combination with competency programs administered by hospitals and other health care organizations. However, these voluntary programs, while laudable, are spotty at best and most health care professionals are not now affected by them. Moreover, no standards exist for assessing the validity and value of these programs.

conceived and executed, regulation can both protect the public's interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients."

## **The Collaboration That Led Us to Here**

In June 2000, CAC convened a small leadership conference titled "Measuring Continuing Competence of Health Care Practitioners: Where are we now? – Where Are We Headed?" The attendees discussed many of the barriers that have frustrated regulators and professional groups that have attempted to institutionalize continuing competency requirements. They also suggested several promising strategies for overcoming these barriers.

To build support for continuing competency assessment, the conferees proposed convening a national summit at which all the stakeholders would seek agreement on action steps to spur the creation or expansion of continuing competency programs. In cooperation with twelve other national organizations, CAC convened this summit in July 2003.<sup>4</sup>

The summit had two primary purposes: (1) to re-examine the legal, cultural, administrative, political, and financial barriers identified at CAC's 2000 meeting, and (2) more importantly, to propose a plan, or road map, specifying actions to be taken by various stakeholder groups, independently or in concert with one another. Although the working groups did not have time to complete detailed road maps, their discussions defined general directions and contours for such a plan. There was a striking degree of consensus across interest groups about recommended actions, priorities and a timetable or sequence. CAC's vision in this road map draws heavily on the output of the 2003 Summit, coupled with our own research and policy deliberations.

## **Principles Underpinning CAC's Road Map**

A number of principles underlie the vision CAC presents here, the most important of which is that valid, reliable continuing competency assessment and assurance requirements mandated by regulatory boards (acting alone or in concert with other public or private entities) can change

---

<sup>4</sup> A full report from the summit is available on the Citizen Advocacy Center Web site, [www.cacenter.org](http://www.cacenter.org). The Citizen Advocacy Center (CAC) is grateful to the organizations that cooperated with us in convening the summit: American Association for Respiratory Care, American Occupational Therapy Association, American Physical Therapy Association, Association of Regulatory Boards of Optometry, Association of State Social Work Boards, Commission on Dietetic Registration, Federation of State Boards of Physical Therapy, National Association of Boards of Examiners of Long Term Care Administrators, National Association of Boards of Pharmacy, National Board for Certification in Occupational Therapy National Board for Respiratory Care, and National Council of State Boards of Nursing.

practitioner performance for the better and result in safer and higher quality health care for the public. This assumption is the rationale for CAC's call for partnership with other groups to move forward quickly in making continuing competence assessment and assurance universal among health care practitioners. Other principles include the following:

1. **Collaborate** -- A broadly based collaboration of stakeholders is absolutely essential for the design and implementation of effective continuing competency assessment programs, particularly to ensure the acceptance and endorsement by the health professions. There appears to be a growing consensus in support of experimenting with various approaches to continuing competency assessment and assurance and general agreement that each stakeholder group has something valuable to contribute. There is virtually universal agreement that no one stakeholder group can drive through a successful program on its own.

2. **Quality is the Purpose** -- A basic underpinning of any effort to assure patient safety and improve the quality of health care practice are systems that assure continued clinician competence which are routine in every professional's practice life. Continuing competence assessment and assurance is not designed for finding "bad apples" among practitioners.

3. **An Evidence-Based Approach is Essential** -- The existing evidence base supporting continued competency programs should be collected and rigorously evaluated and made available in an open, user friendly format. Research should be initiated that focuses on making the case that periodic continuing competency assessment and assurance effects changes in behavior that lead to improved clinical outcomes. It is critical to attempt to build an evidence base that answers the following questions: (a) what is the impact of continuing competency assurance on patient outcomes? (b) is there value-added for practitioners and health care organizations that participate? and, (c) what is the comparative reliability of various methodologies and techniques for assessing continuing competence? That said, CAC emphatically agrees with those at the July 2003 summit who cautioned against postponing all forward movement on competency until more research evidence is available. Innovative pilots and continued evaluation of existing professional competency programs need to proceed simultaneously with new research efforts. Indeed, pilots and experiments are essential to generate the kind of compelling research data that many feel is needed to justify a shift from the status quo of licensure "in perpetuity" to an era of continuing competency assessment and assurance fully integrated into the licensure process and clinical practice.

4. **Build Upon What Works** -- It is both prudent and more efficient to build upon and learn from competency assessment and remediation programs that are already up and running. These include professional development and self-assessment programs presently administered by certification agencies and professional associations. Continuing education (CE) is considered by many, but not all, to be an appropriate tool to help health care professionals upgrade their knowledge and skills, provided a) the courses selected are related to the learning needs identified as necessary based on the practitioner's self-assessment and third party assessments; b) courses are approved by the appropriate professional or state authority and are evidence-based; and, c) practitioners are required to demonstrate that the educational experience has benefit in regard to their knowledge base and/or practice skills .



When all health professionals undergo periodic competency assessment to identify gaps in knowledge or skills, CE courses would be one method for correcting any knowledge deficiencies identified by the assessment. On balance, we would anticipate more, not fewer, CE courses -- specially tailored to individual professional development needs. .

**5. Define Competence Across All Health Care Professions** -- It is important not to reinvent continuing competency assurance 50 times over for every profession. It is absolutely essential for the success of this enterprise that there is a national consensus about the standard definition of professional competencies for each health profession as well the processes which will satisfy the responsible parties that such standards are being met by practitioners

**6. Mandating is Key** -- There is general agreement that agencies and professions that have tried voluntary competency assessment and professional development programs have been able to achieve only minimal participation, no matter how rewarding the experience is for those who do choose to partake. There is general, but not unanimous agreement that routine continued competency assessment must be mandated to be successful. CAC is among those who believe this must be mandated.

**7. Clinician Responsibility is Key** -- The most persistent and difficult obstacle to continuing competency initiatives is resistance by members of the health professions themselves and their trade organizations. Any road map needs to be sensitive to this political reality and the collaborative stakeholder effort referenced above must strive to design programs so that professionals come to view continuing competency assessment and assurance as a positive in the development of their own careers, not an unwanted intrusion or punitive burden.

**8. Use Fees to Pay For Competency Assurance** -- The costs of periodic competency assessment and assurance by licensing boards should be borne by health care professionals as a condition of their continued licensure. It should be no different than the practice of requiring professionals to bear the costs of preparing for initial licensure and to pay periodic fees to retain their licenses. However, private sector agencies that operate continuing competency programs approved by the board should be encouraged to bear some of the cost of competency maintenance.

**9. Respect Due Process and the Right To Know** -- The confidentiality of competency assessments is a sensitive issue. It will take hard work and mutual trust of all parties to the collaborative effort to achieve consensus on a middle ground that both respects the public's right to know and the professional's right of due process. Resolution of this thorny issue is critical if professional participation is not to be discouraged and patient safety not jeopardized by shutting off identification of clinical competency deficiencies that may put patients in danger of harm.

**10. Licensing Boards Have Ultimate Authority** -- A collaborative approach dictates that there be an appropriate division of responsibilities and duties between licensing boards, accreditation and certification bodies, health care organizations that employ, privilege, or otherwise use the services of health care professionals, and professional associations and societies in setting standards for continuing competency assessment and assurance. While CAC believes these

groups should work together, it is the state regulatory boards, as the entrusted entity legally responsible for public protection, which must have the last word on whether the process and outcome of a professional competency program, whether public or private, is serving the public interest well.

## **The Destination**

CAC envisions its roadmap leading within the next decade to a destination where all health care professionals periodically demonstrate their competence through one of a variety of acceptable methodologies. The final parameters of these methodologies will be shaped by the research and experimentation conducted along the way, and will likely evolve in response to the lessons of future experience.

The shape of continuing competency programs is likely to depend somewhat on the profession. For example, the vast majority of physicians are certified by specialty boards. The American Board of Medical Specialties' (ABMS) specialty boards are well down the road toward requiring periodic demonstrations of competence by their certificants. The ABMS programs are likely to be recognized by licensing boards as valid pathways for physicians to fulfill any legal mandate to demonstrate their competence – provided, of course, the programs meet the licensing board's standards. In contrast, only a small percentage of pharmacists are certified by specialty boards. So in that profession, the licensing boards themselves are likely to be more involved in the mechanics of competency assessment and assurance, unless other entities, such as professional associations or employers, step forward and develop continuing competency programs that conform to licensing board standards. Thus, the actual implementation of continuing competency assurance will vary from profession to profession, with various stakeholders dividing their roles differently. In every case, however, the governmental licensing authority must set the standard for any programs requiring a demonstration of competence as a condition of relicensure.

## **The Five Step Model**

The five step model, already incorporated into some continuing competency and professional development initiatives, is a conceptual framework for assessing and demonstrating continuing professional competence. Its purpose is to *enable* clinicians to practice safe, quality health care, and to support their efforts as lifelong learners, not to punish or burden professional practice.

### ***Step One: Routine Periodic Assessment***

Periodic assessment is the key to tailoring lifelong learning programs to the needs of individual health care professionals and to demonstrating continuing competence over the course of one's career. Assessment pinpoints the knowledge gaps that can be filled through continuing education or other professional development mechanisms.

Assessment also is used to determine whether a practitioner competently applies his or her knowledge and skills in clinical situations. The PEW Health Professions Commission, among others, was sensitive to the difference between assessing knowledge and assessing performance. “Most continuing education programs,” they wrote, “do not consider whether the health professionals enrolled know how to apply their new knowledge in appropriate situations.” They cited studies that found “less than ten percent of all inadequate medical practice is due to a lack of practitioner knowledge,” and that “only six percent of hospital-based physician deficiencies resulted from a lack of knowledge....(s)ome studies have even questioned the correlation of superior knowledge retention to professional performance, suggesting that an individual’s ability to ‘bring order to the informational chaos that characterizes one’s everyday environment’ determines whether that professional continues to perform competently.” Regulators in Ontario, Canada concur that “it is the application that is really important. It is immaterial if you have all the knowledge and skills and judgment in the world if you are unable to apply it in the actual practice setting.”

There are two key questions to be answered about assessment: **Who should be assessed?** and **Who should do the assessing?**

CAC believes that demonstrating continuing competence is an affirmative responsibility borne by all practitioners so they can benefit from knowing their own strengths and where they need to improve. It follows from this that *all* practitioners should undergo periodic assessment. It is insufficient to show the absence of disciplinary actions or malpractice lawsuits on one’s record if the focus is on clinicians achieving the highest level of performance and enhancing quality and patient safety.

Officials of the American Board of Medical Specialties (ABMS) and the American Board of Nursing Specialties (ABNS) told CAC’s July 2003 continuing competency summit that beginning a competency assessment program by targeting only people known to have problems would undercut the idea that competency assessment is a positive strategy that benefits all professionals. To be perceived as positive and non-punitive, continuing competency assessment must apply to everyone.

The question of who should do the assessing is more difficult to answer at this point. Self-assessment is the option many voluntary credentialing organizations and even some regulatory agencies have written into their emerging competency or professional development programs. This approach is likely to be more acceptable to many professionals than third-party assessment and appears to be, therefore, a comparatively painless way to introduce periodic assessment into the routines of professional careers.

Critics of self-assessment point out that it does not provide the same degree of public accountability afforded by third-party assessment. They also wonder about relying on professionals’ judgments about their own strengths and weaknesses.

Third-party assessment is, by definition, more objective and more accountable. It is also more expensive than self-assessment and potentially more disruptive to practice. Moreover, there are

not a sufficient number of third party assessment programs available to perform the task. Hybrid approaches have potential appeal, such as methodologies combining self-assessment or professional portfolios, with independent evaluation and consultation at the workplace and random review by a certification or regulatory agency.

CAC's road map foresees that self-assessment is likely to predominate in nascent programs, but the goal is to move to independent, third party assessment over a period of time. Self-assessment tools need to be developed by third parties, according to publicly developed standards. The pilot projects called for in the road map offer an opportunity to evaluate and compare various assessment methodologies -- self-assessment, third-party assessment, and hybrid combinations of the two. Regardless of the chosen methodology, profession-wide, periodic assessment must be mandated and performance assessment should have a high degree of correlation with real situations and practice settings. Advancements in information technology offer the possibility of evaluating electronic medical records and practitioner-specific practice profiles against practice guidelines and peer performance in order to assess individual clinical competence and, significantly, to determine the impact over time of continuing competency assurance on patient outcomes.

### ***Step Two: Develop a Personal Plan***

Based on the assessment, each professional writes a personal learning plan designed to shore up those clinical practice areas or knowledge gaps identified in the assessment. Knowledge gaps, for example, might be addressed by taking an appropriate CE course. Clinical practice deficiencies might be addressed by doing a “mini-residency,” or entering into a mentoring arrangement. The point is to choose competency bolstering activities that derive from the assessment.

### ***Step Three: Implement the Personal Plan***

Implementation depends on the nature of the personal plan. One common denominator is the need to keep a detailed written log to comply with the next step.

### ***Step Four: Documentation***

Practitioners will be expected to document the completion of steps one, two, and three. If, for example, the assessment step uncovers a knowledge gap which the personal plan says will be filled by a CE course, the implementation documentation would include the name of the course, verification that the course was approved by a licensing board, certification agency, employer, or other appropriate body, dates it was taken, and certification that the practitioner passed the course. If the personal plan calls for mentoring by an associate, the documentation would include the dates of monitoring, name of the monitor, and progress reports prepared by the mentor, and so on. Licensing boards and certification bodies, as appropriate, would have access to these reports, as a condition for maintaining a license or/or certificate,

### ***Step Five: Demonstrate/evaluate Competence***

Repeated in regular cycles, steps (1) through (4) represent a pattern of life long learning that is a prelude to demonstrating ongoing competence according to the rules and standards developed by the state licensing board per legislative mandate.

Consistent with the IOM and Pew Commission formulations, CAC envisions legislative language permitting competence to be demonstrated in a variety of ways in a variety of settings and under the purview of a variety of institutions. State licensing boards would be directed by legislatures to recognize and utilize valid, reliable continuing competency assurance programs operated by voluntary certification boards, professional associations, employers, and others. The regulatory board's role will be setting and enforcing standards to assure that effective and accountable competency assurance mechanisms are in place, and only when they are not, would a licensing board do the job itself. Development of standards for continuing competency programs should include participation by all the vital stakeholders – including a generous quotient of consumer interest representatives at every level.

The board-developed standards and criteria should take into account current knowledge about acceptable methodologies and techniques, and should be amended over time to take into account lessons learned from pilot projects, research, and experience.

## **How Do We Get There?**

CAC's road map describes six major action areas and assigns responsibility for achieving stated objectives over the course of the coming decade. The road map is presented in two phases. The first relies heavily on pilot programs. These are critical to gathering evidence about a host of issues, including but not limited to: 1) the comparative effectiveness of self-assessment, third-party assessment, or some combination of the two, in identifying gaps in a clinician's knowledge or skills, 2) the validity and reliability of various methodologies for demonstrating competence, including testing, 3) the relative merits of continuing education, mentorship, and other approaches to learning and skill development, 4) the comparative cost-effectiveness of alternative methodologies.

The second phase benefits from evidence base established during the pilot programs and from related research. It is in the second phase that state licensing boards - at the direction of state legislatures - will establish criteria and standards for approving continuing competency assessment and assurance programs developed by private sector organizations.

The six action areas are:

- Conduct Research
- Seek Enabling Legislation
- Develop Evidence-Based Standards
- Change Expectations During Initial Education
- Use Fees to Pay For Competency Assurance
- Reform Continuing Education Programs

## **Conduct research**

The CAC road map calls for major, ongoing research initiatives to test, validate, and compare competency assessment and assurance methodologies, and to document the impact of competency assurance on patient outcomes. It is expected that the results of this research will reinforce buy-in to the program by professionals and their associations, legislators, policymakers, and others.

To begin the process, the road map calls for a national conference early in Phase I to identify and prioritize a research agenda closely integrated with the pilot programs. A continuous cycle of research, evaluation, and feedback to all interest groups will follow. Forward movement and action on other aspects of the plan should not be delayed pending research findings, but proceed in such a fashion as to incorporate research findings into program revisions as evidence becomes available.

## **Seek Enabling Legislation**

Experience shows that few professionals take advantage of voluntary programs for competency assessment and assurance. Therefore, it is essential to seek state legislative mandates directing licensing boards to develop and implement a series of pilot projects to gather data comparing the validity, reliability, and affordability of various methodologies and techniques for competency assessment and assurance.

While the ultimate responsibility for mandating and overseeing continuing competency programs should be borne by licensing boards, they should recognize acceptable private sector programs and allow a wide variety of pathways for demonstrating continuing competence. It would be unnecessarily costly to give licensing boards exclusive authority to test for continuing competence, and both wasteful and potentially antagonizing to the professions to ignore the growing number of continuing competence programs operated by voluntary credentialing boards and others.

## **Develop Evidence-Based Standards**

Data generated by early pilot projects will enable licensing boards to establish a first generation of standards for assessing knowledge and clinical performance, as well as standards by which programs operated by voluntary credentialing agencies, professional associations, employers and others can be recognized and accepted by licensing boards. In the longer term, data from the pilots will show the impact of continuing competency programs on the safety and quality of health care delivery.

This evidence has significance beyond its use by licensing boards to make sound policy. Buy-in on the part of professionals and their associations – and support within legislatures – will be easier to achieve once there is conclusive evidence of the validity and reliability of competency

assessment methodologies, the positive impact of competency requirements on patient care, and the value-added to individual professionals.

### **Change Expectations During Initial Education**

Health professional education programs have a simple but critical contribution to make. This is to instill the expectation in students enrolled in health professional and occupational education and training that those who go on to practice a health care profession will be required periodically to demonstrate their continuing competence. Schools are ideally positioned to convey this message. Professional associations are in a position to reinforce it.

### **Use Fees to Pay for Competency Assurance**

The road map assumes health care practitioners will pay the bill for their continuing competency assessment and assurance. The precedent is clear – professionals already bear the costs of education and examination leading to initial licensure and of mandatory continuing education required for license renewal.

Nothing in the road map would prevent employers, professional associations, or other entities from subsidizing continuing competency programs, should they chose to do so. Some already subsidize continuing education. In addition, CAC would encourage regulatory boards and certification bodies to design incentives to minimize the clinicians' financial burden associated with continuing competency requirements

There will be costs associated with designing and implementing the Phase I pilot programs called for in the road map. Appeals should be made to professional associations and certification bodies to contribute resources toward pilot projects and independent analysis and evaluation of the results. Health care organizations may be willing to contribute in the expectation of value-added from requiring that all their employees and privileged practitioners maintain their competence. Potential sources of public sector funding include federal grants and in-kind contributions by licensing boards and potentially their associations.

### **Reform Continuing Education Programs**

Assessment will often lead practitioners to sign up for an appropriate CE course, probably generating a need for more, not less, CE in the future.

CE providers have been urged by the IOM and others to bring about reforms in two critical areas in order to play a more meaningful role in assuring the public of the continuing competence of their health care professionals. The first reform is to ensure that CE courses are current and evidence-based. The second is to require CE course enrollees to pass a test to demonstrate they have mastered the course content and improved their knowledge base, skills, and/or practice

management. The road map calls upon CE accreditors to deny accreditation to any CE providers that fail to adopt these reforms.

\* \* \*

The road map is presented below in matrix form. Perhaps the most important assumption on which the road map is based is that, “A broadly based collaboration of stakeholders is absolutely essential to design and implement effective continuing competency assessment programs that are accepted by the health professions ....” This broadly based coalition includes at least the following twelve interest groups (each group has been assigned and acronym for identification in the matrix):

From the Private Sector:

- ACC – accreditation bodies
- CB – voluntary credentialing boards
- CONS – consumer groups
- CEP – continuing education providers
- ER – employers
- HCP – health care professionals
- PASSN – professional associations
- SCH – educational institutions
- IR – independent researchers

From Government:

- LB – licensing boards
- SL – state legislatures
- NCSL – National Conference of State Legislatures

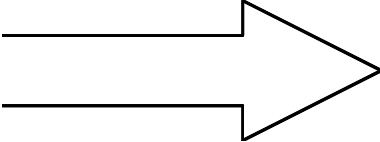
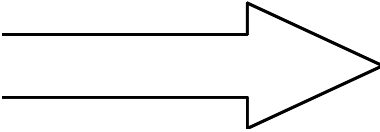
The matrix shows the six activity areas in the left (vertical) column and the time element across the top. For each activity, the interest group or groups responsible for taking the lead are identified by their acronyms. “All” indicates that every interest group should be involved. The road map is presented in two phases, in recognition that progress toward the ultimate goal will be in steps, each building on the ones before.

CAC will take it upon itself to “jump start” movement along the road map by calling a national conference of opinion leaders from the stakeholder groups and researchers with the following agenda:

- 1) Agree on a national definition of competence across all health care professions..
- 2) Pull together existing evidence of the impact of competence and continuing competency assurance on patient outcomes and develop a future research agenda.
- 3) Sketch out the parameters and objectives for state-based continuing competency assessment and assurance pilot projects for various professions and develop legislative language to make them happen.
- 4) Develop a business plan for funding road map activities.
- 5) Appoint task forces to follow up on each aspect.



## THE ROAD MAP

<u><i>ACTION AREAS</i></u>	<u><i>PHASE I</i></u>	<u><i>PHASE II</i></u>
Conduct Research	<ul style="list-style-type: none"> <li>• Convene a national meeting to establish a prioritized research agenda (All)</li> <li>• Conduct research (IR)</li> </ul>	<ul style="list-style-type: none"> <li>• Analyze results of research and feedback to all interest groups, and continuously adjust continuing competence programs to take into account research results (IR, All)</li> </ul>
Seek Legislative and Regulatory Mandates	<ul style="list-style-type: none"> <li>• Draft, introduce and enact state laws requiring all health care practitioners periodically to demonstrate their continuing competence (All)</li> <li>• Authorize licensing boards to launch pilots in each state (SL), and launch pilots in each state (LB)</li> </ul>	<ul style="list-style-type: none"> <li>• Based on lessons learned in pilot projects, move from pilot programs to state wide mandated programs (LB)</li> </ul>
Utilize Evidence-Based Methods to Demonstrate Continuing Competence	<ul style="list-style-type: none"> <li>• Design pilot programs collect evidence of reliability, validity and accuracy of various assessment and assurance methods (All)</li> <li>• Analyze results (IR)</li> </ul>	<ul style="list-style-type: none"> <li>• Based on results in Phase I, develop and implement regulations setting standards for acceptable methodologies, including assessment methodologies (LB) (CB)</li> </ul>
Change Educational Programs	<ul style="list-style-type: none"> <li>• Add to health professional education curricula the message that periodic demonstration of continuing competence will be required throughout their careers (SCH)</li> </ul>	
Finance Continuing Competence Programs	<ul style="list-style-type: none"> <li>• Seek financing support for funding pilot projects and for carrying out research agenda (All)</li> </ul>	
Reform Continuing Education Programs	<ul style="list-style-type: none"> <li>• Urge CE providers to adopt Institute of Medicine (IOM) recommendations that courses be evidence-based and require students to pass a test to earn credit (PASSN, CEP, CB, LB)</li> </ul>	<ul style="list-style-type: none"> <li>• Require, as a condition of accreditation, that all CE courses (1) are evidence-based, and (2) conclude with a test of each student's mastery of the course material (CEP)</li> </ul>