



Issue: Competence Assessment and Competency Assurance of Healthcare Professionals

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Recent articles in this journal addressed the problematic issue of certification of clinical nurse specialists (CNSs), and more specifically how to validate and ensure competence in a specialty.¹⁻⁹ The purpose of this column is to review the larger context of healthcare professionals' regulation and competence validation of healthcare professionals to place in context further efforts related to developing mechanisms for certification of CNSs.

SAFE, QUALITY CARE—THE PURPOSE OF HEALTHCARE PROFESSIONALS' REGULATION

Healthcare regulation is focused first on safe and quality care as Glazer¹⁰ stated in an online discussion of the policy and politics of continued competence. She argues that nursing needs a policy statement about continued competence and it "might be that registered nurses are practicing in complex environments where technology and practice are constantly changing and the American public deserves registered nurses with adequate knowledge and skills to *provide safe quality care.*"^{10(p1)} She points out that beginning and ongoing competence is most importantly about ensuring the performance of care using knowledge and skills, and not only the possession of knowledge and skills. These comments also could be made about advanced practice nurses and other healthcare providers in the United States and globally.

Ensuring healthcare practitioners' competence has concerned a wide variety of stakeholders interested in healthcare regulation, among them are the American Nurses Association, the American Nurses Credentialing Center (ANCC),

specialty nursing certifying organizations, The Pew Health Professions Commission, the Citizen Advocacy Center (CAC) (www.cacenter.org), the Council on Licensure, Enforcement and Regulation (CLEAR) (www.clearhq.org), and the Federation of Associations of Regulatory Boards (www.farb.org). The latter 3 organizations are resources for professional regulatory board members; as such, they do not represent a particular healthcare professional group. The CAC is a resource for the public members of regulatory boards and other governing bodies who serve as representatives of the public interest. The CAC advocates for change in the measurement of healthcare professionals' competence, and, in 2004, published a road map of actions to achieve continuing competence assurance. The road map will be discussed later.

The work of The Pew Health Professions Commission Taskforce on Health Care Workforce Regulation prompted the current debate about healthcare professionals' regulation and continuing competence.^{11,12} Regarding all healthcare professions, the 1998 report identified major concerns about consumer protection, quality of care, and the competence of professionals to provide quality care.¹¹ The taskforce observed that it is possible for a practitioner's competence to diminish years after initial licensure, and, further, that continuing education hours, the most common requirement for continuing competence, do not guarantee competence. The report recommended that state boards should set not only competence standards for entry into practice but also require healthcare practitioners to demonstrate competence throughout their careers. Writing about the issue of continued competence, Lyon and Boland² reported that nursing associations agreed with the basic premise that continued competence of healthcare practitioners is critical to a quality healthcare system but urged that documentation of competency be deferred to professional associations. Lyon and Boland² defined the domains of competence as knowledge competence, technical competence, cultural competence, and communication competence.

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The 1995 and especially the 1998 Pew Health Professions Commission reports activated dialogues and debates in many health disciplines and among others interested in healthcare regulation, such as state legislatures. The Institute of Medicine's reports about medical errors and patient safety added a sense of urgency and engaged more consumers, media, and policymakers in the discussion.^{13,14}

ISSUES FOR SPECIALTY CERTIFICATION

In 2001, Lyon and Minarik¹ reported an analysis of US statutes and regulations. The analysis identified certification as a significant issue for CNSs. Certification examinations are not available for many existing and emerging specialty practice areas, leading to significant barriers when national certification is required for licensure.³ Many specialties are small; development of a valid exam would be too costly for a certifying body; the pool of potential test-takers would be too small. Other new specialties are emerging as they respond to new societal needs. State boards of nursing may recommend that CNSs take generalist exams if there is no specialty examination to validate competency, but this is a mismatch and does not ensure specialty knowledge or skill competency; therefore, this approach does not ensure the safety of the public.⁸ In 2003, the National Association of Clinical Nurse Specialists (NACNS) published a position paper on Regulatory Credentialing of CNSs that again identified the issues with certification as a barrier to the public's access to CNS services.⁵ Recognizing a need, the NACNS and the ANCC engaged in discussions to develop alternative mechanisms to certification examinations.⁶

For CNSs, a major issue is the difficulty of developing legally defensible competency assessment tools for small specialty groups. A similar problem is being encountered by nurse practitioners (NPs) and physician assistants (PAs) who are forging new careers in specialties built upon a primary care education.¹⁵ New focused specialties have created new credentialing demands, especially at the institutional level. For NPs and PAs, issues also include licensure in states that use certification examinations within general primary care specialties such as women's health primary care. In this example, there is no recognition of a more focused specialty such as menopause and therefore licensure provides no assurance or acknowledgement of competence in relation to menopause. Many NPs and PAs are seeking credentials other than national certification through continuing education programs that provide certificates for evidence and make the providers "value-added" for contributions to care in their employment. Physicians find themselves in similar situations when there is no board certification for a specialty such as menopause.¹⁵ The issue of legally defensible competency validation methods for small and emerging specialties is shared among the healthcare disciplines. The NACNS may be able to provide a model for others.

GLOBAL NURSING REGULATION ISSUES

Nursing regulation is an issue not only in the United States but worldwide. In 2004, Judith Oulton, the chief executive officer of the International Council of Nurses

(ICN) urged that all nurses take an interest in nursing regulation, learn what commitments our governments have made to trade in nursing services under the General Agreement on Trade in Services (GATs), and what that may mean for patients and their safety.¹⁶ Oulton expressed concern that globalization might lead to more deregulation or reregulation, leaving patients potentially unsafe. The ICN has produced papers on nursing regulation and holds a regular conference on global issues of regulation. On the basis of the work of the ICN, she listed the goals of regulation as

- defining the profession and its scope of practice;
- setting education standards and standards of ethical and competent practice; and
- establishing systems of accountability and credentialing processes.^{16(p71)}

Oulton urged nurses to embrace these goals of regulation. She identified global trends in regulation such as overlapping scopes of practice between different disciplines. CNSs working on certification mechanisms in the United States would be wise to keep the global context in mind.

TOOLS FOR COMPETENCE ASSESSMENT AND COMPETENCY ASSURANCE

The CAC began focusing on healthcare professionals' continuing competence in the early 1990s. Available on the CAC Web site are the proceedings of a 2000 conference held to look at the state of the art in continuing professional competence assessment and assurance.¹⁷ Updates on progress were provided by the CAC, representatives from respiratory therapy, medicine, pharmacy, and nursing. The detailed text in the proceedings provides valuable information about the disciplines' trials of multiple methods and issues encountered. Barriers identified included core barriers (need for agreement on terms and definitions, need for research to validate methodologies and approaches, need for collaboration), administrative feasibility barriers, public credibility barriers, professional acceptance barriers, legal barriers, and economic feasibility barriers. For each barrier, strategies were developed. These proceedings are too lengthy to recount here but would be useful reading for anyone interested in the issue of healthcare professionals' competence assessment.

In 2004, the CAC produced a report called *Maintaining and Improving Health Professionals Competence: The Citizen Advocacy Center Road Map to Continuing Competency Assurance*.¹⁸ The executive summary is available on the CAC Web site. The road map is an action plan designed to lead to the institutionalization of meaningful, periodic continuing competency assessment and assurance for all healthcare professionals. The CAC presents a 5-step model as a conceptual framework: (1) routine periodic assessment, (2) develop a personal plan, (3) implement the personal plan, (4) documentation, and (5) demonstrate/evaluate competence. The stated purpose of the model is to enable healthcare providers to practice safe, quality healthcare and to support efforts as lifelong learners, not to punish or burden care providers. This model is similar to the portfolio method described below. The first phase

of the road map relies on pilot programs to build the evidence for approaches to competence assessment. The second phase involves commitment by stakeholder groups as the evidence shows its value. For some healthcare disciplines, periodic continuing competency assessment is not news but for those who expected competence validation only at initial licensure, this would be a change. For many CNSs, the issue is validating specialty competence (initial and continuing) in a meaningful, valid, and legally defensible way.

The Pew Health Professions Commission Taskforce on Health Care Workforce Regulation 1998 report¹¹ called Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation identified potential measurement tools for competence assessment, including

- standardized examinations,
- reexamination in area of specialty,
- private professional or specialty board certification or recertification,
- computer simulations,
- standardized patients,
- objective structured clinical examinations,
- office record reviews,
- practice evaluations,
- peer review,
- successful completion of recognized training,
- comprehensive self-evaluation of continuing competence, identification of practice weaknesses, and tailored continuing education coursework with required examination or demonstration of comprehension of course material, and
- patient satisfaction reports.

According to the report, tools must be "...meaningful (empirically based, valid and reliable), effective (psychometrically sound) and cost-efficient."^{11(p40)} A number of these methods are being piloted.¹⁷

Similarly, the NACNS Statement on Clinical Nurse Specialist Practice and Education states, "The scope of CNS practice should be explicated in regulation. The scope of practice should be such that CNSs are recognized and held accountable for nursing at an advanced level. Evidence of specialty expertise may be defined in regulation. Requirements for evidence—psychometric examination, portfolio, continuing education, or other mechanisms—if required, should be obtained from professional specialty organizations, and should be available, legally defensible, and logically linked to the specialty practice."^{19(pp20-21)} The NACNS supports a minimalist approach to state regulation, advocating title protection and scope of practice definition.

Examinations are the most common tools used for competence assessment, especially for initial validation of competence. Important aspects of licensure examinations are identified by CLEAR and are available on the organization's Web site.²⁰ Based on a job analysis that determines the content, licensing examinations require significant amounts of time and money to develop and additional time to administer and maintain the examination. A reliable and valid examination is considered legally defensible. Administrative procedures, such as proctors, proctor-candidate ratios, candidate registration, seating, inventory

and storage of exam materials, and testing conditions, such as candidate handbooks, scheduling, site and time allowed, and number of questions, impact the reliability and validity of examinations. Multiple-choice formats are less costly and are considered to provide a suitable method for assessing complex competencies. Alternative formats such as practical or oral examinations are more costly and additional factors such as documentation of process, standardized procedures, and candidate-examiner ratio affect reliability and validity. All of these factors make examinations a poor option for small specialty groups. A broader examination might be more cost-effective or potentially applicable to more advanced practice nurses but it would be based on a different job analysis than one based on specialty practice. In that case, it would not actually validate specialty competence even if the examination were legally defensible.

Lyon and Boland² describe the portfolio option as an attractive tool for CNSs to demonstrate competence. The portfolio serves as a basis for the recent collaborative work of the NACNS and the ANCC and is supported by the American Nurses Association.²¹ The Quality Assurance Program²² by the College of Nurses of Ontario (CNO), the nursing regulatory agency in Ontario, Canada, is viewed as a model of the portfolio option by the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation,¹¹ the American Nurses Association,²¹ and the NACNS.² It was developed in response to Canada's Regulated Health Professions Act that applied to all healthcare professions in Ontario. The CNO's comprehensive approach includes reflective practice, competence assessment, and practice setting consultation.²² Reflective practice is the most developed part of the CNO quality assurance program.

In a 1999 article about portfolios in *The American Nurse*, ANA Nurse Practice Counsel Windy Carson, JD, cautioned about the potential use of the portfolio in malpractice or disciplinary cases in which self-assessment and an error in an area of deficiency could be damning.²¹ Other potential concerns with portfolio models are how reliably self-assessment measures and ensures competence, and concerns about what to measure.¹⁷ These and other concerns will have to be considered as the portfolio model is developed further. If this option were developed further, current ANCC certification exams for CNSs would continue to be available.

CONCLUSION

Competence assessment and competency assurance of healthcare professionals are old concerns with new urgency. Patient safety and error prevention priorities place competency of healthcare professionals in a spotlight. Globally, healthcare providers' regulation, safety, and quality are greater concerns with international migration of healthcare providers. Programs for competence assessment and competency assurance are being piloted but research is needed to compare methodologies and identify the impact on patients. In this context, the NACNS works to develop the portfolio or other options as a meaningful, cost-effective, and legally defensible mechanism to validate the competence of CNSs.

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