BOARD OF PHYSICAL THERAPY

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
Board Room 1, Second Floor
Friday, February 17, 2012
9:00 a.m.

AGENDA

CALL TO ORDER

ORDERING OF AGENDA

ACCEPTANCE OF MINUTES – Tab 1

- Board Meeting – August 19, 2011
- Adhoc Committee on Foreign Traineeship Evaluations – August 19, 2011

PUBLIC COMMENT

EXECUTIVE DIRECTOR'S REPORT – Tab 2

NEW BUSINESS

- Legislative/Regulatory Report – Elaine Yeatts – **Handout**
- Electronic Medical Records/Impact on the Practice of PT
  Robert Maroon
- Temporary Exemptions for Declared Disaster or Emergency
  Lisa R. Hahn
- Foreign Traineeship Evaluations Update – **Tab 3**
  Melissa Wolff-Burke
- PT's Performing INR Testing in Home Health Settings – **Tab 4**
  George Maihafer
- "Continued Competency" vs. "Continued Maintenance" - **Tab 5**
  George Maihafer
- Guidance Document for Practicing with an Expired License – **Tab 6**
  Lisa R. Hahn

ADJOURNMENT

Tab 1

UNAPPROVED
BOARD OF PHYSICAL THERAPY
MEETING MINUTES

The Virginia Board of Physical Therapy convened for a board meeting on Friday, August 19, 2011 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room #1, Henrico, Virginia.

The following members were present:

George Maihafer, PT, Ph.D, President
Melissa Wolff-Burke, PT, EdD
Robert Maroon, PT
J.R. Locke
Peggy Belmont, PT
Michael Styron, PT, MBA

The following member was absent for the meeting:

Sarah Schmidt, P.T.A.

DHP staff present for all or part of the meeting included:

Lisa R. Hahn, Executive Director
Arne Owens, Agency Chief Deputy Director
Missy Currier, Board Operations Manager

Representative from the Office of the Attorney General present for the meeting:

Amy Marschean, Senior Assistant Attorney General

Quorum:

With 6 members present, a quorum was established.

GUEST PRESENT

Shawn Soper, American Physical Therapy Association (APTA), Sheltering Arms

CALLED TO ORDER

Dr. Maihafer, President, called the board meeting to order at 9:10 a.m. and welcomed the re-appointments of Peggy H. Belmont, PT and Michael E. Styron, PT, MBA.

ORDERING OF THE AGENDA

The agenda was accepted as ordered.

ACCEPTANCE OF MINUTES

- Upon a motion by Ms. Belmont and properly seconded by Mr. Locke, the Board voted to accept the minutes of the May 13, 2011 Board meeting. The motion passed unanimously.

- Upon a motion by Ms. Belmont and properly seconded by Mr. Locke, the board voted to accept the public hearing minutes on June 30, 2011. The motion passed unanimously.

PUBLIC COMMENT

Prior to opening up for public comment, Dr. Maihafer reminded everyone that no comments could be received regarding the traineeship since the comment period ended on July 20, 2011.

There was no public comment.

EXECUTIVE DIRECTOR'S REPORT - Lisa R. Hahn

Welcome

Ms. Hahn also welcomed the new members to the board and stated that she had invited Maureen Lyons and Damien Howell to join the members for lunch following the meeting. Unfortunately, due to a previous engagement, Ms. Lyons would be unable to attend but gratefully Mr. Howell could attend.

FY11 Budget

Ms. Hahn reported that the cash balance as of June 30, 2010 was $335,865; the revenue as of June 30, 2011 was $722,970; direct and allocated expenditures were $454,856; the ending cash balance as of June 30, 2011 was $603,980.

Discipline Statistics

Ms. Hahn reported there are currently 13 open cases; 9 cases in Investigations; and 4 cases at the probable cause level. She added that Ms. Helmick and Ms. Truesdale meet on a weekly basis to review the status of cases.

Virginia Performs

Ms. Hahn reported the clearance rate for the Quarter ending June 30, 2011 was 83%. The age of our pending case load over 250 days is at 22% which is down from 33% as last reported. The time to disposition is at 100% of cases closed within 250 days. The licensing standard of less than 30 days for issuance has been met 100% of the time. The customer satisfaction rating

achieved was 98.9% for which she attributed and thanked Holly Manke, Annie Artis and Vickie Saxby.

Licensee Statistics

Ms. Hahn reported that as of July 2011 there were 5,351 active physical therapists vs. 5,410 in July 2010 and 2,254 active physical therapist assistants as of July 2011 vs. 2,242 in July 2010.

Board Business

NPTE

The 2011 fixed dates are scheduled for Sept 7th, October 26th, and December 5th and registration will close 30 days prior to every date. The 5 testing dates in 2012 will be January 30, 2012, March 29, 2012, July 2, 2012, July 30, 2012 and October 23, 2012. She also shared that they will hold four test dates in 2013 but they have not yet posted a schedule. She concluded by sharing that PTA testing will also convert to fixed dates in the future.

Evaluation for Foreign Educated Trainees

Ms. Hahn stated that Dr. Maihafer has established a committee to develop a foreign evaluation tool for traineeship. The Committee will be meeting following the board meeting and Melissa Wolff-Burke will Chair the Committee. Any information will be shared with the full board at their next meeting.

NPTE Fee Increase

Ms. Hahn reported that the testing fees are set to increase in January 2013 from $370.00 to $400.00.

FSBPT Summit Meeting

Ms. Hahn shared that Dr. Maihafer and Holly Manke attended the meeting held in Dallas, Texas in July. She added that Ms. Manke has been instrumental keeping up with all the changes in the FSBPT testing arena. Ms. Hahn stated the Dr. Maihafer and Ms. Manke would report later in the meeting on the details.

New Board Member Orientation

Ms. Hahn shared that the Department of Health Professions would be holding the orientation on September 23rd and that new member Michael Styron, PT would be attending.

FSBPT Annual Meeting

Ms. Hahn reported that she would be unable to attend this year's annual meeting in Charlotte, North Carolina in September because she was committed to present at the New Board Member Orientation for the Department of Health Professions. She did share that she was already working on sending a substitute to attend the CBA portion of the meeting on her behalf. She concluded that Dr. Maihafer and Melissa Wolff-Burke would also be attending the annual meeting.

Board Meeting Calendar

The next full board meeting is scheduled for November 18, 2011. Ms. Hahn asked the members to look at their 2012 calendars for consideration of next year's meeting dates. She added that she would like to establish a tentative calendar prior to the conclusion of the meeting.

NEW BUSINESS

Reconsideration of Proposed Regulations – Lisa R. Hahn

Ms. Hahn stated that the board needed to adopt the final regulations for Traineeships and Continuing Education with or without change to:

- **18VAC112-20-131. continued competency requirements for renewal of an active license. h. The FSBPT**

After much discussion, motion was made by Ms. Belmont and properly seconded by Mr. Locke to remove 18VAC112-20-131 (h). The motion carried unanimously.

Following the motion, another motion was made by Mr. Styron, and properly seconded by Mr. Maroon to adopt the final regulations with the change noted (removal of 18 VAC112-20-131 h). The motion carried unanimously.

BREAK

The Board took a recess at 10:20 a.m. and reconvened at 10:35 a.m.

Supervisory Limitation for Licensees on Probation

The Board discussed the issue of licensees who are probation being permitted to supervise or whether or not there should be restrictions.

Following discussion, a motion was made by Ms. Belmont and properly seconded by Mr. Locke to include limitations for licensees to supervise while they are on probation in the Sanction Reference Points Manual. The motion carried unanimously.

FSBPT Summit Conference Report – George Maihafer, PT, Ph.D & Holly Manke, Licensing Specialist

Dr. Maihafer stated that the purpose of the Summit Conference was for different States to address concerns about the National PT exam and the recent changes to the way the exam will be administered.

Election of Officers

Upon a motion by Mr. Locke and properly seconded by Ms. Wolff-Burke, the board nominated the election of Ms. Belmont as Vice-President. The motion carried unanimously.

2012 Calendar

The board agreed to have Missy Currier check room availability for the following dates in 2012 to hold meetings; February 17, May 18, August 17, and November 16. The board also agreed that the start time for meetings shall remain 9:00 a.m. Ms. Currier will forward the 2012 calendar once confirmed.

2011/2012 Committee's

Ms. Hahn provided the board with the committee assignments for the upcoming year and stated that an official list would also be emailed.

Board Member Recognition

Dr. Maihafer recognized Damien Howell with a plaque for his dedication and hard work to the board of Physical Therapy as well as his work on the Board of Health Professions. He added that Mr. Howell's experience and voice of reason will be greatly missed.

Mr. Howell replied that his tenure had been very interesting, valuable and enjoyable and that he truly appreciated working with the Staff.

ADJOURNMENT

With all business concluded the meeting was adjourned at 11:18 a.m.

George Maihafer, PT, Ph.D., Chair	Lisa R. Hahn, MPA, Executive Director
Date	Date

UNAPPROVED MINUTES
BOARD OF PHYSICAL THERAPY
Ad hoc Committee on Foreign Traineeship Evaluations
Meeting Minutes

The Virginia Board of Physical Therapy Ad hoc Committee on Non-Approved Applicant's Traineeship Evaluations met on Friday, August 19, 2011 at the Department of Health Professions, 9960 Mayland Drive, 3rd Floor, Board Room #1, Henrico, Virginia.

The following members were present:

Melissa Wolff-Burke, P.T., EdD, Chair
George C. Maihafer, P.T., Ph.D.
Michael E. Styron, PT, MBA

DHP staff present for all or part of the meeting included:

Holly Manke, Administrative Assistant

CALLED TO ORDER

Ms. Wolff-Burke called the Committee meeting to order at 12:00 p.m.

RECOMMENDATIONS

Following the review of the current processes and forms used for evaluation of the traineeship for non-approved applicants, the committee made the following recommendations:

- The priority for the licensure requirements for non-approved applicants should be completed in this order:
  1) Proof of Education – Credentials Evaluation Report verifying substantial equivalency to an approved graduate.
  2) Passage of national examination
  3) 1000 hour traineeship following passage of the national exam.

- The Board should purchase the right to use the online CPI tool from the APTA estimated at approximately $950.00 a year.

- The evaluation of the 1000 hour traineeship should be the online CPI tool by the APTA that will be completed by the supervising Physical Therapist throughout the traineeship.

- The Credentialing Committee to be set by the Board will review the online completion to determine if the traineeship was successful.

ADJOURNMENT

With no further business, the meeting was adjourned at 12.35 p.m.

Melissa Wolff-Burke, P.T., EdD, Chair	Lisa R. Hahn, Executive Director
Date	Date

Tab 2

Executive Directors Report

- Budget
- Disciplinary Case Statistics
- Virginia Performs
- Licensure Statistics
- Additional Information

Virgina Department of Health Professions
Cash Balance
As of December 31, 2011

	116- Physical Therapy
Cash Balance as of June 30, 2011	$ 603,980
YTD FY12 Revenue	59,430
Less: YTD FY12 Direct and In-Direct Expenditures	236,249
Cash Balance as of December 31, 2011	$ 427,161

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
July 1, 2011 through December 31, 2011

	116- Physical Therapy			
	Jul '11 - Dec 11	Budget	$ Over Budget	% of Budget
Revenue				
2400 · Fee Revenue				
2401 · Application Fee	51,055.00	104,700.00	-53,645.00	48.76%
2406 · License & Renewal Fee	4,040.00	0.00	4,040.00	100.0%
2407 · Dup. License Certificate Fee	430.00	550.00	-120.00	78.18%
2409 · Board Endorsement - Out	3,480.00	5,900.00	-2,420.00	58.98%
2421 · Monetary Penalty & Late Fees	425.00	5,235.00	-4,810.00	8.12%
2432 · Misc. Fee (Bad Check Fee)	0.00	35.00	-35.00	0.0%
Total 2400 · Fee Revenue	59,430.00	116,420.00	-56,990.00	51.05%
Total Revenue	59,430.00	116,420.00	-56,990.00	51.05%
Expenditures				
1100 · Personal Services				
1110 · Employee Benefits				
1111 · Employer Retirement Contrib.	2,837.25	4,875.15	-2,037.90	58.2%
1112 · Fed Old-Age Ins- Sal St Emp	2,732.23	5,667.92	-2,935.69	48.21%
1113 · Fed Old-Age Ins- Wage Earners	0.00	736.00	-736.00	0.0%
1114 · Group Insurance	393.49	755.72	-362.23	52.07%
1115 · Medical/Hospitalization Ins.	10,011.45	20,440.80	-10,429.35	48.98%
1116 · Retiree Medical/Hospitalizatn	382.21	733.50	-351.29	52.11%
1117 · Long term Disability Ins	254.63	489.00	-234.37	52.07%
Total 1110 · Employee Benefits	16,611.26	33,698.09	-17,086.83	49.29%
1120 · Salaries				
1123 · Salaries, Classified	37,244.24	74,090.47	-36,846.23	50.27%
Total 1120 · Salaries	37,244.24	74,090.47	-36,846.23	50.27%
1130 · Special Payments				
1131 · Bonuses and Incentives	0.00	0.00	0.00	0.0%
1138 · Deferred Compnstn Match Pmts	390.00	816.00	-426.00	47.79%
Total 1130 · Special Payments	390.00	816.00	-426.00	47.79%
1140 · Wages				
1141 · Wages, General	0.00	9,624.00	-9,624.00	0.0%
Total 1140 · Wages	0.00	9,624.00	-9,624.00	0.0%
1160 · Terminatn Personal Svce Costs				
1165 · Employee Retirement Contributio	841.24	842.00	-0.76	99.91%
Total 1160 · Terminatn Personal Svce Costs	841.24	842.00	-0.76	99.91%
Total 1100 · Personal Services	55,086.74	119,070.56	-63,983.82	46.26%
1200 · Contractual Services				
1210 · Communication Services				
1211 · Express Services	18.64	125.00	-106.36	14.91%
1214 · Postal Services	1,914.50	8,200.00	-6,285.50	23.35%
1215 · Printing Services	0.00	2,650.00	-2,650.00	0.0%
1216 · Telecommunications Svcs (DIT)	445.62	400.00	45.62	111.41%
Total 1210 · Communication Services	2,378.76	11,375.00	-8,996.24	20.91%

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
July 1, 2011 through December 31, 2011

	116- Physical Therapy			
	Jul '11 - Dec 11	Budget	$ Over Budget	% of Budget
1220 · Employee Development Services				
1221 · Organization Memberships	2,500.00	2,500.00	0.00	100.0%
1222 · Publication Subscriptions	0.00	50.00	-50.00	0.0%
1224 · Emp Trning Courses, Wkshp & Cnf	0.00	2,025.00	-2,025.00	0.0%
1225 · Employee Tuition Reimbursement	315.00			
Total 1220 · Employee Development Services	2,815.00	4,575.00	-1,760.00	61.53%
1240 · Mgmnt and Informational Svcs				
1242 · Fiscal Services	11.71	620.00	-608.29	1.89%
1244 · Management Services	5,302.81	750.00	4,552.81	707.04%
Total 1240 · Mgmnt and Informational Svcs	5,314.52	1,370.00	3,944.52	387.92%
1260 · Support Services				
1263 · Clerical Services	0.00	23,025.00	-23,025.00	0.0%
1264 · Food & Dietary Services	0.00	700.00	-700.00	0.0%
1266 · Manual Labor Services	53.14	400.00	-346.86	13.29%
1267 · Production Services	1,022.37	1,525.00	-502.63	67.04%
1268 · Skilled Services	4,171.44	10,962.00	-6,790.56	38.05%
Total 1260 · Support Services	5,246.95	36,612.00	-31,365.05	14.33%
1280 · Transportation Services				
1282 · Travel, Personal Vehicle	762.02	3,600.00	-2,837.98	21.17%
1283 · Travel, Public Carriers	32.65	1,000.00	-967.35	3.27%
1285 · Travel, Subsistence & Lodging	0.00	950.00	-950.00	0.0%
1288 · Trvl, Meal Reimb- Not Rprtble	0.00	716.00	-716.00	0.0%
Total 1280 · Transportation Services	794.67	6,266.00	-5,471.33	12.68%
Total 1200 · Contractual Services	16,549.90	60,198.00	-43,648.10	27.49%
1300 · Supplies And Materials				
1310 · Administrative Supplies				
1311 · Apparel Supplies	4.19			
1312 · Office Supplies	302.91	730.00	-427.09	41.5%
1313 · Stationery and Forms	62.51	-572.00	634.51	-10.93%
Total 1310 · Administrative Supplies	369.61	158.00	211.61	233.93%
1360 · Residential Supplies				
1362 · Food and Dietary Supplies	0.00	100.00	-100.00	0.0%
1363 · Food Service Supplies	0.88			
Total 1360 · Residential Supplies	0.88	100.00	-99.12	0.88%
1370 · Specific Use Supplies				
1373 · Computer Operating Supplies	5.48			
Total 1370 · Specific Use Supplies	5.48			
Total 1300 · Supplies And Materials	375.97	258.00	117.97	145.73%
1400 · Transfer Payments				
1410 · Awards, Contrib., and Claims				
1413 · Premiums	120.00	120.00	0.00	100.0%

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
July 1, 2011 through December 31, 2011

	116- Physical Therapy			
	Jul '11 - Dec 11	Budget	$ Over Budget	% of Budget
Total 1410 · Awards, Contrib., and Claims	120.00	120.00	0.00	100.0%
Total 1400 · Transfer Payments	120.00	120.00	0.00	100.0%
1500 · Continuous Charges				
1510 · Insurance-Fixed Assets				
1516 · Property Insurance	28.39	50.00	-21.61	56.78%
1510 · Insurance-Fixed Assets - Other	0.00	0.00	0.00	0.0%
Total 1510 · Insurance-Fixed Assets	28.39	50.00	-21.61	56.78%
1530 · Operating Lease Payments				
1534 · Equipment Rentals	0.00	0.00	0.00	0.0%
1539 · Building Rentals - Non State	3,167.63	6,441.00	-3,273.37	49.18%
Total 1530 · Operating Lease Payments	3,167.63	6,441.00	-3,273.37	49.18%
1540 · Service Charges				
1541 · Agency Service Charges	0.00	0.00	0.00	0.0%
Total 1540 · Service Charges	0.00	0.00	0.00	0.0%
1550 · Insurance-Operations				
1551 · General Liability Insurance	101.82	454.00	-352.18	22.43%
1554 · Surety Bonds	6.01	11.00	-4.99	54.64%
Total 1550 · Insurance-Operations	107.83	465.00	-357.17	23.19%
Total 1500 · Continuous Charges	3,303.85	6,956.00	-3,652.15	47.5%
2200 · Equipment Expenditures				
2210 · Computer Equipment				
2218 · Computer Software Purchases	184.00			
Total 2210 · Computer Equipment	184.00			
2220 · Educational & Cultural Equip				
2224 · Reference Equipment	170.00	100.00	70.00	170.0%
Total 2220 · Educational & Cultural Equip	170.00	100.00	70.00	170.0%
2230 · Electrnc & Photographic Equip				
2238 · Electrnc & Phtgrphc Equip Imprv	0.52			
Total 2230 · Electrnc & Photographic Equip	0.52			
2260 · Office Equipment				
2263 · Office Incidentals	77.63	15.00	62.63	517.53%
2264 · Office Machines	0.00	100.00	-100.00	0.0%
Total 2260 · Office Equipment	77.63	115.00	-37.37	67.5%
Total 2200 · Equipment Expenditures	432.15	215.00	217.15	201.0%
Total Direct Expenditures	75,868.61	186,817.56	-110,948.95	40.61%
9001 · Allocated Expenditures				
9206 · Funeral\LTCA\PT	47,640.99	89,715.46	-42,074.47	53.1%
9301 · DP Operations & Equipment	29,823.35	102,074.28	-72,250.93	29.22%
9302 · Human Resources	6,621.89	12,382.68	-5,760.79	53.48%

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
July 1, 2011 through December 31, 2011

	116- Physical Therapy			
	Jul '11 - Dec 11	Budget	$ Over Budget	% of Budget
9303 · Finance	17,676.93	36,903.24	-19,226.31	47.9%
9304 · Director's Office	9,417.37	20,340.36	-10,922.99	46.3%
9305 · Enforcement	15,648.91	41,379.48	-25,730.57	37.82%
9306 · Administrative Proceedings	4,824.21	10,753.68	-5,929.47	44.86%
9307 · Impaired Practitioners	256.45	501.12	-244.67	51.18%
9308 · Attorney General	17,652.91	23,793.84	-6,140.93	74.19%
9309 · Board of Health Professions	6,589.20	14,715.00	-8,125.80	44.78%
9311 · Moving Costs	0.00	713.16	-713.16	0.0%
9313 · Emp. Recognition Program	19.74	456.12	-436.38	4.33%
9314 · Conference Center	73.02	557.04	-484.02	13.11%
9315 · Pgm Devlpmnt & Implmentn	4,135.14	8,961.36	-4,826.22	46.14%
987900 · Cash Trsfr Out- Appr Act Pt. 3	0.00	1,520.52	-1,520.52	0.0%
Total 9001 · Allocated Expenditures	160,380.11	364,767.34	-204,387.23	43.97%
Total Direct and Allocated Expenditures	236,248.72	551,584.90	-315,336.18	42.83%
Net Cash Surplus\Shortfall	**-176,818.72**	**-435,164.90**	**258,346.18**	**40.63%**

Discipline Cases

	Feb 2012	Feb 2011	Feb 2010
Investigations	11	5	5
Probable Cause	7	5	6
APD	0	0	0
Informal Stage	0	2	0
Formal Stage	0	1	0
Total	18	13	11

Monitoring:

PT Compliance Cases	7

Virginia Department of Health Professions

Patient Care Disciplinary Case Processing Times: Quarterly Performance Measurement, Q1 2008 - Q1 2012

Dianne Reynolds-Cane, M.D.
Director

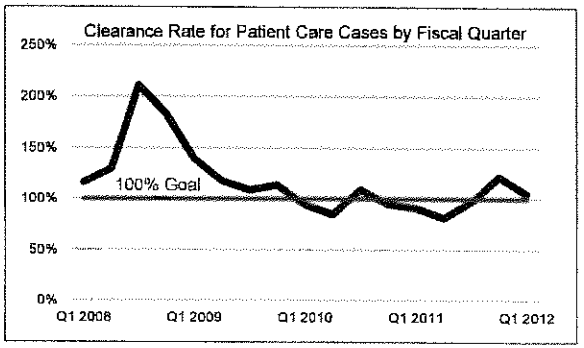
"To ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."
DHP Mission Statement

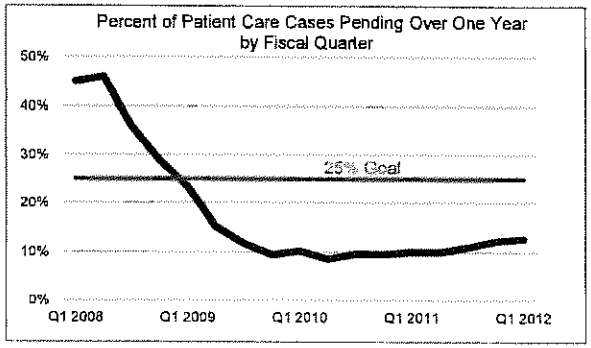
In order to uphold its mission relating to discipline, DHP continually assesses and reports on performance. Extensive trend information is provided on the DHP website, in biennial reports, and, most recently, on Virginia Performs through Key Performance Measures (KPMs). KPMs offer a concise, balanced, and data-based way to measure disciplinary case processing. These three measures, taken together, enable staff to identify and focus on areas of greatest importance in managing the disciplinary caseload; Clearance Rate, Age of Pending Caseload and Time to Disposition uphold the objectives of the DHP mission statement. The following pages show the KPMs by board, listed in order by caseload volume; volume is defined as the number of cases received during the previous 4 quarters. In addition, readers should be aware that vertical scales on the line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

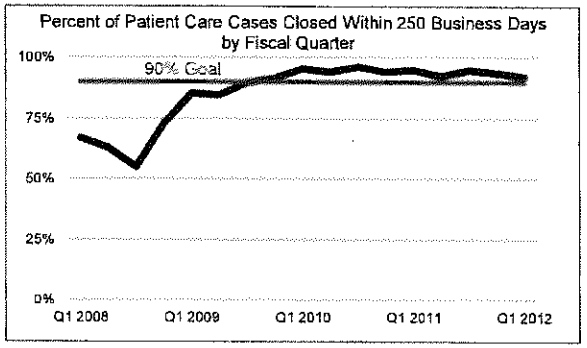
Clearance Rate - the number of closed cases as a percentage of the number of received cases. A 100% clearance rate means that the agency is closing the same number of cases as it receives each quarter. DHP's goal was to achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010. The current quarter's clearance rate is 105%, with 1019 patient care cases received and 1071 closed.

Age of Pending Caseload - the percent of open patient care cases over 250 business days old. This measure tracks the backlog of patient care cases older than 250 business days to aid management in providing specific closure targets. The goal was to reduce the percentage of open patient care cases older than 250 business days to no more than 25% by the end of FY 2010. That goal continues to be acheived with the percent of cases pending over 250 business days dropping dramatically from 45% to 13%. For the last quarter shown, there were 1784 patient care cases pending, with 228 pending over 250 business days.

Time to Disposition - the percent of patient care cases closed within 250 business days for cases received within the preceding eight quarters. This moving eight-quarter window approach captures the vast majority of cases closed in a given quarter and effectively removes any undue influence of the oldest cases on the measure. The goal was to resolve 90% of cases related to patient care within 250 business days by the end of FY 2010. That goal continues to be acheived with 92% percent of patient care cases being resolved within 250 business days this past quarter. During the last quarter, there were 1,071 patient care cases closed, with 989 closed within 250 business days.







Submitted: 10/6/2011

Prepared by: VisualResearch, Inc.

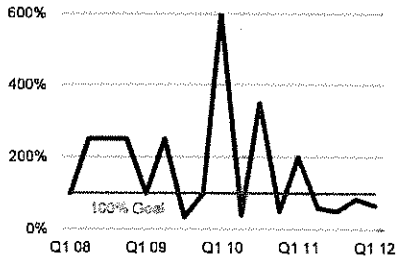
Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

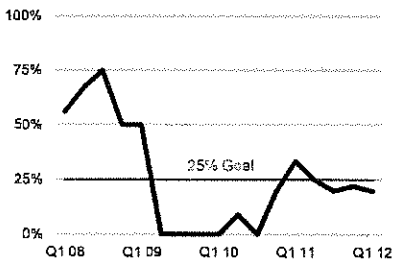
Clearance Rate

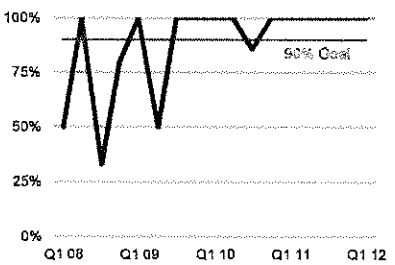
Age of Pending Caseload
(percent of cases pending over one year)

Percent Closed in 250 Business Days

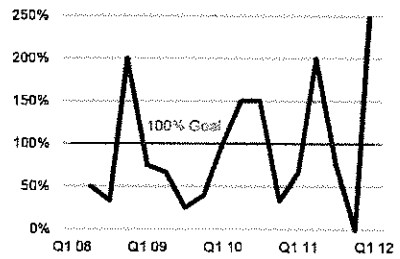
Physical Therapy - In Q1 2012, the clearance rate was 67%, the Pending Caseload older than 250 business days was 20% and the percent closed within 250 business days was 100%.
Q1 2012 Caseloads:
Received=3, Closed=2
Pending over 250 days=2
Closed within 250 days=2

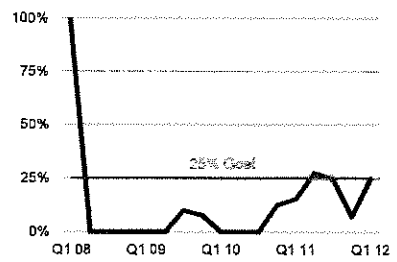


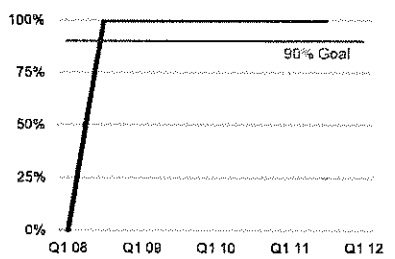




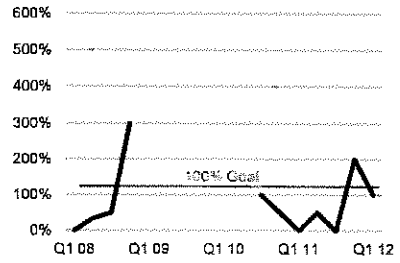
Funeral - In Q1 2012, the clearance rate was 300%, the Pending Caseload older than 250 business days was 25% and the percent closed within 250 business days was 89%.
Q1 2012 Caseloads:
Received=3, Closed=9
Pending over 250 days=2
Closed within 250 days=8

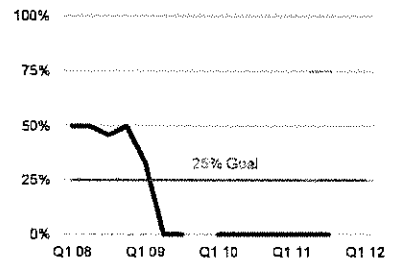


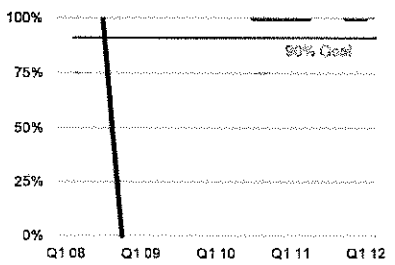




Audiology - In Q1 2012, the clearance rate was 100%, the Pending Caseload older than 250 business days was 0% and the percent closed within 250 business days was 100%.
Q1 2012 Caseloads:
Received=1, Closed=1
Pending over 250 days=0
Closed within 250 days=1







Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Submitted: 10/6/2011

Prepared by: VisualResearch, Inc.

Boards	Clearance Rate (Goal = 100%)	Age of Pending Casesload % Open Cases over 250 Business Days (Goal=25 %)	% Cases Closed within 250 Business Days, last 8 quarters (Goal = 90%)	Customer Satisfaction (Goal = Maintain Average 97% Positive Rating)*	% Licensed within 30 Days of Complete Application (Goal = 97%)
Physical Therapy	67%	20%	100%	95.2% (28)	100.0%
DHP Overall	105%	13%	92%	95.9% (834)	99.9%

Licensure Count Report

	Feb 2012	Feb 2011	Feb 2010
Physical Therapists	6,129	5,454	5,606
Physical Therapist Assistants	2,388	2,098	2,106
Total	**8,517**	**7,552**	**7,712**
Direct Access Certification	**615**	**458**	**355**

Information Only

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COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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FAX (804) 527- 4475

November 29, 2011

Christine M. Sousa
Managing Director, Exam Services
Federation of State Boards of Physical Therapy
124 West Street South
Alexandria, VA 22314

Dear Christine,

I would like to take this opportunity to express our concerns regarding the process with the new fixed date testing since we have experienced two examination cycles.

We are concerned with the limited time between the actual test dates, receiving the test scores and re-registering for those applicants who are unsuccessful on the first attempt. Let me illustrate using the October examination cycle as an example. The test was held on October 26, 2011, we received the scores on November 3, 2011 and the deadline date for applicants to re-register for the exam was November 5, 2011. This placed a tremendous amount of pressure on staff to process the scores and it may not have afforded the unsuccessful applicants with enough time to re-register.

Looking at the 2012 schedule and based on our experience from this year, we are concerned that if an applicant is unsuccessful on the July 2, 2012 examination they will be prevented from registering for the July 31, 2012 examination because the registration deadline is prior to the July 2nd examination. Therefore, those applicants will have to wait until October 2012 to test.

I also wanted to share that we have experienced increased strain on our staffing resources due to the fixed date testing. With 3 fixed test dates scheduled for July 2012 (2 PT and 1 PTA) and 2 tests dates for October 2012 (1 PT and 1 PTA) staff focus will be primarily devoted to the registration and eligibility process during these times and not on other required responsibilities.

Holly Manke attended the July 2011 Conference in Dallas, Texas and indicated that two options were provided during the conference, an option of offering five test dates per year with results given back in 30 days, or four test dates per year with immediate results. Ms. Manke understood "immediate" to be sooner than a full week. Will the one week turnaround continue or should we anticipate receiving the results quicker?

Board of Audiology & Speech-Language Pathology – Board of Counseling – Board of Dentistry – Board of Funeral Directors & Embalmers
Board of Long-Term Care Administrators – Board of Medicine – Board of Nursing – Board of Optometry – Board of Pharmacy
Board of Physical Therapy – Board of Psychology – Board of Social Work – Board of Veterinary Medicine
Board of Health Professions

We understand the necessity of changing from continuous testing to fixed dates for security reasons; however we wanted you to be aware of the issues that Virginia is experiencing and to perhaps consider alternative solutions. Additionally when FSBPT is able to increase the examination offerings, we hope that you will take into consideration the graduation dates of our Virginia approved PT schools which are May, August, and December.

Thank you for your consideration.

Best Regards,

Lisa R. Hahn, Executive Director
Virginia Board of Physical Therapy

DEC 2 9 2011
DHP

December 22, 2011

Lisa R. Hahn, Executive Director
Virginia Board of Physical Therapy
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Lisa:

Thank you for your letter of November 29, 2011 explaining the challenges your board is facing with the move to fixed-date testing for the NPTE. You are right about the tight deadlines between October 26, 2011 and December 5, 2011 – and that candidates who fail on July 2, 2012 will be unable to register for the July 31, 2012 sitting. Our exam services staff is also experiencing the pressure to ensure that all deadlines are met for each test date.

I'd like to provide some background on how we chose the 2011 and 2012 dates. For both 2011 and 2012, we had done an extensive survey of PT and PTA program directors and students. With that information, we went to our test vendor, Prometric to schedule testing dates. We then weighed the survey results with the available test dates that could accommodate the number of candidates we anticipated would test. As you might imagine, selecting test dates that make all stakeholders happy is impossible. We did strive to accommodate as many stakeholders as possible for both 2011 and 2012 but admittedly, not everyone is happy with the results.

We anticipate that beginning in 2013, there will be four PT and PTA tests per year and that they will be given on a quarterly basis on a regular schedule. This should allow us to avoid the tight

deadlines that were seen in 2011 and 2012. We do not expect to see the number of test dates increase beyond four per year. But we hope that once a regular schedule is in place, licensing boards and physical therapy programs will be able to plan and develop procedures for these dates.

Given the number of tests taken in one day, it will continue to take a full week to complete the necessary quality assurance analyses and report test results to you. During that time frame, we receive test records from the Prometric centers, reconcile and verify the records, confirm the scores, and identify/investigate any testing anomalies (e.g., missing records, potential security breaches, missing biometric data, etc.). Given the intense effort involved, and the fact that even the best testing technology is sometimes imperfect, we must work very hard to meet the seven day reporting window. The consequences of making errors during this phase would be extremely burdensome for the states we serve as well as the FSBPT. We apologize that the anticipated delay in score reporting was unclear at the NPTE Summit in Dallas. We anticipate having additional dialogue with our members about score reporting time frames in 2012.

I appreciate that fixed-date testing will continue to be a work-intensive process for your board at least through 2012. If there are any specific suggestions or ideas you have to make the process less burdensome, please share them with us. We would like to assist you in any way we can through this challenging transition.

Sincerely,

Christine Sousa

Christine Sousa
Managing Director of Exam Services

Hahn, Lisa R. (DHP)

From: cba-request@fsbpt.org on behalf of Christine M. Sousa [CSousa@aon.fsbpt.org]
Sent: Wednesday, December 07, 2011 2:18 PM
To: cba@fsbpt.org
Subject: Upgrades to the Jurisdiction Interface
Attachments: Jurisdiction Upgrades.docx

Good afternoon!

This week a number of upgrades to the jurisdiction interface were rolled out. All of these upgrades were the result of jurisdiction feedback since the onset of fixed-date testing. Below is a description of the enhancements. There are also some screen shots attached to this email for your reference.

- We increased the number of days after the fixed-date administrations that the candidate's transaction will move to an "eligibility expired" status. Currently the transactions move to "eligibility expired" the day after the administration. Because scores are not reported for 5 business days, when a candidate checks the status of their registration right after the exam this causes some confusion. This change will begin with the January PT administration.
- A field for "Requested Test Date" was added to the candidate's individual eligibility page.
- A column for school name was added to the ATT Summary Report.
- Additional search parameters were added to the ATT Summary Report and the New Scores Summary Report so that jurisdictions can run these reports by test date as well as by a date range.
- Additional search parameters were added to the eligibility processing page so that jurisdictions can search the list by test date.

Thank you to the jurisdictions that shared their ideas for improvement. Next year the Exam Administration Committee will be taking a closer look at what additional upgrades and tools might be useful to jurisdictions in this new fixed-date testing world. You can expect to see an email early next year soliciting additional feedback and ideas. Hopefully this list will start you thinking about what else can be done to make life easier!

On another topic, the December 5th PT administration went very well. 1,239 candidates tested and you can expect to receive those results on Monday, December 12th.

As always, please let me know if you have any questions.

Thanks,
Christine

Christine Sousa
Managing Director of Exam Services
Federation of State Boards of Physical Therapy
124 S. West Street, 3rd Floor
Alexandria, VA 22314
(703) 739-9420, ext. 201
csousa@fsbpt.org

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COMMONWEALTH of VIRGINIA

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January 6, 2012

TO: Health Regulatory Board Members
Executive Directors
Executive Leadership Team

FROM: Dianne L. Reynolds, Cane, M.D.
Director, Department of Health Professions

RE: Notes from *Great By Choice: Uncertainty, Chaos, and Luck—Why Some Thrive Despite Them All*

Last month Governor Robert McDonnell convened an Agency Head Summit at the University of Richmond where participants joined in an inspiring discussion with bestselling business author, James Collins, who along with Morten T. Hansen, wrote Great By Choice: Uncertainty, Chaos, and Luck—Why Some Thrive Despite Them All. You may recall his previous seminal work, Good To Great.

Based on his uplifting presentation, as told through the findings of a nine year data-driven study regarding the principles of success for building a great business enterprise during challenging times, I want to share with you select highlights of key discussion points.

Dynamic changes in Virginia's healthcare workforce, shifts in the Commonwealth's population, and the economic times in which we live, help make the work of the boards that compose DHP a critical factor in the health and wellbeing of our constituents statewide. There has never been a more important time to gain a fresh perspective on our work to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to healthcare practitioners and the public.

My favorite quote from James Collins is, "Even in a chaotic and uncertain world, greatness happens by choice, not chance." I hope this brief overview of Great by Choice encourages you to read the book and inspires your best thinking at board meetings and hearings in 2012 and beyond.

Consider the following points of view described by James Collins:

- "Greatness is a conscious choice and does not result from chance circumstance."
- Given the uncertainty of the days in which we now live, it is tempting to believe the last 50 years of relative tranquility were usual, though disruption is actually the norm.

- "Humility is actually the X factor of leadership."
- Drive and ambition must be tempered to provide servant leadership.
- "Leadership exists only when people choose to follow [a leader] when they do not have to …."
- Good leaders share a set of deeply held core values that allow them to be consistent in a changing world
- Government agencies represent consistency in government though they often operate in an inconsistent or changing world

Mr. Collins also mentioned leaders often exhibit fanatic discipline, empirical creativity, or productive paranoia-either to their detriment or to their success. More details about these behaviors can be found in his book.

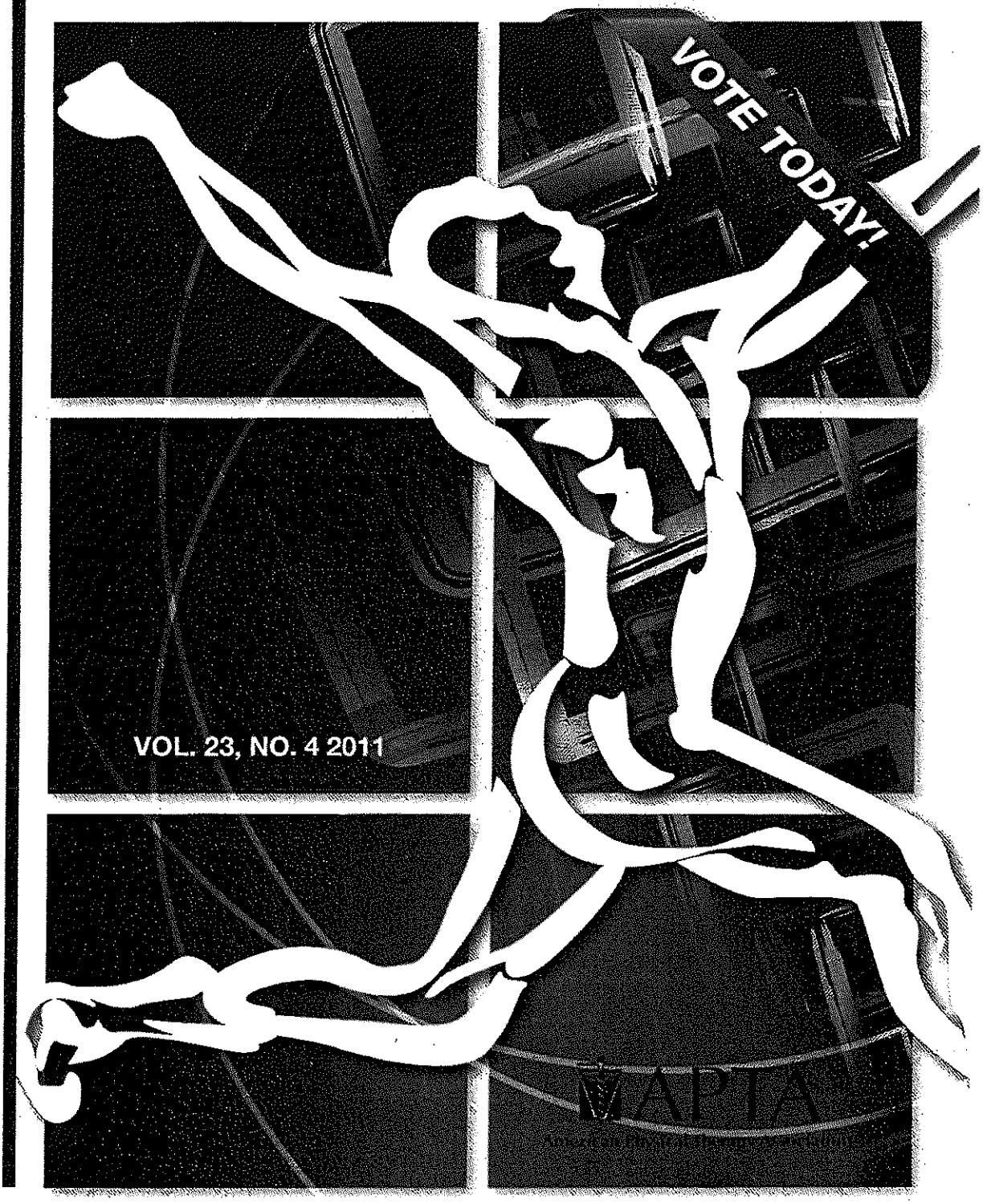
James Collins provided attendees at the Governor's Agency Head Summit the opportunity to learn how corporate and social sectors build and sustain great entrepreneurial institutions during unpredictable times. Your good thinking, as a board members and staff of Virginia's health regulatory boards, is an invaluable asset and this material is likely to provide additional support for all that you do to serve the Commonwealth..

Thank you

ORTHOPAEDIC

Physical Therapy Practice

THE MAGAZINE OF THE
ORTHOPAEDIC SECTION, APTA



VOL. 23, NO. 4 2011

Should Dry Needling for Myofascial Pain be Within the Scope of Practice for Physical Therapists?

Sinéad A. FitzGibbon, PT, MS

Doctoral Student, graduate program in Orthopedic and Sports Physical Therapy, Rocky Mountain University of Health Professions, Provo, UT & Co-owner Manual and Sports Physical Therapy, Sag Harbor, NY

INTRODUCTION

Health care expenditure in the United States reached $2.2 trillion in 2007, increasing 6.2% from the previous year, and amounted to 16.2 % of the gross domestic product.[1] Professional services, including physical therapy, accounted for $62 billion of this cost.[1] Myofascial pain is one of the leading complaints of patients presenting in general medical practice, with reported prevalence of 20% to 93% in general practice[2,3] thus imposing significant financial burdens on state and national health care budgets.[3] With high prevalence and associated costs, there is unrelenting pressure on insurers, clinicians, and researchers to reduce costs while optimizing outcomes. The physical therapy profession is at the forefront of cost containment by promoting comparisons of the effectiveness of different interventions in management of musculoskeletal pain.[4] Physical therapists use nonsurgical, non-pharmaceutical modalities in the prevention and treatment of disability.[5] Moreover, the 2020 vision statement of the American Physical Therapy Association (APTA) reflects the emerging priorities of the profession by emphasizing the provision of expert care using evidence-based practice.[6] With 44 states allowing direct access to physical therapists (PTs) at a lower cost than physical therapy via physician referral,[7] PTs are a part of the vanguard of cost containment in health care.

Physiotherapists began musculoskeletal care in 1894 as a group of nurses practicing remedial massage in the United Kingdom (UK), and evolved into established professional organizations on both sides of the Atlantic. Today there are 170,000 practicing PTs in the United States and 36,000 chartered physiotherapists in the United Kingdom, with therapists recognized as expert clinicians in management of musculoskeletal and myofascial pain.[8,9]

Physiotherapists practicing internationally in the United Kingdom, Australia, New Zealand, and throughout Europe use dry needling alongside traditional modalities in management of myofascial pain.[10-12] The multimodal, direct access practice model is beneficial to both the consumer and the clinical practitioner, as well as cost effective for all involved parties.[7] There are growing numbers of national and international courses in dry needling for physical therapists,[13-15] with 5,500 physiotherapists in the UK[16] and over a thousand such therapists in Australia[17] now licensed to use needling in physical therapy practice.

Direct access ro physical therapy gives patients suffering from myofascial pain a gateway into a broad spectrum of pain management techniques. Physical therapy professionals are expert first-line clinicians in delivery of pain management modalities. With inclusion of dry needling in the battery of techniques available to skilled clinicians, cost-effective nonsurgical pain management options could improve patient outcomes and contribute to containing health care costs. In order to understand how dry needling by physical therapists can enhance pain management, knowledge of its history and current use is warranted. This paper will outline the background of the trigger point theory and describe dry needling as used in management of myofascial pain. It will then compare and contrast the educational processes of acupuncturists and physical therapists with regard to use of needling. Finally, the case will be made for broadening the physical therapist's scope of practice to include dry needling, with special reference to use of evidence-based practice in the current fiscally challenging medical environment.

DRY NEEDLING: BACKGROUND

Dry needling, generally understood as the insertion of filiform (fine filament) needles without use of saline or other liquid substances, has its roots in ancient practice of acupuncture. Nearly 3,000 years of Chinese acupuncture has resulted in regional Asian variations in technique and ideology.[18,19] Development of modern Chinese medical and therapeutic practices has combined with western empirical medical practices to result in the practice of dry needling. This is the use of filiform needles to treat myofascial trigger points without reference to oriental medicine philosophy and principles of practice. Dr. Janet Travell developed and popularized the treatment of myofascial trigger points (MTrP) using dry needling techniques.[20,21] This method of myofascial pain management has become popular among physical therapists and medical doctors worldwide, especially over the past 3 decades. Histopathology, electrical activity, neurophysiology and clinical features of MTrPs have been studied since the 1940s, and though this body of knowledge continues to grow, the mode of efficacy of needling MTrPs remains poorly understood.

Myofascial Trigger Points, Definitions, and Mode of Efficacy

A MTrP is defined as a highly localized and hyper-irritable spot in a palpable taut band of skeletal muscle tissue.[22] The main criteria used for diagnosis of MTrPs are the following: a tender spot in a taut band of contractile skeletal muscle, patient pain report upon palpation of this point, a predictable pattern of referred pain from palpation of this point, and a local twitch response elicited upon palpation.[3] Despite widespread use of these criteria, there have been few studies that have examined inter-examiner reliability and diagnostic sensitivity and specificity,[3,23-24] nor has there been standardization of the manner in which the examination is conducted.[21]

TRIGGER POINT THEORY AND NEEDLING RESPONSE

Trigger points are known to occur and to be maintained at the level of a spinal segmental reflex.[2] It is thought that excessive local release of acerylcholine[2] or calcium[22] at the neuro-motor endplate results in spontaneous electrical activity (SEA), with sustained depolarization and shortening of sarcomeres.[21] The resultant prolonged local muscle spasm is thought to impair blood

flow, cause tissue damage, and perpetuate an inflammatory cycle.[2,21,22] To date, therapy has been aimed at inhibiting muscle spasm and reducing the pain of MTrPs using many modalities, including spraying with ethyl chloride followed by specific stretching, deep massage, injection of various substances, and dry needling.[2,21,25] Elicitation of local twitch response has been demonstrated to occur with needle insertion into active MTrPs.[2,21,26] Pain relief is associated with reduced electrical activity following needle insertion into an MTrP in which a twitch response is observed.[21,22,26,27] Activation of spinal endogenous opioids is a likely factor in the effectiveness of many therapeutic interventions in pain management. Direct stimulation of peripheral nociceptors by needling may act to desensitize the central nervous system via SEA endplate inhibition and enhance stimulation of opioid activity within spinal wide-range dynamic neurons.[22,28] While acupuncture and dry needling are theorized to have similar mechanisms of action, the education, philosophy of practice, and techniques are quite dissimilar.

COMPARING ACUPUNCTURE AND DRY NEEDLING

Acupuncture is one of the oldest forms of therapy, and is based on Chinese philosophy, namely that disease is an outward manifestation of internal imbalance of Yin and Yang energetic forces.[18] Although filiform needles are used in both dry needling and acupuncture, the similarities are limited. Whereas acupuncture is used to diagnose and manage systemic conditions, dry needling of myofascial trigger points purportedly targets specific tissue responses without reference to energetic systems.[22, 27] Acupuncture education entails 3 years of study with mentored residency and competency examinations. Dry needling certification is adjunctive to a medical degree, or a physical therapy masters or doctoral qualification, which takes 5 to 7 years of study. Certification for dry needling in the United States occurs after 50 hours of post-graduate coursework and 200 to 400 documented interventions. Competency examination is required in the United Kingdom, Europe, and Australia with some programs demanding rigorous dissertations at the culmination of a full academic year of acupuncture related physiotherapy.[29] Such competency exams are similar in depth to APTA board certification areas such as orthopaedic sports, and women's health physical therapy certifications. Medical doctors and physical therapists practice dry needling when it is determined to be within the scope of practice by their relevant states. Available evidence for efficacy of acupuncture and dry needling in myofascial pain is limited, and conclusive results are few.[18,19,25,30] Most studies have been limited by small sample size, nonstandardization of techniques and poor research design, with few high quality studies or systematic reviews. The majority of published manuscripts investigating the effects of acupuncture and needling underscore the need for high quality clinical research in this area.[18,30-32]

Dry Needling Within the Scope of Physical Therapy Practice

Canada, the United Kingdom, Ireland, the Netherlands, Norway, Switzerland, Belgium, Spain, Chile, South Africa, Australia, and New Zealand, among other nations, and some 18 states in the United States have determined that dry needling techniques fall within the scope of physical therapy practice.[33,34] Other states such as California, New York, North Carolina, Hawaii, and Tennessee have proscribed the practice outright.[35] In order to understand the potential benefits and risks of amending state practice acts, the arguments of the stakeholders on both sides need to be addressed.

ACUPUNCTURISTS

Acupuncturists have been licensed to practice in the US since 1973[36] and many programs obtained national certification in 1982,[37] culminating in 16,000 acupuncturists currently in practice[38] nationwide. Forty-three states require certification for licensure.[39] Acupuncture practitioners have been opposed to the inclusion of dry needling in physical therapy practice acts in Virginia and Colorado[40,41] and other states.[35] Their objections are based on the duration of the needling certification programs, concerns for the safety of patients and encroachment on professional territory by physical therapists.[35,40,41] with resultant specific criteria changes to the practice acts in these states. Acupuncture professional associations claim that physical therapists can become certified in dry needling techniques with a course of only 54 hours, while the majority of acupuncture certification programs have requirements of 1,905[42] to 3,000 hours of education from some 57 accredited programs.[35,43] This claim disguises the fact that dry needling certification is a postgraduate course following graduation from one of 200 masters or doctoral physical therapy programs that receive accreditation from the Commission on Accreditation in Physical Therapy Education (CAPTE).44 Entry-level DPT programs typically comprise 2,676 hours of education[33,45] and a more extensive anatomy component than acupuncture programs.[33]

Concern for patient safety is not without merit, since skin penetration carries risk of infection, disease transmission, and potential injury to soft tissue, nerve, and blood vessels. However, there is no documented evidence of increased litigation involving therapists practicing dry needling or other skin penetration techniques in states where this is allowed.[46,47] Regarding the territorial concerns, acupuncture practitioners are concerned that the use of dry needling by physical therapists encroaches on their professional practice grounds. Dry needling has been identified as a component of acupuncture practice, with acupuncturists invited to participate and teach on dry needling courses.[14,46] However, dry needling practitioners limit their practice to management of MTrPs, with no claim to diagnosis or management of systemic disease processes. Diagnosis and treatment of conditions using oriental medicine techniques remains the domain of the acupuncture and oriental medicine professions, and this is affirmed by physical therapy practitioners teaching courses in the United States and internationally.[46]

PHYSICIANS

Physicians in particular, have been concerned about skin penetration by physical therapists, objecting to the use of electromyography (EMG) by physical therapists despite the inclusion of such procedures in many state physical therapy practice acts for decades.[33,46,48] Several states license physical therapists to use skin penetration in EMG testing,[33] and to date there has been no documentation of any injuries or health hazards for such therapists.[33,46] Insurance companies providing liability coverage for physical therapists practicing dry needling impose no additional requirements, other than that they practice in a state that permits the technique.[47]

CHIROPRACTORS

The Maryland chiropractic profession took an interesting position towards dry needling, initially opposing dry needling, determining that it fell within the regulatory

practices of the state board of Acupuncture. However, the Maryland Chiropractic Board reversed its position in 2007 and allowed chiropractors to use dry needling under their physical therapy privileges, since the physical therapists in the state had been licensed to do so since 1987. As in other states and international communities, acupuncture is determined to be "the use of oriental medical therapies for the purpose of normalizing energetic physiological functions including pain control, and for the promotion, maintenance, and restoration of health.[36,41,49] The Maryland Chiropractic Board ruling was based on the fact that acupuncture uses needle insertion into fixed points and is based on pre-scientific philosophies, whereas dry needling into myofascial trigger points is solely a local soft-tissue technique. Thus dry needling is not based on Chinese philosophy of energetic systems, does not constitute acupuncture, and is therefore not subject to the regulation of the acupuncture licensing boards.[49]

PHYSICAL THERAPISTS

The APTA is the national professional organization of 72,000 physical therapists in the United States.[8] The APTA does not yet have an official position on dry needling by physical therapists, but recognizes that it is a technique being used by some of its members.[50] The APTA acknowledges that state licensing boards, which have jurisdiction over administration of each state's PT act, have been consulted regarding whether dry needling falls within the scope of practice. The answer across the states is mixed, with 5 states explicitly proscribing dry needling (NV, NY, NC, ID, TN), stating that it is not in the scope of practice. Fifteen boards have interpretive opinions that it is within the scope of practice in states allowing it, and there have been no definitive statements by the remaining 32. Arizona and Pennsylvania are legally prohibited from issuing an interpretive statement. Statements by physical therapy boards in the 18 states that have amended the scope of PT practice to include dry needling include language stipulating that neither the state medical board nor the acupuncture board could rule on the eligibility of appropriately trained physical therapists to practice dry needling.[51,52] Some states issue contradictory statements. For example, Florida proscribes "skin penetration" in dry needling by physical therapists, but allows them to perform and analyze EMGs, which by definition involves skin penetration. Tennessee takes the position that since no academic institutions in that state teach dry needling to physical therapy students, it should remain outside of the scope of PT practice.[53] This introduces the dilemma of what to do once dry needling is part of entry-level DPT programs, as it is currently at Georgia State University,[53] for example. It may be time to encourage a national review of the scope of practice for physical therapists. A recent report by the Federation of State Boards of Physical Therapy (FSBPT) outlines that there is a historic basis, education and training, and a scientific basis for use of dry needling by physical therapists, provided competency is determined to ensure safe practice.[54] The FSBPT conducts an analysis every 5 years to determine actual practices within the profession. Also, the highly respected American Academy of Orthopedic Manual Therapists supports dry needling in the PT scope of practice and indicates that research supports its use.[55] As with any policy or practice change, the process is likely to be slow and piecemeal in nature, but gradual implementation of such changes can facilitate reflection and necessary critical analysis. In order to reflect on the possibility of changing the scope of practice of physical therapists, it is important to understand the process by which practice guidelines are determined.

Determining the Scope of Practice for the Physical Therapists

In the United States, state physical therapy boards determine the legal scope of physical therapy practice in each state. The Federation of State Boards of Physical Therapy (FSBPT) Model Practice Act provides language to states for reference and consideration in the development of their individual practice acts. In evaluating the current climate of health care practice and education, the FSBPT recognizes the overlap of many skills and procedures among professions, stating that it is "no longer reasonable to expect each profession to have a completely unique scope of practice."[54] Devised with the collaboration of the medical, nursing, social work, pharmacist, occupational and physical therapy professional communities, the FSBPT document provides a protocol for state boards to use in decision making about whether an intervention should be included in the scope of practice. This protocol assists in decision-making when considering practice act changes, with the primary focus on whether the proposed changes "will better protect and enhance consumers' access to competent health care services."[54] Proposed changes to the scope of practice should evaluate 4 critical areas: established history of specific practices, adequate training, adequate evidence of benefit to public health, and appropriate regulation. The FSBPT maintains that adequate evidence in each of these areas suggests that scope of practice changes would be in the public's best interest.[54] This position echoes that of the Federation of State Medical Boards (FSMB), an allied, parallel organization for physicians and osteopaths. This group outlines the multifactorial nature of scope of practice decisions, including workforce needs and availability, financial motivations, economic circumstances, and consumer demand, with the ultimate goal of protecting public health and safety.[56] In order for there to be a rational, useful approach to broadening the scope of practice of a health care practitioner, there must be judicious use of the guidelines that have been developed for this purpose.

Guidelines for Changes to the Scope of Practice

According to the FSBPT and the FSMB, scope of practice should be reviewed when the following factors have been considered: where there exists a need for the proposed scope of practice; when the existing scopes of practice, if altered, will result in a positive change in public health and safety; where there exists formal education, training, and accreditation processes for the change in scope of practice; where appropriate evaluation and disciplinary procedures are established; where accountability and liability issues have been clarified and where the effects on other practitioners have been reviewed.[54,56] Using these criteria, the broadening of the scope of practice for physical therapists to include dry needling, would be approved. First, more than a third of the US physical therapy boards have issued interpretations that dry needling is within the PT scope of practice. Such changes in physical therapy state practice acts parallel the practices of Canada and many countries in Europe, Asia, and South America. Second, there has been no increased incidence of injury to the health of patients when managed by physical therapists who use techniques that puncture the skin. Third, there are 3 main US programs for accredited needling education programs, and reciprocity already exists among the international programs for dry needling certification. Fourth,

physical therapists practicing dry needling are accountable under standard rules of practice, and have the same requirements to carry malpractice and liability insurance as those who do not practice needling. Finally, there is no documented adverse financial effect on other practitioners when physical therapists are licensed to practice dry needling. In fact, there may be an opportunity for both acupuncturists and physical therapists to improve their position in the market if both groups could market their nonsurgical, nonpharmaceutical approach to pain management.

Planning or Policy Strategies that Might Mitigate Differences

In negotiations, success results from collaborative efforts to resolve any impasse.[57] The APTA and the American Association of Acupuncture and Oriental Medicine (AAAOM) could collaborate on combined statements, with a unified marketing campaign for consumer education to differentiate between acupuncture and dry needling. University programs for dry needling could be developed in collaboration with all interested parties.[33,58] Combined physical therapist and acupuncturist lobbying for third party payor reimbursement could be more successful than the current situation where each professional community struggles for reimbursement independently.[59,60] Benefits could include improved teamwork of medical doctors, physical therapists, and acupuncturists to optimize patient care. Reduced costs for the consumer could result as all providers compete in the open market for myofascial pain management services. As continued research would determine best practices, collaborating professionals would be quick in adjusting their practice to reflect new knowledge. The concept of an extended scope of practice for physical therapists is not an expansion of physical therapists interest in needling therapy, bnt is a component of a global shift in health care service utilization.

Extended Scope of Practice in Health Care Professions

An international summit on advanced scope of practice and direct access to physical therapy was held in Washington in October 2009 to examine current international demands and practices, and to determine the implications of increased practice scope on interprofessional relationships, professional boundaries, and role definitions.[61] National and international developments

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to alter the scope of practice of physical therapists and other medical professionals are underway, in order to mitigate the current stresses on the health care system.[54,56,61] These scope of practice changes follow the development of the nurse practitioner and physician assistant professions, whose origins as legitimate medical professionals grew, in the past 50 years, out of the financial and workforce constraints on the general physician and medical community.[62,63] Physical therapists are currently being trained in joint injections,[64] musculoskeletal triage in emergency rooms,[65] and first-line health care management.[66] The changing tide of clinical practice is not likely to reverse, as increasing demands on finite financial resources continue.[1]

SUMMARY

Current US and International Practice, Recommendations for the Future

Dry needling is already within the scope of physical therapy practice in many areas (18 US states[34]); skin penetration by physical therapists for EMG is allowed in many US states, and Canada, South America, Europe, Asia, Australia, and New Zealand. With minimal risk and increased benefits to the majority of stakeholders, dry needling practiced within an increased scope of PT professionals will be of benefit to the public, bringing American clinicians in-line with their international colleagues.

The APTA's "2020 vision" for physical therapy includes a commitment to lifelong learning with use of evidence-based practice.[6] Articles published in respected, peer-reviewed journals underscore the continued need for expert clinicians to critically appraise and conduct research. The current emphasis in physical therapy education is on research to support and challenge clinical practices. With increasing use of dry needling by physical therapists, the research emphasis should include dry needling within efficacy and comparative effectiveness studies. Doctoral level physical therapists who acquire these skills as part of their core curricula[67] are well suited for such analysis and research, and their dissertations could explore the comparative effectiveness of dry needling and other manual therapy techniques.

Many techniques are not unique to a specific profession. There are ongoing battles for territory between chiropractors and physical therapists over manipulation and joint mobilization,[68,69] between athletic trainers and physical therapists over manual therapy techniques,[70] with physicians and physical therapists performing EMG tests,[71,72] and physicians referral to in-house physical therapy practices.[73,74] The global trends in health care management are to look broadly across the professional spectrum to determine where patients can benefit from skilled care provided by appropriately trained clinicians, at the lowest cost. The future objective will be to use best practices for best outcomes and for the best financial value. The territorial battles are likely to continue, but will diminish in intensity as adversaries compete to demonstrate optimization of outcomes and not compete over ownership of specific techniques.

CONCLUSIONS

Physical therapists are positioned as expert clinicians in the health care community with a broad spectrum of techniques for nonsurgical management of musculoskeletal pain and dysfunction. Inclusion of dry needling within the scope of PT practice will ensure further high-quality research and clinical practice with better outcomes in this field. Use of dry needling by qualified, licensed physical therapists will bring American physical therapy professionals in line with current international standards of practice, and provide patients with more options for management of musculoskeletal pain. In the costly arena of arthritis, movement dysfunction, and pain management, extending the physical therapy scope of practice to include dry needling will improve in consumer choice, increase evidence-based practice, and facilitate cost-containment.

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Nominations

Orthopaedic Section Awards

Now is the time to be thinking about and submitting nominations for the Orthopaedic Section Awards! There are many therapists in our profession who have contributed so much, and who deserve to be recognized. Please take some time to think about these individuals and nominate them for the Orthopaedic Section's highest Awards. Let's celebrate the success of these hard-working people!

- James A. Gould Excellence in Teaching Orthopaedic Physical Therapy
- Outstanding Physical Therapy & Physical Therapist Assistant Student Award
- Paris Distinguished Service Award
- Rose Excellence in Research Award
- Richard W. Bowling - Richard E. Erhard Orthopaedic Clinical Excellence Award

Visit our Web site for more information about the awards offered by the Orthopaedic Section and the criteria for nominating an individual: http://www.orthopt.org/awards.php.

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Tab 3

APTA
American Physical Therapy Association

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Dr George Maihafer
Virginia State Licensure Board
107 South Arden Circle
Norfolk, VA 23505-4834

Dear Dr Maihafer,

We appreciate your inquiry on behalf of the Virginia Physical Therapy Licensure Board about the web-based version of the Physical Therapist Clinical Performance Instrument (PT CPI): Version 2006. As you are aware, the current version of the PT CPI is administered through the web and requires that all users satisfactorily complete an online training program and assessment to gain access to the PT CPI Web. The PT CPI was designed for use specifically for physical therapist (PT) academic programs to assess their PT professional students during clinical education experiences as a part of the curriculum and in preparation for entering practice. For PT academic programs to access the PT CPI Web, they are required to register with Academic Software Plus and are assessed an annual fee for its use.

You have requested the use of the PT CPI for practitioners who are foreign-educated seeking US licensure in Virginia and are required to complete a practice component as a part of this process. The use of the PT CPI to assess the foreign-educated PT to determine comparable knowledge, skills, and behaviors of an entry-level PT provides one possible mechanism to enable a state licensure board to determine if a practitioner is safe and competent in patient care. In discussing your request with staff at APTA and at Academic Software Plus, issues were identified that warrant further discussion and would need to be addressed prior to making any final decisions about this request. Below is a summary of the issues that have been raised.

- Data resulting from use of the PT CPI Web with foreign-educated PTs would need to be treated confidentially. As such this may warrant a separate server for housing this data. Data from foreign-educated PTs cannot be commingled with that of PT professional students.
- Data is harvested from the PT CPI Web in ways that specifically inform PT program outcomes, clinical education outcomes, student readiness for practice, and accreditation. The reports that can be generated from the PT CPI Web may not be consistent with the needs of the Virginia State Licensure Board. Redesigning the reports and coding the data requires additional time and will incur additional costs. Likewise, if this data is to be benchmarked in some way to PT professional student performance, then that

work will also incur additional costs and time should the Virginia Licensure Board wish to revise any aspect of the PT CPI Web software program, this would need to be discussed in advance with financial implications that would need to be negotiated with Academic Software Plus.

- APTA owns the copyright for the PT CPI and a copyright fee would be assessed for use of the instrument by a state licensure board. The instrument must be used in its current format to ensure its validity and reliability.
- Academic Software Plus would charge a registration fee to the VA licensure board for use of the PT CPI Web that would differ from the PT program registration fee and may include an individual applicant usage fee.
- Should the State Licensure Board be interested in pursuing this request further, we may want to explore the possibility of a pilot to see how the current system might work and additional modifications that may be warranted.

We hope that this additional information is helpful to your continued deliberations in using the PT CPI Web for foreign-educated physical therapists seeking US licensure in Virginia. Please feel free to contact me with any questions or for further discussion. I can be reached at jodyfrost@apta.org or by phone (703) 706-3201.

Sincerely,

Jody Frost

Jody S Frost, PT, DPT, PhD
Director, Academic/Clinical Education Affairs
American Physical Therapy Association

Federation of State Boards of Physical Therapy

Draft Model for Supervised Clinical Practice (SCP)
November 2011

Authority

Statutory authority will be needed in order to require completion of a supervised clinical practice from the foreign educated physical therapist. One example of statutory language may be found in the 5th edition of the FSBPT Model Practice Act. Rules language can be used to further define the parameters of the supervised clinical practice (SCP). Language either in statute or regulation needs to allow for the board to waive or exempt any, or all, of the requirements for the SCP.

Prerequisites

To improve the likelihood of a successful SCP, the board may consider requiring any, or all, of the following PRIOR to the SCP:

- Complete the application process including payment of fees.
- Provide satisfactory evidence that the applicant's education is substantially equivalent to the education of physical therapists educated in an accredited entry-level program as determined by the board. If required, the educational credentials evaluation must be completed and submitted to the board prior to the SCP.
- Complete any additional education as required by the board.
- Pass a board-approved English proficiency examination if the applicant's native language is not English.
- Meet any other requirements established by board rule if applicable.
- The board provides for a temporary permit, provisional or restricted license for the purpose of participating in a supervised clinical practice.

In the commentary of the 5th edition of the FSBPT Model Practice Act, there are three exceptions noted for use of a restricted license other than for disciplinary actions: 1) with a voluntary substance abuse program, and 2) with a professional re-entry after a lapse of a license for two or more renewal periods, and 3) supervised clinical practice for foreign educated applicants.

Timing of the NPTE

The SCP would take place prior to the NPTE. Successful completion of the SCP is a prerequisite to the NPTE.

Parameters

Length

Minimum requirement: 1000 clinical hours to be completed in no fewer than six months and no longer than one year.

Number of Attempts

Limited to a total of two per applicant.

Qualified supervisor

The clinical supervisor and a backup supervisor should be approved by the board. In approving a supervisor, the board should consider the following qualifications:

- the supervisor should have a minimum of three years of clinical experience
- the supervisor should hold an unrestricted license
- there is no conflict of interest in the supervisor's relationship to the candidate
- the supervisor should have direct patient care responsibilities in their current role
- the supervisor should have previous experience as a clinical instructor

Supervision

The level of supervision during the SCP should be onsite supervision as defined in the FSBPT Model Practice Act:

> "Onsite supervision" means supervision provided by a physical therapist who is continuously onsite and present in the department or facility where services are provided. The supervising therapist is immediately available to the person being supervised and maintains continued involvement in the necessary aspects of patient care.

Facility

The facility should be approved by the board. When approving a qualified facility, the board should consider the following:

- the depth and breadth of clinical experience provided by the facility
- the facility's levels of staffing
- the patient volume
- the variety of patient diagnoses
- the opportunity to interact with other healthcare providers in the facility
- location of the facility; different scope of practice in different state, unique practice act

Disclosure

The board should consider potential conflicts of interest between the facility and the applicant. Any disclosures related to conflict of interest should be included as part of the application for SCP submitted to the board. SCP candidates, supervisors, and/or facilities must disclose any known potential for conflict of interest or appearance of conflict. Material gain resulting from candidate's successful completion of the SCP should be furnished to the Board prior to the approval of the SCP.

The facilities disclosure statement should include the following:

- the facilities intent to hire the applicant upon completion of SCP
- stipend or salary to the applicant
- relationship to the supervisor

Performance Evaluotion

The board should establish guidelines for completing the performance evaluation.

- Suggested timelines would be:
    - midterm to be completed after 500 clinical hours and submitted to the board within three days (72 hours)
    - final review completed after 1000 clinical hours and submitted to the board within three days (72 hours)

- If available, the board should utilize an evaluation tool that has been determined to be valid and reliable for evaluating clinical performance of foreign educated physical therapists.

Final Outcome

1. Successful completion of the SCP:

   FEPT would be eligible to sit for the NPTE.

2. Unsuccessful completion of initial SCP:

The Boord should consider developing options for unsuccessful applicants which may include:

- extending the SCP in the same facility up to double the initial time
- complete a second SCP in a new facility
- denial of application for second SCP with opportunity for due process

Exemptions

The board may waive all or a portion of the SCP at the discretion of the board. The board may want to consider:

- the applicant's previous licensed clinical practice in the U.S. Healthcare system in making the decision regarding SCP
- the applicant's performance on the mid-term evaluation

Tab 4

We have queried other states for their policies on PT's & PTA's performing INR testing on Home Health Settings. We will add this information as it becomes available or at the meeting.

Position Statement – North Carolina Board of Physical Therapy Examiners

Performance of Finger Blood Specimens

Adopted – December 28, 2001
Updated – December 6, 2006
Reviewed by the Board – September 23, 2010

The performance of fingerstick blood specimens for analysis of Pro-times is not considered part of the scope of practice for physical therapy; however, it would not be a violation of the **North Carolina Physical Therapy Practice Act** for a PT or PTA to do a fingerstick with a physician's order provided that the physical therapist has been properly trained and is competent, and makes it clear to the patient that this procedure is not physical therapy. When the PT or PTA performs a finger stick, the PT or PTA should communicate the results to a nurse so that the nurse can interpret and communicate the results to the physician to make medications modifications. *(See Board Position regarding the "Physical Therapist's Role in Recording Medications on OASIS Forms".)* In addition, the physical therapist cannot bill for his or her time as physical therapy. Lastly, the NCBPTE cannot speak for other Boards as to whether this would be a violation of their practice acts. The NCBPTE can only say that it is not a violation of the **North Carolina Physical Therapy Practice Act.**

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Tab 5

INFO. FROM THE BOARD OF MEDICINE

"Professional incompetence" is written into our law on unprofessional conduct in a number of different ways, from substance abuse to mental incapacity and just about everything in between. See 54.1-2915 below.

Professional competence also can be seen as being able to provide safe care at the standard expected of a physician in Virginia. The standard is understood on a case by case basis, and the determination of whether the standard was met will depend on the evidence in the case. Standard of care cases are sometimes the toughest and may require the services of an expert medical review, especially if the case involves a subspecialty of medicine or a highly technical procedure, such as microsurgery of the inner ear.

Maintenance of competency is the big push of the American Boards of Medical Specialties. Maintenance of licensure is the big push of the Federation of State Medical Boards. The Board of Medicine originated an Ad Hoc Committee on Competency in 2006. Here are the links to last year's meetings. The Virginia Board is planning on participating in a maintenance of licensure pilot project with the Federation.

General Meetings of the Board

2011 Meeting Dates	Type	Agenda	Minutes
May 24, 2011 10:00 a.m.	Ad Hoc Committee on Competency	Agenda	View Minutes
October 14, 2011 10:00 a.m.	Ad Hoc Committee on Competency	Agenda	View Draft Minutes

§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.

A. The Board may refuse to admit a candidate to any examination; refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct:

2. Substance abuse rendering him unfit for the performance of his professional obligations and duties;

3. Intentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely to cause injury to a patient or patients;

4. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;

12. Conducting his practice in a manner contrary to the standards of ethics of his branch of the healing arts;

13. Conducting his practice in such a manner as to be a danger to the health and welfare of his patients or to the public;

14. Inability to practice with reasonable skill or safety because of illness or substance abuse;

21. Adjudication of legal incompetence or incapacity in any state if such adjudication is in effect and the person has not been declared restored to competence or capacity.

Continuing Professional Development

Step One: Meaningful Assessment

Proceedings from a Citizen Advocacy Center Conference

June 22, 2011

Note: These proceedings are not a verbatim transcript, but they are faithful to the speakers' presentations and the subsequent questions and comments. For the complete content of the conference, you can find the speakers' PowerPoint presentations at http://www.cacenter.org/files/powerpoint/ContinuingCompetence2011/index.html.

Introduction

The Citizen Advocacy Center (CAC) convened this conference in light of the growing consensus that any meaningful continuing professional development scheme must begin with an assessment of the knowledge and skills an individual needs to reinforce to maintain his or hear current competence.

CAC's *Roadmap to Continuing Competence* recommends routine periodic assessment. It reads in part:

> Periodic assessment is the key to tailoring lifelong learning programs to the needs of individual healthcare professionals and to demonstrating continuing competence over the course of one's career. Assessment pinpoints the knowledge gaps that can be filled by 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....
>
> There are two key questions that have to be answered about assessment: who should be assessed and who should do the assessing.... The question of who should do the assessing is more difficult to answer. Self- assessment is the option many voluntary credentialing organizations and 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. It appears to be, therefore, a comparatively painless way to introduce periodic assessment into the routines of professional careers.
>
> But, 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 a professional's 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 right now to perform the task. So, 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 certification and regulatory agencies.

CAC's Roadmap 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 roadmap offer an opportunity to evaluate and compare various assessment methodologies: self-assessment, third-party assessment and a hybrid combination 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 in 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.

Is Self-Assessment Reliable? What Does the Literature Conclude? Research Conducted by the Association of State and Provincial Psychology Boards

Robert Brown, Chair, Maryland State Board of Examiners of Psychologists

There are many ways to think about competence. It is clear that professionals have to retain what they learn in graduate training and to acquire new skills during their careers appropriate to their current practice. They must learn new knowledge based on research findings and new practice methods, new theories, new assessment tools and treatment approaches and new technologies.

Looking back, graduate school was reassuring in lots of ways. While academicians do try to teach clinical skills and judgment, by and large, students are taught what they need to know in a series of core courses prescribed by the faculty. Students are lectured to, coached, tested, observed, and given feedback.

After students graduate, many practice in isolation or behind closed doors. Some are supervised, particularly early in practice, but that supervision is typically cursory and not

hands-on. Professionals take courses in subjects they feel they need to know, rather than subjects selected by others based on what each professional needs to know.

Consumers expect that healthcare providers are competent throughout their professional careers and most are surprised when they learn that regulatory bodies are not acting to ensure continuing competence. Professional societies assume that professionals can determine what kind of skills, knowledge, techniques, approaches, and theories they should be familiar with, and that they can select from the options available to acquire new learning, to stay updated, or to acquire new skills. The assumption that individuals engage in reflection and can accurately self-assess has been the cornerstone of adult education and continuing professional education.

Continuing education is one of several approaches to continuing professional development. One of the things that the psychology boards are trying to do is to broaden the definition, so that in addition to mandatory seminars, credit can be given for peer contacts, portfolios, publications, etc.

What are some of the challenges associated with continuing competence? One is the definition. What competencies are the relevant for individual practitioners? For most professions, declarative knowledge is what the licensing exam assesses. By and large, exams don't get at the delivery of services. They don't get at judgment and the ability to discriminate one situation from another. They don't get at applying knowledge to a set of facts, nor do they assess attitude.

How can we measure competence in ways that are true to consumer expectations, are acceptable to professionals, and are economically and practically feasible? Self-assessment is one of the reasonably economical ways to do this.

Other methods include objective tests and observation by experts. HIPPA regulations make it difficult to observe live patients, but simulations are an alternative. Practice audits, professional profiles are other methods. Patient outcomes are complicated because they are affected by the skill of the practitioner and many other variables, such as the type of illness involved, the resources available to the patient, and institutional constraints.

What can we do about maintaining and enhancing the competence of professionals, knowing that outcomes are not always going to be the most reliable measure of competence?

How accurately can people self-assess their own professional development needs? By this, I mean self-assessment in terms of what is my practice like. What do I do? What kind of skills do my colleagues and peers have? What demands are there on my professional time? What kind of treatment is indicated in particular cases? What is my patient population? It is difficult to mandate something that applies to everybody because professionals specialize in different areas.

Even if a professional can decide accurately what they need, how do they know that a particular educational experience is going to meet that need? How accurately do professionals evaluate what they have learned? There has been a movement to use test questions to determine what people have learned.

The research suggests that people aren't very good at assessing our needs, determining whether the experience meets the needs, and evaluating how much we have learned from the experience. In other words, self-assessment is not useless, but it is not very promising.

What about the accuracy of self-assessment? Poor Richard's Almanac said, "There are three things extremely hard: steel, diamonds, and to know one's self." Charles Darwin said, "Ignorance more frequently begets confidence than does knowledge."

Both of these statements impart some wisdom, and while they do not rule out the potential usefulness of self-assessment, they do temper any excitement that self-assessment is going to be the answer.

Some of the more prominent findings in the literature include these. Learners are not necessarily accurate in assessing their own knowledge as compared with when they are actually tested. Students and practitioners tend to avoid areas that are difficult for them and stay with what they are already good at. At least in Western societies, even people with the lowest objective ratings of competence rate themselves above average. Recent studies found that physicians have a limited ability to accurately self-assess, when self-assessments are compared to measured competencies. People who are less competent tend to exaggerate the quality of their knowledge and their performance more than do more competent people.

What are the sources of bias in self-assessment? Self-assessment of knowledge learned in continuing education (CE) is more related to satisfaction with the course than it is to actual learning. So, self-assessment is generally a more useful indicator of how learners feel about a course than it is an indicator of how much they learned from the course.

Other sources of bias include differences in self-esteem. People with high self-esteem are often more willing to accept that they have deficits than people with low self-esteem. People who fear negative evaluation will rate themselves more highly. People can become defensive if others challenge what they have learned or know. People who are not competent often are not able to recognize competence in others.

People who are more competent are more likely to recognize knowledge and skills they should acquire. People who need continuing professional development the most are the ones most likely to fail to recognize the need.

Should we give up on self-assessment? The evidence is mixed. People can be trained to increase the accuracy of their self-assessment.

The better question is: When and how and can self-assessments be useful? I said earlier that self-assessment indicates how satisfied a learner is with the learning experience. This satisfaction may serve as a motivating factor to do more.

Providing objective feedback, in the form of tests or other measures, can improve the accuracy of self-assessment. This feedback is most useful during the learning process, rather than at the conclusion. The feedback about learners' self-assessments helps students learn how to more accurately evaluate their own performance in the future.

Feedback is complicated. If it is too complimentary, it could interfere with motivation to learn more. If it is critical, it could motivate someone to learn more. On the other hand, critical feedback may prompt another learner to conclude that the evaluation was biased and discourage further learning.

How can self-assessment be used productively? Self-assessment should play a role in continuing professional development, but it should not be relied on solely as a measure of competence or new learning. Self-assessment may be a competency that can be developed among professionals. Self-assessment should be facilitated / supported by providing training and objective measures of feedback and peer feedback at multiple points longitudinally in the learning process. Learners should be given the opportunity to compare their actual knowledge and performance to motivate poor performers to learn more.

Question: My professional association has had conversations about continuing competence for many years. What is your perspective on how regulated professions should tackle this? We have a political challenge to get our constituents to accept the idea that they need to do more than just attend continuing education courses.

Brown: This is a critical point. People become anxious and sometimes huffy about being evaluated. I don't know the answer.

Comment: It depends on how it is done. I have a grandchild who wasn't doing well in math. The teacher could send a letter home threatening that the child will be held back if he doesn't improve. Or, the teacher can send a note saying the child isn't performing up to grade level and the school would like to help him by keeping him after school a few minutes for personalized tutoring.

Brown: There is a body of literature about steps that can be taken to encourage peoples' motivation. I'm not sure professional societies are doing much in that regard.

Comment: I would argue that this is a cultural issue. We have to start teaching in our undergraduate training programs that assessment and evaluation and continuing professional development are a part of being a professional.

Comment: The Federation of State Medical Boards is undertaking an initiative on maintenance of licensure. We believe committed leadership is necessary to make it

happen. State boards should do it because they have a mandate to protect the public. The public wants it because they deserve the highest quality care by the most competent professionals. Physicians should do it because they really care about their patients and care about giving them the best care. If professionals want to perpetuate the system of self-regulation, they need to incorporate procedures for periodically evaluating licensees.

Brown: I believe most professionals want to provide the best services they can. The problem is, how do they know when they are not providing the best possible services? This requires some sort of objective assessment in addition to self-assessment.

The Assessment Program Developed by the National Association of Boards of Pharmacy (NABP)

Carmen Catizone, Executive Director, National Association of Boards of Pharmacy

Our road to continuing professional development has been straight and narrow at times and a very crooked route at times, and we wound up in a completely different place than we ever imagined.

One barrier we faced is economic. Professionals say they are too busy to engage in continuing professional development activities. They are concerned about the impact on their licensure if they don't perform well. They are also concerned about the cost.

We also encountered questions about whether our continuing professional development program would inhibit a professional's ability to practice and to exercise the privilege they earned through licensure. Another twist is the involvement of other agencies, such as the Federal Trade Commission, which alleges that the dental board in North Carolina engaged in anti-competitive activity when defining the scope of practice. Where does the state board's authority end and the FTC's authority begin?

Our journey started almost thirty-five years ago. In 1967, the Department of Health and Human Services recommended mandating continuing competence requirements. In 1970, the Public Health Service questioned the relevance of continuing education to continuing competence and recommended a multi-faceted approach, including peer reviews, professional standard review, re-examination, and self-assessment techniques.

The pharmacy profession decided to establish continuing education requirements, just as other professions did. We believed that if professionals engaged in continuing education, they wouldn't need the mandate that HHS and others were calling for. The accrediting bodies began to approve providers of continuing education to make sure certain standards were met. Eventually, all the states mandated continuing education.

From the regulatory perspective, the boards of pharmacy and the educational accrediting bodies did all they could to ensure that continuing education would be valuable. But, there was no way to control practitioners who waited until their CE was due for

relicensure and hastily read journals and submitted their CE credits. There was no way to monitor that process, no way to say to the practitioner that we don't believe you have actually learned anything or benefitted from that CE. One of the lessons we learned at NABP is that voluntary works best when it is mandatory.

We got a wakeup call in 1997 when it was again recommended that states should require each board to develop, implement, and evaluate continuing competence requirements. We interpreted this to mean that the public no longer believed the "Trust me" philosophy that the healthcare professions had adopted. To say that, "We are learning; we are self-policing; we are competent; we have continuing education requirements" was no longer good enough. The public wanted more. They wanted a "Show me" approach that validated continuing competence.

NABP heeded that call and adopted the recommendation of the Pew Health Professions Commission that "states consider requiring the demonstration of continued competence through some sort of testing mechanism." The message was clear to us that continued competence needs to be assessed, so there needs to be a testing mechanism. They didn't say portfolios. They didn't say reflection. They didn't say let the profession develop it. They said state boards, continued competence, an assessment mechanism.

We looked at the literature to learn how we might measure competence across all practice settings and all levels of specialization. One study from Minnesota showed that fifty-three percent of the medications prescribed to patients were to treat twelve indications, not the ones you would expect: asthma, diabetes, and high cholesterol. In contrast, a study of Medicaid patients and emergency room visits in Mississippi found that those three disease states represented seventy percent of the medications being reimbursed by the state Medicaid program.

So, we realized that pharmacy practice varies by state, by sub-population, and by other factors. We decided we needed to develop a continuing competence mechanism that takes the same approach as the initial licensure examination. Why not use the initial licensure exam to assess continuing competence? Because we found that practitioners in practice for two years or more behave differently than new graduates, so we had to modify the continuing competence exam to measure that subtle difference.

We introduced a continued competence assessment mechanism in 1998 and offered it to boards on an optional basis initially, with the expectation that it would eventually become mandatory for relicensure. It was a computer adaptive multiple-choice tool, which pharmacists could use to assess their knowledge. We intended that completion of the tool would be followed by CE, portfolios, and other methods to address any weaknesses discovered in the assessment.

When we rolled this out to the profession, it generated accusations, controversy and conflict. We were accused of creating the program to generate revenue by selling the assessment tool. The professional associations asked why the regulatory boards should be earning this revenue, even though we planned to run the program at close to cost.

During the debate, these questions came up:

Who defines competence? The professional association said they define it and when the boards become involved, things become punitive. We said the public and regulatory groups define competence and are responsible for it, working with the profession.

Who is responsible for competence? Employer groups wanted to address competence internally, saying they fire incompetent people and don't want regulators involved.

What is the evidence to show competence? Some argued that specialty certification is an indication of competence. Others said that holding a license in good standing should be evidence of competence.

There is truth in all these arguments, but the bottom line for regulators is to demonstrate to the public that every practitioner is competent. A license in good standing sends an important message, but members of regulatory boards know that the resources available to state boards prevent them from becoming involved in a lot of activities to the level necessary.

Hearing all these critiques, we put together a pharmacist self-assessment mechanism. We used the same blueprint, but made it less high stakes. We made it available online instead of secure testing centers. We said to pharmacists: self assess and based upon the results, decide on a CE program for yourself appropriate to your practice and your needs.

The license to practice allows a pharmacist to practice in any setting, from hospital to retail, and in any specialty from pediatric to geriatric. That is why we put together a general assessment that cuts across all practice settings and allows an objective assessment of the pharmacist's competence across multiple areas.

We tried everything to make this a tool that pharmacists would use. The fee was reasonable. Some states recognized the tool for some portion of the CE requirement, providing a mandatory incentive to use the tool. Accommodating requests from the profession, NABP agreed to waive the fee in some states in an effort to persuade pharmacists to participate.

Participation was so disappointing that the program was disbanded and the continuing competence assessment mechanism was never launched. Practitioners are not ready or willing to participate.

So, the recommendations dating back some thirty-five years are now off our table. Some pharmacists are asking why pharmacy can't take the approach being taken by the Federation of State Medical Boards. We say fine, you take the lead. We tried and got no positive response.

So, we scrapped a mandatory continuing competence for state boards. We scrapped the pharmacist self-assessment mechanism. We went back to our member boards and asked what they need to fulfill their daily responsibilities. They replied that they are having trouble assessing practitioners who come back into practice after a lapse.

We have decided to develop an examination to give boards of pharmacy a pharmacist assessment remedial education tool. It will be a computer adaptive exam that pharmacists can take in a secure environment, such as the pharmacy board office. It will consist of 210 operational items in three distinct domains. Based upon a survey of pharmacy practice, we found that fifty percent of the remedial examination will cover the practice of pharmacy and the rest will cover prevention of medication errors and ethics.

We are also launching a program to accredit community pharmacies. It will focus on continuous quality improvement and advancing the practice of pharmacy to the next level so that pharmacists provide patient-centered care. We are giving the boards the tools to look at quality of care and clinical outcomes and to assess practitioners.

We are waiting to see if there is public demand for more continuing competence initiatives. Unfortunately, it is usually a horror story involving a medication error that garners public attention and leads to legislative changes.

Comment: You say you don't hear public demand for continuing competence. AARP Virginia did a survey a few years ago that found that the public assumes that licensing boards are monitoring ongoing competence and believes that healthcare providers should be assessed at least every five years. CAC once hosted a debate between officials from the Federation of State Medical Boards and the National Council of State Boards of Nursing about who needs to demonstrate current competence. The Federation representative said doctors should be assessed when there is a reason to believe they aren't competent. The spokesperson for the National Council said this is not a disciplinary matter, but a question of raising all ships, so every licensee should be assessed. So, it is disappointing to learn that NABP ended up where you have.

Catizone: We readily admit making mistakes along the way. When we introduced the continued competence assessment, we thought we were doing the right thing, but we came on too strong, and the profession viewed it as a disciplinary mechanism rather than something that would help practitioners. If we try again, we will be sure that the profession views our initiative as non-punitive. But any mechanism has to have teeth and be objective. If it is no more than a self-assessment by practitioners, it won't be valuable to our member boards.

Comment: It is very important to be clear that this is not about discipline, but about encouraging and supporting lifelong learning and continuing practice development. The public may be relatively quiet about this, but as regulators, our job is to engage the public because they are our biggest ally.

Catizone: One of the consequences of reduced resources is that boards don't have the time to engage in public outreach activities.

The Assessment Program of the Commission on Dietetic Registration

Grady Barnhill, Director of Recertification and Professional Assessment, Commission on Dietetic Registration

We have self-assessment in four different areas, one of which is a portfolio process. The self-assessment simulations are products used to prepare for specialty certification exams to obtain a credential. Our self-assessment series and assess and learn series are more closely related to continuing professional development.

We developed these products because we wanted a new way of looking at recertification. The first step in the process is self-reflection, which includes questions such as: What am I good at? What do I enjoy? What practice areas do I prefer? What knowledge or skills do I want to add?

Step two is a subjective self-assessment component. It is a checklist based on more than 150 learning need codes. Users assess what they know in each area, what they would like to learn, and at what level. It is easy to use, easy to develop, inexpensive, non-threatening, and it encourages reflective practice. It is voluntary because we do not require users to submit documentation of this step. So, we don't have any participation data to show whether it is being used.

Because self-assessment may not be accurate, we developed an objective self-assessment series. Objective self-assessment is less biased and it can be used in a normative way. And, it is based on a common metric rather than individual standards.

We started using an objective self-assessment tool in 1991. It was developed by the Penn State University Division of Continuing Professional Education and the W.K. Kellogg Foundation. It included performance objectives: what should a practitioner know and be able to do? It focused on the application of knowledge in practice. The original plan was to develop 42 modules covering 21 practice areas.

We used subject matter experts and conducted pilot tests. The modules were scenario based with realistic support materials. Some included video taped interviews, lab test results, and so on. Certificants would look at each scenario and then answer multiple-choice questions based on the materials and submit the sheets for scoring. We provided rationales for why answers were right or wrong. The users loved the normative feedback showing how they compared to their peers.

Follow up evaluation reveals how well the individual performed on a particular task, how important any particular task is to their current work, and how interested the person is in developing the necessary skill. From this, flows a learning plan.

How did it work? The cost was $65.00. People received 7 CPE units.

By 2004, sales had dropped to about 100 per year, out of 75,000 practitioners. The feedback from those who completed the series was outstanding. There were administrative challenges, storage issues, and currency concerns.

We concluded that making a program like this voluntary isn't effective. The product ends up being used most by those who need it least.

The second-generation objective self-assessment program is called Assess & Learn. These are online case-based scenarios using realistic clinical information, documents, case notes, lab tests, descriptive information, interview transcripts, evidence-based sources, and referrals to additional learning opportunities. Because it is online, there are no production or storage costs.

How is this working? It was an effort to streamline the self-assessment process and it is much less expensive than the earlier version. The modules provide realistic and sufficient clinical information and context. The feedback is simple and directly related to the performance of tasks. Feedback is not normative, but indirect links are provided for learning planning. It is self-scoring, which saves staff time. The online format enables candidates to sign on at their convenience.

We sold 350 units in 2010 – already three times better than the older version. This is still a small number, given that there are now 81,000 practitioners.

What we learned from all this is

- Control costs
- Leverage technology
- Keep it simple
- Provide incentives to participate (avoid voluntary)
- Provide utility and normative feedback to participants

Where should we go from here?

We will be using the same instrument for the initial assessment and the demonstration of competence at the end. If you do well in the initial self-assessment, you will be exempt from some or all of the continuing professional development hours for the recertification period. We think that this "carrot" or value-added incentive will be a good way to get better buy-in to the program.

Question: How much does the new product cost? How long does it take to complete?

Barnhill: It costs about $50.00 per person, so it is more economical. The startup costs were about $20,000.00 to get into the computer platform. It can be completed in five hours or less. The older module took closer to seven hours.

Question: Have you considered making this mandatory for recertification?

Barnhill: We are looking at possibly restructuring our credential. One of the things we are looking at is the vexing issue of focus areas. If we redo our initial certification exam to accommodate five different focus areas so candidates will take the basic core exam and then choose additional questions in a focus area, that sets the stage for us to develop self-assessment in focus areas.

I think one of the best models is mandatory self-assessment that practitioners are not required to pass. It is easier to sell a mandatory self-assessment that gives practitioners information, but they don't necessarily have to pass. At worst, they would have to do targeted CE in the areas where they are weakest. Many people really like getting feedback.

Question: Are employers interested in using this to assess their workforce?

Barnhill: One large employer has incorporated our portfolio process into their management scheme. We have not seen an employer requiring completion of the Assess and Learn series.

Question: Have you analyzed the user population?

Barnhill: We do not have good data on the participants, but it is a great idea to obtain demographic data.

The Assessment Program of the National Board for Certification in Occupational Therapy

Margaret Bent, Managing Director, Competency Assessment, National Board for Certification in Occupational Therapy

NBCOT has developed tools for assessment and self-directed learning for initial certification and renewal. The primary competency assessment for initial certification is an examination at either the occupational therapist registered (OTR) level or the certified occupational therapist assistant (COTA) level. The content is driven by periodic in-depth practice analysis studies based on large-scale surveys of practicing OTs about skills and attributes they need in their daily practice. Nothing that appears on the examinations should be outside the content of the practice analysis.

The examinations provide evidence of entry-level competence. They are computer-delivered on demand. There are multiple-choice sections in both exams and a clinical simulation section for the OTR exam.

We began using the clinical simulations in 2009. They are very popular with the students because they help them to think and make decisions as they would in practice. They are

designed to simulate actual situations a therapist is likely to encounter in every day practice.

They typically start with a description of a fictional client. The applicant is then asked what type of assessment is appropriate and what kind of treatment plan would be recommended based on the results of the assessment. The various sections complete the full picture of that client or patient. The simulations are dynamic in that there are lists of decisions and actions a candidate can choose. When they choose an option, a feedback box appears on the screen giving information about the consequences of that decision or action.

The simulation questions are designed to measure a candidate's knowledge and critical reasoning ability sequentially across the continuum of care, beginning with screening and continuing to formulating conclusions, providing and adjusting interventions and assessing outcomes. These questions take about ten minutes to answer. The majority of candidates agree that the simulation portion of the test covers situations that practitioners typically experience in the clinical practice.

We see self-assessment as the key to our certification renewal program. We promote lifelong self-reflection and encourage certificants to identify their learning needs and develop a plan that will benefit their practice. During the three-year recertification cycle, certificants are encouraged to complete some level of self-reflection and 36 professional development units. There are 28 different ways to accrue these units.

Last year, we introduced an option to renew with a practice area of emphasis. This is optional because some practitioners want to be viewed as generalists, able to move from one practice area to another. Others want to be viewed as specialists.

Our annual audit of a sample of the renewal group finds a compliance level of about 92 - 96 percent over six years. Reclassification of Certification Status is the renewal process for people who have been noncompliant or inactive. Part of the process is completion of one of the general practice self-assessment tools.

We have designed several study tools, including online practice tests, an Occupational Therapy Knowledge Exam, and entry-level self-assessment tools. Applicants use these tools to prepare for the entry-level exam. The objective is to identify candidate strengths and weaknesses. We encourage students to complete a self-assessment before going out on clinical rotations. We encourage a 360-feedback loop where students, supervisors and other colleagues independently complete the self-assessment tool.

Tools developed for certification renewal include self-assessment tools, a professional development tracking log, a professional development provider registry, an "Essentials Credentials" toolkit, and NBCOT's Connect E-zine.

Since April 2010, 59,274 certificants have used the self-assessment tools. They are designed to empower certificants to engage in critical self-reflection with the ultimate

goal of assessing current levels of proficiency within the domains of occupational therapy practice. The self-assessment tools cover these areas of practice: general practice, older adult, physical disabilities, mental health, pediatrics, orthopedics, and community mobility. Certificants can choose to complete the general practice tool and another one related to their current or anticipated practice area. The score report reveals areas of strength and weakness. It also provides links to professional development resources from the provider registry.

The uses of these tools include: documenting strengths in specific practice areas, identifying gaps in knowledge and skills, identifying professional growth opportunities, linking current abilities to critical job skills and performance plans, assessing learning needs prior to re-entry or transitioning between practice settings, assessing staff competence for planning in-service education.

NBCOT'S future plans for its recertification program include a review and a practice analysis study to be completed in 2012 which will identify the knowledge and skills necessary for ongoing competence. The practice analysis will reveal the knowledge required to transcend all practice areas, such as communication skills, ability to use evidence-based practice, ability to demonstrate effective service, and so on.

The results of the practice analysis will be used to develop tools to enable us to measure ongoing competence. Renewal requirements will be enhanced to embrace self-reflection, knowledge assessment and traditional continuing education.

Question: How are you linking the continuing competence requirements of voluntary certification with mandatory licensure?

Bent: We have worked with the state licensure boards to make our requirements consistent with theirs. We don't want to introduce a different set of requirements.

Question: What can be done with the information from the self-assessments? Could a state regulatory board request the results if, for example, they have a re-entry candidate for licensure who has completed a self-assessment, or if there were a disciplinary case before them?

Bent: The results of a self-assessment are not shared with any third parties. In a disciplinary situation, I could see the results of a self-assessment being used in evidence, but that has not happened so far.

Question: The first speaker addressed the limits of self-assessment. What do you do to overcome some of these limitations?

Bent: Remember that NBCOT certification is voluntary so we don't want to be burdensome. We want to support the professional development and clinical practice of certificants. The tools we have developed help the individual focus on where he or she

needs to go in terms of their own development, rather than having something imposed by an external body.

Comment: I am impressed with your provider registry and it occurs to me that it would be useful to identify courses that correspond to any weaknesses identified in an assessment.

Question: Do re-entry candidates have to take a test in addition to completing the self-assessment?

Bent: No, they do not have to take a test and they do not have to re-take the initial certification exam. But, they have to complete the self-assessment tool and the professional development unit requirements and submit all the documentation to verify completion.

Question: What kinds of questions are used in the self-assessment tool? Is this available online?

Bent: It is available online. The first section of the self-assessment asks about specific knowledge and skills an occupational therapist uses in a practice setting. The second section looks at ability to interpret the results of a client assessment. The third domain relates to detailed intervention strategies. The fourth relates to professional practice, including such things as documentation, working within clinical systems, and so on.

The Assessment Program of the North Carolina Board of Nursing

Linda Burhans, Associate Executive Director, North Carolina Board of Nursing

The North Carolina Board of Nursing uses a reflective practice model for continuing competence and encourages a commitment to lifelong learning. We determined that continuing competence is important for public protection. It serves an important regulatory function and contributes to patient safety and quality care.

Our board began working seriously on continuing competence after the Pew Health Commission report in the mid-1980ies. In 1998, we began developing a strategic plan for creating a continuing competence program in the state. At that time, the Board of Nursing had no requirements for even continuing education. In 1999, we began working with stakeholders, including public members, practicing nurses, employers and educators.

That group determined that it was important to look at more than just continuing education. By 2001, the board staff recommended a reflective practice model to the board. That model was based primarily on work done in Canada and Kentucky.

By 2002, we had developed tools and in 2003, focus groups were held across the state to evaluate the tools, seek recommendations for modifications, and explore options for

implementation. In 2004, we implemented a Web-based pilot, giving nurses an opportunity to fill out some of the self-assessment forms and give the board feedback.

In 2005, legislation was passed requiring continuing competence as a condition of renewal or reinstatement of a license. The board promulgated rules applying to RNs, LPNs, and APRNs.

Our reflective practice approach is based on individual responsibility. It requires routine biannual self-assessment at the time of license renewal. Nurses identify their strengths and opportunities for growth and improvement in their practice. Then they implement a learning plan, focusing on the areas they have identified for development.

We ask that when conducting their self-assessment, nurses compare themselves to existing standards of practice. We want them to collect feedback from peers, colleagues, supervisors, and/or patients. Licensees can choose from any one of eight learning options ranging from national certification to 30 contact hours of continuing education, to refresher or academic courses, to publications and presentations, and a combination of CE and active practice. Licensees are randomly selected for audit of the documentation showing that they completed the requirements. We do not require that the self-assessment or learning plan be submitted to us. Nurses told us they were uneasy about sharing a self-assessment with a regulatory agency.

Our challenges in implementation included resistance from licensees, employers, educators, and a little bit from the public. There was a fear of change and uncertainty about the time commitment and the cost. Nurses wondered where they would find educational opportunities. The biggest worry employers expressed was that the board would interfere with the supply of nurses by prohibiting non-compliant nurses from working.

We tried to overcome that resistance by focusing on public safety and nurses' responsibility for professional accountability and lifelong learning. We also tried to balance stakeholder viewpoints and concerns. We tried to stay realistic and to compromise.

We also tried to communicate as much as possible. Every nursing bulletin and our board Web site contained information about the program as it evolved. Board members and staff explained the program in every speech and public presentation.

Among the lessons learned is that it is impossible to communicate enough. Regardless of our efforts, a small number of licensees will fail to comply and will require disciplinary action. Their reasons for non-compliance remain a mystery to me. Most of the fewer than 30 nurses who have been disciplined for not meeting the requirements have also not come to the administrative hearing when their license was revoked.

We know we are dependent on self-assessment and we know that that is far from ideal. Our nurses are still getting used to the process of self-assessment. It is easiest for nurses

who work in large academic hospital centers where they are working in a learning environment and have lots of resources and peers and supervisors they can talk to about their self-assessment. It is more difficult in small facilities or a physician office situation.

We suspect that most of the nurses in the state are not putting as much time as the board would like to see into their self-assessment and learning plans. Most of the nurses choose either to do the 30 hours of continuing education or the 15 hours of continuing education and work hours. But, there are nurses who have used national certification, refresher courses, or academic education.

The National Council of State Boards of Nursing is continuing to work on continuing competence, but the member boards are not ready to move forward. There are still nursing boards that have no requirements for relicensure.

Question: Certifiers worry that people will drop out rather than meet recertification requirements. This appears not to be true. What is your drop out rate at a regulatory board?

Burhans: We also worried about a wholesale loss of nurses. We saw a small increase in non-renewals in the first two-year period, but it has stabilized back to the rate we saw before implementing the program.

Question: What is your definition of "active practice?"

Burhans: Active practice means the person is functioning in a nursing role, where the person's job description requires that he or she be a nurse. They do not have to be delivering direct patient care. So, as a regulatory nurse, I am using my nursing knowledge all the time and this is considered my active practice. But, I couldn't be working for IBM developing new operating systems. I might be working for IBM as a nurse consultant working on clinical systems.

Question: It seems intuitive that if nurses keep up their skills and knowledge, assess their needs, and engage in professional development, their practice will be better. How do you think you can measure outcomes from the program?

Burhans: We did not do any pre-assessment and we have not looked at outcomes. We are struggling in any case with how to separate out which clinicians in a team setting are affecting patient outcomes. Anecdotally, we have received calls from nurses who have said they didn't think they needed this program but they are glad they completed the self-assessment because it made them aware of areas where they needed to update their knowledge and skills.

Question: Please expand on what has taken place at the National Council Delegate Assembly.

Burhans: I can't supply details, but I know that some of the discussions have centered on objective measures of continued competence up to and including the development of a new test. Oftentimes, as soon as the word "test" is uttered, resistance increases.

Question: How was the legislative process? Second, does the statute protect the self-assessment and learning plan documents from discovery in the event of a malpractice lawsuit?

Burhans: Adding the continuing competence requirement to our practice act was basically a walk in the park. It was an easy sell in the context of public safety. The nurses association was fully on board.

There is no specific language in the law or the rules that protects the privacy of the self-assessment and the learning plan.

Question: You were ahead of the curve for licensing boards. Have you considered changes in your program to bring it up to the current state of the art?

Burhans: We have always expected the program to evolve. Currently, we are looking at what the board of nursing in Washington State is developing. They have just begun a continuing competence program into which they have incorporated a feedback mechanism. We know that we need to move our program forward in North Carolina, but we haven't decided what shape that will take.

The Assessment Program of the National Certification Corporation

Fran Byrd, Director, Strategic Initiatives, National Certification Corporation

For several years, the NCC Board of Directors believed it is a good idea to tie continuing competence to the maintenance of NCC credentials. The question was not "should it be done?" but "could it be done – and cold it be done in a way that our certificants would embrace lifelong learning as an integral part of their certification maintenance process?"

In 2005, NCC embarked on a demonstration project to validate the need for a continuing competence initiative. Fifteen hundred randomly selected women's healthcare practitioners were asked to do an assessment of where they thought the stood in their practice. They then completed a 100-item multiple-choice tool, which would more objectively assess where they stood. The tool covered three levels: entry to practice, "cutting edge" practice, and a combination of both levels.

The board wanted to determine if nurses could self-assess their areas of weakness. They also wanted to collect data showing whether assessment should relate to entry level or recent practice in a specialty. The pilot was also designed to give nurses feedback regarding their specialty knowledge and competence. Finally, the pilot looked at developing CE to meet identified learning needs.

The pilot results showed that individuals do not correctly assess where they are strong and where they have gaps of knowledge. So, NCC decided to develop a more objective evaluation tool and to keep the assessment at the same level as the current certification exams in specialties. For NPs, that is entry into practice. For other nurses, it is a level of two years' expertise in the field. One reason for this is that there is already a task analysis and content validation for the current core exam.

Based on the pilot, NCC decided to design a system of focused feedback for each certificant, so they can see where gaps exist. The plan was to create content categories reflecting the core competencies for each specialty and to rate the results of the assessment to create a personalized education plan. The plan also called for enhancing the existing NCC self-assessment program modules so the results are coded to help certificants match their education plan to a specific module.

The assessment is a125-item multiple-choice computer-delivered tool based on the knowledge competencies for each specialty. The items are co-related with the competency categories on the certification exam and they are weighted to equal 50 hours of CE across all categories. The competency categories are different for each specialty, such as inpatient obstetric nursing, neonatal intensive care nursing, and the women's health care nurse practitioner specialty.

We developed a platform allowing certificants to access the assessment from their own personal computers. This was important to us because the pushbacks from the profession are concerns about time, cost, and inconvenience. In addition to built-in security features, prior to be allowed access to the assessment, certificants sign an agreement acknowledging that this is a secure evaluation tool to be taken by them alone.

We implemented the program in two stages. The first is an orientation stage, which went live in June 2010. In 2014 the process will become binding.

We mailed an explanatory brochure to every certificant, posted information on the Web site, and mailed reminder post cards prior to each maintenance cycle. There are still people who don't read the material.

The binding stage began in April 2011 for those individuals whose renewal is in 2014. They need to take this assessment to direct what their CE can be to maintain their credentials. The assessment has to be completed prior to their beginning to do CE.

If I were an individual with a June 30, 2011, cycle deadline, I would submit my maintenance assessment this time. I would earn credit for 5 hours of CE for taking the assessment, dropping the requirement from 45 to 40 hours. Having taken my specialty assessment, I have my individualized education plan now and can look for conferences, modules, and other educational opportunities consistent with my education plan.

The Specialty Index Report is issued immediately upon completion of the assessment, plus the corresponding education plan. It is sent to my password-protected account on

the NCC Web site. This is because certificants told NCC it is important to them to have control over where this information goes.

The assessment uses mathematical calculations on a one-to-ten scale in each competency content category. For establishing whether I need additional education in a particular area, NCC set a 7.5 or higher cut off. There is a carrot in the program because if I earn 7.5 or higher, I will not be required to have additional education in that area. However, if I show weaknesses, I will have to complete a CE requirement in addition to the fifteen-hour baseline requirement in my specialty.

NCC doesn't call the assessment a test. People don't pass or fail. We don't use the terms "need" or "weakness." We use terms that are not threatening. If you want buy-in, your constituents have to feel the program is there for positive reasons, rather than to be a club.

The resistance has not been as bad as we feared. We think introducing the program with the "Try it, you'll like it!" orientation phase overcame some resistance. There are no fees. The emphasis is on the assessment/evaluation tool versus an exam or test. Delivery is convenient on one's own computer. The five-hour credit for taking the assessment is a carrot for the current cycle.

Among the lessons learned, no matter how much information you provide, people don't read it. Any process dependent on computer systems will create headaches associated with compatibility, Internet outages, etc.

This has been a dynamic process from the start, and we expect to see refinements in the process, the content of the assessment tool, and in NCC's continuing education resources. We are working toward having a better platform to handle this function. Changes will be based on what we see in content validation and task analysis, what the psychometrician tells us based on a review of the results of an assessment, and feedback from the NCC population.

In terms of NCC's CE, we are working on multi-media formats, podcasts, PowerPoint with audio, avatar-based simulations, and procedural review for advanced practice nurses.

Question: Could you talk more about the security of the assessment, given that it is completed in people's homes?

Byrd: Our IT people can see people's log-in and log-out times and they can tell if more than one person has logged in from the same place. The assessment tool is timed to take 2 hours and 15 minutes. The bottom line is that we are looking to our certificants to embrace lifelong learning. If they can look up answers or have a discussion group in that length of time, more power to them. If security appears to be a big problem, we will look at it further. At this point, we feel it is not a key concern.

Question: What are the requirements for certificants who do not want to participate in the self-assessment piece?

Byrd: We have an "opt-out" process, which will come into effect in stage two because we don't want to deny anyone the right to maintain their certification. It is intentionally an onerous process to discourage its use. If people refuse to take the assessment, it is impossible to say where their strengths and weaknesses are, so they are required to take 50 hours across the five content areas of their specialty. Also, the maintenance fee is higher.

Question: How do you determine how many hours of CE are needed for areas of weakness?

Byrd: It is based on the percentage of items in the core exam for each particular area.

Question: How many items did you decide was necessary to get reliability in each area? How much is the initiative costing?

Byrd: The 125 item exam was based on the spread in the core exam. As to the cost, we had a head start because we have our own testing platform already in place. The additional development of the specialty assessment was about $40,000.00. Our content experts are volunteers.

Assessing the Communications Skills of Physicians in Training as a Condition of Entering a Residency Program

Ann Jobe, Executive Director, Clinical Skills Evaluation Collaboration. National Board of Medical Examiners

Graduates from a U.S. medical school who want to become licensed as a physician, have to take the USMLE and be in a residency program. Graduates from an international school have to have all their credentials verified, take the USMLE and do another residency in the United States.

The USMLE is the product of a partnership between the Federation of State Medical Boards and the National Board of Medical Examiners (NBME), which creates a single pathway for US graduates and international graduates to demonstrate competence to practice without supervision. This replaces state-based exams and separate national exams for U.S. and for foreign medical graduates.

USMLE is a computer-based multiple-choice examination. It assesses medical knowledge, clinical pathology, pharmacology, pathophysiology, and so on. It assesses clinical knowledge and clinical skills. In addition to multiple-choice, there is a small component that is computerized case simulations, similar to those described on occupational therapy.

Licensure usually occurs while graduates are in residencies. Re-licensure is the responsibility of the state licensing authority, not USMLE. Board certification and maintenance of certification is the responsibility of specialty boards. Most medical students take the first two USMLE exams (12CK and clinical skills) before they graduate from medical school and take step three while they are in residency.

USMLE is important because it is a performance assessment, on Miller's scale of Knowledge / Competence / Performance / Action. In other words, candidates "show how" to do something.

Kirkpatrick's criteria are 1) Reaction; 2) Learning; 3) Behavior; and 4) Results. We want to see results, change in organizational practice, benefits to patients and clients. So we look at what assessments we are doing that bring about change in our culture, and why. Because we assess communication, we are assessing something very different than standard computer-based exams assess.

How did the NBME develop its exam? The first exams in 1916 were voluntary and took a week to complete. From 1922-1950, exams included essay questions and observed patient encounters. In the 1950ies, "selective response" (multiple-choice) questions replaced essay questions. The bedside oral examination demonstrated more about the raters than it did about the test-takers. It was eliminated in 1964.

The NBME then started looking for something reliable to assess performance. In 1960, they tried to assess clinical performance using videos in large auditoriums. It didn't work. They tried "latent-image management" problems. That didn't work either. Everything reverted to multiple-choice in the 1980ies, even knowing that this does not get at performance.

The public was saying that physicians don't listen. The most frequent complaints to medical boards related to communication. Litigation was skyrocketing and most malpractice cases involved communication. The Joint Commission agrees that the communication breakdown is the basis for sentinel events. In nearly 3,000 sentinel events the root cause was communication breakdown.

Take home message: high level skills in "bedside medicine" is the cornerstone of safe, quality patient care.

Some medical schools have courses in clinical communication skills. Still, more than 60 percent of medical graduates said they had never been observed doing a complete history and physical.

NBME and the Educational Commission for Foreign Medical Graduates (ECFMG) wanted to assess clinical skills. ECFMG implemented the Clinical Skills Assessment exam in 1998. It is a national standardized assessment using standardized patients. However, it was only for international medical graduates.

The clinical skills evaluation collaboration was created in 2003 by the presidents of NBME and ECFMG who saw no reason for two competing examinations and created the Clinical Skills Evaluation Collaboration (CSEC). The first administration of the clinical skills examination occurred in June 2004.

The state boards and the USMLE composite committee felt this exam would be a national validation of the clinical skills of medical graduates. The medical schools and medical students and the AMA opposed the exam, arguing that schools were already assessing students.

As of May 2011, CSEC has examined 229.091 candidates with 2,749,092 standardized patients. We have five centers in Atlanta, Chicago, Houston, Los Angeles, and Philadelphia that run 5-6 days a week. We have 2 – 3,000 examinees a month, which is about 24 per day at each center. It costs about $1,100.00 per examinee.

The cases include important situations typically found in a clinic, a doctor's office, emergency department, or hospital. There is a blend of cases in each exam for an undifferentiated physician. We try to be sure everyone has a comparable level of difficulty for the exam, regardless of which test site.

We build our blueprint to relate to system, gender, age, and acuity. Every exam involves 12 encounters, which take 25 minutes apiece – up to15 minutes with the standardized patient and 10 minutes to write a patient note.

It is a pass/fail exam and they have to pass all three sections in a single administration. Communication and interpersonal skill are rated by our standardized patients who are people from the lay public representing all different backgrounds. Examinees are assessed on their ability to ask questions and explain and counsel to patients, their professional manner and rapport, respect, privacy, modesty, comfort, empathy.

Spoken English proficiency is included because 43% of examinees are international graduates. The integrated clinical encounter has two pieces. One is data-gathering and the other is patient notes – communication of the findings. For data-gathering, standardized patients use checklists to indicate whether the appropriate questions have been asked and the appropriate physical was done. The patient note is evaluated by physician raters, who evaluate the conclusions and recommendations for what to do next.

The failure rate for U.S. examinees is about 3-4 percent, mostly because of deficiencies in the integrated clinical component. This represents 500-600 individuals. For international graduates, the failure rate is around 25 percent, also because of weakness in the integrated clinical component.

Why do we use standardized patients and not physicians as raters? Because physicians may decide to deviate from the checklist and then there isn't standardization. Standardized patients are less expensive, more available, and easier to train to be standardized. Studies have shown that physicians are unable to distinguish standardized

patients from real patients. Standardized patients are more accurate than physician raters. There is a one-way mirror in the exam rooms, so other observers can look in and assess the accuracy of the standardized patients' rating.

We believe we are enhancing patient protection by assessing communication skills and improving quality and safety. The educational validity of the exam is proven. The majority of medical schools now have clinical skills centers. Most use standardized patients for teaching. Most have clinical skills courses.

What do I worry about? In the exam, we often see "paint-by-the numbers" rote performance by examinees. However, real life situations are unique and test-taking strategies may not apply. Another thing that is concerning is that examinees may short-cut the exam because they know they won't find physical findings, such as a heart murmur. The exam does not effectively assess whether an examinee can discern abnormal findings. The exam is only a snapshot. It is not longitudinal, so I am not sure it will ever be able to assess whether an individual can distinguish abnormal from normal.

But, we are trying to assess whether an individual can synthesize and integrate all the information gathered from a patient. Another thing that is concerning is that this is a high-stakes exam, and just like any other important activity, there are secondary review courses that are money-makers.

We provide feedback in a grid that shows examinee's performance compared to national standards. However, they don't receive this feedback until 4-6 weeks after the test.

What is CSEC working on? Enhancements to the exam, such as counseling patients about behavioral change, delivering bad news, disclosing errors, negotiating a treatment plan which includes patient preferences, starting medication, health literacy, medication reconciliation, functional status assessments, communicating with more than one person in the room, using an interpreter, functioning in a team environment, hand-offs.

What is measured is important. Individuals and organizations change their behavior in the lens of high stakes examinations.

Potential opportunities include collaboration with specialty boards that provide assessments for certification, partnering with graduate medical education, partnering with certification and licensure to administer assessments for other professions.

Question: Please say something more about assessing practice teams.

Jobe: It is on the horizon, but we haven't settled on a protocol. We are thinking of assessing how a physician reacts when challenged by a standardized nurse or other team member. We would welcome input.

Question: What do you think about assessment using simulations?

Jobe: I am a proponent of simulations for educational purposes, but I'm not sure they would be effective in high-stakes exams, especially assessment of communication. I think simulations would be useful for longitudinal assessments.

Question: Please talk a bit about patient-physician communication.

Jobe: There is some literature showing that there are behaviors and communication patterns that lead to increased patient adherence and better outcomes. We are in the process of changing our scale to reflect the behaviors that are being used more consistently across disciplines and specialties. It doesn't take away from individual style, but there are some essential components of communication that we believe we can observe and assess. If a person can easily communicate findings, but is unable to develop respect and foster a relationship of trust, the outcome is not as positive.

We don't have data showing that outcomes are improved with good communication, but the Medical Council of Canada has had a clinical skills exam longer than we have and researchers have shown that there are improved clinical outcomes. The data also links those who did poorly on a communications scale with more substantive complaints to the licensing authority. I would like to do an outcomes study at NBME, but since we are changing the communications scale, it doesn't make sense to do a study based on the old scale.

Question: How do you see clinical skills assessment being used for continuing competence?

Jobe: I have had conversations with several of the specialty boards and encouraged them to use our test for initial certification, let alone recertification. I ask them if they are sure every one of their residency programs is of the same caliber and if they can guarantee every graduate is of the same competency. A few specialty boards are thinking about it. I don't know if they would use the test for recertification, but I think the place to start is initial certification. If we were to assess all the graduates in every specialty, we would probably have to establish some more centers incrementally.

Discussion: Points to Consider When Developing an Assessment Program

Cynthia Miller Murphy, Executive Director, Oncology Nursing Certification Corporation

ONCC is looking at improving our measurement of continuing competency. I am going to walk you through our decision-making process and identify questions we still have to answer.

I like a definition of competence that talks about knowledge and skills in the context of doing something successfully and applying prior experience to new situations with good

effect. Competence helps those around us feel more comfortable and inspires others to seek knowledge.

We can define competence, but how do we reliably measure it? ONCC's mission refers to having the knowledge to practice competently, but we aren't sure we can measure whether our certificants actually do.

When we began in 1986, we were one of the few nursing organizations that required recertification, by passing the test again. The pass rate was high, but the average recertification rate was only 59 percent, implying they weren't re-certifying because they didn't want to take the test.

In 2000, we launched a points renewal option, where nurses can acquire points in 7 or 8 different categories, one being CE, others being publishing a paper, teaching a course, earning academic credit, and so on – in addition to having the required number of practice hours. It has increased our recertification rate up to 74%. We still have 5% choosing to re-test. Those who aren't in active practice have to earn points and take the test.

Of the points, at least 60% must be in the oncology specialty. The problem is that an individual can get all his or her CE in one area or subspecialty. But, their credential says that they are certified broadly.

In 2010, we initiated a Mega-Issue discussion about "How should ONCC implement a more rigorous process for the measurement of continued competency?" We use an approach called "knowledge-based governance," which asks four important questions followed by dialogue about the pros and cons of all available choices.

Question 1: What do we know about our stakeholders' needs, wants and preferences that are relevant to this issue?

Our stakeholders fall into three groups: nurses, employers, and healthcare consumers. We know that nurses want to become certified and remain certified. We know they don't want to take a test again. Paying for certification is considered an obstacle by many of them. Half the nurses have their initial certification paid for by employers, but only 38% have their recertification paid for by their employers. We know that consumers think it is important to verify current competence.

Question 2: What do we know about the current realities and evolving dynamics of our stakeholders' environment that is relevant to the issue?

We looked at the economy, technology trends, and so on. We know there is a nursing shortage, but there are also unemployed nurses. We know computer-based testing and electronic recertification are very popular. The trend, as evidenced by the American Board of Medical Specialties, is toward much more rigorous recertification requirements. There is a drop-off in conference attendance, but an increase in electronic education.

Question 3: What do we know about the capacity and strategic position of our organization that is relevant to this issue?

We have a platform for our online practice tests, but don't have the capacity to administer an assessment tool in house. This will be a huge financial investment, but we are a stable organization. We have the human resources and can retain consultants to supplement.

Question 4: What are the ethical implications of our choices?

There isn't a lot of data to support any particular approach to recertification. We looked at consistency with our mission and the implications for quality and safety. We looked at our certificants' likely perception of our decisions and the effect on access to recertification.

We identified options and looked at the pros and cons of each. One option is to make no changes. Or, we could postpone changes until we have more data. We could require a portfolio, or require re-testing. We considered requiring CE in all areas of the test blueprint.

What we decided to require, with lots of advice and help from NCC, is individual learning needs assessment (ILNA) based on a blueprint and targeted CE related to results. We won't call this self-assessment, because the assessment will be administered and scored by ONCC. ONCC will instruct examinees as to what CE and other professional development activities they need to complete.

We formed another task group including consumers, educators, managers, and nurses in different roles. We decided there were many more benefits than barriers for all our stakeholders. We think if it is communicated well, nurses will think of it as an advantage. Most likely, most of them will need to obtain fewer points, but in targeted areas.

We know we will need many more volunteers for test development in each of our five active programs and two retired programs. It will require psychometrician and test vendors. We are evaluating proposals. We need to address legal issues, such as test security, reliability, and identification of CE sources in all the content areas.

We have a timeline that is fairly rapid. The assessment has to be available to certificants a couple of years prior to when we require them to use the system. New certificants will use the diagnostic score report for their certification exam to identify the CE needed for the first cycle.

Eventually, we will probably have to raise recertification fees because it will cost us more. We will be careful not to raise the fees at the time the ILNA is being launched. Communication and marketing will be very important, beginning in 2012, assuming that the program will be in effect in 2015.

We have a research team that is working on short- and long-term goals for the program and evaluation strategies. We want to be able to collect evidence related to outcomes measures. We may ask certificants to conduct a self-assessment after completing the assessment we administer to see if there is any correlation. It would be good data for us to have to demonstrate to our constituency why we want them to take the ILNA.

We need to develop something equally rigorous for those who refuse to take the assessment and for the holders of our two retired credentials. We want to offer a mechanism for the renewal of more than one credential at a time.

Question: What percent of oncology nurses are certified?

Miller-Murphy: We don't really know the universe, but we estimate that there are about 63,000 oncology nurses of whom we certify 32,000. The membership society has 35,000 members.

Question: Has your 74% recertification figure changed since 2000?

Miller-Murphy: That percentage has drifted to 74% since we put in the point system and as the certificants got used to the program.

Question: Have you thought of ways to incentivize certification and recertification?

Miller-Murphy: Recertification is mostly employer or workplace-driven. There is a program of "magnet recognition" for hospitals that promote professional nursing practice and pay for certification and recertification of their employees. Certified nurses can make up to $10,000.00 more per year. State boards will recognize certification as a way to meet re-licensure requirements. Nevertheless, our surveys show that oncology nurses get certified for intrinsic, not extrinsic reasons.

Question: The conversation today differentiated between pure self-assessment as opposed to more objective types of assessment using a tool. Objective assessment tools have to include feedback so examinees know where they didn't do well. Has anyone considered using volunteers from another geographic area to provide personalized feedback –similar to mentoring – to help people structure their continuing professional development plan?

Comment: The North Carolina Physical Therapy Board began developing a continuing competence program several years ago after hearing a keynote speaker from a Canadian pharmacy board. His view was that if professionals are "engaged" in their profession, it helps ensure competence. Our board developed a menu of activities, including CE, online courses, volunteerism, specialty certification, and so on. This was necessary in our state where development opportunities are not readily available in rural areas.

Miller-Murphy: I think engagement is changing and membership societies are recognizing that there will be fewer face-to-face encounters and more electronic engagement.

Tab 6

Guidance document: 112-18 **February 17, 2012**

VIRGINIA BOARD OF PHYSICAL THERAPY

DISPOSITION OF DISCIPLINARY CASES FOR PRACTICING ON EXPIRED LICENSES

The Board of Physical Therapy delegates to the Executive Director for the Board the authority to offer a prehearing consent order to resolve disciplinary cases in which a Physical Therapist or Physical Therapist Assistant has been found to be practicing with an expired license.

Disciplinary Action for Practicing with an Expired License

The Board adopts the following guidelines for resolution of cases of practicing with an expired license:

Cause	Possible Action
First offense; 90 days or less	Confidential Consent Agreement
First offense; 91 days to two years	Consent Order; Monetary Penalty of $500
First offense; more than two years	Consent Order; Monetary Penalty of $1000
Second offense	Consent Order; Monetary Penalty of $1500