CCI THINK TANK

Continued Competence Leadership Forum: From Pieces to Policy

Post–Event White Paper

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Reviewed By Shannon Carter & Deborah Vandewater

The Competency & Credentialing Institute (CCI) convened scholars and thought leaders in healthcare competency from across North America at a Think Tank September 16 – 19, 2007, to explore how nursing can collaborate to develop a framework for continuing competence driven by the principles of patient safety. The 2007 forum built on the initial work of a multidisciplinary Think Tank held in 2005 (CCI, 2005).

The 2007 participants represented a wide spectrum of perspectives. (See Appendix A for a list of participants.) An expected outcome of this discussion was documentation of current thinking and issues surrounding the topics of continuing competence and patient safety. This active engagement of scholars and thought leaders can be viewed as participatory action research, which is intended to move theory to action for communities addressing complex challenges. This White Paper communicates the collective understanding from the CCI 2007 Think Tank of how nursing can ensure ongoing competence development that enhances both the profession and patient care.

BACKGROUND

The concept of "continuing competence" is a dynamic and evolutionary process, as the profession of nursing is constantly evolving to meet consumer needs, technological advancement, professional responsibilities, and expanded knowledge. Therefore, the Think Tank coordinators consciously decided to share multiple definitions of continuing competence with the participants. A search of the expansive literature yielded the definitions listed below as most pertinent for the purposes of the Think Tank. These definitions were communicated to the participants before the meeting to help set a contextual framework for the discussion.

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DEFINITIONS OF CONTINUING COMPETENCE

"Continuing competence is the ongoing application and integration of knowledge, critical thinking, and interpersonal and psychomotor skills essential to the safe and effective delivery of occupational therapy services within the context of a practitioner's role and the environment."

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National Board for Certification in Occupational Therapy, Inc.

Self-Assessment Resource Tool

(Gaithersburg, MD, 2005).

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Competence is "the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health."

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National Council of State Boards of Nursing

"Assuring Competence: A Regulatory Responsibility" (position paper)

(Chicago, IL, 1996).

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Competence is "possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards."

<div align="right">

Federation of State Medical Boards

Report of the Special Committee on

Evaluation of Quality of Care and Maintenance of Competence

Approved as policy in May 1998.

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"Continuing competence is the ongoing ability of a registered nurse to integrate and apply the knowledge, skills, judgment, and personal attributes to practice safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs."

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Saskatchewan Registered Nurses' Association

www.srna.org/registration/ccp.php

(Accessed Jan 15, 2008).

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REVIEW OF THE LITERATURE

A review of the literature addressing continuing competence in nursing was conducted before the Think Tank, and several documents were sent to participants in advance of the meeting. Planners determined that the manuscripts authored by Vandewater (2004, 2006) reflected the most comprehensive summaries of the issues currently affecting the nursing profession. These manuscripts provide an extensive literature review on initial and continuing competence assessment in nursing and medicine. Another significant manuscript is Implementing Continuing Competency Requirements for Healthcare Practitioners (Swankin, et al, 2006). This manuscript provides recommendations from a study that contains a review of the literature on assessing and assuring continuing competence of health professionals. This document also includes a critical analysis of information by licensing boards, associations, agencies, and specialty certification boards, as well as discourse for key stakeholders from a myriad of interested communities.

> *The concept of "continuing competence" is a dynamic and evolutionary process, as the profession of nursing is constantly evolving.*

The Framework, Concepts and Methods of the Competency Outcomes and Performance Assessment (COPA) Model (Lenburg) and information about the Quality and Safety Education for Nurses (QSEN) project also was provided to participants.

Think Tank planners identified and critiqued tools and instruments currently used to assess and evaluate competence. One resource, Toolbox of Assessment Methods, was created jointly by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) and includes recommendations regarding the most suitable instruments and tools to assess competency of medical residents (ACGME, ABMS September 2000). This resource was shared with participants as a potentially useful tool to assess nurse continuing competence.

Originally, the Think Tank agenda included activities designed to create a similar toolbox for nursing, one to address assessment methods and link them to the myriad of nurse competencies. The participants reviewed a draft template for such a toolbox and discussed the various elements. It is a tool that CCI remains interested in creating; however, the Think Tank participants elected at this meeting to use a scenario planning methodology to address the issues of continuing competence.

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CONSUMER PERSPECTIVES

Joyce Dubow, representing AARP's Office of Policy and Strategy, provided participants with a contextual background and a consumer perspective of continuing competence and patient safety. She proposed that requiring demonstration of continuing competence was one component of a broader healthcare reform strategy that should include universal coverage, greater accountability with mandated public reporting, payment and performance alignment and delivery reforms. These reforms were deemed necessary in light of rising costs for consumers and businesses, eroding health insurance coverage, and quality deficits. She noted that, from a consumer perspective, cost and access are two sides of the same coin and reflect growing consumer dissatisfaction with the current healthcare system.

Dubow reported some of the Institute of Medicine's statistics on an increasing numbers of patient injuries and deaths occurring in hospitals. A majority of these errors were viewed as preventable; causes of errors include communication problems, inaccurate medication prescribing behaviors, and the lack of adequate quality systems.

Several barriers that prevent consumers from using information to make informed healthcare and treatment decisions were outlined by Dubow. First, she believes that health literacy is a major and under-recognized health policy concern; many individuals have low health literacy and numeric skills. In addition, it has been found that people do not use information on healthcare quality because data often lacks salience, shows little variation, and is presented in a unit of analysis that is not always relevant, timely, or readily available to them.

Although it is recognized that many consumers lack the ability to understand public reports, such reports were viewed positively by many consumer groups because they can:
- drive improvement,
- provide consumer protection and reassurance,
- facilitate benchmarking,
- stimulate development of better measurement and data systems, and
- maintain focus on important issues.

Dubow suggested that quality improvement can be hastened through public accountability, which is accomplished by publishing comparative reports on clinician and institutional performance, promulgating licensure requirements that address ongoing competence, and providing education to healthcare professionals. In addition, the application of evidence-based guidelines, decision support tools, as well as patient engagement and patient education also facilitate safe and reliable practice.

Dubow believes that all health systems should be required to collect and report standardized performance data and that individual states should publish performance reports on licensed healthcare

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entities and individuals. Clinicians can motivate improvement by exercising leadership and supporting evidence-based strategies and interventions. Medicare and other purchasers can advance standardization with a multi-pronged strategy to improve care—realigning payment with performance, reengineering the healthcare system through delivery reforms, and assessing performance, including continuing competency of healthcare providers. Future research is needed to find effective ways to measure continuing competence that is objective and fair to providers while leading to better patient care.

PARTICIPANTS' PERSPECTIVES ON TRENDS IN HEALTHCARE

Think Tank participants shared their perspectives, addressing the business environment and current trends affecting continuing competence and patient safety. The following trends were identified: patient safety movement, greater demand for research dollars, informed patients, increasing fragmentation of care, and increasing complexity of standards of care. Every intricate system is wrought with challenges, and workforce resistance was viewed as a major challenge. There are many different models for competency assessment and evaluation, and these often are isolated from one another. Assessing continuing competence may be difficult due to limited financial or human resources. Further, there are no specific and agreed upon data to make a unified case for change.

> { *Future research is needed to find effective ways to measure continuing competence that is objective and fair to providers while leading to better patient care.* }

Think Tank participants advocated for change. They suggested that the areas supporting change include the more effective use of technology and other contemporary avenues of information sharing. Another positive support for change are nurse scholars who have the ability to conduct systematic research in the area of continuing competence and patient safety. This group believes that they also have the ability to learn from their physician colleagues and other disciplinary experts, including those from a number of countries such as Canada, which has been proactive in regulating the measurement of continuing competence. They also suggested that employers of nurses may provide support in the measurement, recording, and reporting of continuing competence.

In reviewing background issues of continuing competence, the Think Tank participants identified that the priorities for action include shared definitions as well as the collection and reporting of data to build a case for change. This group was an exemplary illustration of collaboration with the ability to suggest solutions to complex problems.

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PHYSICIAN INITIATIVES FOR CONTINUED COMPETENCE

Carol Clothier, representing the Federation of State Medical Boards (FSMB), shared information on the "Physician Accountability for Physician Competence" program, an initiative underway in medicine to promote consistency in how stakeholders measure and determine the competence of physicians throughout their careers (FSMB, 2008). The FSMB is a national non-profit organization representing state medical boards. Its primary services are education, policy development, credentials verification, and a disciplinary data bank.

The Physician Accountability for Physician Competence initiative involves a coalition of more than 30 organizations with a shared interest in ensuring physician competence. Their purpose in convening since 2005 is to determine how the healthcare system will determine, measure, evaluate, and assure the public of a physician's competence throughout the course of his or her professional career. These stakeholders agree that today's system of physician self-regulation is not prepared to deal with rapid changes taking place in today's environment; "license for life" is no longer acceptable. They also believe that inter-agency collaboration will reduce duplication among the multiple reporting requirements that agencies have in place, thereby relieving the administrative burden on physicians and contributing to meaningful, accurate information for stakeholders, including the public. Contemporary issues impacting medicine's initiatives for continuing competency are similar to those identified by Think Tank participants as impacting nursing issues that include:

- a growing sophistication of patients/public,
- globalization of economy/healthcare,
- the role of government in healthcare,
- rapid changes in technology and science,
- an aging population,
- rising costs of healthcare, and
- the ease of communication via the internet.

This group convened its first summit in March 2005. Using outside experts, scenario planning was employed as a process to envision the future. The scenarios were five stories describing the U.S. healthcare system in 2020. The focus on the future facilitates moving participants beyond individual interests toward common ground. A total of five summits have been held to date, the most recent in December 2007. The frank and open dialogue underway has built a growing sense of trust among participants. The group has coalesced around core principles for ensuring continuing competence. These competencies include periodic demonstration of competence, practice-based assessment, and quality improvement. The group agrees that collaboration is critical, and there is excitement among the participants as they are actively shaping the future of healthcare.

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The tangible results from this group include a document titled "Good Medical Practice USA" (GMP-USA, 2007), which describes behaviors and values that a competent physician practicing in normal circumstances would demonstrate. This collaborative project is a dynamic and evolutionary work intended to provide guidance to physicians, educators, and licensing and certifying boards. Future work includes pilot projects for applying measures for competencies and determining what data will be meaningful to the public. Learning portfolios also are being investigated, along with remediation plans for incompetent physicians.

The positive effect from medicine's coalition is that people are staying engaged in the dialogue and the number of participating organizations is growing. Learning through exposure to new concepts has been critical to the group's work. The group was self-organized, which has minimized hierarchy and political agendas. The gatherings are viewed as fun and intellectually stimulating. Future challenges include keeping people at the table and engaging an even broader audience of participants, including practicing physicians and public groups. Success will depend in part on the group's ability to ensure the theoretical components being discussed remain grounded in the real-life implications for practicing physicians. Finally, it will be critical that solutions developed are win-win for all parties involved.

> *The positive effect from medicine's coalition is that people are staying engaged in the dialogue and the number of participating organizations is growing.*

Medicine's implications and key applications for nursing are: community, conversation, and collaboration. They have defined the following factors as being critical to success:

- a shared vision helps people stay focused,
- trust is foundational for progress, and
- trust should not only be developed among participants, but ultimately among organizations.

THINK TANK SCENARIO PLANNING

The CCI Think Tank participants pursued discussions about continuing competence by employing the strategic planning methodology of "scenario planning," similar to that used by the medical coalition. Various definitions of scenario planning exist, one of which defines it as "a planning method that some organizations use to make flexible long-term plans" (Wikipedia). Scenario planning was first introduced in the 1960s and has become a primary planning tool for both the military and business. As mentioned earlier, one of the advantages of this methodology is that it allows participants to step outside their

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current environment and to plan freely for a future time, unencumbered by today's realities and limitations. In scenario planning, a "future event" is introduced and participants are encouraged to consider possible options and alternatives.

During the 2007 CCI Think Tank, four scenarios were adapted from the previous work of the FSMB, which attempted to present a picture of how the U.S. healthcare system might look in 2020. Each group was to examine the implications for nursing and to address the gaps between the status quo and the Think Tank participants' views for future nursing continuing competence. The following summarizes the four presented scenarios; complete descriptions are included in Appendix B.

Scenario #1 -- Big Brother: a world where federal oversight of all aspects of the healthcare system is in effect by 2020.

Scenario #2 -- Techno Community Alliance: a healthcare system in which information technology provides a platform for the provision of safe and effective healthcare. The healthcare community voluntarily collaborates to develop standards for the collection of data and for how those data are used to hold practitioners accountable for demonstrating competence. Data are collected and stored in a national database, and national standards for performance are developed.

Scenario #3 -- Data Cacophony: a world where the healthcare community is unwilling to collaborate. Public demand for change in the way healthcare is delivered generates much discussion but little response. Chaos emerges.

Scenario #4 -- Happyhealthcare.com: skyrocketing healthcare costs, combined with increased public dissatisfaction with the system, prompt dramatic change in who controls healthcare dollars. Patients become true consumers of healthcare services, basing buying decisions on value and cost. In response, the healthcare community turns to continuous quality improvement as the basis for how they deliver care.

THE THINK TANK PROCESS AND OUTCOMES

For each scenario, six to nine Think Tank participants considered the situation and developed the following: a vision statement, a list of gaps between the vision and the status quo, and an outline of imperatives for closing these gaps. Several common themes emerged from those conversations that suggest action items for nursing to consider in developing guidelines for continuing competency:

1. **Competence is evolutionary.**
   Although the concept of continuing competence is complex and still evolving, each nurse must understand that competence is not reflected by a single measure in

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time. Instead, it is an ongoing commitment made to the individual, the profession and to consumers. Competence is both a process and an outcome. Different strategies may need to be used to evaluate process initiatives and summative evaluative outcomes. Further, the group warns that too narrowly defined lists of nurse competencies may become outdated almost immediately.

2. Educational Reform.

Nursing has always struggled with the best way to prepare nurses and, unfortunately, that struggle continues today with many educational routes and strategies being used to teach nursing practice. Think Tank participants strongly suggested that, regardless of the credential sought, nursing re-evaluate traditional academic structures, systems, and teaching practices. Active teaching-learning strategies that focus on competency-driven learning and student self-awareness are critical. The importance and recognition of learning as a lifelong process must be communicated to all.

{ *Although the concept of continuing competence is complex and still evolving, each nurse must understand that competence is not reflected by a single measure in time.* }

3. Information literacy needs to be developed.

Knowledge is not static, but is dynamic, evolutionary, and experiential. Information literacy is the ability to access, evaluate, and ethically use information. As the nursing profession strives for evidence-based practice, it is assumed that information literacy skills are foundational for current and future practice. A new concept originated in some discussion circles as a futuristic need for nurses. This concept was "critical synthesis" skills. Critical synthesis was discussed as a higher level of analysis than critical thinking, as nurses are bombarded with new knowledge daily. To be successful in daily practice, nurses need to analyze and act on data quickly, which requires the ability to critically synthesize.

4. Impact on policy issues must be considered.

Healthcare, and therefore nursing practice, do not exist in a vacuum; both are influenced by a myriad of social, economic, and political factors. Nursing has a professional commitment to examine the impact of practice on policy issues. Conversely, nursing also must influence policy issues that affect nursing practice. Policy issues demand that nurses are taught content on regulatory, governmental,

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and insurance policies, as well as networking with consumer groups to understand a variety of perspectives around the healthcare system. The complexity of policy issues in healthcare should be addressed in the interdependent manner in which they occur.

{ *Healthcare, and therefore nursing practice, do not exist in a vacuum; both are influenced by a myriad of social, economic, and political factors.* }

5. Work and learn in multidisciplinary teams.

Collaboration in healthcare delivery is essential for safe patient care. Nursing must continue to seek alliances with a variety of members of the healthcare team. Traditional academic programs rarely have multidisciplinary teaching teams or courses. Further, medicine, nursing, pharmacy, and other professions often report to different management teams, so it is difficult to promote or even realize multidisciplinary excellence in work settings today.

6. Data management is crucial.

The effective use of data can help determine what constitutes safe patient care and nursing practice. Data can be overwhelming, but it also can be critical in defining practice guidelines and standards. Having well defined standards and outcomes allow for the tracking, centralizing, and transmission of data to relevant sources that will influence effective and safe care. Currently, information systems and personnel often fail to communicate effectively or measure standards for safe patient care.

COALITION PLANNING

These themes illustrate a compelling case for change in nursing and healthcare. On the final day of the Think Tank, a sub-group of participants discussed the value of establishing a collaborative coalition to drive this needed change.

Coalition Value

The group identified the following benefits of a coalition:
- creates synergy,
- generates collective ideas,
- allows for sharing of resources,
- establishes critical mass for funding and political empowerment,
- provides value to both industry and participating organizations,

- articulates a clear message to the nurse community,
- represents a proactive approach to problem solving,
- enhances nursing's credibility,
- models core values,
- creates a model in healthcare,
- creates a platform for change, and
- minimizes duplication of efforts.

Coalition Guiding Principles

The group suggested the following guiding principles for enhancing the coalition building process and maximizing the possibility of achieving defined goals:

- set aside differences,
- attempt to seek a unified voice,
- communicate collective perspectives and common goals frequently for organizational input and collaboration,
- create an outcome-oriented focus,
- look for "quick wins" to build momentum and energy for future success,
- capitalize on existing collaborative models of success,
- be inclusive rather than exclusive,
- establish common goals,
- avoid excessive complexity,
- define operating principles,
- create and sustain a non-threatening environment,
- appoint a neutral convener,
- establish equitable power,
- share resources,
- employ the principles of shared governance,
- appoint a coordinating team,
- acknowledge that the group can expand and contract as needed,
- create continuity in participants, and
- make a commitment to the work being done.

Coalition Charter Statement

It was suggested that a charter statement be created to describe the mission and purpose of the coalition, such as

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"A collaborative initiative to build consensus for a process for continuing competence assessment for professional nurses that is practical, cost-effective, transparent, transferable, and a nationally-accepted platform to ensure patient safety and quality of care for the public."

Coalition Challenges

For complex issues such as continuing competence, there are obstacles to overcome. The following issues were shared as cautions that future groups may want to consider and address.

- Understand that people and organizations are busy, and there will be competition for attention, energy, and resources.
- Create buy-in from necessary stakeholders.
- Realize that groups have a tendency to move slowly.
- Challenge individuals to put aside differences.
- Relinquish individual power in favor of group power.
- Resolve whether the complex issue of initial competence is included as part of the overall dialogue.
- Address the resistance from states and other organizations that already have continuing competence programs.
- Capture the intellectual capacity of this esteemed group through strong facilitations and diligence.
- Realize that there will be challenges in maintaining momentum and focus in an environment where "initiative overload" is common.

The group suggested that, as nursing embarks on coalition building, it identify potential resources, seek buy-in from a variety of stakeholders, and create a timely message that is inspirational and motivating for change. Think Tank participants suggested that coalition stakeholders represent a myriad of groups, such as public forums, nursing organizations, funding sources, payers, risk management groups, educators and academicians, physician groups, credentialing bodies, quality groups, and accrediting bodies. These stakeholder groups were further developed into a list of specific organizations (Appendix C).

SUMMARY

The success of the Think Tank can be summarized in the commitment participants were willing to make for future activities. According to the audience response system, approximately 92% of the participants indicated their interest in continuing some level of involvement, and more than half of the participants were willing to fund future activities.

The CCI 2007 Think Tank provided a dynamic forum for scholars and thought leaders to network and discuss the issues of nursing continuing competence and patient safety. Participants heard about issues

of consumer groups and how our physician colleagues are addressing continuing competence. Using scenario planning, Think Tank participants identified challenges with the areas of competency evolution, educational reform, informational literacy, policy, multidisciplinary team learning and data management that must be addressed as part of any discussions on continuing competence. To further influence continuing competency and patient safety issues within nursing, the Think Tank participants recommend that an interdisciplinary coalition be created to develop, implement, and evaluate future initiatives.

{ *The success of the Think Tank can be summarized in the commitment participants were willing to make for future activities.* }

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APPENDIX A: 2007 THINK TANK PARTICIPANTS

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APPENDIX B – SCENARIOS

THE SCENARIOS

The four scenarios contained in the following pages were developed in March 2005 by a group of individuals representing 34 national medical organizations. The scenarios are an attempt to tell stories about how the U.S. healthcare system will look in the year 2020. They are not to be seen as final in any way, or as definitive predictions of what the future will look like. Rather, they are an attempt by the group to grapple with and anticipate critical trends and uncertainties that will influence the evolution of the U.S. healthcare system.

SCENARIO 1: BIG BROTHER

2010-2015:

The economy goes into a tailspin. Corporate America pushes the burden of healthcare costs to employees, resulting in an increasing number of uninsured Americans. A call for universal coverage generates the political will to develop it. The difference this time around is that the government already has the data it needs. A multi-stakeholder committee is formed in which the public, the government, and the profession collaborate to develop a plan for universal healthcare coverage. Many aspects of the current system would be nationalized, including oversight of accreditation and licensure.

The coalition is fragile, dependent upon each party trusting the other. However, it holds together and produces a plan that all stakeholders can support. The plan calls for the creation of a national office of secretary of health to oversee the elements of the new federal health plan. A "Medicare for all" system emerges that guarantees minimum coverage for all Americans, but the option to purchase private insurance in the open market is also retained. The system encourages preventative health, relies on the national standards developed through years of data collection to drive disease management, and depends heavily on non-physician providers to triage primary care needs of patients. The role of physicians changes from independent practitioner to team leader.

This new model for reimbursing care results in the forging of new alliances within the healthcare community, and a coalition of medical organizations representing all the health professions is formed.

2020:

Regional integrated delivery systems are responsible for monitoring the competency of practitioners and providing standards by which teams of health professionals are evaluated. These systems employ virtually all the health professions and use information systems to manage performance and monitor competence.

Care is less expensive and more readily available for everyone, but only those who can afford the private health insurance are ultimately assured of receiving high quality care.

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SCENARIO 2: TECHNO COMMUNITY ALLIANCE

2005-2010:

The U.S. healthcare system is besieged by escalating costs, public dissatisfaction, decreasing labor pools, and misaligned incentives encouraging over-utilization of procedures.

Providers become increasingly disgruntled because payers are implementing pay for performance measures as a means of lowering costs and improving quality. Each payer has its own set of measurement criteria, and the administrative work involved with collecting the data necessary to meet the varied requirements is increasingly burdensome and overwhelming. Few providers are willing to invest in electronic medical records, in part because of the expense involved but mostly because there are no assurances that IT systems would be interoperable and that the investments will pay off financially.

The federal government intervenes by developing standards for an IT infrastructure that would allow health professionals to share data electronically. The initiative receives positive public reaction but has mixed results within the healthcare community, due in part to provider concerns about lack of funding and mandates. Little progress is made in developing standards for performance measurement.

Recognizing that interoperability could be possible by 2020, a consortium of the healthcare community – healthcare professionals, hospitals, insurers, educators, regulatory bodies, peer review organizations, and professional associations – meet and agree to collaborate to develop national standards for measuring practitioner performance. After many months of dialogue, the group releases standards for performance measurement that are applicable across professions. The standards are predicated on development of a central data repository containing millions of cases that would facilitate a number of improvements in quality. It is proposed that the database be controlled by the consortium; however, public concerns about transparency and public accountability prompt significant debate about this recommendation. The provider community prevails but only after agreeing to report to a federally appointed public oversight agency.

2010-2015:

Healthcare costs continue to increase, and physician and nursing workforce shortages coupled with an aging population continue to negatively impact public access to care. Demand for more affordable healthcare choices spurs insurers to begin reimbursing non-traditional healthcare services, such as telehealth services or services provided by non-physicians or alternative medicine providers. Businesses and insurers begin to outsource healthcare services to countries like India, which offers state of the art facilities and U.S. trained health professionals at a fraction of the cost in the U.S. Use of telehealth services increases, with many of the telehealth providers located outside the U.S.

Budget deficits, the rising costs of healthcare, and the aging of America take their toll on Medicare, as the system appears to be headed for insolvency. State-based Medicaid programs also face crippling budget cuts.

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The percentage of Americans who are uninsured increases annually. Bowing to public pressure, Congress introduces legislation that would create a national healthcare system; the public is generally supportive of the bill, but businesses and special interest groups prevail and the initiative is narrowly defeated.

Meanwhile, acceptance of the consortium's performance measurement standards slowly gains ground, particularly among multi-state payers and healthcare systems. These progressive healthcare systems are using the standards to measure the performance of healthcare teams rather than individual practitioners. Use of electronic medical records (EMRs) is also slowly increasing, although an effort by the federal government to mandate their use is blocked by the provider community in part due to the mandate being unfunded. However, the Center for Medicare and Medicaid Services (CMS) implements such requirements of its participants.

2015-2020:

CMS' mandated use of EMRs, coupled with the influx of newly educated, techno-savvy healthcare professionals, and reduced costs in hardware and software, results in exponential growth in the use of EMRs. Providers are capturing performance data using EMRs and transmitting the data to the central repository. The data are used by the healthcare community and the government to develop standards of care and disease management profiles and to perform outcome analysis. Trend analysis across graduate and undergraduate education for physicians, nurses, and allied health personnel are available to the government and the public. Assessment tools are developed to evaluate the performance of the healthcare system. All data are available to the public for use in selecting providers.

By 2020, patients are using health smart cards that contain their medical history and which can be updated from their providers' health networks via the internet. Patient care is managed using evidence-based protocols, and EMRs are used at the point of care. Significant advances in patient safety are gaining ground, as hospitals and healthcare institutions employ technology such as optic scanning to confirm patient identity or electronic prescription and order entry systems that are integrated with EMRs.

Medical advances resulting from genomics and nanotechnology are less costly and are increasingly available to all patients, not just to the affluent. Healthcare providers use computers to help identify possible diagnoses and suggested methods of treatment based on patient data entered. Patients have immediate access to their own individual health information as well as provider performance. Pay for performance is the norm.

SCENARIO 3: DATA CACOPHONY 2020

2005-2010:

It is 2005, and the medical delivery system is under tremendous pressure to improve the quality and safety of care being provided to the American public. Costs are skyrocketing, there has been little improvement in the rate of medical errors occurring, and both patients and practitioners are becoming increasingly frustrated and disillusioned.

Information technologies such as electronic health records (EHRs) are cited as offering opportunities both to significantly reduce costs and improve quality. However, providers are reluctant to implement EHRs because

they are expensive and no standards are in place to ensure interoperability across systems. Provider groups, licensing boards, the health professions, federal and state governments, and the payer community can not agree on either basic IT standards or data sets necessary to develop such standards.

Growing budget deficits, fueled in part by escalating healthcare costs, force states and the federal government to cut back in funding for social programs. Although the government is encouraging the use of EHRs, neither private insurers nor federal or state governments have the funds to significantly support investment in them. With no indications that interoperability will be a reality any time soon, EHR use declines and in fact falls well short of predictions.

2010-2015:

Insurers and employers attempt to deal with cost increases by shifting the burden to patients. Incentives aimed at encouraging patients to take more responsibility for their health are implemented. Patients become better educated about the "real" costs of healthcare and the limited value received for dollars spent. More and more patients opt for health savings accounts, and public interest in personal health records spikes.

Put in the position of having to "value shop," patients ask for performance data on healthcare providers but the lack of uniformity in standards for quality comparisons make access to meaningful information impossible. Frustrated at having to pay high prices for care they perceive as unsatisfactory, patients increasingly turn to non-physician providers who provide healthcare services for less money. They also turn to the internet, where healthcare entrepreneurs are offering low cost medical care via the internet. They also increasingly turn to the international community for healthcare services, which offer state of the art facilities and U.S. trained doctors at a fraction of the costs for similar services in the U.S. Entrepreneurs find ways to capitalize on the public's search for more accessible healthcare by using the internet as a means of providing services. There is little control over the quality of care being provided to patients.

An increasingly competitive market, coupled with a frustrated public and little agreement on what constitutes quality medicine, results in an erosion of trust between patients and their providers. Legislators respond by implementing more regulatory interventions, resulting in even more punitive and complex accreditation and licensure processes.

2015-2020:

As the public becomes more value-conscious, it increasingly recognizes the importance of early intervention. Research into genomics and nanotechnology begin paying off with the development of new diagnostics and therapies that allow patients to anticipate what diseases they are susceptible to. Patients begin to see reductions in health expenses in exchange for improved health practices. However, these incentives, while intended to give patients greater personal control over their risks, in fact increases the divide between the wealthy and low-income, since the latter group lacks education, access to technology, and the money to take advantage of new diagnostics and therapies. In addition, patients experience decreased access to care resulting from a growing shortage of health professionals coupled with the changing healthcare needs of the U.S. population brought on by the "graying of America."

CCI

Healthcare organizations are collecting performance data on their network providers, but the environment is so unfriendly that no one is willing to collaborate on establishing national standards, making it impossible to conduct meaningful research regarding the validity of performance measurement schemes. Attempts by various providers to make data available for quality improvement purposes are frustrated by privacy concerns and the legal profession's demand that any data be fully discoverable for the purposes of litigation. In several areas of the nation, instances of manipulation of data to increase market share begin to surface. In many of these instances, this manipulation of data actually was responsible for worsening rather than improving care.

This toxic state leaves a serious trust vacuum between patients and the entire healthcare community over the quality of American healthcare. By 2020, multiple data sets, many conflicting, are required at each patient encounter. Numerous entities including CMS, specialty boards, state licensing boards, and payers have so many different standards that there is no way to validate even the basic definition of quality of care or physician competence.

As a result, quality improvement stagnates, costs continue to rise, and the profession remains fragmented and continues to lose the trust of the public.

SCENARIO 4: HAPPYHEALTHCARE.COM

In an effort to bring spiraling healthcare costs into control, employers and insurers begin using health savings accounts as a means of shifting healthcare costs to patients and encouraging patients to be more responsible for both their health as well as for dollars they spend on healthcare. As patients become more comfortable with the increased responsibility, they begin demanding better resources – like personal health records and better provider comparison data – for use in making decisions about their healthcare needs. Portable health insurance becomes the norm, and patients who were once completely oblivious to the cost of healthcare become very shrewd shoppers for value-driven care.

Faced with such dramatic shifts in how healthcare dollars and decisions were being managed, providers respond by collaborating to redesign the delivery system using continuous quality improvement as the foundation for change. This collaboration is aided when the federal government publishes national standards for information technology as a means of facilitating better data collection and sharing.

Federally funded regional partnerships between providers, patients, and employers are formed to develop and manage performance data collection for use in accreditation, credentialing, licensure, and public education. Performance standards are developed and implemented at a regional level and monitored nationally by the federal government for significant variances across pre-determined public health indicators. Reports are used by the regional collaborations to make improvements to care.

Healthcare remains a market-driven industry, with both traditional and non-traditional providers competing for patients' healthcare dollars. While this model benefits the majority of Americans, it also results in a greater divide between the haves and have-nots.

CCI

As patients become more knowledgeable consumers of healthcare, they increasingly demand more public investment in health prevention, disease management, and stronger incentives for research and development to meet public health goals. A whole industry of watch-dogs, product testing and consumer reporting companies develop to support patients in their new role as healthcare decision makers and payers.

Teaching institutions benefit from the reformed delivery system because they can track and measure their students more efficiently across the continuum of practice. Public calls for more and better applied research are possible because of the available performance data, and providers benefit from more customized lifelong learning offerings.

Licensing boards begin holding practitioners accountable for outcomes in patient care, rather than for meeting minimum standards. With the help of the provider community, practitioners whose patient outcomes are in question are identified early and receive appropriate intervention and remediation; liability insurance providers agree to cover this practice because it reduces the risk of malpractice suits. The public is not initially supportive of this shift, fearing it is an attempt by providers to "protect their own" in the face of change, but through education, research and most importantly, improved patient care, public trust increases.

There is a level of provider attrition because some practitioners don't measure up to agreed-upon performance standards. However, the emphasis on continuous quality improvement and collaboration between the health professions facilitates systems-based practice and team-based care, so that attrition is manageable. Because of the reliability of the data, there is also better risk management.

Initially, these changes prompt a push-back from the health professions – and in particular the physician community. Many long-time practitioners, perceiving a loss of control and autonomy, resent the philosophical premises upon which continuous quality improvement and consumer driven care are predicated. In particular, the notion of being compared against one's peers is perceived as very threatening. These perceptions, while not enough to prevent the revolution from occurring, do hamper progress.

APPENDIX C – RECOMMENDED CONTINUING COMPETENCE COALITION STAKEHOLDERS

Public
> AARP
> Citizen Advocacy Center

Nursing Organizations
> American Board of Nursing Specialties
> Nursing certification organizations
> American Nurses Association
> Nursing membership organizations
> Sigma Theta Tau

Funders
> Health Resources and Services Administration
> Pew Health Professions Commission
> Robert Wood Johnson Foundation

Payors

Risk Management
> American Society for Healthcare Risk Management

Educators
> American Association of Colleges of Nursing
> National League for Nursing

Physician Groups
> Federation of State Medical Boards
> Accreditation Council for Graduate Medical Education (David Leach)
> American Board of Medical Specialties

Credentialing Bodies
> State boards
> National Council of State Boards of Nursing

Quality
> Institute of Medicine
> Institute for Healthcare Improvement
> National Quality Forum

Accrediting/Regulatory Bodies
> The Joint Commission
> Centers for Medicare and Medicaid Services