healthcare provider

ASSESSMENT & REMEDIATION

resource manual

PREP 4 PATIENT SAFETY

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ASSESSMENT AND REMEDIATION RESOURCE MANUAL

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For more information on the Practitioner Remediation and Enhancement Partnership (PreP 4 Patient Safety), we invite you to visit the program web site at www.4patientsafety.net.

I. Background: Post-licensure Assessment and Remediation

Key components of the PreP (Practitioner Remediation and Enhancement Partnership) 4 Patient Safety program are the assessment and remediation of participants who are identified as below standard in some area of their practice. In fact, in its report on the first year of the program, the Citizen Advocacy Center posed a number of questions for the future of PreP 4 Patient Safety, including:

- What is the best way to go about developing guidelines for uniform or consistent assessment techniques and remediation strategies? How can PreP programs be sure the remediation fits the assessment in an individual case, or fixes the problem(s) when system issues are present?
- What are the most appropriate means for measuring the effectiveness of individual remediation plans in improving the skills and knowledge of the practitioner?
- Can PreP learn from and work with continuing competence programs being established by many voluntary credentialing bodies? What information and resources can be shared in connection with needs assessment methods and techniques as well as remedial education?

In order to answer these questions and meet a growing need on the part of PreP 4 Patient Safety pilot programs, Citizen Advocacy Center received a second contract from the Health Resources and Services Administration to explore the issues of assessment and remediation.

Assessment and remediation are closely linked in the history of the licensure of health care professionals, and the process is circular. A provider's knowledge is assessed in the context of the continued education that is expected of nearly every licensee in the country, from medical and nursing school to clinical training to continued education, yet for some providers a more focused educational experience is triggered by an event or pattern of practice. The analysis of that pattern or practice is the most general of assessments, and the education that results, often initiated by colleagues and employers, is remediation.

Hospitals have been using assessment in nursing since the beginning of formalized employment programs, in the new employee evaluation model. Today this model takes many forms and is used at many times. Two important factors are affecting the employment use of nurse assessments on an ongoing basis. First, more and more temporary nurses (nurses that are employed through a staffing agency rather than directly by the organization, or seasonally, or otherwise temporarily by the organization) are being utilized. Second, turnover of nursing staff decreases the effectiveness of ongoing, employment-based assessments. The focus on patient safety, documented competence and quality improvement, on the other hand, by organizations like the Joint Commission on the Accreditation of Healthcare Organizations, would seem to put more emphasis on at least some type of ongoing assessment.

For physicians, the use of peer review has been the "assessment" tool of choice for hospital medical staffs and others, since it carries certain specific legal protections when performed according to Federal and State standards. Wide variations exist in the privileging of physicians, and in the quality and type of reviews done, but the widespread use of peer review, including reviews triggered by "adverse events" continues.

Both employment reviews and peer reviews have a significant weakness as objective assessments to determine the need for remediation. The weakness is that some believe that both of these methods are punitive, subjective, or both.

Another problem is a history of poor communication between licensing boards and hospitals. The PreP 4 Patient Safety program is designed to address that issue head-on, by requiring that the two work together with the participant to provide adequate assessment, remediation, and monitoring.

The discussion of assessment and remediation techniques here, along with the listing of remediation and assessment resources, should provide much-needed information, help and bases for discussion about these important processes, and help put an end to the suspicion and distrust among and between licensing boards, hospitals, and health care practitioners.

Assessment and focused education, or remediation, are becoming more accepted by professional associations as well. The American Board of Medical Specialties has for a number of years encouraged its members to require periodic re-assessment (called re-certification), and now the member boards are beginning to relate the re-assessment tools to quality problems in the specialties, using the "six sigma" model of quality measurement. Wider acceptance in the professional communities will help reduce the punitive reputation of assessment and remediation as a part of ongoing practice.

Both in nursing and medicine, there is new interest in looking at types of assessment tools, and determining how best to use and combine these tools to get an adequate picture of a practicing licensee's competence. In fact, the State of the art is to combine a number of tools based on the type of practitioner, practice and information available. The State of the art in remediation is less clear, with no real evidence yet on what types of interventions, under what circumstances, are effective in improving a physician's or nurse's practice.

Even though assessment tools are better, however, little is known about how and how frequently the tools are used. One major purpose of this undertaking was to determine the use of available assessment tools, and begin discussions to try and see how the actual can be made more like the possible.

Remediation is more widely used than formal assessments, but little is known about how remediation programs are structured and used. In medicine, what has developed appears to be a number of relatively expensive, centralized assessment and remediation programs associated with a few large teaching institutions or other institutions. In nursing, on the other hand, smaller, often private or nursing-school-run programs provide similar but less comprehensive services.

In answering these questions, (What is available? How is it used? How does it compare with the "State-of-the-art?"), we hope to provide tools for discussion, decision-making and resource planning to the PreP 4 Patient Safety participants.

In order to provide tools to begin the discussion about effective assessment and remediation programs for "PreP' participating licensing boards and provider institutions, we have developed this resource manual. The manual attempts to answer two questions:

1. What is currently available?
2. How are available resources utilized by licensing boards?

The manual also includes summaries of many recent articles and studies, both here and abroad, dealing with assessment and remediation.

We intend to update this manual periodically and frequently. We especially need to add information on assessment and remediation programs currently utilized by participating hospitals and participating long term care facilities.

I. Current Status of Assessment and Remediation in the U.S.

Little data exists describing how currently available assessment and remediation tools are used in practice. A survey of the literature reveals that most of the "data" that exists on the use of assessment tools is actually centered around the characteristics of those who participate in the assessments and remedial programs, rather than longitudinal data on effectiveness of the assessments and remedial programs. Therefore, it was necessary to establish a baseline from which to measure changes in the use of assessment and remediation and the effectiveness of assessment and remediation in changing behavior over time.

In January 2003, Citizen Advocacy Center, with assistance from the National Council of State Boards of Nursing (NCSBN) and Administrators in Medicine (AIM), surveyed all State medical and nursing regulatory Boards on their use of assessment and remediation tools.

The goals of the survey were two-fold: first, to determine what types of assessment and remediation resources were already being used by the States, and how frequently they were used, and second, to compile a directory of assessment and remediation resources in use by Boards.

We received responses from 19 State boards of nursing. From boards of medicine, we received responses from 43 States representing 46 boards (some States have boards of osteopathic medicine and allopathic medicine in an umbrella organization). The Administrators in Medicine declined to provide the identity of the medical/osteopathic board respondents, so when analyzing the results, we are unable to discuss factors such as size of State, geographic location, etc., as those factors are unknown to us. While this causes our analysis to be less comprehensive, we were nonetheless able to draw conclusions about the use of assessment and remediation programs by State boards and to compare use by nursing and medical boards.

Assessment Information

A number of different resources are available to boards that wish to assess practicing licensees differently than they assess candidates for initial licensure. These resources include examinations, "formal" assessments (conducted at schools of medicine and nursing, for example,) and "informal" assessments, which are often conducted by Board members or staff, or by outside consultants to the boards, on an as-needed basis.

The examinations available to medical/osteopathic licensing boards include the Special Purpose Examination (SPEX), a computer-delivered, multiple choice examination developed by the Federation of State Medical Boards and the National Board of Medical Examiners in the 1980s to test practicing physicians. A second type of examination frequently used by medical/osteopathic boards is the specialty board certification and re-certification examination. Finally, some States use State-specific exams (such as jurisprudence exams) or smaller examinations such as the COMVEX exam, an examination designed to test the practicing osteopathic physician. Examination use among medical boards responding to our survey is shown in Table 1.

Table 1. Examination Usage - Medical/Osteopathic Boards

	Use Exams to Assess Competency			Exam Numbers	
Respondent Board	SPEX	ABMS Certification or Re-certification	Other Exam	Number of Exams in Last 12 Months	Number of Exams in Last Five Years
Survey 1	X		X (Note A)	SPEX: 15* ABMS: 2* Other:20* (Note A)	SPEX: 100-125 ABMS: 10-15 Other: 100-125
Survey 2	X			1	2
Survey 3	X		B	6 (B)	20
Survey 4			C		1
Survey 5	X		X (D)	4-5 (D)	10*
Survey 6	X				3
Survey 7					
Survey 8	X	X			
Survey 9					
Survey 10				50	170
Survey 11					
Survey 12	X	X		4	10*
Survey 13	X	X	X (E)	6 (E)	10-20*
Survey 14	X		F	1-2	6
Survey 15	X	X		2	10*
Survey 16					2
Survey 17		X	G	1	
Survey 18	X		X (H)	3 (H)	6 (H)
Survey 19	X	X		4-6	20 - 25
Survey 20					
Survey 21	X		X (I)	5-7*	25*
Survey 22	X			8-10	40-50
Survey 23	X			J	
Survey 24	X		X (K)	3 (K)	4
Survey 25					
Survey 26	X		X (L)	SPEX: 0 JP Exam 1	SPEX: 10 JP Exam: 2
Survey 27					
Survey 28	X		M	6 (M)	8
Survey 29				5	unk.
Survey 30				3-5*	15-25
Survey 31					
Survey 32		X		unk.	unk.
Survey 33					
Survey 34	X			5	20
Survey 35	X				
Survey 36			X (N)	6*	6*
Survey 37			Other Exam	0	
Survey 38	X	X		3 (P)	unk.
Survey 39	X	X		2	10
Survey 40			Q	2	
Survey 41	X	X		1-2*	10*
Survey 42	X	X		R	
Survey 43	X	X	X (Z)		
TOTALS	25	12	9		

Table 2. Examination Usage - Nursing Boards

State BON	Exam Name used to assess competency in a practicing licensee	How many times have you used this exam as described above in the last 12 months?	How many times have you used this exam as described above in the last five years?
Alabama	Note AA		
Colorado	NCLEX	4	12
District of Columbia	Note BB		
Florida			
Georgia - PN			
Kentucky	NCLEX	None.	Several times, not sure of the exact number. It is used for revoked licenses.
Maine			
Minesota			
Missouri	NCLEX	0	3
Montana	NCLEX Specialty Board Exam, Advanced Practice Certification Exam, Re-Certification Exam or other National Exam	Ongoing – all candidates We don't use the exam per se – we accept them for APRN endorsements	Ongoing – all candidates
Nevada	Note CC		
New Hampshire	NCLEX Exelsior College Course Exams	3 2	10 2
North Carolina			
North Dakota	Note DD		
Oklahoma	NCLEX	10	
Rhode Island	Note EE		
South Carolina	NCLEX Nurse Refresher Course	2-3 times per year 3	Approximately 10-15 times in last 5 years. 15
Vermont	Advanced Practice Certification Exam, Recertification Exam	Every renewal period.	
West Virginia-PN	NCLEX	3	10
TOTAL	9		

Tables 1 and 2 show that a small number of licensees are referred by most States for these assessment tools, although the tools are widely available and appear to be well known.

Tables 3 and 4 show the use of other assessment resources by State boards of nursing and medicine/osteopathy in determining the competence of a practicing licensee. These resources include national assessments, either examinations/evaluations that are used on-site (such as the evaluation developed by Dorothy Del Bueno), assessment centers that provide focused assessments (such as the assessment centers identified in Table 3), and internal assessments by board members,

staff or outside consultants. Again, results show that relatively few assessment resources are used, and that internal resources are generally used more frequently than outside or national resources.

At times, the assessment is done by the licensing board as a part of the investigation; that is, the problems identified in the investigation become the assessment. For example, the Maine Board of Nursing states, "If the Board has a concern about a nurse's competency, it…may require completion of some specific area of practice - whether education, preceptorship - according to facts and issues as identified in meeting with licensee…"

Remediation Information
This use of the investigation as the assessment is also illustrated in the number of assessments used compared to the number of remediation resources used. The remediation resources used by medical/osteopathic and nursing boards are identified in Tables 5-8.

For medical/osteopathic boards, commonly known remediation resources have already been collected by two sources: The Ohio State Board of Medical Examiners and the Federation of State Medical Boards. These lists of resources (some of which were duplicative) were used as the basis for this section of the medical/osteopathic board survey, rather than asking the boards to recall what resources have been used. Medical/osteopathic boards were also able to list resources that were not in these collections. Nursing boards, on the other hand, maintain no such list that we were aware of. Interestingly, though, their resources are mostly local, with many nursing programs offering "refresher" courses in various areas. This may be related to the practice pattern of nurses leaving nursing and returning or changing areas of practice more frequently than physicians. (For more information, see the article by Sarah Marks in the Remediation bibliography.)

For medical/osteopathic boards, we divided the resources into groups representing programs that provide remedial education in prescribing, in ethics, and in other areas. It is important to note that the assessment centers shown in Table 3 also provide remediation programs. These remediation programs can be general (some of those are also represented in the remediation tables) or specific to the individual's assessment. Remediation in specific clinical areas does not seem to be widely or regularly offered by these assessment centers or otherwise.

The remediation resources listed by the respondent boards, both those already known (i.e. from the Ohio and FSMB collections) and those previously unknown (such as the local resources used by boards) have been collected into an "Assessment and Remediation Resource Directory" which is provided here by State and provided on the PreP 4 Patient Safety web site (www.4patientsafety.net) in a searchable format, by type of assessment (i.e. one can look for all "prescribing" assessments and remedial education programs,) by region, and by provider. One important function of this survey, then, is bringing boards, hospitals and others that potentially need to assess and remediate licensed health care practitioners into contact with national and local remediation resources.

The survey reveals, though, that remediation programs for topics such as ethics and prescribing are more widely used by medical/osteopathic boards than more clinically focused remediation programs, while nursing boards almost exclusively use the clinically focused programs.

Respondent Board	National Assessment Centers					Internal Assessments		Internal Assessment Numbers		See Resource List for Other Organizations		
	Albany	CARES	CPEP	IPE	PACE	Agency Evaluation by Board Member or Agency Staff	Agency Evaluation by Medical Consultant or Others	Agency Evaluations in Last 12 Months	Agency Evaluations in Last Five Years	Use of In-State Assessment Centers	Use of National or International Assessment Centers	Use of Other Organizations to Assess
Survey 1					X		X	20	100-125	X		
Survey 2						X			3			
Survey 3							X	5	15			
Survey 4							X	3-5	3-5/year		X	
Survey 5			X	X			X	333		X	X	X
Survey 6									2			
Survey 7										X		
Survey 8				X	X		X	10	30			
Survey 9		X										
Survey 10											X	
Survey 11										X		
Survey 12											X	
Survey 13		X									X	
Survey 14											X	
Survey 15												
Survey 16									2			X
Survey 17								(Note S)	(Note S)		X	X
Survey 18							X	2-3	5*		X	X
Survey 19						X	X	Several				
Survey 20						X		2	2		X	
Survey 21								unk.	unk.	X		
Survey 22			X		X		X	5-8	50-60			
Survey 23		X										X
Survey 24										X		X
Survey 25					X		X			X	X	
Survey 26							X	6	18			X
Survey 27							X	62	378		X	
Survey 28						X				X		
Survey 29					X		X	1	5*			
Survey 30										X	X	
Survey 31									unk.			
Survey 32											X	
Survey 33						X		3-4	15-20		X	
Survey 34										X	X	
Survey 35					X		X	30	150	X		X
Survey 36					X		X	15-20	100*	X		
Survey 37		X				X		5*	20*			
Survey 38	X									X		X
Survey 39	X			X						X		X
Survey 40												
Survey 41												
Survey 42		X		X			X	not often	not often		X	
Survey 43							X			X	X	
TOTALS	2	5	2	4	7	6	16			15	17	10

Table 4. Other Assessment Usage - Nursing Boards

STATE BON	Resource(s) used to assess competency in a practicing licensee	How many times have you used this exam as described above in the last 12 months?	How many times have you used this exam as described above in the last five years?
Alabama			
Colorado	Evaluation by a Board Member or Agency Staffer	30	220
District of Columbia			
Florida			
Georgia-PN	Evaluation by a nurse consultant to the Board or other individual contracted by the Board.	Seven (3)	22
Kentucky	Evaluation by a nurse consultant to the Board or other individual contracted by the Board. Only as an expert witness, when a case calls for it.		
Maine	If the Board has concern about a nurse's competency, it (as a whole or subcommittee) may require completion of some specified area of practice – whether education, preceptorship – according to facts and issues as identified in meeting with licensee – sometimes refers to a refresher course; requires quarterly (or some period of time) report from nurse employer (usually immediate supervisor).		
Minnesota	Evaluation by a nurse consultant to the Board or other individual contracted by the Board (does NOT include the use of an outside assessment center, university, etc.)	Many (30?)	150-200
Missouri			
Montana	Evaluation by a Board Member or Agency Staffer Evaluation by a nurse consultant to the Board or other individual contracted by the Board (does NOT include the use of an outside assessment center, university, etc.)	#: OVER 100 ALL PROBATIONARY LICENSEES – QUARTERLY REPORTS LESS THAN 10	#: DO NOT HAVE NUMBER OF QUARTERLY REPORTS SUBMITTED FOR PAST FIVE YEARS
Nevada			
New Hampshire			
North Carolina			
North Dakota			
Oklahoma			
Rhode Island			
Vermont			
West Virginia-PN			
Wisconsin	NCLEX	It was offered twice as an alternative to a refresher course to nurses who had not been licensed for 5 y	It was offered twice, but declined on both occasions.

Table 5. Medical/Osteopathic Remediation Resources: Prescribing

	Specific Clinical Remediation Resources: Prescribing											
Respondent Board	**CWRU/Prescribing (1)**	**USoFL/Prescribing**	**Mercer/Prescribing**	**Atlanta/Prescribing**	**UKY/Prescribing(1)**	**NJBME/Prescribing**	**CWRU/Prescribing (2)**	**OBME/Prescribing**	**Vanderbilt/Prescribing**	**Vilensky/Prescribing**	**PACE/Prescribing**	**UKY/Prescribing(2)**
Survey 1											X	
Survey 2												
Survey 3	X	X		X		X	X	X	X		X	
Survey 4												
Survey 5	X						X	X	X		X	
Survey 6												
Survey 7	X	X										
Survey 8	X	X				X	X		X		X	X
Survey 9	X						X		X			
Survey 10	X		X						X			
Survey 11												
Survey 12												
Survey 13	X	X		X		X	X	X	X			
Survey 14	X						X			X		
Survey 15												
Survey 16		X										
Survey 17												
Survey 18												
Survey 19	X	X	X				X	X	X	X	X	
Survey 20							X					
Survey 21			X									
Survey 22	X	X	X	X	X		X		X	X	X	X
Survey 23			X									
Survey 24												
Survey 25	X	X						X			X	
Survey 26												
Survey 27		X									X	
Survey 28	X	X										
Survey 29												
Survey 30		X										
Survey 31										X		
Survey 32	X						X					X
Survey 33									X	X		
Survey 34										X		
Survey 35						X	X	X	X		X	
Survey 36											X	
Survey 37			X									
Survey 38	X						X		X	X		
Survey 39	X	X								X		
Survey 40												
Survey 41									X			
Survey 42									X			
Survey 43	X	X			X	X	X	X	X		X	X
TOTALS	16	13	6	3	2	5	13	7	14	8	1	4

Table 6. Medical/Osteopathic Remediation Resources: Ethics

Respondent Board	Specific Remediation Resources: Ethics									
	ProBE(1)	IMQual/Ethichs	ProBE(2)	KYProfRenewal/Ethics	PRIM-E	NEOUCOM/Ethics	CWRU/Ethics	Xavier/Ethics	IGE/Ethics	CCC(OH)/Ethics
Survey 1		X								
Survey 2										
Survey 3	X	X								
Survey 4	X		X							
Survey 5	X		X		X		X			
Survey 6										
Survey 7	X		X							
Survey 8	X		X		X		X			
Survey 9										
Survey 10							X			
Survey 11										
Survey 12										
Survey 13	X		X	X	X		X			
Survey 14	X		X							
Survey 15										
Survey 16										
Survey 17			X							
Survey 18	X		X							
Survey 19	X		X							
Survey 20										
Survey 21										
Survey 22	X		X		X		X			
Survey 23										
Survey 24										
Survey 25										
Survey 26										
Survey 27										
Survey 28										
Survey 29										
Survey 30										
Survey 31										
Survey 32	X					X	X	X	X	X
Survey 33	X				X		X			
Survey 34			X	X	X					
Survey 35	X		X		X		X			
Survey 36										
Survey 37										
Survey 38	X				X		X			
Survey 39	X				X					
Survey 40										
Survey 41										
Survey 42										
Survey 43										
TOTALS	15	2	12	2	9	1	9	1	1	1

Table 7. Medical/Osteopathic Remediation Resources: Other Resources

	Other Specific Remediation Resources					
Respondent Board	OMA/Treating	CPEP/Documentation	PACE/Communication	PACE/Education	PACE/Records	KSProfRenewal
Survey 1			X	X	X	
Survey 2						
Survey 3	X	X			X	
Survey 4						
Survey 5		X			X	
Survey 6		X				
Survey 7		X	X		X	X
Survey 8		X	X		X	
Survey 9		X				X
Survey 10						
Survey 11						
Survey 12		X				
Survey 13		X				
Survey 14		X				
Survey 15						
Survey 16				X		
Survey 17		X				
Survey 18						
Survey 19		X			X	X
Survey 20		X				
Survey 21						
Survey 22		X	X		X	
Survey 23						
Survey 24		X				
Survey 25		X	X	X		
Survey 26						
Survey 27		X				
Survey 28		X				
Survey 29		X				
Survey 30		X				
Survey 31						
Survey 32		X				
Survey 33		X				
Survey 34		X				X
Survey 35			X	X	X	
Survey 36			X	X	X	
Survey 37						
Survey 38						
Survey 39		X				
Survey 40						
Survey 41						
Survey 42		X				X
Survey 43		X				
TOTALS	1	25	7	5	9	5

Table 8. Nursing Remediation Resources

State BON	Exam Name used as assessment to determine competency in a practicing licensee	How many times have you used this exam as described above in the last 12 months?	How many times have you used this exam as described above in the last five years?
Alabama			
Colorado			
District of Columbia			
Florida	Other organization	4	12 estimated
Georgia			
Idaho	In-state assessment center: St. Luke's Regional Medical Center Dorothy Del Buono Assessment PBDS		
Kentucky			
Maine			
Minnesota	Would like to have an in-state assessment center or the Dorothy Del Buono Assessment if a provider were available.		
Missouri			
Nevada			
New Hampshire	Board approved refresher course with clinical competency assessment National or international assessment center (not in your state)	35 5	150 20
North Carolina	Dorothy Del Bueno Assessment Other organization	1 (PREP) used by the employer 4 (PREP) Competency assessments are commonly unstructured and completed by employers, using nurse educators or clinical nurse specialists	
North Dakota			
Oklahoma			
Rhode island			
Vermont			
West Virginia-PN			
TOTAL	4		

Survey Conclusions

This survey fills an informational void in the study of the assessment and remediation of practicing licensees. It establishes that there is wide use of available assessment and remediation resources by both nursing and medical/osteopathic boards. Even in those boards that do use assessment and remediation resources, however, the numbers of affected practitioners are small. Boards use remediation resources somewhat more often than assessment resources, perhaps believing that the investigation itself is the assessment.

Among medical/osteopathic respondents, for example, fourteen of 43 States (less than 30 percent) responded that their medical/osteopathic boards use national assessment centers, and 22 of 43 States responded that their medical/osteopathic boards used internal assessments. Twenty-six of 43 States reported using either national or internal assessments (just over 60 percent), and only seven reported using the assessments more than five times in the last 12 months.

Of the nursing respondents, 12 of 18 State boards of nursing (67 percent) do not use any type of exam to assess practicing nurses, and 13 of 18 boards (72 percent) report using no other types of assessments. With the smaller sample, conclusions on volume are harder to draw, nonetheless a number of States who use the exams do so only rarely.

Remediation resources seem to be more used, but numbers remain small. One strong finding of the survey, though, was how many State boards have developed or discovered local resources to assist them when they do use assessment and remediation. We have collected over 10 previously unknown local resources via this survey, and now have information on more than 35 total assessment and remediation resources compiled into one location.

Note Reference	*Other Exam Description Note*	*Notes on Exams Used in Last 12 Months*	*Notes on Exams Used in Last Five Years*
Note A	Business & Professions Code Section 2292 allows the administration of a Professional Competency Exam. This is an oral exam, administered by three physicians. Examinee is required to receive a passing score of 70 percent.	These exams are taken pursuant to settlement agreement or Board order. An accurate count would require that all orders for the time period in question be reviewed manually to see if they contained the requirement. Therefore, these are approximate numbers: SPEX: 15 ABMS: 2 Other:20	SPEX: 100-125 ABMS: 10-15 Other:100-125
Note B	CPEP	6	20
Note C	Physician and/or Mental Examinations		SPEX - 1 time (retired returning to active) Physical/Mental - 3-5 times/year
Note D	Post Licensure assessment programs, specifically CPEP and PLAS	We use CPEP more frequently and an estimation of use in the past 12 months would be about 4-5 physicians being evaluated	Approximately 10. (I can only account for time during the past 1 1/2 years for accuracy.)
Note E	CPEP, Florida CARES, PLAS	6	Maybe 10-20
Note F	On occasions we use the SPEX examinations, but not routinely	1-2	6
Note G	The Board can use SPEX and COMVEX but never has in the almost 4 years that I have been here. The Board requires ABMS or AOA board certification if an individual does not complete the licensure exams in the 7 yr. period	None for SPEX and COMVEX; the Board has required a physician who is on probation to take ABMS exams as a way to show continues competency	None, to my knowledge other than as described above
Note H	COMVEX-USA	SPEX: 1-2; COMVEX-USA: 1	SPEX - 5 or more; COMVEX-USA - just the one time
Note I	U of Wisconsin may test the individual to see where their weaknesses are in a particular specialty of medicine through the Continuing Education Dept. and Dr. Thomas Meyer	Approximately 5-7 times	Approximately 25 times
Note J	University of Florida CARES Program University of South Florida Clinical & Legal Course most frequently used	University of South Florida Clinical & Legal Course most frequently used University of Florida CARES-second most used Board Certification-option to show competency not a requirement SPEX-occasionally	
Note K	Colorado Personalized Education Program for Physicians (CPEP)	3 (that we paid for). We don't keep statistics on those that we send to CPEP that have to pay for the evaluation themselves.	4 (See above answer.)

Note Reference	*Other Exam Description Note*	*Notes on Exams Used in Last 12 Months*	*Notes on Exams Used in Last Five Years*
Note L	State Jurisprudence Exam	SPEX:0 Jurisprudence Exam: 1	SPEX: 10 Jurisprudence Exam: 2 (That exam has only been in place 2 years).
Note M	COMVEX	6 total - 5 SPEX and 1 COMVEX	8
Note N	We use the NBOME COMVEX exam for assessing competency	approx. 6 times	approx. 6 times
Note O	COMVEX	0	
Note P		SPEX: 1 ABMS: 2	Unknown
Note Q	They take the National Board of Osteopathic Medical Examination	2	
Note R	We rarely use SPEX as the sole test of competency. We use the specialty exams even less frequently.	See above.	I have heard that East Carolina University is planning to resurrect their IPE program, but do not know that for sure.
Note Z	Texas Medical Jurisprudence Exam		
Note AA	We do not use any of the mechanisms listed in the survey prior to discipline.		
Note BB	The DC Board uses none of the suggested options.		
Note CC	Nevada does not use any of the methods listed in your survey. However, we do have a requirement in our Nurse Practice Act that applicants for license renewal who have not practiced during the immediately preceding 5-year period much complete a refresher course. Here is the specific portion of our Nevada Administrative Code: *NAC 632.192 Expiration and renewal of license or certificate* *4. An applicant for renewal of a license who has not practiced nursing during the immediately preceding 5-year period must complete a course or program approved by the board if he has otherwise satisfied the requirements for renewal set forth in this chapter and chapter 632 of NRS. The board may issue to the applicant a temporary license for not more than 4 months after the date on which it was issued for the purpose of completing the course or program in which he is enrolled. Upon submission of evidence of completion of the course or program, the board will issue to the applicant a permanent license if he has satisfied the requirements of subsection 2.*		
Note DD	No to all questions.		
Note EE	To date the RI Board has not used any of the methods identified in the CAC survey. Issues of quality of care/competency are addressed through required continuing education, usually at a local college/university and a "refresher course" used for nurses with surrender/suspended licenses asking for reinStatement if there has been an extended period since the action was taken.		

III. State-of-the-Art: Assessment

In developing Section III, a literature search was conducted using the National Library of Medicine's database and other sources to develop a bibliography of articles dealing with the assessment of practicing nurses and practicing physicians. Articles dealing with the assessment of physicians are more prevalent, in part owing to the Tenth Cambridge Conference on medical education, held in 2001, which focused on assessment and evaluation of physicians.

The most recent and pertinent articles were selected for summary here.

These articles generally support:
1. The consistent use of assessment (i.e. not using just the apparent problem to determine the remediation necessary)
2. Defining the purpose of assessment
3. Matching assessment tools to practice
4. Balancing reliability and validity (formality) with feasibility, cost and acceptance (practicality)

CAC supports the consistent use of assessments in the PreP 4 Patient Safety program, and suggests the following:
1. Boards and hospitals should become familiar with the various assessment tools and resources available.
2. All proposed participants should go through an assessment
3. A spectrum of assessments, ranging from the simple (yet effective) and affordable to the comprehensive, should be considered for each case.
4. The least cumbersome assessment tool that is likely to be effective should be used first, and if it is not effective, increasingly more comprehensive tools should be used..

Assessment Article Summaries

Overview of the Use of Assessments

1. Crossley, J., et.al., “Assessing health professionals,” **Medical Education** 2002; 36: 800-804.

This article provides context, and some background on key issues, for a series of papers on assessment that stemmed from the 10th Cambridge Conference on medical education held in 2001. Citing medical performance failures in the UK and the resulting loss of confidence in self-regulation as an impetus for their work, the authors provide a rationale for assessment and discuss the central concepts and controversies in assessment design.

The concepts and controversies that the authors address are: 1) the challenge of defining the focus of assessments, owing in part to the difference between assessing a health professional’s attributes and his/her performance of tasks, 2) the use of “blueprints” as a means of coordinating various assessment methods (a blueprint specifies all the elements of physician performance relevant to the assessment to the end of selecting appropriate samples of activity), 3) the need to define the purpose of an assessment (e.g., for “registration” or “formative feedback” purposes), 4) the challenge of designing assessment tools that are reliable over a range of performance contexts and valid with respect to the assessment’s purpose, and 5) the need to balance an assessment’s “rigour” (reliability and validity) with “practicality” (feasibility, cost and acceptability).

2. Epstein, R., et.al., "Defining and Assessing Professional Competence," **JAMA, 287(2):226-235;** (2002).

This article 1) defines and discusses the concept of professional competence and, 2) critiques the current means of assessing competence. The authors concisely define professional competence and then explore several of its "dimensions," including a physician's acquisition and use of knowledge; his or her ability to integrate knowledge and judgment, and to reflect upon and examine one's own clinical reasoning; and habits of mind that promote competence by enabling a physician to be "attentive, curious, self-aware, and willing to recognize and correct errors."

The authors reviewed the available literature on assessment to learn about the current availability of assessment methods that examine some of the non-objective qualities that comprise the fabric of professional competence. They found that few assessment tools use measure a physician's ability to engage in participatory decision-making. They also found that, "few reliably assess clinical reasoning, systems-based care, technology, and the patient-physician relationship." They go on to discuss a few innovative assessment tools that show promise in assessing a physician's professionalism more fully.

3. Watson, R., et.al., "Clinical competence assessment in nursing : a systematic review of the literature," **Journal of Advanced Nursing 2002; 39(5):421-431**.

This article addresses the question, "What is the research evidence for the use of clinical competence assessment in nursing?" To answer the question, the authors carried out a literature review covering the period between 1980 and 2000. They identified sixty-one papers suited to their purposes.

The authors preliminarily trace the origins of clinical competence assessments and identify some of the key controversies in the field. Their evaluation of the research literature found that considerable confusion exists about the definition of clinical competence. They also found that most of the methods used to measure competence have not been developed systematically, and that issues of reliability and validity have barely been addressed. They conclude that aspects of clinical competence assessment are at odds with the higher education of nurses.

4. Robb, Y., et.al., "Measurement of clinical performance of nurses: a literature review," **22 Nurse Education Today 2002; 22:293-300**.

This article describes an extensive review of the research literature involving the measurement of nurses' clinical performance. The authors' review spanned the decades between 1960 and 2000. They found thirteen articles on point and discuss and contrast the various measurement methods and their efficacy.

The authors note that while many assessment tools have been developed over the years, none are universally accepted. They discuss at length the approach taken by Smith and Kendall in a 1963 study, and conclude that their method offers a robust approach to generating a useful assessment tool regardless of the practice setting. The authors also analyze the noteworthy findings of the several other articles they reviewed.

5. Finucane, P.M., et.al., "Towards an acceptance of performance assessment," **Medical Education 2002; 36:959-964.**

This article observes that the usefulness of any performance assessment tool depends on its acceptance by three groups of stakeholders: consumers, doctors, and employers and funding

organizations. Acknowledging that the negative views of some doctors are likely to hinder the smooth introduction of performance assessment procedures, the authors review the literature dealing with motivational theory to identify strategies to promote acceptance of performance assessment.

The authors review the various expectations that the different stakeholders have of performance assessment, and observe that they share many expectations in common. They go on to offer a practical approach to introduce and implement a performance assessment program. They break down the process into three phases: 1) getting started, 2) facilitating the transition, and 3) consolidating acceptance. For each phase, they elaborate on specific steps on the way to building acceptance for new assessment programs (also see Rethans, at number 15, below, for a discussion of the rationale behind performance assessment).

6. Taylor, C.M., et.al., "Appraisal of doctors, problems with terminology and a philosophical tension," **Medical Education 2002; 36:667-671**.

This article considers the meaning of the term "appraisal" and its lack of a useful definition. The authors observe that the term is used to describe both "summative assessment," which is part of performance management, and "formative assessment" which is an educational process. The authors suggest that these two forms of appraisal serve two different purposes—quality and equality—within health care systems. Summative assessment, related to organizational concerns and dealing with standards, serves the purpose of equality. Formative assessment, related to education, serves the purpose of quality.

The authors observe that these two purposes are in creative tension within the health care system, and that this reflects the tension between liberty and equality that exists in western political and philosophical systems. These two seemingly incompatible values are themselves in creative tension, and thus form the context in which efforts to define terms, and to agree upon a common language of performance appraisal, take place.

Descriptions of Assessment Tools

7. Wilkinson, T.J., et.al., "The use of portfolios for assessment of the competence and performance of doctors in practice," **Medical Education 2002; 36:918-924**.

This article discusses the use of portfolios, defined as a "dossier of evidence collected over time that demonstrates a doctor's education and practice achievements," as a component of an assessment program. The authors observe that portfolios have been used for many years in other employment sectors, and can be a useful learning and assessment tool. They review the various purposes of portfolios, and discuss at length the nature of learning cycles and how portfolios can record learning activities.

The authors provide a four-point guide for constructing a portfolio. They suggest that a portfolio include evidence: 1) covering the domains of patient care, personal development and context management; 2) that the doctor assesses his or her own performance and takes steps to address areas that need improvement; 3) that has been generated by acceptably reliable assessments; and 4) that is sufficient, valid, current and authentic, when taken in its entirety. A portfolio, they maintain, should contain: a) a Statement of the doctor's context, i.e., areas of expertise and scope of practice, b) results of formal assessments (e.g. tests, patient satisfaction surveys, outcomes of complaints or disciplinary proceedings), c) learning activities, d) a reflective, synthesizing, Statement in which the doctor "makes

sense of the journey," and e) validating evidence or referees' reports (also see the two commentaries, at numbers 13 and 14, below).

8. Commentary, "Models of portfolios," **Medical Education 2002; 36:897-898.**

This brief commentary reports on four portfolio (see Wilkinson, "The use of portfolios for assessment of the competence and performance of doctors in practice," at number 7, above) models that researchers identified through a study that evaluates the use of portfolios in assessing the learning and competence of nurses. In reviewing case studies of nursing programs, the authors found that the composition of portfolios can be very different, and that the four models differ as to validity in assessing learning and competence. They raise several questions about the application of the different portfolio models in practice. They propose to explore those questions in the upcoming final stage of their research project.

9. Commentary, "Portfolio-based assessments in medical education: are they valid and reliable for summative purposes?" **Medical Education 2002; 36:899-900**.

This brief commentary addresses a key question about the credibility of portfolios in summative assessments, e.g. in the revalidation of doctors (see Wilkinson, "The use of portfolios for assessment of the competence and performance of doctors in practice," at number 7, above). The authors report that they found only two papers that provided limited data—in the context of medical education—to substantiate the reliability of portfolio based assessment. Though portfolios may be valid in formative assessments, the authors assert that portfolios need sound psychometric properties if they are to be recommended for high stakes summative purposes. They found that there is little evidence currently to support the widespread introduction of portfolios in summative assessment programs.

10. Lew, S.R., et.al., "Procedures for establishing defensible programmes for assessing practice performance," **Medical Education 2002; 36:936-941**.

The article offers a detailed project-planning tool for setting up performance assessment programs. Such a tool, the authors maintain, is needed to help defend a performance assessment's fairness in cases where the stakes—restricted licensure, for example—are high and the assessment (especially its data gathering procedures) is subject to challenge.

The authors' project-planning tool contains a series of questions about assessment programs, grouped according to 1) the purposes and outcomes of the assessment program, 2) planning the assessment program, and 3) the steps taken in the process of administering the assessment program to make it fair and defensible. Examples of these questions include, "What are the purposes of the assessment? Whose purposes are being met? Who are the assessors and how were they selected? How are the assessors prepared? Is there an ability to appeal?" The authors also address the need to evaluate the costs and benefits of a proposed assessment in a project plan.

11. Farmer, E., et.al., "Assessing the performance of doctors in teams and systems," **Medical Education 2002; 36:942-948**.

The article addresses the need to assess doctors' performance in the context of their relationships with other doctors and health care professionals. In making the case for team-based assessment, the authors observe that increasingly doctors work in complex environments involving teams and health

care systems. They illustrate the point with a profile of a British National Health Service surgeon and the various teams and systems with which he or she would be involved.

Noting that assessment programs usually focus on individual performance, the authors suggest a model for assessing doctors' performance in teams and systems that incorporates the principles of continuous feedback to improve future performance. They also assert that the successful implementation of their inclusive approach to assessment will require cooperation between professional, educational and regulatory institutions.

12. Hays, R., et.al., "A performance assessment module for experienced general practitioners," **Medical Education 2002; 36:258-260.**

This article reports on an Australian trial study on a performance assessment module that videotaped general practitioners in consultation with their patients. The research aimed at determining the reliability and validity of videotaped consultations as an assessment method. Thirty-three doctors each provided twenty videotaped consultations that were rated by a single trained rater.

The authors found that videotaped consultations can achieve validity and reliability criteria in performance assessments (a generalisible coefficient of 0.86). They recommend that videotaped consultation be explored further as an optional method for certification or re-certification assessments. (Also see Hays, "Selecting performance assessment methods for experienced physicians," at number 16, below).

13. Lim, T.O., et. al., "Assessing doctors' competence: application of CUSUM technique in monitoring doctors' performance," **International Journal for Quality in Health Care; 14(3):251-258,** (2002).

This article discusses the effectiveness of the cumulative sum, or CUSUM, charting technique in performance assessments for physicians in five practice disciplines. Observing that some have argued that the credibility of self-regulation depends, in part, on the inclusion of comparative treatment outcome data in assessments, the authors argue that the CUSUM technique can be useful in some contexts in the effort to objectify and quantify physician performance. CUSUM charting is, according to the authors, "a graphical representation of the trend in the outcomes of a series of consecutive procedures performed over time." The result is that physicians see a graphic representation of their case outcomes.

The authors describe CUSUM charting's rationale, how they approached its design, and how it worked within their design. They report that the physicians who participated in their study "found the technique acceptable, particularly as a personal self-assessment tool." The same physicians, however, were wary of its use for credentialing purposes. The authors concluded that the technique is perhaps most useful as a personal audit tool as a method of assessing technical performance, and then in practice contexts where "performance has a quantitative outcome that can be measured reliably…." They question the CUSUM technique's usefulness in the cognitive medical disciplines.

Designing Assessments

14. Melnick, D.E., et.al., "Conceptual challenges in tailoring physician performance assessment to individual practice," **Medical Education 2002; 36:931-935**.

The article posits that performance assessments for established doctors should be tailored to reflect their actual practice. The authors acknowledge, however, that the effort to tailor assessments to actual practice faces a number of conceptual and procedural challenges. They discuss four of these challenges at length.

The authors address first the challenge of "multiple audiences." They observe that the needs of the public, the medical profession and individual doctors will influence the effort to tailor assessments. Second, they discuss how overlapping practice domains, including the doctor's observable practice, potential practice, the professional field in which he or she specializes, and patient expectations, complicate the assessment picture. The third challenge—acquiring the information one needs to tailor an assessment to a doctor's actual practice—is complicated by the absence of automated data systems. The authors discuss the validity of the available alternative methods, including self-reporting and observation. Fourth, the authors suggest that a "core domain" of knowledge, skills and attributes for a professional field or specialty is likely to be a consideration—depending on the purpose of the assessment—in constructing assessments tailored to an individual doctor's practice.

15. Rethans, J-J., et.al., "The relationship between competence and performance: implications for assessing practice performance," **Medical Education 2002; 36:901-909**.

This article discusses the difference between testing for competence and assessing performance and proposes a model for understanding and designing assessments of practice performance. The authors assert that there are differences between what doctors can do in controlled testing situations and what they do in actual practice, and that the relationship between the two appears to be "at the least problematic." Preliminarily, the authors define competency-based and performance-based assessments. Competency-based assessment, they assert, measures what doctors can do in controlled representations of professional practice. On the other hand, performance-based assessment measures what doctors do in practice.

The authors proceed to offer a model, called the "Cambridge Model for Performance and Competence," that extends Miller's four-stage assessment model ('knows,' 'knows how,' 'shows how,' and 'does') by including system-related and individual related influences in the performance assessment. They contend that assessing physicians in practice is best done using a three-stage model that consists of: 1) a screening phase for all doctors, focusing on real practice, 2) a continuous quality improvement phase for those who pass the screen, and 3) a detailed assessment process for those who are viewed as "at risk."

16. Hays, R.B., et.al., "Selecting performance assessment methods for experienced physicians," **Medical Education 2002; 36:910-917**.

This article contains a useful discussion of the gaps in performance assessment research, within a broader analysis of research findings about how to define the content and purpose of assessments, and how to choose the most appropriate assessment methods. The authors analyze the reliability and validity of six assessment methods that include direct observation in practice, video observation of practice, covert simulated patients, surveys, interviews, and record and data analyses.

As to gaps in performance assessment definitions and methods, the authors identify four areas for further development. These are: 1) "teamwork," or how well individuals collaborate with others in interdisciplinary teams to achieve desired health care outcomes, 2) "patient empowerment," or how well patients improve their understanding of their health situation as a result of a doctor's efforts to educate and instruct, 3) "currency," or how well individual doctors stay up-to-date with new

developments, and 4) "insight," or the extent to which doctors are aware of their own strengths, weaknesses and limitations.

17. Schuwirth, L.W.T., et.al., "When enough is enough: a conceptual basis for fair and defensible practice performance assessment," **Medical Education 2002; 36:925-930**.

This article discusses the lessons learned in competence assessment research, and their implications for the concept and practice of physician performance assessment. The authors contend that a fair and defensible performance assessment requires the use of multiple instruments, including both objective measurements and subjective judgments, in order see the whole picture. They address a "popular misperception" about the alleged unreliability of subjectivity, and argue in favor of incorporating—and controlling for—subjective judgments in performance assessment.

The article also outlines a proposed plan for gathering information and "samplings" sufficient for a performance assessment process. The authors list several factors for assessors to consider when deciding when "enough is enough" in designing a performance assessment plan.

Methods of Getting Assessors and Assessment Data

18. Duckett, C., "Personalized Medical Education by Assessment and Prescription," **Federation Bulletin, 83(2):88-94**; (1996).

This article makes the case for individualized physician assessment and study. The author describes the evolution in thinking about continuing medical education (CME), particularly the growth in personalized assessment and education programs and the related shift from exclusive reliance on didactic learning methods (e.g. lectures). He discusses the origins of several individualized programs in the USA and Canada.

The author goes on to explore the options that exist for individualized assessment and for personalized study. With respect to assessment, he discusses the Special Purpose Examination (SPEX) for those who have been away from practice for a long time, chart-stimulated recall, structured oral examinations, medical and psychiatric screening, and more. As to personalized study, he addresses mini-fellowships, preceptor/mentor activities, home study and self-assessment courses, videotapes and computer-assisted instruction, and more. He concludes that work is needed to adopt "acceptable standardization and validation of the (education) methods" in order to build confidence among program participants, referring organizations and the public.

19. "The New Performance Procedures: Some Questions Answered," **Federation Bulletin; 84(4):247-249** (1997).

This brief article, excerpted from **GMC, the newsletter of the General Medical Council**, describes and explains the UK's performance procedures that took effect in September 1997. The article preliminarily describes the purpose behind the performance procedures, namely to protect patients from doctors whose performance is seriously deficient, and the framework the GMC uses to screen, assess and follow up on those doctors. The bulk of the article is devoted to questions and answers.

The article contains twenty-three questions and answers about the performance procedures and the GMC's administration of the system. The questions include, for example, "Is performance the same as competence?" "What is seriously deficient performance?" Who will decide if the GMC proceeds

with a case?" What is involved in an assessment?" "How will the assessment be made relevant to a doctor's particular specialty?"

20. Wall, D., et.al., "Learning by doing: training general practitioners to be appraisers," **British Journal of Clinical Governance, 7(4):294-298** (2002).

This article reports on a new, day long, British training program (see above) for General Practice (GP) appraisers. The authors designed the training in support of the appraisal component of the UK's new performance procedures. The authors underscore the importance of effective appraisal in the UK's monitoring and remediation system and observe that, "appraisal provides a structured opportunity to permit an honest conversation about an individual's past performance and the identification of development needs."

The authors describe the evolution and objectives of their appraiser training program, and discuss at length many details of their "learning by doing" course and its supporting materials. They report that they are well on their way to recruiting and training 900 GP assessors. In the program's first four months, more than 800 physicians had signed up as assessors and had completed the training.

21. Prins, H., et.al., "Availability and usability of data of medical practice assessment," **International Journal for Quality in Health Care, 14(2):127-137;** (2002).

This article reports on a Dutch study, the purpose of which was to determine the extent and usefulness of electronic data available to assess medical practice in caring for pediatric patients with suspected meningitis. The researchers asked two questions: 1) which performance indicators, case-mix, and exploratory information should be selected for medical practice assessment, and 2) are required data electronically available and usable for medical practice assessment?

The authors found that many data, including admission information, time-points, and severity of illness were not readily available in electronic format. They report that, "even if it were possible to select patients reliably, five of the fourteen performance indicators could not be quantified." They conclude that, "patients with suspected meningitis were not an easy group to study." Reasons for the difficulty include the challenge of establishing that the suspected diagnosis was meningitis, along with the "great variability" in the severity of illness.

22. Hays, R.B., et.al., "Is insight important? Measuring capacity to change performance," **Medical Education 2002; 36:965-971**.

This article explores the nature of insight and its relationship to professional performance. The authors conclude that some individuals may lack insight to such an extent that they are beyond remediation. They suggest that testing for adequate levels of insight could be a cost-effective way to determine how to focus remediation efforts.

The authors explore what it means to have the "capacity to change." They maintain that it implies insight into personal strengths and weaknesses and the presence of motivation to improve one's performance. They go on to discuss the need to measure capacity to change in terms of remaining current with developments in practice, and in terms of remediation efforts. The authors offer three methods to measure a doctor's capacity to change, along with the advice that ideally such measures "would provide comparative data from both the individual doctor and others who interact with that doctor.

IV. State-of-the-Art: Remediation

As in the previous section, a literature search was conducted using the National Library of Medicine's database and other sources to develop a bibliography of articles dealing with focused remedial education for practicing nurses and practicing physicians. In this case, more articles exist, but they are not as recent, and most are descriptive rather than scientific. Many articles deal with characteristics of physicians and nurses who needed focused education rather than the effect of the education on the providers. Few articles describe monitoring providers for any length of time.

The most recent and pertinent articles were selected for summary here.

CAC supports the consistent use of remediation and monitoring in the PreP 4 Patient Safety program, and suggests the following:

1. Remedial education programs in clinical areas are not widely available or inexpensive, especially for physicians, so the use of more local resources is encouraged and national resource centers are urged to address this issue.
2. Monitoring in a planned, objective, measurable way is an essential component of remediation.
3. Both the remedial education and the monitoring should address weaknesses discovered in the assessment.

Overview

23. Mark, S., et.al., "Reentry Into Clinical Practice," **JAMA, 288(9):1091-1096;** (2002).

This article discusses the challenge presented to the medical education community by physicians and other health care providers who leave—and later reenter—clinical practice. The authors describe the roots of the issue. These include providers—both women and men—who suspend their clinical activity 1) to assume child-rearing responsibilities, 2) to care for an ill relative or to tend to their own illness, 3) to leave the stress of a dissatisfying or unfulfilling career, and 4) to pursue other professional interests.

The authors describe several programs designed to smooth the reentry of nurses and physicians into clinical practice. They go on to list and discuss nine recommendations of the National Task Force on Reentry into Clinical Practice for Health Professionals. These recommendations include, for example, a call to conduct a national needs assessment; to create a national director of reentry programs, and to make reentry programs mandatory after a certain time away from practice. The authors conclude that "reentry poses a challenge for women and men; thus, these initiatives are intended to 'humanize, not feminize,' the profession."

24. Agresta, R., "QIP Comes of Age: An Update on Ohio's Quality Intervention Program," **Federation Bulletin, 86(2): 81-84** (1999).

This article reports on the development of the State Medical Board of Ohio's Quality Intervention Program (QIP), the goal of which is "to correct poor practice habits before the need for disciplinary action arises." The author describes the program's evolution, including the reasons that underlie recent changes in panel composition. These panels consult with the medical board by assessing physician practice, and determining if an identified substandard practice can be corrected through re-education.

The author discusses, in turn, the results of QIP review, the use of remedial education programs, the characteristics of QIP participants, and program outcomes. Of note, the author reports that the average age of physicians referred by QIP for educational intervention is 51, with an age range from 36 to 78. The author states further that all indicators point to QIP's success in preventing "today's poor practice habits from becoming tomorrow's disciplinary action statistics." He reports that only one physician, among 69 referred for remedial education, has been the subject of another complaint filed with the State board.

25. Andrew, D., et.al., "Regulation of Physicians: The Monitoring Maze," **Federation Bulletin; 86(1): 13-19;** (1999).

This article identifies and examines various components of the disciplinary system that monitors the practice of individual physicians. They dub this multi-faceted and complex system "the monitoring maze." The authors interviewed fourteen experts who represent different organizations involved in physician monitoring. They draw on these interviews to detail the workings of a system that includes an initial screen in which someone decides if a case will enter a disciplinary arena, and three "disciplinary arenas" that include professional peer review, the judicial arena and the mandatory regulatory arena.

The authors describe the several parties—including law enforcement officials and other health professionals—who compose the "initial screen." They go on to examine the strengths and weaknesses of the three disciplinary arenas. While the authors observe that the "three arenas appear to work reasonably well according to their individual purposes," they caution that "cavalier and purposeful avoidance of the system is a matter of serious concern, as is the ineffective enforcement of statutory requirements for inter-arena correspondence." They offer several other suggestions for improving the work of the "monitoring maze."

What Impacts the Results of Remediation?

26. Turnbull, J. et.al., "Cognitive Difficulty in Physicians," **Academic Medicine, 75(2): 177-181;** (2000).

This article discusses an effort to determine if physicians who have serious problems with competence also have neuropsychological impairments that would explain their problems and their inability to improve with remedial education. The authors describe how twenty-seven participants in a Canadian competence assessment program called PREP all received a neuropsychological test battery that assessed cognition and mood within the context of the broader assessment.

The researchers found that seven of the physicians who performed poorly on the competency assessment also had moderate to severe cognitive difficulties. A "mood disturbance" was identified in three of the twenty-seven. Thus, the authors found that a third of those with competency problems also had neuropsychological impairments sufficient to explain their poor performances. They note that the difficulties "were more marked in elderly physicians." The authors assert that these results are important for two main reasons: 1) the benefit of identifying and treating unrecognized conditions that affect cognitive function, and consequently competence, and 2) the benefit of preventing futile educational interventions to restore competence. They conclude that, "a strong case can be made for including neuropsychological screening in all intensive physician-assessment programs." (See Hanna's related article, at number 27, below.)

27. Hanna, E., et.al., "Results of Remedial Continuing Medical Education in Dyscompetent Physicians," **Academic Medicine, 75(2):174-176** (2000).

This article reports on a study that looked at the results of an intensive, long-term, continuing medical education program for five physicians with serious incompetencies that Ontario's PREP assessment program had identified. The five physicians—ranging in age from 50 to 72 years—agreed to participate in a three-year CME program that comprised individualized review, small group and evidenced-based discussions, simulated patients and role-playing, chart review and peer review. After the remedial CME program, the five physicians were re-assessed. The authors found that one physician's PREP rating improved, while two remained the same and two declined.

Based on these findings (and admitting the limitations of a small study sample), the authors conclude that most severely incompetent physicians do not improve with intensive CME, or at least where the remedial education uses the learning methods involved in this study. While the authors raise the possibility that the physicians' incompetence arose from age-related cognitive decline or organic conditions, they caution that, "age alone is not the defining variable, as other elderly physicians perform well in practice and at PREP." They conclude that it is essential for us to better understand the basis of physician incompetence, to develop better methods of educating incompetent physicians and to better predict the success or failure of remedial education for them. (See Turnbull's related article, at number 26, above.)

28. Davis, D., et.al., "Impact of Formal Continuing Medical Education: Do Conferences, Workshops, Rounds, and Other Traditional Continuing Education Activities Change Physician Behavior or Health Care Outcomes?" **JAMA, 282(9): 867-874;** (1999).

This article addresses the question, "Do formal continuing medical education (CME) programs work?" The authors reviewed the relevant medical education literature, spanning the period from 1993 to January 1999. They note that although physicians report devoting many hours to CME in the course of a year, there is little evidence to indicate that traditional CME courses contribute to the improvement of practice or to favorable patient outcomes.

The authors conclude that traditional CME activities, such as lectures, failed in changing performance or improving patient care. They found, in contrast, that interactive techniques like case discussions, role-playing, and hands-on practice sessions were more effective in changing performance and health outcomes. These results are consistent, the authors observe, with "learner-centered" adult education theory. The authors conclude by raising and discussing the question, "Why would the medical profession persist in delivering" what is, essentially, an ineffective CME product?

Specific Programs

29. Swiggart, Wm., et.al., "Continuing Medical Education Courses on Proper Prescribing of Controlled Substances in the United States," **Federation Bulletin; 86 (1): 20-28** (1999).

This article reports on the authors' effort to locate and produce a list of Continuing Medical Education (CME) courses that deal specifically with the topic of prescribing controlled substances in a proper manner. The authors surveyed forty-nine medical licensing boards, asking them to identify their CME and other educational options for physicians who misprescribe controlled substances, but who are not impaired or criminally motivated.

Based on forty responses, the authors identified seven, regularly scheduled, programs to which licensing boards refer physicians. They list and describe the programs, including information about course topics, length, cost and contact numbers. The authors note that while the courses are offered in seven different States, all but one are located in the eastern half of the country. The authors also describe in less detail six additional educational experiences (that did not meet certain criteria for regular scheduling, length, etc.) available in three other States.

30. Dobson, D., et.al., "Remediation Versus Discipline in Oregon," **Federation Bulletin; 81(1): 14-18,** (1994).

The authors describe the work of the Oregon Board of Medical Examiners (OBME) and the Oregon Foundation for Medical Excellence to address the problems of substance abuse and inappropriate prescribing of controlled substances. They report that an OBME review of data on discipline in 1983 revealed that approximately one third of sanctioned physicians had been accused of inappropriately prescribing controlled substances. Another third had been involved in personal substance abuse.

The authors describe how a Diversion Program for those involved in substance abuse, coupled with a remedial rather than a disciplinary approach to improper prescribing, have transformed OBME's investigative and disciplinary statistics. Investigations for substance abuse, for example, fell to 3.13 percent of the total in 1993 from 35 percent of the total in 1983. The authors also discuss their effort to evaluate their program's effectiveness. They report on the responses of 102 physicians, who attended a two-day remediation workshop, to a follow-up questionnaire. They found, for example, that more than one-fourth of the respondents had made significant changes in the way they prescribe narcotics to suspected drug addicts.

31. Vilensky, Wm., "Remedial Education in Prescribing Controlled Dangerous Substances," **Federation Bulletin; 82(2): 94-97,** (2002).

This article describes a fifty-hour, "mini-residency," course offered in New Jersey on proper prescribing of controlled dangerous substances. The author offers information on the gender, profession and State of residence of 375 program participants. The overwhelming majority of program participants were male physicians. Thirty States and one Canadian province were represented among the participants.

The author details the course's twelve main objectives. He describes the faculty and its expertise in relevant fields, and the efforts of course organizers to sensitize them "to the psychological aspects of working with this special group of student professionals." The author describes the evaluative aspects of the course, including a pre-test to identify weaknesses in knowledge, and post-course exam. He notes that a "major value" of the test results is to identify, and communicate, deficits in the core curriculum in professional schools.

32. d'Oronozio, J., "The ProBE Program: Remedial Education in Professional and Problem-Based Ethics," **Federation Bulletin, 83(3): 143-148** (1996).

This article describes a program, developed in response to a New Jersey State Board of Medical Examiners request, to address the need for professional ethics remediation. The author observes that nearly all infractions for which practitioners are sanctioned by licensing boards, involve "unethical conduct at some level." The author observes that those in need of ethics remediation

usually find only standard college courses on philosophical theory, or courses in bioethics that deal with decision-making in critical care cases. These are not appropriate for remediation. From this gap in resources grew the author's "professional and problem-based ethics" (hence the name ProBE) educational intervention.

The author describes the rationale and goals behind the ProBE seminar. It is offered three times a year in New Jersey, over a weekend. It is an "intensive, 18-hour retreat." The author discusses the four learning methods—including lecture, case study and reflection—employed in the seminar. He also details its seven modules that include such titles as "The Physician and Public Accountability," and "The Commercial Aspects of Medical Practice." At the end of the course, each participant is required to write a final essay that connects the ProBE intervention with his or her particular violation. The licensing board gets a copy of the essay, along with commentary from seminar faculty, for its review and action.

V. Resources Summary

Nationally Known Resources[1] (listed alphabetically by program name.)

Albany Medical College

Resource Affiliation	Medical School
Name	UpState New York Clinical Competency Center at Albany Medical College
Address	Albany Medical College 47 New Scotland Avenue, MC-34
City, State, Zip	Albany, NY 12208
Years in Existence	
Contact Person(s)	Henry Pohl, M.D.
Phone	518-262-5919
E-Mail	
Web Site	
Services Provided	2.5-day assessment which evaluates clinical skills and identifies strengths and weaknesses, and recommendations in areas identified as in need of improvement
User List[2] (Boards)	State Medical/Osteopathic Boards of: NY
User List (Others)	

Appropriate Prescribing of Controlled Substances

Resource Affiliation	School of Pharmacy Mercer University Southern
Name	Center for Substance Abuse Education and Research
Address	3001 Mercer University Drive
City, State, Zip	Atlanta, GA 30341
Years in Existence	
Contact Person(s)	
Phone	404-986-3174
E-Mail	
Web Site	
Services Provided	Week-long course conducted on Mercer University campus in Atlanta, offered twice per year. Targeted to practitioners interested in upgrading clinical skills for substances associated with a high abuse potential;

[1] From information provided by the Federation of State Medical Boards of the United States, Inc., the Ohio State Medical Board or the National Council of State Boards of Nursing, Inc.
[2] User lists of boards and others are reported by the assessment or remediation program, not the State boards or other organizations.

	involved in the treatment of substance abuse; at risk of being targeted by drug-seeking abusers; seeking licensure reinStatement.
User List (Boards)	
User List (Others)	

Appropriate Prescribing Workshop

Resource Affiliation	Medical Board Oregon Board of Medical Examiners
Name	Appropriate Prescribing Workshop
Address	
City, State, Zip	
Years in Existence	
Contact Person(s)	**See Appendix B**
Phone	
E-Mail	
Web Site	
Services Provided	Proper prescribing practices.
User List (Boards)	
User List (Others)	

Biomedical Ethics

Resource Affiliation	Medical School NEOUCOM (Northeast Ohio Universities College of Medicine)
Name	Human Values in Medicine Program
Address	4209 State Route 44 PO Box 95
City, State, Zip	Rootstown, OH 44272
Years in Existence	
Contact Person(s)	Martin Kohn, Ph.D.
Phone	330-325-2511
E-Mail	
Web Site	
Services Provided	Increased awareness of the ethical dimension of patient care. Develops abilities and confidence in analyzing complex bioethical dilemmas and expands awareness of personal and professional values.
User List	

(Boards)	
User List (Others)	

CARES

Resource Affiliation	Medical School
Name	University of Florida Comprehensive Assessment, Remediation and Education Services (CARES)
Address	
City, State, Zip	
Years in Existence	
Contact Person(s)	
Phone	
E-Mail	
Web Site	
Services Provided	UF developed an assessment center for physicians and other medical professionals providing personalized, specialty-specific educational service for physicians. This program utilizes the training facilities and faculty expertise of the University of Florida College of Medicine to provide a detailed assessment of the physician's medical practice skills. If any problems or deficiencies are noted, detailed recommendations for remediation are developed.
User List (Boards)	
User List (Others)	

Clinical, Legal & Ethical Issues in Prescribing Controlled Drugs

Resource Affiliation	Medical School University of South Florida College of Medicine
Name	Office of Continuing Medical Education
Address	
City, State, Zip	Tampa, FL
Years in Existence	
Contact Person(s)	
Phone	800-852-5362
E-Mail	
Web Site	www.cme.hsc.usf.edu
Services	This program is specifically designed for physicians but is open to all

Provided	health professionals. Course includes basic pharmacokinetic principles, basic pharmacology of different classes of drugs, assessing the need for the different classes of drugs and managing acute and chronic pain, and mood disorders, laws and policies, record keeping and enforcement, and problem avoidance.
User List (Boards)	
User List (Others)	

CPEP

Resource Affiliation	Not-for-Profit Private Corporation
Name	Center for Personalized Education for Physicians (CPEP)
Address	14001 E. Iliff #206
City, State, Zip	Aurora, CO 80014
Years in Existence	13
Contact Person(s)	Beth Korinek (Executive Director)
Phone	303-750-7150
E-Mail	Cpep@cpepdoc.org
Web Site	www.cpepdoc.org
Services Provided	Physician, Physician Assistant, Podiatrist Assessment Also offers **Documentation Course/Medical Record-keeping**
User List (Boards)	State Medical/Osteopathic Boards of: 40 States and 3 Canadian Provinces
User List (Others)	Multiple hospital medical staff and peer review committees Group practices Medical malpractice and disability insurers Health Care Lawyers Self-referrals Residency Programs

Ethics Across the Medical Professions

Resource Affiliation	College Cuyahoga Community College
Name	Ethics Across the Medical Professions
Address	2900 Community College Avenue Science and Technology 126
City, State, Zip	Cleveland, OH 44115
Years in Existence	
Contact Person(s)	Donna F. Homenko, PhD

Phone	216-987-4410
E-Mail	Donna.homenko@tri-c.cc.oh.us or smiledfh@aol.com
Web Site	
Services Provided	2.5 hour segments for a total of 10 hours (additional casework can be included). Includes definition of ethics, constructs of professional ethics, physician-patient relationships (understanding and applying the basic principals of autonomy, benificence/non-maleficence, confidentiality, fidelity, justice, veracity), application and accountability.
User List (Boards)	
User List (Others)	

Ethical Fitness Seminar

Resource Affiliation	Private Corporation The Institute for Global Ethics
Name	Ethical Fitness Seminar
Address	PO Box 563
City, State, Zip	Camden, ME 04843
Years in Existence	
Contact Person(s)	
Phone	207-236-6658
E-Mail	Ethics@globalethics.org
Web Site	www.globalethics.org
Services Provided	Course outline includes moral awareness, values definition, ethical analysis and dilemma resolution
User List (Boards)	
User List (Others)	

Intensive Course in Controlled Substance Management

Resource Affiliation	Medical School Case Western Reserve University College of Medicine
Name	An intensive course in controlled substance management
Address	Office of Continuing Medical Education
City, State, Zip	Cleveland, OH
Years in Existence	
Contact Person(s)	Ted Parran, MD
Phone	216-368-2409 or 800-274-8263
E-Mail	
Web Site	

Services Provided	Course duration is 3.5 days and course is offered twice per year. Objectives include learning pharmacologic profiles, understanding diagnostic criteria for substance abuse, anxiety disorder, chronic and acute pain, insomnia and depression, interviewing techniques relating to substance management, management of substance abuse and prescription drug abuse, beliefs and stereotypes, and their treatment implications.
User List (Boards)	
User List (Others)	

IPE

Resource Affiliation	Not-for-Profit Private Corporation National Board of Medical Examiners and Federation of State Medical Boards
Name	Institute for Physician Evaluation (IPE)
Address	
City, State, Zip	Philadelphia, PA Dallas, TX
Years in Existence	1
Contact Person(s)	Tom Henzel
Phone	888-348-0928
E-Mail	Ipe@nbme.org
Web Site	Ipe.nbme.org
Services Provided	Comprehensive assessments (in current or intended areas of practice) and identification of areas of practice that require educational intervention. Assesses medical knowledge, clinical reasoning and case management skills, and recommendations regarding remedial education
User List (Boards)	
User List (Others)	

Medical Ethics for Physicians

Resource Affiliation	Not-for-Profit Corporation California Medical Association
Name	Institute for Medical Quality
Address	PO Box 7690
City, State, Zip	San Francisco, CA 94120-7690
Years in Existence	
Contact Person(s)	Leslie Iacopi, Program Administrator
Phone	415-882-5151

E-Mail	liacopi@imq.org
Web Site	www.imq.org/imqdoc.cfm/6
Services Provided	This is a seminar that teaches physicians what ethical issues are and how they arise in the context of one's professional work. The program is sponsored by the California Medical Association (CMA) in cooperation with the Medical Board of California. The program is scheduled on Saturdays.
User List (Boards)	The Medical Board of California
User List (Others)	

Medical Record-keeping

Resource Affiliation	Medical School Case Western Reserve University College of Medicine
Name	An Intensive Course in medical Record Keeping with individual preceptorships
Address	Office of Continuing Medical Education
City, State, Zip	Cleveland, OH
Years in Existence	
Contact Person(s)	Ted Parran, MD
Phone	216-368-2409 or 800-274-8263
E-Mail	
Web Site	
Services Provided	Two-day course with two additional opportunities to receive feedback on charts submitted, one at three months and one at six months.
User List (Boards)	
User List (Others)	

Mini-Residency in the Proper Prescribing of Controlled Substances

Resource Affiliation	Medical Board New Jersey Board of Medical Examiners
Name	Mini-Residency in the Proper Prescribing of Controlled Substances
Address	
City, State, Zip	
Years in Existence	
Contact Person(s)	**See Appendix B**
Phone	
E-Mail	
Web Site	

Services Provided	Proper prescribing practices.
User List (Boards)	
User List (Others)	

PACE

Resource Affiliation	Medical School
Name	University of California at San Diego Physician Assessment and Clinical Education (PACE) Program
Address	UCSD Medical Center 200 W. Arbor Drive
City, State, Zip	San Diego, CA 92103-8204
Years in Existence	6
Contact Person(s)	Betsy White Williams, Ph.D., M.P.H.
Phone	619-543-7495
E-Mail	bwilliams@ucsd.edu
Web Site	www.paceprogram.ucsd.edu
Services Provided	Comprehensive assessment and on-site, medical school/residency level clinical remediation for all specialties, and follow-up in-practice monitoring. Also offer: **Prescribing course, communication, focused education in specific clinical areas, and medical record-keeping.**
User List (Boards)	State Medical/Osteopathic Boards of: CA, AZ, CA(o)
User List (Others)	Hospital Medical Executive Committees, Well-being Committees, Attorneys

PBDS

Resource Affiliation	Dorothy Del Bueno, Ed.D., R.N. Performance Management Services, Inc., a consulting firm
Name	Performance Based Development System
Address	13522 Newport Avenue Suite 200
City, State, Zip	Tustin, CA 92780-3707
Years in Existence	
Contact Person(s)	Elliott Saulten
Phone	714 731-3414
E-Mail	elliot@pmsi-pbds.com

Web Site	http://www.pmsi-pbds.com/
Services Provided	Valid and reliable assessment of nursing staff in the following areas: critical thinking skills, clinical judgment, problem solving, customer relations, teamwork
User List (Boards)	
User List (Others)	Hospitals

PEER

Resource Affiliation	Medical Association
Name	Oregon Medical Association Physician Evaluation, Education and Renewal (PEER) Program
Address	5210 SW Corbett
City, State, Zip	Portland, OR 97201
Years in Existence	7
Contact Person(s)	Roy Skoglund, M.D. (Medical Director)
Phone	503-672-3224
E-Mail	Rskoglund@ormedassoc.org
Web Site	www.ormedassoc.org
Services Provided	Assessment Remediation/Education Re-assessment/Follow-up
User List (Boards)	State Medical/Osteopathic Board of: OR
User List (Others)	Hospitals Third-party Payers (IPA's and Insurance Plans) Government Payers (welfare)

The Prescribing and Use of Controlled Substances

Resource Affiliation	University of Kentucky College of Pharmacy
Name	The Prescribing and Use of Controlled Substances
Address	Mini-Residency Program College of Pharmacy
City, State, Zip	
Years in Existence	
Contact Person(s)	
Phone	606-257-3170
E-Mail	

Web Site	
Services Provided	Four-day course offered twice per year. Program designed to educate health care professionals who are DEA registrants in the proper prescribing/dispensing and appropriate use of controlled substances and psychoactive drugs.
User List (Boards)	
User List (Others)	

Prescribing Controlled Drugs, Critical issues and Common Pitfalls

Resource Affiliation	Medical School Vanderbilt University Medical Center
Name	Center for Professional Health
Address	1107 Oxford House
City, State, Zip	Nashville, TN 37232-4300
Years in Existence	6
Contact Person(s)	Anderson Spickard, Jr., M.D
Phone	615-936-0678
E-Mail	
Web Site	www.mc.vanderbilt.edu/root/vumc.php?site=cph&doc=479
Services Provided	This three day course includes components examining professional practices, increased self-awareness, management of difficult patient problems, appropriate physician boundaries, new skills in substance abuse identification and prescribing practice and development of a plan for changing ideas, skills, attitudes and behaviors that have contributed to misprescribing.
User List (Boards)	
User List (Others)	

PRIM-E

Resource Affiliation	Medical School The University of Medicine and Dentistry of New Jersey
Name	Professional Renewal in Medicine [through] Ethics
Address	
City, State, Zip	NJ
Years in Existence	
Contact Person(s)	
Phone	
E-Mail	
Web Site	www2.umdnj.edu/ethicweb/PRIMEreview.html

Services Provided	Ethics seminar for individuals who have been threatened with licensing actions.
User List (Boards)	
User List (Others)	

ProBE

Resource Affiliation	Private Corporation The Ethics Group, LLC
Name	Professional/Problem Based Ethics
Address	89 Summit Avenue -- Suite 185
City, State, Zip	Summit, New Jersey 07901
Years in Existence	
Contact Person(s)	Joseph d'Oronzio Ph.D., MPH
Phone	908-522-8740
E-Mail	Director@EthicsGroup.org
Web Site	www.ethicsgroup.org/index.html
Services Provided	The ProBE program is the original educational intervention in ethics for health care practitioners who are under discipline by their licensing boards or other oversight agencies. Although originally designed for physicians, the range of professional ethics it addresses is applicable to all health care professionals. Participants have included practitioners from dentistry, nursing, podiatry, chiropractic and physicians assistants.
User List (Boards)	36 Boards provide CE credit in Ethics for the ProBE program
User List (Others)	

Professional Ethics

Resource Affiliation	Xavier University Graduate Program in Health Services Administration
Name	Professional Ethics
Address	3800 Victory Parkway
City, State, Zip	Cincinatti, OH 45207
Years in Existence	
Contact Person(s)	
Phone	513-745-3392
E-Mail	
Web Site	
Services Provided	Individualized study program. Outline includes introduction, obligations of professionals to clients, truth-telling in professional relationships, obligations to

	third parties, obligations to employers and profession, lying to peers and subordinates.
User List (Boards)	
User List (Others)	

The Program for Professionals

Resource Affiliation	Case Western Reserve University Center for Marital and Sexual Health Inc.
Name	The Program for Professionals
Address	3 Commerce Park Square, Suite 350
City, State, Zip	Beachwood, OH 44122-5402
Years in Existence	
Contact Person(s)	Stephen Levine MD
Phone	216-831-2900
E-Mail	
Web Site	
Services Provided	Understanding the ethical principals and how they function to regulate the practice of medicine, and recognizing the gray zone in boundary violations and the undebatable boundary violations…appreciate the usual deliberations of medical ethicists and why sexual contact is not one of them, among other information. Program designed to meet the needs of individual clients.
User List (Boards)	
User List (Others)	

The Proper Prescribing of Controlled and Dangerous Substances Seminar

Resource Affiliation	Medical School Kennedy Memorial Hospital, University of New Jersey Medical Center
Name	The Proper Prescribing of Controlled and Dangerous Substances Seminar
Address	Forensic Education Consultants
City, State, Zip	NJ
Years in Existence	
Contact Person(s)	William Vilensky, DO
Phone	800-973-0590
E-Mail	
Web Site	
Services Provided	Continuing medical education course for health providers whose licenses are subject to sanction for injudiciously prescribing controlled dangerous substances. Includes laws, pharmacology and toxicology, principles of prescribing different

	types of CDS, recognizing the warning signs of drug-seeking behavior, interviewing techniques, medical record-keeping, detection of clinical signs of patients under the influence.
User List (Boards)	
User List (Others)	

Treating Patients Right

Resource Affiliation	Medical Association
Name	Oregon Medical Association
Address	5210 SW Corbett
City, State, Zip	Portland, OR 97201
Years in Existence	7
Contact Person(s)	Roy Skoglund, M.D. (Medical Director)
Phone	503-672-3224
E-Mail	Rskoglund@ormedassoc.org
Web Site	www.ormedassoc.org
Services Provided	Continuing education program.
User List (Boards)	
User List (Others)	

University of Wisconsin Medical School

Resource Affiliation	Medical School
Name	University of Wisconsin Medical School
Address	Office of Continuing Medical Education 2715 Marshall Court
City, State, Zip	Madison, WI 53705
Years in Existence	16
Contact Person(s)	Tom Meyer MD Dick Christiansen Cathy Means
Phone	608-263-2850
E-Mail	Tcmeyer@facstaff.wisc.edu (Meyer)
Web Site	www.cme.wisc.edu
Services Provided	Assessment and Remediation of Physicians: MD Assessment within the profile of his or her practice. Primary foci are: Knowledge base; Problem solving; Communication and Counseling

	Abilities; Therapeutic abilities Remediation: design and supervision of remedial programs with emphasis of revision of basic science along with the appropriate clinical experiences
User List (Boards)	State Medical/Osteopathic Boards of: WI, WV, MI, CA, TX, ND, KY, OH
User List (Others)	

Local Resources[3] (listed alphabetically by State/geographic location)

*Note: The description of each resource is an edited or unedited version of that provided by the survey respondent who listed the resource.

Connecticut

Name of Resource	Bayer Institute for Health Care Communication
Street Address	400 Morgan Lane
City, State and Zip	West Haven, CT 06516
Description*	Dedicated to enhancing the dialogue between clinicians and patients through education, research and advocacy.
Resource Contact Person	J. Peter Maselli, M.D.
Resource Contact Phone	860-873-2235
Resource Contact E-Mail	jpmaselli@snet.net
Resource Contact Web Site	www.bayerinstitute.org
Listed by	Unidentified BOM[4]

Florida

Name of Resource	Intervention Project for Nurses
Street Address	Box 49130
City, State and Zip	Jacksonville Beach, FL 32240-9130
Description*	Does ability to practice nursing safety evaluations
Resource Contact Person	Linda Smith, Executive Director
Resource Contact Phone	800-840-2720
Resource Contact E-Mail	lsmith@ipnfl.org
Resource Contact Web Site	http://www.ipnfl.org
Listed by	Florida BON

Idaho

Name of Resource	St. Luke's Regional Medical Center
Street Address	190 E. Bannock
City, State and Zip	Boise, ID 83702
Description*	Regional hospital – with BON to do PBDS testing for individuals referred by BON
Resource Contact Person	
Resource Contact Phone	
Resource Contact E-Mail	
Resource Contact Web Site	
Listed by	Idaho BON

Minnesota

Name of Resource	Leonard Lichtblau, PhD

[3] Local resources are those resources previously unknown to PreP 4 Patient Safety, and listed by the respondent Boards. They may not be local to the Board that provided them to us. Local resources were edited to exclude resources that dealt primarily with physical, mental, or drug/alcohol impairment, boundary violations and mental health issues and "disruptive" providers.

[4] Because Administrators in Medicine did not disclose to us the identity of the individual survey respondents, we are unable to identify the source for this information.

Street Address	5712 Schaefer Road
City, State and Zip	Edina, MN 55436
Description*	Pharmacology - Independent study consisting of reading materials, discussion, and five exams.
Resource Contact Person	Leonard Lichtblau, PhD
Resource Contact Phone	612-385-3531
Resource Contact E-Mail	
Resource Contact Web Site	
Listed by	Unidentified BOM[4]

New York

Name of Resource	Physician Prescribed Education Program
Street Address	475 Irving St. Suite 200
City, State and Zip	Syracuse, NY 13210
Description*	This program is offered through the SUNY UpState Medical University.
Resource Contact Person	William Grant, Ed.D, Director
Resource Contact Phone	315-464-6982
Resource Contact E-Mail	grantw@upState.edu
Resource Contact Web Site	www.physicianevaluation.com
Listed by	Unidentified BOM[4]

Name of Resource	CHDR/Maximus
Street Address	1 Fishers Road
City, State and Zip	Pittsford, NY 14534
Description*	CHDR/Maximus is a peer review organization that evaluates substandard care cases for us and provides expert opinions as to whether the standard of care was met.
Resource Contact Person	Pat Macy, RN, JD
Resource Contact Phone	
Resource Contact E-Mail	
Resource Contact Web Site	
Listed by	Unidentified BOM[4]

North Dakota

Name of Resource	Continuing Education Network of North Dakota
Street Address	531 Airport Rd., Suite D
City, State and Zip	Bismarck, ND 58504
Description*	Self-study Refresher Course for RNs and LPNs who have been out of practice. Includes written and clinical competency assessment (by correspondence).
Resource Contact Person	Kathleen Wise, MSA, RN
Resource Contact Phone	(701) 223-7105
Resource Contact E-Mail	NDNA@prodigy.net
Resource Contact Web Site	
Listed by	New Hampshire BON

	South Carolina BON

Oregon

Name of Resource	Risk Assessment and Management Program
Street Address	5210 S.W. Corbett Ave.
City, State and Zip	Portland, OR 97201
Description*	RAMP is designed to identify and correct practice problems that may lead to malpractice lawsuits, obstacles to insurability or restrictions on licensure.
Resource Contact Person	Thomas Miller, MD
Resource Contact Phone	503-226-1555
Resource Contact E-Mail	
Resource Contact Web Site	
Listed by	Unidentified BOM[4]

South Carolina

Name of Resource:	GREENVILLE TECH
Street Address:	PO BOX 5616
City, State and Zip	**GREENVILLE, SC 29606-5616**
Description*	**LPN/RN NURSE REFRESHER COURSE ON-LINE (THEORY) LABORATORY (GREENVILLE TECH), CLINICAL (STATE HOSPITAL FACILITY)**
Resource Contact Person:	JENNIFER WALKER, RN,MSN,CNS
Resource Contact Phone	**864-250-8405**
Resource Contact E-Mail	**WALKERJCN@GVLTEC.EDU**
Resource Contact Web Site	**WWW.COLLEGE-ONLINE.COM CLICK ON THE CONTINUING EDUCATION HEALTH SCIENCE/NURSING LINK, THEN CLICK BOB761**
Listed by	South Carolina BON

South Dakota

Name of Resource:	**SOUTH DAKOTA STATE UNIV. COLLEGE OF NURSING**
Street Address:	BOX 2275
City, State and Zip:	BROOKINGS, SD 57007-0098
Description*:	LPN/RN NURSE REFRESHER COURSE ON-LINE (THEORY) CLINICAL (IN STATE HOSPITAL FACILITY)
Resource Contact Person:	GLORIA P CRAIG EDD, RN,

	COORDINATOR
Resource Contact Phone:	605-688-5745
Resource Contact E-Mail:	GLORIS_CRAIG@SDSTATE.EDU
Resource Contact Web Site:	HTTP://LEARN.SDSTATE.EDU/NURSING
Listed by	South Carolina BON

Washington

Name of Resource	**WASHINGTON STATE UNIVERSITY COLLEGE OF NURSING**
Street Address	**2917 W FORT GEORGE WRIGHT DR**
City, State and Zip	**SPOKANE WA 99224-5291**
Description*	**RN/LPN SAFE MEDICATION ADMINISTRATION COURSE, PROFESSIONAL DEVELOPMENT**
Resource Contact Person	**KATHY THISTLE**
Resource Contact Phone	**509-324-7356**
Resource Contact E-Mail	
Resource Contact Web Site	
Listed by	South Carolina BON

VI. Future Directions

The future of assessment and remediation will depend on three factors, each evidenced in this report:

1. The acceptance of assessment and remediation as principles of routine practice, rather than punitive actions by employers, colleagues or regulators. This includes increased acceptance of the use of assessment and remediation tools by boards. These tools are not at all widely used by medical or nursing boards, indicating a lack of awareness, understanding, or trust in these resources by the boards. Even though relatively few resources exist, these resources are not being used to capacity. Many boards made comments that gave the impression that they may at times skip a formal assessment and use the investigation findings to determine the focus of the education. This is not supported by the literature reviewed here, yet available resources do not provide an assessment process that is fast or inexpensive.
2. Increased ease-of-administration and ease-of-use of these tools. Many of these resources require face-to-face meetings, and often travel, for assessment and remediation. A greater use of technology might facilitate their use.
3. The ability of assessment and remediation resources to show long-term changes in the practice patterns of those who undergo them.

The findings of this report show a need for:

An assessment toolbox that is available to a range of health care providers (physicians, physician assistants, advanced-practice and licensed nurses, pharmacists, etc.) and have the following characteristics:

1. The assessment is staged so that the practitioner is not required to use a "one-size-fits-all" assessment. The stages include a basic, problem-focused assessment that can ensure that the concern which seems obvious based on the action or inaction by the practitioner is analyzed to see if other issues are discovered. If additional assessment is necessary a battery of assessment exams and interviews can take place to further pinpoint the problems and the remediation potential of the applicant. If a more complete, broader-based assessment is called for then the most comprehensive program, including clinical rounds with a teaching physician, etc., can be used.
2. **2.** Parts of the assessment can be delivered via a distance-learning model, to reduce travel costs;
3. **3.** Outcome information about the results of these assessments and remedial interventions can be tracked.

Appendix A

The following two pages is a sample nursing board survey instrument. The next three pages are a printed version of the on-line medical/osteopathic survey instrument. The remainder of this page is intentionally left blank.

Appendix B.

State Medical and Osteopathic Board Respondents

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Arizona Medical Board
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Arkansas State Medical Board
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Medical Board of California
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Osteopathic Medical Board of California
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Colorado Board of Medical Examiners

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Florida Board of Medicine
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www.ai.org/hpb

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Kansas Board of Healing Arts
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www.ksbha.org

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Augusta, ME 04333
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www.docboard.org/me-osteo

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www.ecodev.state.mo.us/pr/healarts/

Nebraska Board of Medicine and Surgery
Health and Human Services
Regulation and Licensure Credentialing Division
Vicki Bumgarner, Credentialing Coordinator
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New Mexico Board of Osteopathic Medical Examiners
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New York State Board for Professional Medical Conduct (Discipline)
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Office of Professional Medical Conduct
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North Dakota State Board of Medical Examiners
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State Medical Board of Ohio
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Oklahoma State Board of Medical Licensure and Supervision
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Pennsylvania State Board of Medicine
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Rhode Island Board of Medical Licensure and Discipline
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South Carolina Board of Medical Examiners
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.htm

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