LETTERS

An Old Photograph Promotes the Certification of Graduates by Examination
To the editor: An old photograph of a young CRNA administering a mask anesthetic appears on the cover of the December 2014 AANA Journal. I believe the photograph was designed to promote the certifying of graduate nurse anesthetists by examination. A basic historical analysis explains why this might be so.1,2,3

An American Association of Nurse Anesthetists membership pin can be seen just beneath the nurse anesthetist's left lapel. (It’s like the one in the upper right corner of the cover of this Journal.) A membership pin indicated that the nurse anesthetist had passed the AANA’s certification examination.

The nurse anesthetist in the photograph was not identified, even though she is its ostensible subject. I believe she was a new graduate, because she looks young and appears a little anxious. The pin, which she probably earned very recently, is the real subject of the photograph. The pin was evidence of her accomplishment. And the photo was designed to promote certification when certification of graduates was a new reality.

The AANA pioneered the certification of graduates by examination beginning in 1933. In 1945 the first examination was administered. Certification was delayed by World War II and by numerous unsuccessful attempts by the AANA to gain support from other professional associations. The photograph in question is undated but I bet it was made just after 1945.

Passage of the examination entitled nurse anesthetists to use the initials MAANA, (Member of the AANA). The initials CRNA were adopted in 1956. No one knows how many uncertified nurses practiced anesthesia historically. But today, for a nurse to practice anesthesia without such certification is unheard of.

REFERENCES

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DISCLOSURE
The author has no conflict of interest or financial involvement in the subject material.

NBCRNA Response to Zambricki et al Guest Editorial
To the editor: This letter is in response to the guest editorial by Zambricki, Horowitz, Blumenreich, and Fallacaro.1 We appreciate the opportunity to reflect on the editorial in order to address a number of general misrepresentations and specific misinterpretations of the Continued Professional Certification (CPC) Program. We also desire to move the dialogue toward embracing much needed change in the 40-year-old recertification program for nurse anesthetists.

The process for examining and revising the current recertification program began in 2008. The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) employed an extensive and thorough 6-year process to arrive at the new CPC Program requirements. The process involved an extensive review of the literature, evaluation of current nurse anesthesia practice, examination of the credentialing practices of other medical and non-medical organizations, engaging a variety of stakeholders through surveys and at state and national workshops, and multiple revisions of the program based on that stakeholder input.

The depth, breadth, and details of this process can be examined by all nurse anesthetists by accessing the Evolution and Development of the CPC Program 2008-2014 report posted on the NBCRNA website (www.NBCRNA.com/CPC).2

Stakeholder Involvement in the Process
In their February 2015 editorial, Zambricki et al1 called for a national dialogue on recertification of nurse anesthetists. In point of fact, there has already been considerable national dialogue on the continued certification process. The evidence and chronology of this dialogue is available to all at the NBCRNA website (www.NBCRNA.com/CPC).

The NBCRNA sought input and involvement in the initial development of the CPC Program from multiple invested stakeholders and to this day continues to seek stakeholder input. Indeed, an AANA/NBCRNA taskforce is currently evaluating potential enhancements to the existing process. This input
has resulted in numerous revisions to the program. Stakeholder engagement has included nurse anesthetists, the American Association of Nurse Anesthetists (AANA), the Council on Accreditation (COA), NBCRNA’s accrediting bodies [Accreditation Board for Specialty Nursing Certification (ABSNCE) and National Commission for Certifying Agencies (NCCA)], continuing education vendors, and the public. Input from each of these groups was considered as the CPC Program was developed and revised. Stakeholder input will continue to be an important part of the process as the program is implemented.

Since 2008, the NBCRNA has conducted a benchmarking study and practice analysis; formed working committees and subcommittees composed predominately of practicing CRNAs, including direct appointees by the AANA Board of Directors; developed an evidenced-based proposed program; and used stakeholder participation and input to operationalize the program. NBCRNA has also sought input from the AANA Continuing Education (CE) committee. With input from this committee and the multiple other stakeholders, the NBCRNA has responded with five iterations of changes to the CPC Program. There have been multiple presentations at state and national meetings, webinars, and email communications. As evidence of the extent of the outreach to, and participation of, the community of interest, we note there have been over 22,000 interactions and exchanges with stakeholders since 2010.

Consideration of the opinions and expectations of a credentialing body’s primary stakeholder, the general public, was of the utmost importance when designing a revision of the current nurse anesthesia recertification program. A Citizen Advocacy Center (CAC) and the American Association of Retired Persons (AARP) public opinion poll in 2007 found that 90% of the respondents believed it was important for healthcare providers to be periodically re-evaluated, 84% believed healthcare professionals should be evaluated based on their qualifications (certification and recertification), and 78% believed healthcare professionals should be required to pass a written test of knowledge at least every 5 years.3 In addition, a Harris Interactive Poll conducted in 2013 jointly by the CAC and the NBCRNA found that 74% of those surveyed believed that healthcare providers should not be excused from lifelong learning regardless of years of practice and 85% believe it is important that healthcare professionals have an independent body of health professionals evaluate their skills/knowledge to certify them as competent.4

It is clear that the public desires a rigorous program that includes lifelong learning and periodic assessment. The CPC Program addresses the concerns of the public. The rigor of the previously cited surveys, one of which was conducted by a well-established and respected polling organization, is in stark contrast to the polls referenced by Zambricki et al,1 which were unscientific in design and relied on the limited business databases of the continuing education providers. Most strikingly, none of the continuing education providers who generated these polls chose to query the public, the stakeholders who have the greatest vested interest in the process by which nurse anesthetists are certified and recertified, and one reason why the NBCRNA Board of Directors includes a public member.

Continued Certification and the Concept of Competence

The National Commission of Certifying Agencies, an accreditor of the NBCRNA, defines competence as “the ability to perform a task, function, or role up to a set of prescribed standards” and continuing competence as demonstrating “specified levels of knowledge, skills, or abilities not only at the time of initial certification but also throughout an individual’s professional career.”5 Using these criteria, continued competence is admittedly best-judged by the outcomes associated with patient care achieved through the appropriate application of current knowledge, skills, and abilities. Indeed, a number of studies have provided evidence that nurse anesthetists deliver excellent patient care, as demonstrated by their history of exceptional clinical outcomes. However, a long and laudable record of exceptional patient care will not protect our profession from having to demonstrate our future commitment to mastering the evidence-based knowledge necessary to continue that standard of care in a rapidly evolving healthcare environment.

A 2015 Institute of Medicine (IOM) report on the future directions of credentialing research in nursing notes that: “If researchers could identify the pathways or specific nursing practices by which credentialing leads to better outcomes, then credentialing organizations would know how to design their programs to optimize outcomes through evidence-based pathways.”6 However, in regard to the current unavailability of methods to achieve this goal they suggest: “It may no longer be necessary to establish that a credentialing program itself causes better outcomes. Instead, certifying bodies could design their programs to promote adherence to evidence-based processes, leading to better outcomes.”6

The CPC program does not directly measure competence, nor does it claim to do so. It does, however, afford a method for affirming continued professional certification in nurse anesthesia practice by requiring timely, multidimensional, iterative, assessed, evidence-based
knowledge and as such provides surrogate evidence of competence. This evidence is and should be from a variety of sources. Ira Gunn, CRNA, MLN, FAAN, recognized that assessing competence required several components and that likely no single component would suffice. The determination of competence can likely only be made by direct observation of the clinician in actual practice, which is not a reasonable process for any credentialing organization. However, what that credentialing organization can do is objectively measure a specific component of competence, such as knowledge. In this regard, credentialing organizations such as the NBCRNA are partners with hospital and institutional credentialing departments, which require objective observations of clinical skills and abilities associated with competence through such mechanisms as peer and record review. This partnership is an affirmation of the need for a multi-faceted approach to providing evidence of competence.

In 2001, the Institute of Medicine’s Crossing the Quality Chasm report emphasized the need for the periodic demonstration by healthcare providers of the necessary skills, knowledge, and judgment to practice in an ever-changing healthcare system. The use of a multimodal approach for continued certification is precisely what the CPC Program accomplishes. The program requires nurse anesthesia practice, assessed continuing education, core educational modules (voluntary for the first 4 year cycle), professional development activities, and a periodic examination. All of these components work together in a multimodal approach to provide evidence for validating continued professional certification in nurse anesthesia. In an era in which metrics used to measure quality of care and the educational requirements to practice and seek reimbursement seem to be ever increasing, having a continued certification program that is robust and multimodal is essential.

Zambricki et al1 state their belief that “there are no data to support the premise that activities such as a mandatory recertification examinations or a required ‘one-size-fits-all’ study modules will increase patient safety or reduce morbidity and mortality.” This belief is contrary to both common sense and empirical evidence and the statement undermines the general credibility of the nurse anesthesia credential. In the worst case scenario, the lack of evidence of the effectiveness of core modules and periodic examinations to improve patient safety does not mean there is evidence of noeffectiveness. That being said, several healthcare related studies have shown a positive relationship between testing and quality of care delivered. Tamblyn et al9 found that certification examination scores for primary care physicians were associated with improved preventative care and acute and chronic disease management. Wengofer et al10 examined the relationship between physicians’ scores on licensing examinations and practice, and found that lower scores on the examination were significantly correlated with future problems with the quality of care delivered by the providers.

There is evidence as well that the preparation for examinations and other learning activities increases both the knowledge of the learner and their perception of the quality of care they deliver. Westanno et al11 found that 91% of pharmacists who took the Board Certified Pharmacotherapy Certification exam felt that preparation for the exam helped them gain knowledge and improved the care they delivered. While none of these studies were specific to nurse anesthesia, it is a gross inaccuracy to suggest that there is no evidence that examinations, core educational modules, and other assessments and activities do not add to improving the delivery of quality healthcare, especially in an ever-changing and complex healthcare system.

With regard to the one-size-fits-all commentary by Zambricki et al, the CPC Class B requirements encourage and recognize self-directed learning as well as provide flexibility for certificants to address individual learning needs as defined by Malcolm Knowles’ Six Principles of Adult Learning. The CPC Program is not a “one-size-fits-all” program. It is instead a multimodal, dynamic, iterative program providing a range of evidence for continued professional certification for nurse anesthetists.

Problems with the Zambricki et al Program Design
Zambricki et al1 have proposed a series of alternatives to the CPC Program, all of which include a 10-year certification cycle. A careful review of the Accreditation Board for Specialty Nursing Certification (ABSNC), an accreditor of the NBCRNA, Standard 13 would have eliminated this alternative, as this standard requires that recertification should be time-limited and no longer than 5 years. In addition, Criteria XIII of the Advanced Practice Registered Nurse (APRN) Consensus Model requires maintenance of certification at least every 5 years. Lastly, Zambricki et al1 propose assessed continuing education, directed continuing education, an examination, and a practice requirement as potential components for a recertification program. It should be noted that each of these components is included in the existing CPC Program.

Final Thoughts
We again are grateful for the opportunity to respond to the editorial by Zambricki et al. We have attempted in our response to offer facts and our perspective on the timeline, process, product, stakeholder involvement, and need for development of the CPC Program. We have also addressed the relationship between
continued certification and competency as it relates to the program. While we acknowledge that the authors of the Zambricki et al1 editorial are representative of the depth and breadth of the nurse anesthesia profession, we submit that the more than 50 nurse anesthetists who have been directly and intimately involved in the 6-year process of developing and revising the CPC Program, who are themselves accomplished and respected academicians, administrators, and practitioners and who will also be impacted by its implementation, are a better and broader representation of the depth and breadth of the profession and have a greater collective expertise.

We have clearly acknowledged that the CPC Program can improve with the input of nurse anesthetists, as evidenced by the substantive revisions that have been made as a product of stakeholder input. We are committed to continue to seek input as the components are implemented. However, the CPC Program is the product of your nurse anesthesia colleagues’ concerted effort and judgment in responding to rapid and ongoing changes within the healthcare system, as well as public concerns regarding assessment of healthcare provider quality. We are confident that the CPC Program designed by the NBCRNA with input from many stakeholders will further enhance the outstanding value of the CRNA credential going into the future.

REFERENCES

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DISCLOSURES
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