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INFECTION CONTROL

EDITORIAL

Certification for Infection Control Practitioners: The Time Is Now

As advances in medical care and technology extend our lifespan beyond that of any prior civilization, dramatic changes are occurring in the pattern of health care delivery. Included in these changes is a rapid acceleration in the utilization of biomedical knowledge and technology, which has spawned an increasingly larger number of allied health professions and personnel. The recent growth of Infection Control as a profession and organizations such as the Association for Practitioners in Infection Control (APIC) illustrate this trend. As a consequence of such rapid growth, health manpower issues have become increasingly important.

Increased federal funding for the development of health care personnel reflects a national consensus concerning the importance of education, training and full utilization of the nation's manpower resources. Understandably, the American taxpayer wants an equitable return of this public investment. Credentialing* of health care personnel has experienced a sharp increase in the last quarter of a century, due mainly to specialization in both established and new professions. In the past, health care issues such as licensure and certification were thought to be the concern of only the professional individuals and organizations that were affected by them. Today there is general agreement and intense concern by the public, federal government, and national health organizations as well as professional organizations that the public should be protected from incompetent practitioners acting under the guise of competence, and that to assure competence some appropriate measures of qualification should be applied. Health care delivery is too dynamic, too important to consumers, for health professionals to be utterly unregulated. Federal government interest in credentialing stems primarily from the large sums spent for health manpower training and for services reimbursed under federal health insurance programs. The Department of Health and Human Services, the Public Health Service, the Department of Justice and Labor, the Federal Trade Commission, and the Equal Employment Opportunity Commission have all made statements in this regard. This interest is reflected in a recent publication by the Department of Health and Human Services entitled *Perspectives on Health Occupational Credentialing*, in which it is stated: "It may be anticipated that certification will be of increasing importance as a criterion for the payment of health professionals under federal health care financing programs."[1] A recent and portentous example is the Rural Health Clinic Services Act of 1978, which establishes certification of nurse practitioners and physician assistants as one measure of eligibility for reimbursement under this program.[2]

Although certification of health care personnel seems to be of increasing future importance, especially for new professions, the quality and diversity of various certification mechanisms has not gone unnoticed.

In 1971, in accordance with the requirements of Public Law 91-519, subsection 799A, the secretary of Health, Education and Welfare submitted to Congress a report identifying the major problems associated with licensure, certification and other qualifications for practice or employment of health personnel.[3] Some of the major problems identified with certification of health manpower were that, while some occupations had no formal certification mechanism at all, others had two or more certification organizations vying for members within the same occupation and for recognition by public bodies. Certification policies and procedures also varied greatly among these organizations. While some certification agencies

*CREDENTIALING: *The formal recognition of professional or technical competence. "Credentialing" is a generic term referring to the processes of certification and licensure.*

CERTIFICATION: The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

LICENSURE: The process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

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required specific educational, examination, and practice qualifications, others granted certification merely upon payment of a membership fee. Furthermore, many of the certification requirements were diluted because of liberal "grandfather clauses" that exempted members already in practice.

In response to the 1971 report and subsequent followup report in 1973, many professional organizations, states, and the federal government initiated a number of critical studies and demonstrations in the field of health manpower licensure and certification.[4] Of particular importance were the HEW studies of the feasibility of a "national certification system"[5,6] whose functions would include:

1. Developing and continually evaluating criteria and policies for the purpose of recognizing certification organizations and monitoring their adherence to these criteria;
2. Participating in the development of national standards for certifying agencies; and
3. Providing consultation and technical assistance to certification organizations.

Support by the private sector for a voluntary nongovernmental national system of certification was manifested in a conference in August 1976 under the aegis of the American Society of Allied Health Professions, in which representatives of more than 70 organizations adopted a series of recommendations relating to the establishment of a nation certification system.

In 1977, through federal support and endorsement by certifying and professional organizations, the National Commission for Health Certifying Agencies (NCHCA) was developed. The stated purposes of the commission are "to establish national standards for certifying bodies that attest to the competency of individuals who participate in the health care delivery system; to grant recognition to certifying bodies that voluntarily apply and meet the established standards; and to monitor the adherence to these standards by the certifying bodies which it has recognized." This is in essence a commission that certifies certifying bodies that meet the commission's standards. The commission is the first attempt to standardize the certification mechanism on a national scale, and is endorsed by the federal government, American Hospital Association and other national and professional organizations.

It would seem prudent for any new certifying agency to develop its certification mechanism within the context of the NCHCA guidelines, so that eventual membership would enhance professional recognition. These guidelines and standards have been reviewed in depth by the Association for Practitioners in Infection Control Certification Committee and Board of Directors. In addition, formal lines of communication have been established between the NCHCA and APIC's Certification Committee to keep abreast of new developments.

Relationship Between Certification and Licensure

Despite these somewhat divergent regulatory thrusts, certification and licensure continue to evolve in parallel fashion, and a considerable amount of overlap is apparent. Licensing bodies—state agencies or boards—sometimes rely on certifying agencies for demonstration of the competence of individuals and selective incorporation of certification requirements and procedures into licensing statutes and regulations in common. This is especially true where the appropriate certifying agency is national in scope and requires completion of an established and relevant core curriculum.[7,8,9] This could have considerable future impact should a state develop or require licensure for practice of infection control.

Certification Eligibility Requirements

Requirements for certification generally include not only completion of formal education or training but, in most instances, an applicant must obtain a stated amount of work experience or have completed an internship or practicum in the relevant discipline or specialty. These requirements of demonstrated clinical experience represent widespread certifying agency acceptance of the notion that academic or didactic education prerequisites by themselves are insufficient to assume a practitioner's proficiency.

Since certification may be based on minimal competency, excellence in practice, superior performance, proficiency, and peer recognition, the degree of education and experience required are dependent on the agency's specific usage of the term. For example, APIC has proposed eligibility requirements geared at an entry level or minimum knowledge of pre-set standards,[10] whereas other associations, such as the American Nurses Association, define certification at an advanced or specialty level.[11] Thus, a clinical specialist in Medical-Surgical Nursing or Psychiatric and Mental Health Nursing would require a master's degree for certification.

In some cases certifying agencies appear flexible in their requirements and permit applicants to substitute greater amounts of work experience or successful completion of training programs for degree requirements. This is usually a function of the Certification Board of the agency, which may review applicants individually and may have the ability to waive certain educational requirements based on the applicant's previous experience or training.

Continuing Competence or Recertification

Continuing competence is an area of increasing attention and controversy. The current trend in most credentialing projects is to develop a method to assure both initial and continued competence in the chosen profession. This changes a once in a lifetime check of

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competence to a periodic one. In context of the rapidly changing technology of the health field, this concept seems particularly relevant. Most certification programs have relied on continuing education to assure continued competence. This method has received some substantial criticism since it is often unvalidated and of questionable relevance.[12] The NCHCA requires some process of recertification, which may take the form of continuing education, reexamination (which many specialty boards have adopted)[12], peer review (i.e., PSRO), self assessment techniques, supervisory assessment (i.e., practice audits and patient management problems) or performance tests. Methodologies for assessing competence, particularly clinical competence, need further research and development, but it can be anticipated that continuing education as it exists today will be superseded by a more valid process in the future.

Advantages of Certification

The potential advantages of certification are many, but primarily it will serve as a well-needed educational forum. Currently APIC's Education subcommittee on certification has begun the task of compacting the essentials of the accumulated body of knowledge referred to as "Infection Control" into a standard core curriculum. Once made available, this core curriculum, possibly coupled with a practicum for new practitioners, will provide a basic educational foundation and help standarize the practice of Infection Control, especially in those areas known to be efficacious. Although currently we have entitled ourselves Infection Control practitioner, Infection Control coordinator, clinician, or nurse, Hospital Epidemiologist, Nurse Epidemiologist or Epidemiologist, we must consider the diversity of answers to the questions: How did we obtain such titles? And what special training did we receive? This is especially evident in a profession of individuals from multidisciplinary backgrounds. Certification will help unify and define the knowledge and function of the Infection Control professional. In addition, it will aid in elevating the stature and status of Infection Control professionals in both the academic and professional worlds. An association with a valid certification mechanism that was recognized by the national health associations and regulatory agencies would potentially increase its legislative lobbying power and possibly make it more attractive for research funding activities. Certification, for many professions, has elevated their internal status in an institution, provided a basis for salary structure and advancement, and allowed for more effective roles in decision making.

Since it appears correct to assume that the advances made in health care and medical technology will continue at a rapid rate, it is also correct to assume that without prevention the complications and diseases produced by such advances will increase almost proportionately. Among these diseases produced by medical progress, institutionally acquired infections will remain a prominent concern. There now exists a sufficient quantity of knowledge concerning the detection, prevention and control of these infections to require development of a new profession with the primary task of learning and subsequently translating this knowledge into working practice. One may anticipate increased demands on Infection Control professionals to demonstrate their competence in applying such knowledge.

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