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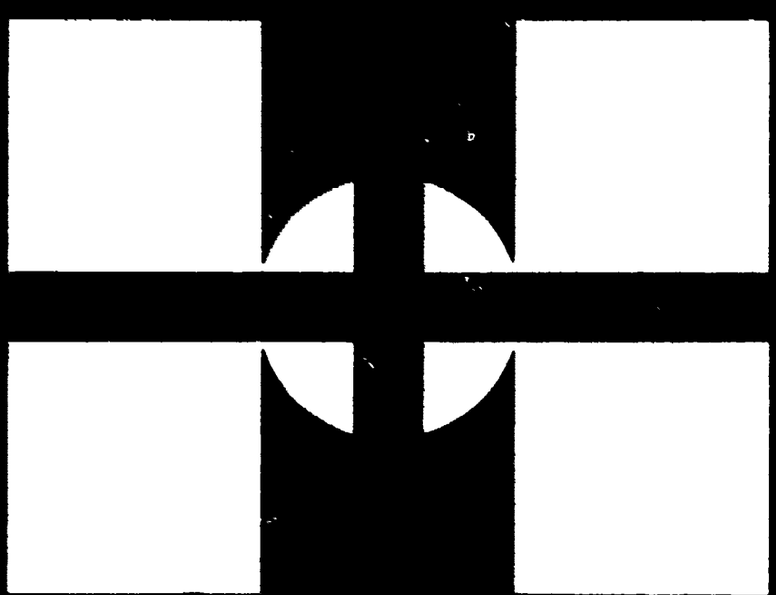
ABSTRACT

The Ohio allied health manpower invitational conference was the initial step of a Federally sponsored project to develop and utilize allied health manpower in Ohio, especially the delivery of health care services. Conference participants included college/university educators, administrators of State health agencies, State/Federal governmental representatives, and health care delivery facility representatives. Communication was an integral part of the conference theme. The keynote address was delivered by Dr. J. Warren Perry, State University of New York--Buffalo, who focused on needs, strategies, and a discussion of the team approach. Eight groups of conference participants addressed their thinking to major discussion topics: transference of academic credits, cooperative planning for program approval and accreditation, personnel credentialling, cooperative planning for continuing education, developing innovative programs, recognition of life experience through proficiency skill and academic equivalency tests, a health manpower information bank, and clinical affiliations. Each group made recommendations pertaining to their topic. The report also includes participant reaction questionnaire summary information and minutes of conference evaluation meetings. Half of the document consists of appendixes pertaining to the conference program, conference participants, questionnaire forms and compilation, annual meeting minutes, an article on licensure-certification-accreditation trends, and a summary of changes in Ohio health education programs. (EA)

INVITATIONAL CONFERENCE

COMMUNICATION COOPERATION AND COORDINATION

In Allied Health Manpower Preparation And Utilization



May 6-7, 1974
Ramada Inn North
Columbus, Ohio

Health Careers Of Ohio

COMMUNICATION, COOPERATION AND COORDINATION

IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION

INVITATIONAL CONFERENCE.....May 6-7, 1974

Health Careers of Ohio

Columbus, Ohio

The research and performance of work upon which this publication is based, was pursuant to Contract No. NO1-AH-44073 awarded to Health Careers of Ohio by the Bureau of Health Resources Development, Public Health Service, Department of Health, Education, and Welfare. The findings and conclusions do not necessarily represent the views of the supporting Governmental Agency.

ACKNOWLEDGMENT

The "Communication, Cooperation and Coordination in Allied Health Manpower Preparation and Utilization" Invitational Conference project was undertaken as the first step in the development of an outline methodology and action plan which will affect the preparation and utilization of allied health manpower in the state; especially as it will relate to the delivery of health care services. The concentration in this first phase was "Communication".

The Board of Health Careers of Ohio, with Donald E. Bender as its President, sanctioned the project. It named the Ad Hoc Committee for the 1973 survey as the Steering Committee with Frances E. Williamson continuing to chair the committee. The Steering Committee functioned as a Sub-Committee of the Program Operations Committee chaired by Jeanne L. Burson, Ph.D.

Funds were provided by the Division of Associated Health Professions, BHRD, HRA, DHEW with voluntary contributions of time and effort from Steering Committee members.

Most gratefully acknowledged is the guidance and assistance of Frances E. Williamson, Chairman of the Steering Committee, who with her co-workers contributed endless hours of work, support and valuable consultation.

Deep thanks are extended to the moderators and recorders who guided the work groups at the conference.

Most appreciated is the enthusiasm and diligence of the participants without whom this conference would not have been successful.

Monica V. Brown
Project Director
May, 1974

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SCOPE OF WORK C.C.C. INVITATIONAL CONFERENCE CONTRACT - NO1-AH-44073 - MAY, 1974

DIVISION OF ASSOCIATED HEALTH PROFESSIONS

ARTICLE I. Scope of Work

A. The Contractor shall supply facilities, materials, personnel and other required support to develop an outline methodology and action plan for Statewide articulation and coordination of Allied Health educational programs. In order to accomplish this the Contractor shall:

1. Plan and conduct a 2 day conference in May, 1974, of formal presentation and workshops for approximately 125 participants. The agenda for the conference will include but not be limited to the topics stated in A.2. below.

   a. The Contractor shall provide the planning and agenda requisite to the conduct of the conference. The agenda shall be reviewed and approved by the Project Officer.

   b. The conference participants are to be selected with the approval of the Project Officer and will include:

      (1) Members of the faculty and administration of State and non-State universities, community and technical colleges.

      (2) High-level representatives from State health agencies.

      (3) Representatives from both State and Federal Government.

      (4) Representatives from health care delivery facilities (hospitals, clinics, HMO).

2. As a result of the conference, the Contractor will produce a formal document of proceedings which shall present summaries of the discussions, findings and recommendations based on the following topics:

   a. Outline of methodology for coordination and articulation required for the master planning of health manpower education. It should include both horizontal and vertical articulation among education and health care institutions which would permit a more rapid and effective educational response to the evolving changes in the nature and delivery of health-related services. Alternative mechanisms should be delineated and should include provisions for those with military medical training and experience and others whose knowledge and training have been acquired through other than traditional means.

b. Action plan for implementation of methodology and alternatives in sufficient detail so that each could be carried out by a coordinating body.

c. Identification of individual campus administrative organizations for the coordination of the Health-Related curricula, including the various clinical affiliations;

d. Inter and intra systemic organizations, including the interface [illegible]icies, which presently exist for the support of [illegible]alth-related education programs;

e. Identification of Task Force areas, and the scope of membership for each Task Force, which will be needed for programmatic decision-making in Health Manpower Education;

f. Establishment of requirements for continuing communication with licensing, certifying, and accreditation agencies for the purpose of planning Health Manpower Education.

g. Plan for acquiring data needed for planning relative to manpower needs, employment opportunities, existent student education and training spaces etc.

3. The Contractor shall complete within six (6) weeks after the conference adjournment, a draft of the conference proceedings in accordance with the specifications of paragraph A.2 above. The Contractor shall submit the draft to the Project Officer for approval. Upon receipt of approval, the Contractor shall finalize the document and provide one copy to each participant and five copies to the Project Officer within ten (10) weeks after conference adjournment.

4. The Contractor shall design and conduct an evaluation of the conference which will take the form of a response questionnaire to all participants and which shall be conducted at the conclusion of the conference.

5. The Contractor shall convene the Steering Committee after completion of the conference to study the findings, recommendations and evaluation response. Five copies of the committee analysis shall be provided to the Project Officer.

ARTICLE I. Scope of Work - continued

B. In connection with and as a part of the work and services to be performed hereunder, the Contractor shall furnish to the Project Officer, the following:

1. Four (4) copies of the preliminary draft of the conference proceedings, as indicated in A.3., above, six (6) weeks after conference adjournment, for the approval of the Project Officer.

2. Five (5) copies of the final Proceedings Document, ten (10) weeks after conference adjournment.

3. Five (5) copies of the Steering Committee Analysis document ten (10) weeks after conference adjournment.

4. A final report, eighteen (18) weeks after conference adjournment summarizing accomplishments, problems, solutions to problems, suggestions, personnel utilization and summary of expenditures upon contract completion. This report should provide a basis for a thorough understanding of what was done and how it was done.

BACKGROUND

In August, 1973, the survey, "Communication, Cooperation and Coordination in Allied Health Manpower Preparation and Utilization" was undertaken by an Ad Hoc Committee of Health Careers of Ohio in an effort to identify common concerns as they affected the preparation and utilization of health manpower in the State of Ohio; especially as they related to the delivery of health care services.

The need for action had been previously discussed on many occasions. In April, 1973, Health Careers of Ohio named Robert J. Atwell, M.D., Ronald L. Harper, Ph.D., Sylvia C. Upp, Frances E. Williamson and Monica V. Brown to study the Ohio background on this subject.

An Ad Hoc Committee, which later became the Steering Committee for the Invitational Conference, chaired by Frances E. Williamson, was formed and met June 7, 1973 at which time the following were identified:

I. SOME MAJOR ITEMS OF CONCERN AND NEED

1. Resolving of problems involved with the employability of high school graduates from health related vocational programs.

2. Establishment of Statewide communication, cooperation and coordination with and between the health professional, technical and occupational education and training programs in the State of Ohio at all levels.

3. The provision of qualified employable graduates.

4. Introduction of dialogue within and between, educational areas, employers and all concerned with health service delivery.

5. The need for central, accurate, immediately available information on health manpower education and data pertaining thereto, on an ongoing basis.

6. The need for introduction of cooperative efforts which would result in ongoing coordination between general educational and allied health educational institutions and programs.

7. Need for common nomenclature.

8. Transference of credits within institutions.

9. Identification of health manpower needs based on tasks - what they are; where located.

10. The need for identification and provision of continuing education programs. Proliferation and new undergraduate health professional and occupational educational programs.

11. The need for examination of all aspects of credentialling; legislative, professional and institutional.

12. Introduction and availability of academic equivalency and skill proficiency tests.

13. The need for coordination with and between those involved in health manpower educational and general planning among them being, Ohio Board of Regents; Health Careers of Ohio; State Department of Education; Ohio Office of Comprehensive Health Planning and its 11 areawide agencies; Ohio Environmental Health Association; Governor's Task Force on Health Care; Governor's Commission on Nursing; Ohio Hospital Association and its member hospitals and hospital councils.

14. Need for commitment by the Board of Regents and others.

15. Lack of funds for implementation which continues to hinder progress.

16. Identification of an organization or group to assure prime responsibility for the task at hand.

II. POSSIBILITIES FOR INITIAL IMPLEMENTATION

1. A general conference to include all components; namely education at all levels, health professional personnel, health planners, health personnel employers, voluntary and official health agencies.

2. Separate and/or joint meetings of the associate and higher degree programs in allied health convened by the Ohio Board of Regents.

3. Separate meetings of those involved in vocational education.

4. Separate meetings of employers with clinical instructors.

5. Separate meetings of educators in programs outside of technical colleges and universities.

6. Joint and/or separate meetings of those in medicine, osteopathic medicine, dentistry, veterinary medicine, pharmacy, nursing, podiatry, optometry and their allied personnel.

7. One statewide conference to include 'mini conferences' which would report back to the total planning body. This to be followed by regional and/or local conferences.

8. Mini conferences of individual organizations each of which would elect one (1) representative to speak in their behalf on a major planning body.

An instrument was devised and representative individuals were contacted in August, 1973.

SUMMARY OF SURVEY FINDINGS

Of the 300 people contacted, 171 (57%) responded. Since the survey was designed for informational purposes only, no statistical analysis was performed.

Responses were received from comprehensive health planning agencies, educational organizations, state, county and city governments, voluntary and official health agencies, volunteers, health professional associations, health insurance, hospitals, individuals, technical institutes/colleges, universities and branch or regional campuses along with some others. The respondents represented all levels of educational instruction taught, as well as employers, planners and consumers. Also represented were a diversity of professional qualifications and/or classifications. The majority indicated a need for assessment of factors of interest and/or concern which affect health professional, technical and occupational education and/or training in regard to transference of academic credits. It was also evident that cooperative and coordinative efforts in educational offerings need to be expanded. Further, the majority indicated definite needs for assessment of factors of interest and/or concern as they affect planning and employment.

The Ad Hoc Committee was encouraged at the interest in meeting with others to share concerns and the willingness of the respondents to participate in meetings and conferences. Also expressed was willingness to assist in the planning and evaluation of any such conferences. Of the choices presented, the largest number of respondents indicated preference for one state-wide conference which would include "mini conferences" and would involve educators, employers, health personnel, planners and consumers which would report back to a state-wide planning body. This to be followed by regional and/or local conferences.

On Thursday, September 20, 1973, the Ad Hoc Committee reviewed the findings of the questionnaire. The desire and the need for coordinated leadership in allied health in Ohio was evident. The consensus of the Ad Hoc Committee was to work toward planning a state-wide conference as suggested by the survey respondents. This was presented to the Board of Trustees of Health Careers of Ohio who named the Ad Hoc Committee, the Steering Committee for an invitational conference.

COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION - Invitational Conference

In January, 1974, the Steering Committee set the dates of May 6 and May 7, 1974 for an invitational conference. It was decided that the focus would be "Allied Health Manpower" and that the conference would stress "Communication" in the first phase.

Invitations were mailed to the survey respondents in late January, 1974 advising them that the conference would have to be self-supporting unless federal funding, for which application would be made, was forthcoming. Meanwhile, the Steering Committee continued to meet and finalize plans.

On April 18, 1974, the Division of Associated Health Professions, Bureau of Health Resources Development, Health Resources Administration, DHEW accepted the proposal and awarded the contract. The conference registrants were notified accordingly.

The conference report and findings follow.

SUMMARY OF CONFERENCE PROCEEDINGS - RECOMMENDATIONS

That there be established, a coordinating body, (umbrella organization) for allied health manpower in the State of Ohio which would address the concerns stated in Article I, A.2 of the Scope of Work of the Contract. This would be achieved through an interdisciplinary approach.

The body would be a new organization provided one presently existing would be unable to assume the function. It would be jointly sponsored and staffed by the Office of Comprehensive Health Planning, Ohio Department of Health and the Ohio Board of Regents with input from other concerned groups. Alternatively it could be Health Careers of Ohio which has the necessary components. However, in order that Health Careers of Ohio be an effective coordinating mechanism, it would need full commitment and financial support from the Ohio Department of Health, the Board of Regents, State Department of Education, independent agencies and organizations, health professional organizations, technical institutes, colleges, universities and employer groups.

The coordinating body would appoint ad hoc action committees, (task forces) to address themselves to the specific recommendations of the conference, the primary ones being:

1. Development of statewide guidelines for proficiency skill and academic equivalency tests.

2. Implementation of a study on formal education versus life experience, knowledge and skill acquisition.

3. Definition of the quality of formally educated versus non-formally educated health personnel. (example the military medical person)

4. A cooperative partnership between government and professional organizations, employing agencies, health professional individuals and educational institutions that would include establishment of compatible guidelines for continuing education including setting of standards and methods of financing.

5. Implementation of a study to determine the extent of, desire for, plus the ability and number of students wishing to transfer credits.

6. Analysis of all formal allied health professional and occupational education programs in the State, no matter in what setting (public, state, private, hospital, etc.) they are taught. This should be done prior to development or implementation of any additional allied health programs in Ohio.

7. Determination of the possibility of innovative solutions to problems in allied health manpower training and formal education using interdisciplinary approaches.

8. Implementation of a study to evaluate the current practice of health manpower planning in Ohio which would identify prospective participants and users of a data bank. This could lead to the determination of whether or not there is a need for a data bank and if specific common nomenclature for Ohio is required.

9. In clinical affiliations, to have educational institutions work cooperatively with clinical affiliations to plan and implement an orientation program for clinical areas.

   Development of a model affiliation agreement that would be universally applied or applied as the situation(s) directed.

10. Determination of statewide allied health manpower demands and needs in relation to overall community health and health care service goals; development of a statewide allied health manpower plan.

    Allocation of state resources to implement the plan; development of a mechanism for periodic evaluation of the effects.

11. Coordination of State licensing boards through the Ohio Department of Health.

12. Implementing a study by areawide health agencies to determine the number and quality of educational services from local public and private educational institutions to educational programs in hospitals and other health facilities.

SUMMARY OF EVALUATION PROCEEDINGS - RECOMMENDATIONS

Two evaluation sessions to which the Steering Committee, moderators and recorders were invited, were held on May 16th and June 5th, 1974.

At the first session, the reaction questionnaires, summary and group reports from the conference were thoroughly reviewed and discussed.

There was consensus that the manner in which Ohio would use the findings of the conference, the steps which should be taken and the publics to be involved were matters that needed definition; in addition to the full report of the proceedings for the Federal Government. It was also evident that the group reports properly expressed the opinions of the participants.

The second session reiterated the consensus from the first. Reaffirmed was the need for a coordinating body, ("umbrella organization") to speak to and for allied health manpower in Ohio. This consensus followed the Summary of Conference Proceedings and Recommendations. Existing agencies were again discussed and considered among them were the Ohio Board of Regents, the State Department of Education, professional organizations, a state chapter to be organized of the American Society of Allied Health Professions, the Ohio Hospital Association, foundations and Health Careers of Ohio. The viability of Health Careers of Ohio was a factor of concern. This matter will be brought before its board meeting on June 27, 1974. If the Ohio Department of Health linkage system for the State has the contract approved, it could provide the means for implementation of an action committee for allied health manpower.

It was the consensus of those present that there be an Action Committee For Allied Health Manpower Preparation And Utilization In Ohio. Among the functions of an allied health manpower action committee would and/or could be coordinating, advising, catalyzing and regulating aspects.

1. Control of Regulations. Serving as a resource to the present controlling agencies rather than as a regulatory body within itself.

2. Planning in various phases including credentialling, educating and provision of services.

3. Gathering and disseminating Information.

4. Acting as a Resource agency to allied health professionals, governmental bodies, state legislature, educational institutions and other agencies.

5. Implementing Studies in response to expressed needs in allied health.

6. Coordinating relationships with and between various organizations, educational institutions, individuals and government as they affect preparation and utilization of allied health manpower in the delivery of health services. This would help prevent duplication and enhance cooperation.

Some other functions that could be addressed, although the primary responsibility may rest with other organizations, include:

1. Determining professional standards, including interstate mobility of health professionals.

2. Developing proficiency tests.

3. Transferring academic credits.

4. Coordinating clinical affiliations.

It was further agreed that a letter would be sent to the members of the Steering Committee and the moderators and recorders from the conference soliciting their willingness to be nominated for election to an allied health manpower action committee. The names of those interested will be placed on a slate which will then be voted upon by all of the conference participants.

INTRODUCTION

The conference opened on Monday, May 6, 1974. Frances E. Williamson, who chaired the Steering Committee presided and welcomed all present. She introduced the moderators and recorders and thanked the Steering Committee for their work. Ms. Williamson expressed appreciation to Dr. Bourgeois who responded in behalf of the Federal Government. Ms. Williamson re-emphasized the importance of the task ahead.

Mr. Bender, President of Health Careers of Ohio extended greetings and welcomed the participants. He commended all those present for being willing to take the "giant step" forward, begin to work on the problems and seek the answers which will surely result in even more effective health service delivery for Ohio citizens.

Health Careers of Ohio
Columbus, Ohio

KEYNOTE ADDRESS

INVITATIONAL CONFERENCE - "COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION. May 6, 1974.

J. Warren Perry, Ph.D.

Dean, School of Health Related Professions
State University of New York at Buffalo.

Director, Study of Allied Health Education
American Association of Junior and
Community Colleges.

Dr. Perry, in his opening remarks stated that it was a privilege to be at this conference in Ohio. He was impressed with the briefing session and the direction given by Frances E. Williamson, who chaired the Steering Committee and those who worked with her.

Dr Perry pointed out that only Ohio could provide its own workable plan and that this was an excellent beginning. The heterogeneous composition of the participants was an indication of involvement for the good of overall health care in Ohio. This was the first time Dr. Perry had been with a group which represented so many different aspects of health. He stated, "That's what makes it so unusual. In so many places and in so many settings, there is always a big piece of the pie missing in terms of those who should be present and working together."

Dr. Perry alluded to the forthcoming new health legislation and the responsibility which must be accepted and discharged by regions, states, counties and cities if the best results were to be derived under the new decentralization edicts.

Dr. Perry continued that, whether we like it or not, the one element we can be certain of in the health field, and one about which we all know, is change. Change to what and by what means none of us really knows today. It would help if we knew the manpower needed. We are faced with the demand for plans without knowing the tasks to be performed. It is therefore imperative that we communicate, cooperate and coordinate fully. If we are going to do this job together, we must trust each other. We must work together for the common good. This is much more important than the vested interests of any one of us.

We should envision these times as ones of renaissance and rebirth. Our health programs are being reborn with the emphasis on primary health care delivery. Not only have we heard mandates from the American Medical Association and the American Association of Medical Colleges and others indicating its importance, but there is indeed a great need existing throughout our nation for personnel to deliver primary health care.

Included in this primary care, is consumer health education for those who are well, emergency health services and primary care in rural areas and in the inner city. If we look at the situation, we will find in the examination of our educational programs, that we all talked a good line on primary health care, but did not implement too much, especially in the clinical experience of students. Those of you who are educators, think of your own programs and you will know this to be a fact. There are exceptions however such as The Robert Wood Johnson Foundation, (which funds the SAHE project), and the Kellogg Foundation, which, with other foundations are funding significant projects and programs in primary care both in this country and overseas.

At no time in modern history has there been a greater need for coordination between all elements of the health care system in the United States. I still see it as a system, although many people speak of a non-system. However, if you have ever tried to the best of your ability to change that 'non-system', you will find quite a strong system working! The geographical maldistribution of available health manpower resources, increasing physician and other health professional specialization, the under-utilization of nurses and allied health personnel, the inefficient organization of services; all of these have been cited as key contributory factors in the malfunctioning of the primary health care system. In some cases, it has literally taken state mandates to develop and/or to redevelop departments of family practice in medical schools. It has also taken threats of withdrawal of funds in some instances to ensure graduates with experience in general practice.

Medicine is not the only area where specialization exists. Our educational curriculum until a few years ago was in almost direct conflict with the needs of society. It developed like the dachshund who grew so long that he hand't any notion how long it took to notify his tail of his emotion. While his eyes were filled with woe and sadness, his little tail went wagging on because of previous gladness! That unrealistic gap between what we have today and what is really needed, is only now becoming a part of the potential for change. However, the 'tail' in many of our educational institutions is still wagging on merrily.

How have the health professional educational centers responded to needs? One of the major thrusts we all know, has been to increase physician manpower. I understand that in Ohio at least two additional medical schools are planned. There are those experts who believe that if we increase in magnitude with more of the same, the health crisis will be removed. I do not believe that either this works, or that creating more fields works.

The proliferation of health manpower titles today is approaching a national disaster. In the allied health fields alone, there is a listing of over two hundred titles for which educational programs at all levels have been introduced. We have a fantastic talent in this country for creating something new rather than learn how to better utilize that which we have. For example, I recently reviewed a Federal grant proposal which was to create a bachelor of science degree in "stroke technician technology". This was certainly not needed, especially when we know that a rehabilitation nurse or a physical therapist can do the entire job without having a new specialist for stroke by itself. One of the wildest proposed programs applying to the American Association of Junior and Community Colleges for credentialling was titled, "Invalid leakage technician".

We were told by the representatives from the American Medical Association from whom this had come, that a program was in operation in one medical center which was related to a new specialty in open heart surgery. Where will this stop? Until policy decisions are made, or until we in our own areas become responsible for what is being developed, it will continue.

Moratoriums have been called in terms of licensure, but educational institutions are still bent on adding new specialties. They take a piece of some of another health profession and create something new, rather than learn how to better utilize what they have. This emphasizes and re-emphasizes the need for constructive planning which will stop the proliferation of new unneccessary offerings. We must cooperate if we are ever to coordinate constructively. Many of the projects today have a, "Let's try and see" attitude, because there are no overall policies in primary care. There is no real definition of who, what, where and how things should be done.

The National Academy of Sciences is planning to study terminology. However, this may not go beyond its Institute of Medicine as the initial findings show the tremendous involvement of all health professions in primary health care. Without the involvement of all of the health professions working cooperatively together, implementation of the study and educational program development will be meaningless. At a recent American Association of Medical Colleges meeting in Washington, the present situation was demonstrated by a chart showing a large square representing one hundred per cent of health care services that should be delivered to people. In one corner was an area showing that only about two per cent of patients received their care in university hospitals where we are teaching health care delivery. This becomes significant in planning for we must add additional clinical sites in order to ensure that the graduate be able to function and respond to all areas where health care is or should be delivered.

Each one of the major discussion items you will be addressing in your groups is the key to the implementation of a comprehensive, coordinated health care program. In my opinion, one of the most important priorities that we can give in planning, is in the area of educational programming. An old term, certainly a good one is that we really need to put into practice interdisciplinary planning and interdisciplinary health professional and occupational education programs. I can almost hear you say, "Oh, here we go again with someone who thinks a team really can work!" I do. And there are many others who believe that the future will be better if the interdisciplinary approach to education is used.

One of the most encouraging recent programs I have read about and which was given practically no publicity, was one conducted by Dr. Edmund Pellegrino at the National Academy of Sciences, Institute of Medicine. The planning meeting comprised four physicians, three nurses, two dentists, two pharmacists, and they allowed one person to represent allied health! It was decided to invite one hundred and twenty health professionals with equal representation among these five fields to a conference at the Academy to examine the following:

1. Why do we need to educate teams for the delivery of health care?

2. Who should be educated for the team?

3. How should we educate health professional students to work in teams?

4. What are the requirements for educating students to practice in teams?

5. What are the obstacles?

These questions are ones you will address in your group challenges. Please remember the obstacles for they become extremely important in the initial discussion phases and assist in determining the plan you wish to implement.

The report of the conference to which I have alluded, is "Educating The Health Care Team". It is available from the National Academy of Sciences. There are plans to replicate the conference in regional meetings throughout the country. What becomes of it will depend upon the people involved. Perhaps the most important finding is that utilization of health professionals must be taught if they are to be utilized well. It does not "just happen".

Were you taught how to work with others in a clinical setting? Where were you taught? How do you introduce this into educational programming? Medicine and dentistry are implementing utilization studies. However, they must also address the curriculum itself. Nursing and allied health have a like responsibility. We must teach utilization patterns in our educational programs and coordinate the clinical efforts of our associate and baccalaureate degree programs. We must implement joint clinical projects. Some are already in operation which are exciting. Barriers between and within health professions, associations and agencies must be broken. This will happen when people learn to work together in an atmosphere of mutual respect and trust. The relationship of professions to each other must be based on the relationship of each to the systems of care, coupled with the function of each in relationship to the persons consuming the delivery of health services.

I am convinced that team work and interdisciplinary action among and between the health professions will emerge if the emphasis on our individual professionalism is under-emphasized in deference to the higher goals of the entire planning effort of the future. With this kind of team work, we will begin to understand the diversity of functions that created our individual professions and finally gain respect for that diversity.

In looking again at your program for tomorrow, the group discussions will be focusing on ways to answer the challenges. You will be making recommendations on some of the most important challenges facing the health professions and especially allied health. I compliment you again for coming to work together. Many regions and states are in the process of attempting such interaction, but it has not yet come about.

One of the most difficult factors, is to bring about the interaction needed for the health programs based upon what education can provide. At present there is no model anyone can provide you of what should be done for the future. This must come from you and from others who will react to your recommendations. The fact that you are communicating and will be looking at the issues is extremely important.

With the SAHE project, we have travelled a good deal and looked at many state plans, but none of them have been complete. Most have come either from education or from the health departments. None have combined the elements into a unified state plan. For example, in my own State of New York, health and education are in completely separate buildings and work separately in most instances.

Keynote Address
J.Warren Perry, Ph.D.

I am now pleased to share a little information on the Robert Wood Johnson Foundation project, Study of Allied Health Education, (SAHE), which is being conducted at the American Association of Junior and Community Colleges, (AAJC). This association has, during the past few years, had major grant support from the United States Office of Education, the Kellogg Foundation and the Commonwealth Foundation in their work with occupational and technical education and health programs. While they have been involved with health, must more involvement is needed which was the reason for this project.

In the total spectrum of community colleges, there are over 2,800 individual programs with a student enrollment approaching 100,000 in allied health at the associate degree level or less. There are approximately 16,150 two-year college faculty which will give you a measure of the magnitude of what has been started in the associate degree areas. This move of the Association to look at the total allied health picture in community colleges, affords guidance in the development for the future. One of the most important recommendations from our national advisory committee, which comprises outstanding leaders in colleges, universities, community colleges, state and local groups, has been to stay out of health manpower predictions and data banks. The reasons are that the Association feels it should consult studies which have already been completed and do whatever possible to communicate through them to those who can make use of said studies. Data collected should be usable and not just hidden away as a study. This has happened to many data studies of existing vacancies. Data should be built on a plan of what will be needed in the future. When you add that dimension to the prediction of what we are going to have on a federal level, the job is extremely difficult. We consulted the Bureau of Health Statistics and various other areas of the Federal government. Each had a small piece of portion, but no one had everything together in a comprehensive plan. In the SAHE project however, we are not involved with data.

One of the major areas of concern is the relationship of the total community college programs to allied health in primary health care settings. The community colleges are in a unique position because of their relationship to the communities they serve. This enables them to be involved in all areas including some exciting modes of consumer health education.

We have interviewed consumers and most are logical. We also have discovered some very interesting models of programs that have educators going from a community college to a church or other location to reach the community and any group which asks. There are programs given at night for credit which will probably never be used for a degree, but the credit means something important to someone who sought information and achieved through learning. If I had a map I could identify over 1,200 locations where innovative programming is being carried out. Some of these programs have especially real meaning in rural areas and other areas which previously have had no programs. There are some exciting models.

The study shows an urgent need for a resource center that will have as much information as is possible available to institutions at all levels with the information kept current on what is happening in allied health.

Keynote Address
J. Warren Perry, Ph.D.

The study has worked with 55 representatives from 35 health professional agencies and associations. The National Advisory Group includes some of the outstanding leaders including those from the American Society for Allied Health Professions. We have attempted to communicate with every group possible as we have moved out on the study. We have no way yet of knowing what will be the implications. We have listened to the voice of the entire country as we have travelled. We have not stopped at the issues and the problems. Neither will you. We have all been in meetings which deal only with problems and which make no attempt to find solutions. The challenges that face all of us are:

What are the recommendations for the strategies which will answer the issues facing us today?

What are the strategies themselves?

I hope in every way that the comments on communication, cooperation and future coordination of the total spectrum starts with input that will define the action needed for the future; that it will begin to answer some of your unmet needs in health in both education and practice. As you address the questions tomorrow, your actions will speak much louder than these words tonight. Each person assembled here; each and every health care person must expand his or her sphere of influence. I know the dangers of using the word, "expand", but it is vital that you do expand your own influence in terms of the planning that is going on today. I am pleading for all of us involved in planning that we must be sincere and translate that sincerity in terms of good for the health needs of society. We must plan without concern for any of our own vested interests. We must become involved. My definition of involvement is, "a dissatisfaction with the status quo of today." Be involved in progressive change!

The Italian statesman and scholar Machiavelli said, and it is relevant to our needs today, "There is nothing more difficult to take in hand, more perilous to conduct or more uncertain in its success, than to take the lead in the introduction of a new order of things". May the advice of this great sage be one of your commands tomorrow. Thinking is easy, acting is difficult. To put one's thoughts into action is one of the most difficult things in the world.

In the areas we are talking about in health planning, all one can cover in the period of time that we can spend together here are a few forksful of what is really needed. The action of the future is indeed in your hands here in Ohio. I greatly compliment the Health Careers of Ohio organization for bringing this diversified group together. Many of us will be looking and hoping fervently that you will produce some exciting answers and recommendations for the future as you communicate, start to cooperate, and, even more, perhaps coordinate something meaningful for the future. Finally, I want again to sincerely thank Health Careers of Ohio for the privilege of being here.

May 6, 1974
Columbus, Ohio

GENERAL SESSION

Presiding: Ronald L. Harper, Ph.D.

Dr. Harper outlined the three phases I. Communication, II. Cooperation, III. Coordination for the conferences, with the GOAL being "A Plan for Ohio".

The key factors were identified as follows:

1. Structure - Mechanism.
2. Identification of People. Who are the people to plan the Cooperation Phase?
3. Development of a Time Frame. The amount of time there should be between Phase I and Phase II. Too much time between the two would undo the conference action.
4. Public Relations. How can public relations be implemented for Allied Health?

Dr. Harper asked that each group make at least one key recommendation and stated that the notes from each group and the reaction sheets from each participant would be reviewed at an evaluation session being held May 16th. A copy of the final project report will be sent to each participant. Comments will be invited that will assist in implementing the next phase which will be "Cooperation".

It was emphasized that no one expected to find the answers to all the problems at this conference, but that it was a starting point toward the second phase which will be "Cooperation". Members of the Steering Committee would act as resources to the groups where needed.

The groups worked for the remainder of the conference. The recommendations, reactions and evaluations follow.

GROUP I.

TRANSFERENCE OF ACADEMIC CREDITS

Moderator: Ernest G. Huntz, Ph.D.

Recorder: Lynn Timmons

1. What is the number and percentage of students who would transfer credits?

2. What are your ideas on establishing a "review" or "coordination" committee to evaluate course content in the various programs, (associate, baccalaureate, military, vocational, technical, hospital, proprietary, etc.)

3. What are the necessary interfaces between curricula of associate degree and baccalaureate degree programs?

4. What are the specific problems and alternative ways to resolve problems in transference of credits:

   a. between individual areas within one institution

   b. between different institutions of higher learning

   c. from certificate (academically based) to higher programs

   d. between associate degree and baccalaureate degree programs

   e. from hospital based programs to degree granting institutions

   f. from military medical training to degree granting institutions and also to certification

   g. from proprietary schools to non-profit institutions

Reporter: Michael J. Leymaster

1. What is the number and percentage of students who would transfer credits?

RECOMMENDATION: There be a study to determine the extent of desire for, plus the ability and numbers of students who would wish to transfer credits before a valid recommendation be made for action.

Amount the factors raised and discussed were:

(1) How many students are concerned with career mobility via the transfer route? 2%-10%?

(2) Between what and for what are subjects for study considering transfer and utilization of credits.

(3) Would occupational counselling help an individual make a better career decision and negate much of the transfer quest.

Reporter: Michael J. Leymaster

2. Ideas on establishing a "review" or "coordination" committee

RECOMMENDATIONS:

1. There be specific allied health career advisory committees regarding manpower, education, etc.

2. There be a coordinating committee to help coordinate the work of the specific advisory committees. This could be the Board of Regents, Health Careers of Ohio or some other agency, perhaps even one that needs to be established.

Members of the advisory committees for specific areas might come from professional disciplines and others related to those disciplines which would involve the professional viewpoint and also providers and others so that consumers could also be involved.

3. Interfaces between curricula of associate degree and baccalaureate degree programs

Do not know what precisely are/would be the interfaces. Within related areas there might be identification of core areas between certificate, associate and baccalaureate degree offerings. If core were identified, mobility might be facilitated efficiently and credits transferred with ease.

4. Specific Problems and Alternate Ways to resulve problems in transference of credit

The feasability of alternative ways to resolve problems in transference of academic credits should be investigated. More academic equivalency and proficiency skill tests should be encouraged.

NO CONCLUSIVE RECOMMENDATION RESULTED ALTHOUGH THERE WAS MUCH DISCUSSION.

Some factors discussed and questions raised were:

(1) Who makes the decisions to accept the transferred credits?

(2) Role of the faculty in transference - faculty proposes but does not have the final decision.

(3) Role of admissions office.

(4) Role of department.

(5) Methods of measuring skills - transcripts, reputation of institution; competency examinations.

(6) Accuracy of catalogue course description was questioned.

(7) Establishment of a "review" or "evaluation" committee and the power of such a committee.

GROUP II.

COOPERATIVE PLANNING FOR PROGRAM APPROVAL AND ACCREDITATION

Moderator: Mary Alice Beetham

Recorder: Sister Elizabeth Ann Byrne

1. What specific statewide body should be responsible for:

   a. approving new programs?

   b. continued state accreditation of such programs?

   c. ending outmoded programs?

2. What are the appropriate interfaces in the aforementioned situations?

3. What are the appropriate mechanisms for establishing costs of proposed programs and relating this to funding available in the State of Ohio for:

   a. technical education?

   b. higher education?

   c. vocational education?

4. What is a realistic procedure for making a valid occupational analyser need in developing allied health curricula?

5. Although also the concern of group VII, some attention might be given to:

   What are the realistic mechanisms for maintenance of a current inventory of programs, curricula, entering slots, graduates of programs, placement of graduates, etc.?

   In other words, how can planning of new programs be interfaced with manpower needs?

Reporter: Sister Elizabeth Ann Byrne

RECOMMENDATIONS:

1. That the Board of Regents have a more formalized coordination with comprehensive health planners throughout the state in order to approve or encourage more allied health programs which are needed; private and independent colleges and universities should be included in addition to state supported institutions.

2. That all formal allied health programs in the state, no matter in what setting they are taught, be registered with one central state agency.

3. That an analysis be made of existing available allied health programs before any more are developed or implemented in the State of Ohio.

4. That accreditation be considered separately from the development of programs. Ours was a dual challenge; we had both program approval and accreditation which is not only a whole big ball park, but a world series in fact!

GROUP II. (Continued)

Reporter: Sister Elizabeth Ann Byrne

Following is a summary of some of the discussion:

1. With constructive planning in operation, Ohio will be prepared when National Health Insurance arrives.

2. Geographic maldistribution should be studied in any analysis and should include physicians, dentists, nurses, et al.

3. Ohio must implement and use an information data bank to institute good preventive health education for the public.

4. For justification of educational programs, there should be valid analyzed data from communities to state level and vice-versa.

5. The "A" agency of comprehensive health planning could take the responsibility and work with and through the "B" agencies (areawides).

6. The Office of Comprehensive Health Planning, Ohio Department of Health, should be the one to assist the areawide agencies in distribution of funds for educational programs throughout the state.

7. Allied health educators must be realistic with students about professional levels.

8. A central coordinating body could eliminate the communications problem among schools when plans come forth to start new programs.

9. Statistical analysis is needed.

GROUP III.

CREDENTIALLING OF PERSONNEL

Moderator: Rene C. Lachapelle, Ph.D.

Recorder: Jane H. Garvin

1. What guidelines, although not the same for each profession and occupation, should be established for the State of Ohio with regard to whose responsibility should it be to do the credentialling for each profession and occupation?

2. What is the proper mechanism for determining who shall perform what task and what education and/or training will be necessary for persons to function in specific capacities within the State of Ohio?

3. What are the alternatives to licensing?

4. What are the alternatives to certification?

5. What are your thoughts on institutional licensing?

6. Should there be credentialling of teaching personnel for allied health programs?

7. How do we acquire and maintain an updated inventory of credentialled personnel?

Reporter: Rene C. Lachapelle, Ph.D.

RECOMMENDATIONS:

1. That there be an interim Ad Hoc Advisory Council on Health Professions in Ohio. Its purpose would be to recommend policy, coordinate plans, define activities of professional organizations, assist in approving qualifications of professionals. The Council would be advisory to the legislature, professional organizations, Board of Regents, Ohio Department of Health, etc.

2. That there be uniform regulations for individual practitioners in all health professions, not necessarily through licensure, but through some type of regulation and that the requirements be delineated for each one of the health professions.

3. That there be a study of all health practitioners to define the duties of each and develop common terminology with national agreement and that there be representation of all professional organizations participanting in the conduct of said study. The Federal Government would hopefully provide the finances necessary.

GROUP IV.

COOPERATIVE PLANNING FOR CONTINUING EDUCATION*

Moderator: Jean H. Baird

Recorder: Carol A. Jenkins

1. What are and/or what should be the continuing educational requirement(s) as related to licensure, certification and registration and/or employment?

2. What are realistic mechanisms for recording continuing education participation?

3. What is the role of the employer in continuing education of allied health personnel; what should be the role of the employer?

4. Who should pay the cost of continuing education in relation to offerings, faculty and participants?

   a. government?

   b. the profession?

   c. the individual health personnel?

5. What are your thoughts on continuing education programs being composed of self-contained skill units adaptable to changing job requirements and to variations in time and money constraints for program development and maintenance?

* Discussions SHOULD include in-service education.

Reporter: Jean H. Baird

We felt we did not know enough about the 200 health professions and occupations in allied health to precisely state what were their continuing education needs.

RECOMMENDATIONS:

1. That a compilation be made of the existing 200 health careers so that the next group that comes together and/or this group when it meets again will be able to examine the statements being made by national organizations and their constituents for the individual professions and what they feel ought to be their requirements.

   There was a belief within the group that many commonalities exist between the various professions and occupations as to their requirements. However, there is a need for an 'across the board' assessment on what is required and deemed necessary.

   The group also thought it was necessary to know more about the standards being set within the employing agencies; what is the comprehensive health planning master plan and what does it say about standards of care because continuing education should relate directly to the care that people receive.

Group IV. (Continued)

Reporter: Jean H. Baird

RECOMMENDATIONS: (continued)

2. That there should be some umbrella organization that would speak for allied health. This could be Health Careers of Ohio, the Office of Comprehensive Health Planning (A agency), but it is vital there be such a body in the State. Such a body would help alleviate the fragmentation which is of great concern in regard to continuing education which presently exists at the local levels. With regional coordination working in a complementary capacity with state coordination, fragmentation may even be eliminated.

3. That continuing education needs to be a cooperative partnership of government, professional organizations, employing agencies, health professional individuals, and educational institutions to plan, set standards and finance programs.

   This type of partnership would provide a firm position. The group felt that it was not the sole domain of the state legislature but there should be an organization representing allied health which would provide a voice to be heard in the State.

   If every state would have different specifications for continuing education, this would result in 50 different mechanisms and further fragmentation.

Some of the additional factors discussed were:

(1) The need for employees to keep up-to-date.

(2) The matter of unions was discussed and questions raised as to where it would fit and would this lower the standards; would there be a danger of inhibiting persons who could otherwise be certified and so forth.

(3) There is a need for an evaluation process to measure the worth of continuing education.

(4) Fear was expressed that an umbrella organization would result in persons being controlled by other than their peers.

(5) Continuing education is the organized improvement of educational background of individuals following initial basic education and entering into the profession.

NOTE: Item (5) is the definition by which this work group functioned.

GROUP V.

DEVELOPMENT OF INNOVATIVE PROGRAMS

Moderator: Anne S. Allen

Recorder: Braxton E. Tewart

1. Who should determine the need for innovative programs in health care delivery?
2. What freedom should there be to innovate?
3. What are your thoughts on each of the following topics?
   a. establishing criteria for developing costs of innovative programs?
   b. developing a group of resources people who can assist in planning and implementing innovative programs?
   c. developing procedures for the development and implementation of innovative programs?
   d. developing necessary standards related to innovative programs?

Reporter: Anne S. Allen

The group defined innovative programs as follows:

a. a new program
b. altering a traditional program
c. interfacing various programs
d. changing existing programs
e. a specific discipline called a program

We had quite a group going which came to their conclusions with only one minute to go! There was extensive discussion on the importance of the client. Deep concerns were expressed that many of the programs seem to be proliferating in such a way that we were selling a package of goods; a new product to the consumer and were not worrying about the people receiving the health services. Everything that follows underlines the concern about the kind of health care provided to the people of Ohio. The group decided that need for innovative programs eixsted and covered the waterfront.

Some areas of discussion were health education programs for the public in general by letting the public know what to expect (mental hygiene is not a bad word); that cancer is something with which one can cope if detected early.

In desperate need of innovation is the distribution of services in Appalachia, ghetto areas and other places where there are no services.

Group V. (Continued)

Reporter: Anne S. Allen

The education of personnel in the in-service training as well as formal educational programs, needs innovation. The upgrading of personnel is required so that they are not bound into dead-end jobs. Students need innovative counseling.

The whole health continuum needs innovation and needs commitment of people in preventive care, primary care, acutecare, extended care, custodial care.. all types of care.

There was a strong consensus that the team approach is the viable and meaningful approach to all of these problems. We recognize that the concept of teams does in fact presently exist, but it does not function at the level felt necessary for innovation with better and newer approaches.

RECOMMENDATION:

That there be established, a Council of planners to include health trainers, health educators, health practitioners and providers to promote the interdisciplinary approach in both the training and the practice for the State of Ohio. (Think Tank) The modus operendi should be persuasion and ethics rather than coercion and mandate. It should develop ideas and input; it should gather information and make suggestions and should comprise representatives of health care institutions, academic units and professional organizations.

GROUP VI.

RECOGNITION OF LIFE EXPERIENCE THROUGH PROFICIENCY SKILL AND ACADEMIC EQUIVALENCY TESTS

Moderator: Christine A. Hayward

Recorder: Kenneth P. Glassford, Jr.

1. Who should develop the tests?

2. Who should administer the tests?

3. What do the results of the tests mean in terms of health care delivery?

4. Can life experiences be evaluated in terms of independent study and be recognized toward:

   a. academic credit?

   b. certification?

   c. licensure?

5. How can various programs and professions and occupations be persuaded to utilize proficiency and equivalency tests?

Reporter: Christine A. Hayward

RECOMMENDATIONS:

1. That statewide guidlines be established for standards in the development of proficiency skill and academic equivalency tests. This could possibly come from the Board of Regents through the office of the Vice Chancellor for Health Affairs when this comes into existence.

2. That there should be a cost study on the "per student" and "per patient" costs which may be reduced by utilizing life-experience people versus people educated within the formal system.

3. That there should be a competency study which would hopefully evaluate the performance of people who have been introduced through the life-experience channel and evaluate them after they have been on the job. We could possibly start with the MEDIHC program since a good base of information already exists there. We thought that probably the MEDIHC program and Health Careers of Ohio could share in this responsibility.

GROUP VII.

HEALTH MANPOWER INFORMATION BANK - DATA GATHERING - COMMON NOMENCLATURE - JOB DESCRIPTIONS

Moderator: Thomas N. Chirikos, Ph.D.

Recorder: Marilyn C. Ryan

1. Should a task force be formed to outline nomenclature for use within Ohio?
2. How can the utilization of common nomenclature be increased?
3. Should a task force be developed to outline the kind of data bank necessary and alternative proposals for implementation?
   a. what data are needed?
   b. should be required?
   c. are desired?
   d. who needs the data?
   e. who collects the data and maintains the bank?
   f. how can it be financed?

Reporter: Thomas N. Chirikos, Ph.D.

RECOMMENDATION:

That there should be an evaluative work group commissioned immediately. This would be appointed by and would operate under the auspices of this conference. Included should be representatives from agencies involved in health manpower planning, preparation and utilization. The charge to the group would be to:

A. Evaluate the current practice of health manpower planning in Ohio.

B. Lay the groundwork necessary by contacting prospective participants on users of a data bank.

C. Direct their efforts and coordinate their work with the current plans of the Ohio Department of Health in the development of a health manpower linkage system for Ohio.

D. To ensure at all times that the group coordinate activities with Ohio Department of Health.

E. Upon completion of the task, the work group could begin to design and implement a task force that would consider the question of whether Ohio needs a data bank and/or common nomenclature.

Group VII. (Continued)

Reporter: Thomas N. Chirikos, Ph.D.

Our group was asked to evaluate the need for establishing a task force which would develop common nomenclature of the particular job ittles of health personnel in the State as well as a task force designed to start a data bank for health manpower planning purposes. After considerable discussion, it was concluded that while such a need exists, it would be premature and perhaps counterproductive to establish such task forces in the immediate future, the reason being that effective planning grequently leads to the development of appropriate data sources, but the development of data sources infrequently leads to effective planning. There are all too many illustrations of data banks sitting idly around this country without effective planning and planners utilizing them. For this reason, we began to discuss what the data bank should do and what purposes it should serve. We concluded that we were after usable information, social intelligence if you will, about the current and future nature of the labor market for health manpower in Ohio. In order to accomplish that objective, it was necessary for us to view health manpower as an inextricable pool in that effort to examine the occupational needs of an occupational therapist, independent needs for physicians or any other kind of health personnel is bound for failure. We established the principal that one needs to examine health manpower in some integrated whole. We recognize that this is not being done in Ohio at the moment. Instead, in actual fact, there are a number of disjointed, non-integrated efforts to plan various components in the manpower pool and therefore as interim strategy, it would be well for us to evaluate these disjointed efforts and to assess the possibility of integrating them. There was the advantage that there was some feeling in the group that much of the data that we might like to have for planning purposes perhaps already exists; it simply is not being used to the fullest possible extent.

GROUP VIII.

CLINICAL AFFILIATIONS

Moderator: Charles B. Stearns

Recorder: Peggy K. Hull

1. What are your thoughts on affiliation needs versus benefits to the institution?

   a. academic institution?

   b. health care?

2. Should the reimbursement of cost be made on a cost benefit basis?

3. How do you assess the problems of affiliation agreements that currently exist?

4. Would a general affiliation agreement be useful to institutions in the State of Ohio?

5. If yes, who should develop the agreement?

6. Should there be a commitment by third party payment groups with regard to the support of clinical affiliations (training)?

7. Are clinical instructors the responsibility of the educational institution or the agency providing the experience?

8. What are appropriate evaluation mechanisms or procedures and who should administer them?

Reporter: Charles B. Stearns

First of all, I would again like to express my appreciation for my group. We had a good one and I think that we came up with some good ideas and discussion that was productive for all of us. I believe we benefited greatly from being together.

RECOMMENDATIONS:

1. That educational institutions working cooperatively with clinical affiliates, plan and implement an orientation program for clinical advisors.

2. That an affiliation agreement be developed and referred for action to the Steering Committee of this conference. We spent time looking at some of the factors that might be included in a model agreement which could be universally applied or at least apply as situations demanded or required. Some of these are:

Group VIII. (Continued)

Reporter: Charles B. Stearns

RECOMMENDATIONS: (continued)

(1) A clear concise statement of goals and objectives of the clinical affiliation.

(2) A definition of the responsibility of each.

(3) An organizational structure.

(4) Provision for updating and evaluating the agreement.

(5) Criteria for students participation or rejection.

(6) Identification of the signators.

(7) Statement of insurance liability.

(8) Financial support if any.

(9) Bilateral termination or modification.

(10) Duration of the agreement and then again sort of a general open-ended agreement depending upon the circumstances involved.

3. That the purposes, goals and objectives would be used for evaluating the clinical affiliation.

4. That education is an integral part of health care and as such is a justifiable expense for third party reimbursement.

Health Careers of Ohio
Operation MEDIHC
(Military Experience Directed
Into Health Careers)
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INVITATIONAL CONFERENCE - REACTION QUESTIONNAIRE SUMMARY -

Communication, Cooperation and Coordination in Allied Health Manpower Preparation and Utilization

May 6-7, 1974 ..... Columbus, Ohio

Your reaction to the conference you are now completing, will enable us all to make further progress in our deep concerns affecting the preparation and utilization of allied health manpower, as they relate to the delivery of health services, in the State of Ohio. PLEASE BE FRANK IN RESPONDING to the questions which follow. Your individual answers will remain anonymous.

Responded: 53 out of 80 (66%)

1. Employment Affiliation

a. (2) Health Planning Agency
b. (9) Government
c. (5) Hospital
d. (10) Associate Degree granting institution
e. (17) Baccalaureate and higher degree granting institution
f. (3) Voluntary Agency
g. (7) Other .. specify ..

_____

_____

2. Position Category

a. (5) Provider
b. (8) Planner
c. (25) Educator
d. (9) Practitioner
e. (6) Other .. specify ..

_____

_____

3. How would you rate the value of the conference as a whole?

Excellent	Good	Average	Below Average	Poor
(19)	(26)	(7)	(1)	(-)

53 respondents

4. In what way did this conference meet, or fail to meet, your prior expectations? Explain.

Enthusiastic	29 respondents with 12 comments
No Prior Expectation	14 respondents
Less Enthusiastic	10 respondents with 9 comments

ENTHUSIASTIC .... 29 respondents with 12 comments

No. Persons	
2	Very good and agenda was good preparation for program.
5	Expectations met-enjoyed problem solving experiences.
12	Diverse composition of group far exceeded expectations and made for 'great' and "exciting" experience.
2	Great dialogue and group stayed on assigned topic.
1	Vocational-technical education, better represented than expected.
3	Excellent cooperative spirit in groups but not time enough to accomplish all hoped for.
2	Group came to terms faster and more directly than any other groups involved in at previous conferences and was full and informative.
1	Definitions and discussions of innovative programs was addressed as thoroughly as hoped.
1	Enlightening on health manpower.

14 NO PRIOR EXPECTATION - DID NOT KNOW WHAT TO EXPECT - OPEN

LESS ENTHUSIASTIC .... 10 respondents with 9 comments

1	Should have placed people in relationship to problems with experts to advise them .. problems too broad.
2	Needed more time to overcome "discussion" and progress to "objective" function.
1	Insufficient accomplished.
1	Number of "no shows" disappointing in group.
1	Understood it would deal with students.
1	No information on current status and trends in developing allied health manpower programs.
1	Too much rehash.
1	Expected data analysis on existing and continued education.
1	Rotate groups in order to meet more people.

Reaction Questionnaire Summary (continued)

53 respondents

5. What aspects of the conference disappointed you most? What changes would you like to see at any forthcoming conference? Be specific

No Disappointments 22 respondents

Disappointments 31 respondents

NO DISAPPOINTMENTS .... 22 respondents

No. Persons	
16	No disappointments with no comment.
2	Excellently conducted.
1	Fine for Phase I - Phase II groups should be more definitive to allow for more conclusive results.
2	Continue with dialogue.
1	Present was a beginning - continuing conferences are needed.

DISAPPOINTMENTS .... 31 respondents

1	Need bigger name tags; printing too small.
1	Need more baccalaureate and master's degree program people.
1	Need fewer baccalaureate and master's degree program people.
1	The potential that HCOO may represent as allied health, splinter professions and nursing, is great.
1	Would like to have chosen discussion area.
1	Areas of people representation were too narrow.
1	Noble idea but one needs complete isolation to think in depth.
1	Participants unprepared to view themselves as part of proposed manpower system.
2	Would like to have rotated to more than one (1) group.
1	Discussed issues but no power to solve them.
1	Should have documented needs.
1	Too many educators and not enough health professionals.
1	Group moderator lacked leadership.
1	Resource person should have restricted comments and let group develop unhindered.
2	Keynote speech.
4	Need 1 to 3 more days for recommendations and discussion.
10	Goals too broad for so short a time. Less fattening delicious food!

Reaction Questionnaire Summary (continued)

53 respondents

6. How did the degree of group participation and the kind of contribution participants made, add to or detract from the conference? Explain.

Positive Response 46 respondents

Negative Response 7 respondents

POSITIVE RESPONSE .... 46 respondents

No. Persons	
20	Excellent group participation which was the strength of the conference.
1	Discussions pertinent and stimulating.
1	Moderator and recorder encouraged a high degree of participation.
13	Mixing groups made for good idea interchange - was most helpful and people with hang-ups realized others had them too and the result was cooperation instead of dissent.
1	Dialogue led to reasonable group questions and recommendations.
1	Very enlightening.
3	Groups were planned very well.
2	Sharing and extending information most beneficial. Recommend some continuity between the groups and the next session.
1	Brought out individual biases which is good preparation for what we can expect when communicating and cooperating on a larger scale.
1	No barriers in communication and the tone of the meeting was excellent.
1	Everyone received complete consideration of ideas and input was encouraged.
1	Good balance - no one person dominated the discussions.

NEGATIVE RESPONSE .... 7 respondents

1	Too much time spent on educating other people.
1	Too many things "could not be done".
1	Some individuals are too concerned with "Professional" protection than with public protection.
1	Better participation would have occurred if one could be involved in two (2) groups.
1	More stimulation was needed.
1	Real thinking was impossible and too much time getting together.
1	Lack of knowledge about problems existed.

53 respondents

7. How do you intend to apply the concepts discussed in this conference to your future actions and to your employment and/or profession? Give specific examples.

Plan to apply concepts	35 respondents
Will not apply concepts/or criticisms	5 respondents
Don't know precisely	13 respondence

PLAN TO APPLY CONCEPTS .... 35 respondents

No. Persons	
14	Continue and increase awareness; communicate with other health professionals, educational institutions, planners, etc.
6	Refer back to professional organizations and work with different groups on status of health care; obtain reaction and recommendations from professional organizations; obtain suggestions for input to Health Careers of Ohio.
1	Through auxiliary will be spokesman for various aspects of conference.
1	Plan more sharing with others.
1	Would hope to stop talking and ACT. Further communications between educational institutions to be more cooperative and work together to coordinate.
1	Promote greater cooperation with the other health service professions.
1	Continue to work with clinical affiliations in a more organized and systematic way.
1	Apply these ideas to my total thinking; I doubt my feeling has changed but my viewpoint has definitely been broadened.
1	Have a better idea of how other groups might approach a change; for example, did not realize how much diverse information is collected by others.
1	Will press for added emphasis on continuing education offerings.
1	Will cooperate in future development.
1	Will relate to staff, the values of interdisciplinary communication as suggested.
1	Want a data bank of information now.
1	We are doing it now in our university so will continue.

Reaction Questionnaire Summary (continued)

PLAN TO APPLY CONCEPTS (continued)

No. Persons	
1	Work toward clear concise affiliation agreements.
1	Relationships between State Department of Health, arewide agencies; Board of Regents, should be more centered around communication and my job will be to give some greater direction.
1	Will encourage two (2) and four (4) year institutions to sit down together in environmental health areas and discuss transfer of credits problem.

---

13 DO NOT KNOW

CRITICISM .. DO NOT PLAN TO APPLY CONCEPTS .... 5 respondents

1	Too much problem discussions.
1	Topics not influential except to professional associations.
1	Needs as a basis for development of programs do not always work.
1	Already implement many of the concepts myself.
1	Already planning a committee to operate on a statewide level.

53 respondents

8. In what ways, other than discussed at this conference, could you employer, your profession, government, health planning agency and/or other organizations implement the concepts presented at this conference? Give specific examples.

Respondents with examples 31 respondents

Those who either did not respond, or did not know 22

TOTAL RESPONDENTS: 53

RESPONDENTS WITH EXAMPLES .... 31 respondents

No. Persons	
1	Mobilize!
1	Lots of luck!
5	Cooperate with conference steering committee, etc.
1	Biomedical engineering needs to coordinate more with allied medical programs.
1	Reluctantly feel that governmental agency presently is only existing vehicle.
1	Before implementation, all areas must give attention and listen.
1	Will encourage that no new programs come about without expression of need.
1	Increasingly distressed at number of different organizations working independently toward same goals.
1	Felt that efforts in Ohio were duplicating American Society of Allied Health Professions which could have greater influence than one state and work more efficiently.
1	Help to obtain federal funds.
1	Encourage professional organizations to implement ideas and take initiative in solving.
1	Expand relationships with other health professionals and provide assistance.
1	Would hope that personal broadening will help employer.
3	Support additional conferences as there is a need for more communication.

Reaction Questionnaire Summary (continued)

RESPONDENTS WITH EXAMPLES (continued)

No. Person.	
1	Support statements of policy for improved relationships and improved health care delivery.
1	Give staff time to creation of a recommended council from Group V and open to coordinate efforts from all allied health fields.
1	Incorporate recommendations and approaches into ultimate development of a comprehensive state health plan.
1	Establish current and projected needs for new health professions (physician assistant).
1	Work to implement a working system in Ohio for allied health.
1	Form a committee and communicate desire to assist education in allied health.
1	Provide outside funding resources.
1	Work toward elimination of self interest and advancement of cooperation.
1	Organize next conference in conjunction with Health Careers of Ohio and Ohio Department of Health, Comprehensive Health Planning "A" Agency and Board of Regents.
1	Promote involvement and commitment to allied health.
1	Ask again when conference report is out.

Health Careers of Ohio
P.O. Box 5574
Columbus, Ohio 43221
Telephone: 614/422-9566
Monica V. Brown, Director

MINUTES - EVALUATION MEETING - May 16, 1974

Combined Steering Committee, Group Moderators and Recorders

COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION

Meeting Held: Thursday, May 16, 1974, Ramada Inn South, Columbus, Ohio

Attendance: 17

Steering Committee Present: 8

Robert J. Atwell, M.D. .. Monica V. Brown .. Ronald L. Harper, Ph.D. .. Wesley J. Peterson, Ph.D. .. Marvin D. Strauss .. Sylvia C. Upp .. Nancy L. Walters .. Frances E. Williamson

Steering Committee Absent: 5

James E. Bartholomew, D.D.S. .. Jeanne L. Burson, Ph.D. .. William B. Coulter .. A. E. Misko, Ed.D. .. William Slabodnik

Moderators and Recorders Present: 8

Anne S. Allen .. Mary Alice Beetham .. Thomas N. Chirikos, Ph.D. .. Christine A. Hayward .. Peggy K. Hull .. Rene C. Lachapelle, Ph.D. .. Michael J. Leymaster .. Lynn Timmons

Moderators and Recorders Absent: 9

Jean H. Baird .. Sister Elizabeth Ann Byrne .. June H. Garvin .. Kenneth P. Glassford, Jr. .. Ernest G. Muntz, Ph.D. .. Carol A. Jenkins .. Marilyn C. Ryan .. Charles B. Stearns .. Braxton E. Tewart

Presiding: Frances E. Williamson, Chairperson

The meeting was called to order by Ms. Williamson at 10:00 a.m. Those present were welcomed and introduced themselves.

The Reaction Questionnaires Summary and Group Reports from the Conference which were mailed to Steering Committee members, Moderators and Recorders were considered incorporated into these minutes.

There was consensus that in addition to the full report of the proceedings for the Federal Government, the manner in which Ohio would use the findings of the conference, the steps which would be taken and the publics that should be involved must be defined.

It was agreed that the conference proceedings needed study so that both common and diversified elements could be identified and highlighted. This would assist in future planning and ensure positive progress toward Phase II as outlined in the Progress Chart which is attached to and incorporated in these minutes.

Minutes-Evaluation Meeting-
May 16, 1974

Noted with appreciation was the fact that during the conference and again at the meeting being reported in these minutes, all present worked cooperatively together. Although from diverse backgrounds and points of view, participants cooperated fully by attending the groups to which they were assigned, even though in some instances they were not completely familiar with the topics being discussed. It was agreed that in the next phase, participants might be given the choice of group(s) in which they would be involved.

Full discussion followed with representatives from each of the conference groups elaborating on the group reports and reaction of the participants. Additional constructive remarks were contributed by others present.

It was evident that the group reports properly express the feelings and opinions of the respective groups. Following are additional comments which did not appear in the group reports.

Group I

The Board of Regents goal was that a minimum of 50% academic credits would be transferable with technical being transferable on an optional basis between institutions. In some instances this is being achieved, but a problem exists even within institutions.

Brought out was the fact that although an admissions office accepted transferred credit, the specific discipline had the right to accept or reject the credit. There was also no uniformity of acceptance. The extent of the problem in transference of credits has not yet been fully identified.

Group II

One participant in this group stated that there was no doubt that he had been overtrained for what he was doing and under-trained for what he should be doing. It was generally agreed among those present at the evaluation meeting, that the situation was/is not unique.

Vital need for better career counseling was emphasized.

Statistical analysis should be performed to identify the types of personnel needed in order to program constructively. There have been instances in the State where a professional association disagreed with the need for establishing a program and were overriden. This would hopefully not take place if statistical analysis coupled with coordination were taking place.

Group III

A more detailed group report was presented and replaced the initial report previously given. See attached.

Group IV

No representatives from group IV were present. The topic of continuing education was generally discussed. The need for education legislators about allied health was stressed. The fact that allied health professionals, while needing continuing education, are not always in the position to pay for said education, was stated.

Group V

A Council of Planners was recommended as the body to solve problems of innovation; should be a "think tank" creative body.

The need to include the users of health services was stressed. Consumers will be the decision makers of the future, not the providers. The consumer will function well if given the orientation and the opportunity.

Group VI

The matter of evaluation of military medical experience was discussed and the fact that studies have been done was stated. Those mentioned were the Robert R. Nathan Associates study in Cooke County Hospital; the Altoona, Pennsylvania hospital usage of medical corpsmen. It was stated that MEDIHC would in fact be a good resource for study as to the capability of those who had gained knowledge and skills through other than the formal educational route.

Group VII

The majority of participants in this group were people who were not familiar with the topic. It was rewarding to have them respond and work together enthusiastically.

A substantial amount of 'homework' is required in connection with data. Nomenclature was not discussed in depth as not all realized that this was a problem.

A recent proposal submitted by the Ohio Department of Health to the Federal Government concerning a data bank, did not include a large number of allied health professions since it would deal only with 13 health professions. The fact that allied health needs more visibility becomes increasingly evident.

Group VIII

The institution does not always take into account the needs of the clinical affiliates.

There is a need for orientation and evaluation programs in clinical areas.

After the reports had been given and thoroughly discussed, those present stated that another meeting must be held to discuss the recommendations made and decide "WHERE AND HOW DO WE GO FROM HERE"???

It was fully understood that transportation reimbursement would not be possible, however, Health Careers of Ohio will provide luncheon. Notices will be mailed to all members of the Steering Committee, Moderators and Recorders to invite their attendance,

The next meeting will be Wednesday, June 5, 1974 at 10:30 a.m. at the Ramada Inn South - I71 at Stringtown Road, Columbus, Ohio.

The agenda will be, "WHERE AND HOW DO WE GO FROM HERE?"

The meeting adjourned at 3:30 p.m.

Monica V. Brown

Health Careers of Ohio
P.O. Box 5574
Columbus, Ohio 43221
Telephone: 614/422-9566
Monica V. Brown, Director

MINUTES - SECOND EVALUATION MEETING - June 5, 1974

Combined Steering Committee, Group Moderators and Recorders

COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION

Meeting Held: Wednesday, June 5, 1974, Ramada Inn South, Columbus, Ohio

Attendance: 15

Steering Committee Present: 10

James E. Bartholomew, D.D.S. .. Monica V. Brown represented by Judith A. Bird .. Jeanne L. Burson, Ph.D. .. William B. Coulter represented by Kathy Stafford .. Ronald L. Harper, Ph.D. .. Wesley J. Peterson, Ph.D. .. Marvin D. Strauss .. Sylvia C. Upp .. Nancy L. Walters .. Frances E. Williamson

Steering Committee Absent: 3

Robert J. Atwell, M.D. .. A. E. Misko, Ed.D. .. William Slabodnik

Moderators and Recorders Present: 5

Anne S. Allen .. Mary Alice Beetham .. Thomas N. Chirikos, Ph.D. .. Peggy K. Hull .. Carol A. Jenkins represented by Sandra Bennett, Ph.D.

Moderators and Recorders Absent: 12

Jean H. Baird .. Sister Elizabeth Ann Byrne .. June H. Garvin .. Kenneth P. Glassford .. Christine A. Hayward .. Rene C. Lachapelle, Ph.D. .. Michael J. Leymaster .. Ernest G. Muntz, Ph.D. .. Marilyn C. Ryan .. Charles B. Stearns .. Braxton E. Tewart .. Lynn Timmons

Presiding: Frances E. Williamson, Chairperson

The meeting was called to order by Ms. Williamson at 10:30 a.m. Those present were welcomed and introduced themselves.

The minutes of the last meeting were reviewed as well as the Summary of Recommendations which have been sent to each person.

It was noted that four members from the group had been appointed to an advisory health group of the Board of Regents. This type of participation is encouraging.

The business of the day was "Where Do We Go From Here?" A review of the reports gave the direction that lead to action. The consensus was that some mechanism was needed whereby the progress made to date would continue through communication, cooperation and coordination; that a group, or more than one, would be responsible for continuing to move this broad concept so that a plan of action would evolve.

The discussion of the morning focused on: Who? With what support? How?

Minutes-Second Evaluation Meeting
June 5, 1974

As alternatives were discussed, it became evident, that by identifying the functions of a core or nucleus committee for allied health; the present group might be better able to focus on the business at hand.

Probably and/or possible functions were identified. (The functions were considered in terms of action: advisory, catalytic, regulatory or controlling).

Following are identified functions for a core or nucleus committee for Allied Health Manpower in the State of Ohio:

1. Control of regulations. This may or may not be appropriate but certainly interphases with it all.

2. Planning.

3. Information both gathering and dissemination.

4. Resource. To act as a Resource Agency which might be information produced in personnel and it has several ramifications. To be a resource to a variety of groups such as the Board of Regents, Department of Education, etc.

5. Interaction with the Legislature.

6. Study function. A creative task group to do special kinds of studies which need to be done.

7. The establishment of committees with special expertise. Will function as a catalyst in various kinds of ways.

8. Multi-directional coordination. In terms of relationships with Legislature, state bodies of various kinds, professional organizations, educational institutions and individuals.

Questionable Functions are:

1. Professional standards.

2. Development of general proficiency testing.

3. Transference of credits.

4. Interstate mobility of people.

5. Clinical affiliations. So many problems related to this but maybe a group may be able to address some of these problems.

In light of these functions, existing agencies and organizations in the state were considered: Board of Regents, State Department of Education, professional organizations, a possible state chapter of the American Society of Allied Health Professions, private agencies or foundations, Ohio Legislature, Ohio Hospital Association and Health Careers of Ohio.

Health Careers of Ohio was discussed in length as to its viability as a support agency. The outcome of the conference and the evaluation meetings will be discussed at the Health Careers of Ohio Board Meeting, June 27, 1974.

Minutes-Second Evaluation Meeting
June 5, 1974

The Ohio Department of Health and their linkage system was discussed. If funding for this is approved, then the appropriate functions might be integrated into it and possibly could be funded.

It was agreed that two issues were involved, one being trying to find a fiancial and staff support agency and the other being to organize a representative group to continue to develop the needs as discussed.

It was felt that no logical group now exists that meets the varied needs identified. It was suggested that a certain kind of group should be formed to deal with these needs.

This new committee would be speaking for allied health. This committee would have as a principal function that of "communicating" with the regulatory agencies, organizations, Board of Regents, health care practitioners, hospitals, academic institutions, schools and the consumer. This should be the committee that would formulate questions that need answers. Some of those questions of course are listed in the summary of recommendations from the conference. In addition, one of the functions of the committee also would be the establishment of the ad hoc committees which would then address themselves to the fact finding missions that would be necessary to come up with the answers that are needed for the questions that are proposed. There has to be a coordinating group that serves as the spokesman for allied health. The committee should reach down into its own ranks to appoint the ad hoc committees that are necessary to solve the questions or at least propose solutions to the questions. Having received that kind of input from the ad hoc committees it could then be communicated to the different "super organizations". This committee would have to sell itself and its services to the Board of Regents, to the hospital boards and to the different institutions. The best way to do that would be to have some of their people as part of the committee. They should communicate for cooperation and coordination and above all plan for implementation and action.

It was a recommendation of this group that a letter and a return post card be sent to the original Steering Committee, Moderators and Recorders asking if they would be willing to have their name placed in nomination for a action implementation committee, if not, would they be willing to be a resource person and could they nominate another person for the committee.

For continuity, the conference participants will be asked to elect a viable, creditable Action Implementation Committee.

Chairperson Frances E. Williamson thanked everyone for their efforts and the meeting was adjourned at 2:30 p.m. Some of the group stayed to formulate the letter mentioned previously.

Jeanne L. Burson

Jeanne L. Burson, Ph.D.

THIS LETTER WAS SENT TO THE STEERING COMMITTEE, MODERATORS AND RECORDERS

Health Careers of Ohio
Operation MEDIHC
(Military Experience Directed Into Health Careers)
P.O. Box 5574
Columbus, Ohio 43221
Director, Monica V Brown
Phone: (614) 422-9566

ACTION COMMITTEE NOMINATION SOLICITATION

June 6, 1974

Dear :

As a result of the two sessions in which the Communications, Cooperation and Coordination Conference was evaluated the Steering Committee, augmented by representatives from the group moderators and recorders, came to consensus concerning the need to develop an action implementation committee. It is suggested that this action committee be made up of persons from among the moderators, recorders and Steering Committee, elected by the conference participants.

The challenge the action committee will address is moving the conference recommendations forward on a priority basis. This means finding financial support and appropriate sponsorship. It will be the committee's responsibility to monitor its membership and structure and amend as deemed appropriate.

Would you, as one of the previous groups, be willing to be nominated for election to the action group? If not, could you suggest someone equally representative of allied health interests whom we might ask to be a nominee? Alternatively, would you be willing to serve as a resource person to work on a specific problem?

Please complete the enclosed card and return no later than June 28. Your interest and support are really appreciated.

Sincerely,

Frances E. Williamson
Chairperson
Steering Committee

Please check the appropriate response and return.

I will_____ will not_____ be a nominee.
I would like to nominate: _____
(name)

_____
(title)

_____
(organization)

_____
(address)

I will_____ will not_____ serve as a resource person.

_____
Signature

APPENDIX TABLE OF CONTENTS

Health Careers of Ohio
Operation MEDIHC
(Military Experience Directed
Into Health Careers)
P.O. Box 5574
Columbus, Ohio 43221
Director, Monica V Brown
Phone (614) 422-9566

INVITATIONAL CONFERENCE

COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION

DATE: *May 6 and May 7, 1974*
TIME: *4:30 p.m. Monday through 2:30 p.m. Tuesday*
PLACE: *Ramada Inn North, SR 161, Columbus, Ohio*

Health Careers of Ohio is pleased to invite you to this initial conference planned in accordance with the results of our August, 1973 questionnaire. Additionally, the proliferation of health programs is very apparent as can be seen from the results of a recent survey conducted by Health Careers entitled "Summary of Changes in Health Educational Programs in Ohio". The total of all certificate, associate, baccalaureate, Master's and higher degree programs in Ohio as of September, 1970 was 453. The total for the same categories was 589 in November, 1973, with at least 90 more programs proposed. Concomitant with the increase in number of programs there is a lack of standardization of terminology applied to allied health programs. All of this lends credence to both the importance and timeliness of this conference.

Attendance at this working conference will be limited to 125 participants. We ask that you identify the one category which best describes your role. These are:

a. Provider *(hospital, clinic, private office, nursing home, etc.)*
b. Health Planner
c. Educator *(associate degree, baccalaureate degree, certificate, vocational, technical, etc.)*
d. Practitioner *(medical technologist, physical therapist, etc.)*
e. Government *(state, county, city, etc.)*
f. Other

There will be ten (10) discussion groups comprising no more than two representatives from any one category. The initial focus will be COMMUNICATION.

We have made application for funding for the conference and received verbal assurance that the application will be approved. Should this eventuate, major expenses for participants will be provided. If funds are not forthcoming, registration, which will include two meals, will be $20.00. Not included in the registration fee are transportation, breakfast, incidentals, and lodging which may be obtained at the special rate of $18.00 for two persons in a twin-bed room.

Please return your Application Card by February 15, 1974 in order to ensure your participation. Do not submit fees with your application. Additional details will be forthcoming as plans are finalized.

We look forward to hearing from and working with you. If you wish further information, please contact Monica V. Brown, 614-422-9566.

Enclosure: 1
(Conference Application Card)

FEW:jb

INVITATIONAL CONFERENCE

"Communication, Cooperation And Coordination In Allied Health Manpower Preparation And Utilization"

Monday, May 6th.

4:00 p.m. to 5:30 p.m.	Registration
4:00 p.m. to 5:15 p.m.	*Briefing Session for Moderators and Recorders*
6:00 p.m.	Opening Session - Dinner
	Presiding: Frances E. Williamson, M.P.H. *Assistant Chief, Office of Comprehensive Health Planning, Ohio Department of Health*
	Greetings: Donald E. Bender *President, Health Careers of Ohio*
	Keynote Address: J. Warren Perry, Ph.D. *Dean, School of Health Related Professions, State University of New York at Buffalo. Director, Study of Allied Health Education, American Association of Community and Junior Colleges*
	Questions and Answers
8:30 p.m.	Idea Exchange

Tuesday, May 7th.

7:30 a.m.	Breakfast
8:30 a.m.	General Session
	Presiding: Ronald L. Harper, Ph.D. *Associate Director, School of Allied Medical Professions, Ohio State University*
8:45 a.m.	Group Sessions
to	*Consult registration tag for group number*
11:30 a.m.	*A fifteen minute break will be taken at 10:00 a.m.*
12 noon	Luncheon
1:30 p.m.	Group Sessions *Reconvene in the same group to which assigned in the morning.*
2:45 p.m.	"WHERE DO WE GO FROM HERE" ? ? ? ?
3:30 p.m.	Adjournment

GROUPS

Group I

Transference of Academic Credits

Moderator: *Ernest G. Muntz, Ph.D.*

Recorder: *Lynn R. Timmons*

Group II

Cooperative Planning for Program Approval and Accreditation

Moderator: *Mary Alice Beetham*

Recorder: *Sister Elizabeth Ann Byrne*

Group III

Credentialling of Personnel

Moderator: *Rene Lachapelle, Ph.D.*

Recorder: *Jane H. Garvin*

Group IV

Cooperative Planning for Continuing Education

Moderator: *Jean H. Baird*

Recorder: *Carol A. Jenkins*

Group V

Development of Innovative Programs

Moderator: *Anne S. Allen*

Recorder: *Braxton E. Tewart*

Group VI

Recognition of Life Experience through Proficiency Skill and Academic Equivalency Tests

Moderator: *Christine A. Hayward*

Recorder: *Kenneth P. Glassford, Jr.*

Group VII

Health Manpower Information Bank-Data Gathering-Common Nomenclature-Job Descriptions

Moderator: *Thomas N. Chirikos, Ph.D.*

Recorder: *Marilyn C. Ryan*

Group VIII

Clinical Affiliations

Moderator: *Charles B. Steams*

Recorder: *Peggy K. Hull*

STEERING COMMITTEE

Chairman: Frances E. Williamson, M.P.H.

Robert J. Atwell, M.D.
Director, School of Allied
Medical Professions
The Ohio State University
Columbus, Ohio

James E. Bartholomew, D.D.S.
State Supervisor of Health
Occupations
Division of Vocational Education
State Dept. of Public Instruction
Columbus, Ohio

Monica V. Brown
Director
Health Careers of Ohio-
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Jeanne L. Burson, Ph.D.
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Ohio Department of Health
Columbus, Ohio

Conference conducted by Health Careers of Ohio and sponsored by the Division of Associated Health Professions, Bureau of Health Resources Development, Health Resources Administration, United States Department of Health, Education and Welfare.

Contract N01-AH44073

PARTICIPANTS - INVITATIONAL CONFERENCE

Communication, Cooperation and Coordination in Allied Health Manpower Preparation and Utilization

May 6-7, 1974...Columbus, Ohio

Pre-Registrants.....	123	
Additional Registrants....	6	
		Total Registrants:..... 129
Cancellations.....	21	
No Show.....	28	
		Total Absent:..... 49
		Total Participants:..... 80

Steering Committee (13) present: 8 Absent: 5

MAMDOUH M. ABDALLAH
Assoc. Dir., Urologic Physician's Asst. Program, University of Cincinnati

ANNE S. ALLEN
Asst. Professor, School of Allied Medical Professions, Ohio State University

ROBERT J. ATWELL, M.D.
Director, School of Allied Medical Professions, Ohio State University

JEAN H. BAIRD
Assoc. Executive Director, Mahoning Shenango Area Health Educ. Network

JAMES E. BARTHOLOMEW, D.D.S.
Supervisor, Health Occupations, Div. of Vocational Educ., State Dept. Education

MARY ALICE BEETHAM
Assistant Professor, Health Education
Ohio State University

DONALD E. BENDER
Personnel Director, State Automobile Mutual Insurance Company

LYALL BIRNIE, JR.
Coordinator of Health Programs
University of Toledo, University and Community College

LOUIS D. BOURGEOIS, Ph.D.
Project Officer, C.C.C. Conference
Div. of Assoc. Health Professions
BHRD, HRA, DHEW

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Tech. Advisor, Hlth. Manpower Planning
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BHRD, HRA, DHEW

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THOMAS N. CHIRIKOS, Ph.D.
Assoc. Professor & Associate Director
Center for Human Resources Research
Ohio State University

JAMES A. CONFORTI, D.P.M.
Vice President
Ohio College of Podiatric Medicine

JUDY CRIBB
President Elect, Ohio Dental Hygienists Association

Participants-C.C.C. Invitational Conference

CAROLE H. DEBAER
Director of Hlth. Serv. & Mpr. Planning
Summit-Portage County C.H.P.

DWIGHT L. DILLER
Asst. to the Vice Chancellor, Two-Year Campuses, Ohio Board of Regents

JOHN R. ERVIN, Ph.D.
Manager, Office of Planning & Coord. & Resources, Ohio Dept. of Mental Health and Mental Retardation

JOHN FISHEL
Health Planning Coordinator
Ohio Department of Health

HELEN BODEY FOX
Woman's Auxiliary, Ohio State Med. Assn.

JANE H. GARVIN
Program Head, Nutrition and Dietetics
University of Cincinnati

RONALD M. GILBERT, O.D.
Ohio Optometric Association

KENNETH P. GLASSFORD, JR.
Admin. Asst. to Executive Director
Hlth. Planning Assn. of Northwest Ohio

KATHY GOLDBERG
Ohio Dental Hygienists Association

KAY GRANT
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School of Allied Medical Professions
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State Department of Education

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Health Education Network

WILLA H. HEDRICK
Program Director, School of Med. Tech.
Kettering Medical Center

RAY HOLMES, D.D.S.
Ohio State Dental Association

PEGGY K. HULL
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Ohio State University Hospitals

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Ohio State University Hospitals

INVITATIONAL CONFERENCE

Communication, Cooperation and Coordination in Allied Health Manpower Preparation and Utilization

May 6-7, 1974.....Columbus, Ohio

GROUP COMPOSITION PARTICIPANTS

GROUP I.

TRANSFERENCE OF ACADEMIC CREDITS

Moderator: Ernest G. Muntz, Ph.D.
Recorder: Lynn Timmons

Mahmoud Abdallah
Roger Keller, Ph.D.
Michael J. Leymaster
Melanie Moersch
Frances M. Veverka
Herman R. Weed, Ph.D.

GROUP II.

COOPERATIVE PLANNING FOR PROGRAM APPROVAL AND ACCREDITATION

Moderator: Mary Alice Beetham
Recorder: Sister Elizabeth Ann Byrne

Donald E. Bender
David A. Bowers
Carolyn N. Burnett
John Fishel
Ray Holmes, D.D.S.
Anita R. McCormick, Ed.D.
Dale Maczka
Virginia J. Mott
Joyce Wolonsky

GROUP III.

CREDENTIALLING OF PERSONNEL

Moderator: Rene Lachapelle, Ph.D.
Recorder: Jane H. Garvin

Lyall Birnie, Jr.
Joseph A. Conforti, D.P.M.
Judy Cribb
Ronald M. Gilbert, O.D.
Kathy Goldberg
Willa H. Hedrick
John T. Mount
Kathy Stafford
Larry A. Sturgis

GROUP IV.

COOPERATIVE PLANNING FOR CONTINUING EDUCATION

Moderator: Jean H. Baird
Recorder: Carol A. Jenkins

E. William Greene
David C. Jehnsen
James Kreutzfeld
Nancy Lapp
Nicholas Paraska
C. H. Sedgwick

Group Composition Participants

GROUP V.

DEVELOPMENT OF INNOVATIVE PROGRAMS

Moderator: Anne S. Allen
Recorder: Braxton E. Tewart

Charles J. Chantell, Ph.D.
John R. Ervin, Ph.D.
Helen Bodey Fox
Freida McNeill
Elizabeth E. Roberts
Dale E. Mapes
Joan Gatewood White, Ph.D.

GROUP VI.

RECOGNITION OF LIFE EXPERIENCE THROUGH PROFICIENCY SKILL AND ACADEMIC EQUIVALENCY TESTS

Moderator: Christine A. Hayward
Recorder: Kenneth P. Glassford, Jr.

Kay Grant
Rogene E. Shoffner
Dwight L. Diller
Wayne Stires

GROUP VII.

HEALTH MANPOWER INFORMATION BANK-DATA GATHERING; COMMON NOMENCLATURE; JOB DESCRIPTIONS

Moderator: Thomas N. Chirikos, Ph.D.
Recorder: Marilyn C. Ryan

Suzanne S. Brown
John Hammond, D.O.
Paul R. Reibel
Jerome M. Sullivan
Harold Weir
Susan Weiss

GROUP VIII.

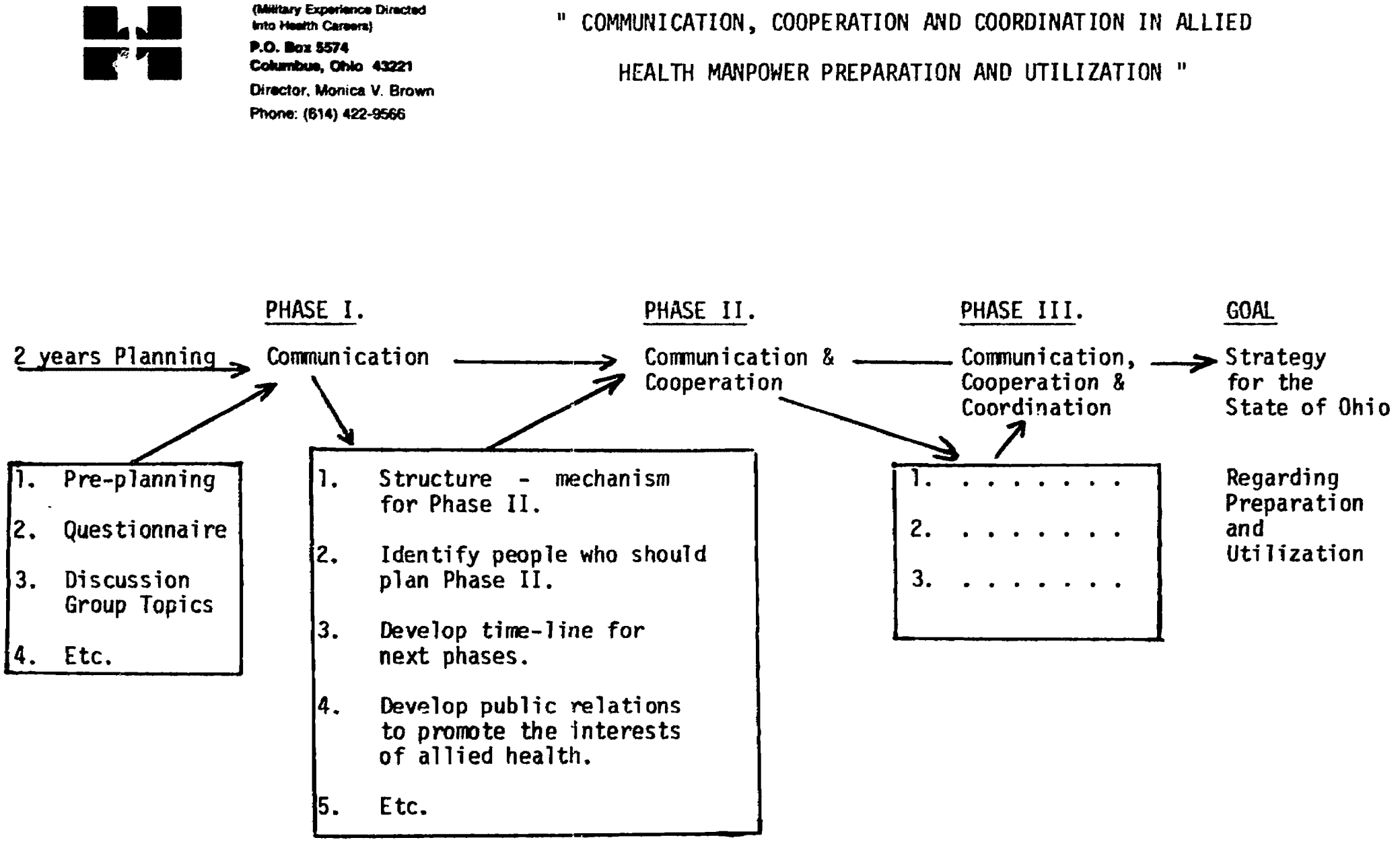
CLINICAL AFFILIATIONS

Moderator: Charles B. Stearns
Recorder: Peggy K. Hull

Carole DeBaer
Elizabeth Gurney
DeLois Johnson
Naurine S. McCormick
Virginia Schaffner
Clinton W. Trott, M.D.
Corinne Zitsman

Health Careers of Ohio
Operation MEDIHC
(Military Experience Directed Into Health Careers)
P.O. Box 5574
Columbus, Ohio 43221
Director, Monica V. Brown
Phone: (614) 422-9566

" COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION "



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INVITATIONAL CONFERENCE - REACTION QUESTIONNAIRE

Communication, Cooperation and Coordination in Allied Health Manpower Preparation and Utilization

Your reaction to the conference you are now completing, will enable us all to make further progress in our deep concerns affecting the preparation and utilization of allied health manpower, as they relate to the delivery of health services, in the State of Ohio. PLEASE BE FRANK IN RESPONDING to the questions which follow. *Your individual answers will remain anonymous*

1. Employment Affiliation

a. ( ) Health Planning Agency

b. ( ) Government

c. ( ) Hospital

d. ( ) Associate Degree granting institution

e. ( ) Baccalaureate and higher degree granting institution

f. ( ) Voluntary Agency

g. ( ) Other .. specify ..

_____

_____

2. Position Category

a. ( ) Provider

b. ( ) Planner

c. ( ) Educator

d. ( ) Practitioner

e. ( ) Other ..specify ..

_____

_____

3. How would you rate the value of the conference as a whole?

Excellent	Good	Average	Below Average	Poor
( )	( )	( )	( )	( )

Please turn over .....

Conference Reaction Questionnaire (continued)

4. In what way did this conference meet, or fail to meet, your *prior expectations?* Explain.

5. What aspects of the conference disappointed you most? What *changes* would you like to see at any forthcoming conference? *Be specific*

6. How did the degree of *group participation* and the kind of contribution participants made, add to or detract from the conference? *Explain.*

7. How do you intend to apply the concepts discussed in this conference to your future actions and to your employment and/or profession? *Give specific examples.*

8. In what ways, other than discussed at this conference, could your employer, your profession, government, health planning agency and/or other organizations implement the concepts presented at this conference? *Give specific examples.*

THANK YOU.....

PLEASE GIVE THIS REACTION QUESTIONNAIRE TO US BEFORE YOU LEAVE.

Health Careers of Ohio
Operation MEDIHC
(Military Experience Directed
Into Health Careers)
P.O. Box 5574
Columbus, Ohio 43221
Director, Monica V Brown
Phone: (614) 422-9566

October, 1973

"COMMUNICATION, COOPERATION AND COORDINATION IN HEALTH MANPOWER PREPARATION AND UTILIZATION"

The Ad Hoc Committee thanks all those who participated in the survey, "Communication, Cooperation and Coordination in Health Manpower Preparation and Utilization". Since this survey was designed for informational purposes only, no statistical analysis was performed.

In summary, 300 questionnaires were mailed of which 171 (57%) were returned. Responses were received from comprehensive health planning agencies, educational organizations, state, county and city governments, voluntary and official health agencies, volunteers, health professional associations, health insurance, hospitals, individuals, technical institutes/colleges, universities and branch or regional campuses along with some others. The respondents represented all levels of educational instruction taught, as well as employers, planners and consumers. Also represented were a diversity of professional qualifications and/or classifications. The majority indicated a need for assessment of factors of interest and/or concern which affect health professional, technical and occupational education and/or training in regard to transference of academic credits. It was also evident that cooperative and coordinative efforts in educational offerings need to be expanded. Further, the majority indicated definite needs for assessment of factors of interest and/or concern as they affect planning and employment.

The Ad Hoc Committee was encouraged at the interest in meeting with others to share concerns and the willingness of the respondents to participate in meetings and conferences. Also expressed was willingness to assist in the planning and evaluation of any such conferences. Of the choices presented, the largest number of respondents indicated preference for one state-wide conference which would include "Mini-conferences" and would involve educators, employers, health personnel, planners and consumers which would report back to a state-wide planning body. This to be followed by regional and/or local conferences.

On Thursday, September 20, 1973, the Ad Hoc Committee reviewed the findings of the questionnaire. It was evident that coordinated leadership in Allied Health is desired and needed in Ohio. The consensus of the Ad Hoc Committee was to work toward planning a state-wide conference as suggested by the survey respondents. The Committee will proceed with plans for such a conference.

Frances E. Williamson, M.P.H.
Chairman

Members:

Robert J. Atwell, M.D.
James Bartholomew, D.D.S.
Monica V. Brown
William B. Coulter
Ronald L. Harper, Ph.D.
A.E. Misko, Ed.D.
Wesley J. Peterson, Ph.D.
Marvin D. Strauss, M.P.H., M.C.P.
Sylvia C. Upp
Nancy L. Walters

Health Careers of Ohio
P.O. Box 5574
Columbus, Ohio 43221

Director, Monica V. Brown
Phone: (614) 422-9566

July 23, 1973

From: Frances E. Williamson, M.P.H., Chairman, Ad Hoc Committee

Subject: "Communication, Cooperation and Coordination in Health Manpower Preparation and Utilization"

You have been recommended as one of those able to assist us in identifying common concerns as they affect the preparation and utilization of health manpower in the State of Ohio; especially as they relate to the delivery of health care services. As you know, this matter continues to be of primary importance to all those involved with the education, training, planning for and employment of health personnel.

In behalf of the Ad Hoc Committee on "Communication, Cooperation and Coordination in Health Manpower Preparation and Utilization", we invite you to work with us so that constructive progress can be made and recommendations developed that will be in the best interests of the citizens of Ohio.

We ask your cooperation in completing the enclosed questionnaire. A prepaid envelope is provided for your convenience.

Please return by Monday, August 6, 1973.

FEW:jb

Enclosures: 3

Ad Hoc Committee Members
Questionnaire
Prepaid envelope

Health Careers of Ohio
P.O. Box 5574
Columbus, Ohio 43221
Phone: 614/422-9566
August, 1973

TOTAL COMPILATION OF RESPONSE TO QUESTIONNAIRE

TOTAL: 171 Total Questionnaires Mailed: 300

Total Questionnaires Returned: 171

"COMMUNICATION, COOPERATION AND COORDINATION IN ALLIED HEALTH MANPOWER PREPARATION AND UTILIZATION" 57% Return

PLEASE ANSWER EVERY QUESTION IN THIS QUESTIONNAIRE

I. EMPLOYMENT AFFILIATION. (Please check appropriate box indicating your present primary employment affiliation)

1. ☐ Auxiliary		13. ☒ Health Insurance	1
2. ☒ Comprehensive Health Agency	10	14. ☐ High School	
3. ☒ Educational Organization	13	15. ☒ Hospital	33
4. ☒ Government, Federal		16. ☒ Individual	2
5. ☒ Government, State	11	17. ☐ Industry	
6. ☒ Government, County	1	18. ☐ Nursing Home	
7. ☒ Government, City	2	19. ☒ Technical Institute/College	14
8. ☒ Health Agency, Official	2	20. ☒ University	66
9. ☒ Health Agency, Voluntary	3	21. ☒ University Branch/Regional Campus	2
10. ☐ Health Clinic		22. ☐ Voluntary Agency	
11. ☐ Health Manpower Careers		23. ☒ Other, specify	5
12. ☒ Health Professional Association	6		

II. EDUCATIONAL INSTRUCTORS
(Please rank your teaching responsibilities in order of your primary obligations by placing the appropriate code numbers in the boxes below)

First Choice	Total	Code	Total	Code	Total	2nd Choice	Total	Code	Total	Code	Total	3rd Choice	Total
Code 1	91	05	4	10	3	Code 01	6	05	13	09	7	Code 1	4
Code 2	10	06	3	11	1	Code 02	31	06	6	10	8	Code 2	4
Code 3	2	07	2	12	13	Code 03	5	07	5	11	4	Code 3	17
Code 4	2	09	7			Code 04	9	08	3	12	6	Code 4	15
												Code 5	9
												Code 6	7
												Code 7	4
												Code 8	1
												Code 9	4
												Code 10	4
												Code 11	3
												Code 12	5

Code No. 1 Administrator (program director, dean, etc.)
2 Allied Health Professional Educator
3 Clinical Instructor
4 Counselor
5 General Educator
6 Health Occupations Educator
7 Hospital Program Educator
8 Nursing Educator
9 Other health professional/technical educator
10 Pre-health Professional Advisor
11 Pre-health Professional Educator
12 Other; specify_____

III. LEVEL OF EDUCATIONAL INSTRUCTION TAUGHT
(If you are an educational instructor, please rank your primary teaching area(s) by placing the appropriate code numbers in the boxes below)

1st Choice	Total	Code	Total	2nd Choice	Total	Code	Total	3rd Choice	Total
Code 1	17	05	3	Code 1	3	07	4	Code 1	2
Code 2	41	06	2	Code 2	16	08	8	Code 2	4
Code 3	3	08	6	Code 3	1	09	11	Code 3	1
Code 4	24	09	4	Code 4	26	10	4	Code 4	1
		10	12	Code 6	3			Code 7	2
								Code 8	1
								Code 9	5
								Code 10	7

Code No. 1 Associate Degree
2 Baccalaureate Degree
3 Diploma (two to three yrs. post h.s.)
4 Graduate (post baccalaureate)
5 High School
6 One Year post high school
7 One to two years post high school
8 On-the-job Training
9 Post Baccalaureate Degree Certificate
10 Other, specify_____

IV. PROFESSIONAL QUALIFICATION AND/OR CLASSIFICATION (Please check appropriate box indicating your present primary professional qualification and/or classification)

Administrative

1. [XX] Administrator, Educational 80
2. [XX] Administrator, Hospital 16
3. [ ] Administrator, Nursing Home
4. [XX] Administrator, Public Health 5
5. [XX] Health Manpower Planner 11
6. [XX] Health Planner Other 8
7. [XX] Other, Specify _____ 21

Clinical

8. [XX] Medical Technologist 7
9. [XX] Physical and Biological Scientist 5
10. [XX] Radiologic Technologist 2
11. [XX] Respiratory/Inhalation Therapist 3
12. [XX] Other, Specify _____ 5

Dietary

13. [XX] Dietitian 3
14. [XX] Home Economist 2
15. [XX] Nutritionist 2
16. [ ] Other, Specify _____

Environmental Health

17. [ ] Environmental Health Specialist
18. [ ] Industrial Hygienist
19. [XX] Sanitarian 1
20. [XX] Other, Specify _____ 1

Informational

21. [XX] Communications (public relations etc.) 3
22. [XX] Educator, Public Health 4
23. [XX] Educator, School Health 3
24. [XX] Medical Records Administrator 2
25. [XX] Other, Specify _____ 4

Medical-Dental, etc.

26. [XX] Dentist 2
27. [ ] Dental Hygienist
28. [XX] Optometrist 1
29. [XX] Pharmacist 4
30. [XX] Physician 12
31. [XX] Podiatrist 2
32. [ ] Surgical Assistant
33. [XX] Veterinarian 2
34. [XX] Other, Specify _____ 3

Nursing

35. [XX] Nurse, Baccalaureate (R.N.) 5
36. [ ] Nurse, Associate Degree (R.N.)
37. [XX] Nurse, Diploma (R.N.) 2
38. [ ] Nurse, Practical (LPN)
39. [XX] Other, Specify _____ 4

Rehabilitation

40. [XX] Occupational Therapist 5
41. [XX] Physical Therapist 5
42. [ ] Rehabilitation Counselor
43. [XX] Special Educator (mental retardation; special education, etc.) 1
44. [XX] Speech Pathologist & Audiologist 3
45. [ ] Other, Specify _____

Social and Behavioral

46. [XX] Psychologist 3
47. [XX] Social Worker 3
48. [XX] Sociologist 1
49. [XX] Other, Specify _____ 5

Miscellaneous (not included in other categories)

50. [XX] Specify _____ 7

V. NEED FOR ASSESSMENT OF FACTORS OF INTEREST AND/OR CONCERN AS THEY AFFECT HEALTH PROFESSIONAL, TECHNICAL AND OCCUPATIONAL EDUCATION AND/OR TRAINING.

Please answer each question as you view the following needs.

Needs for the Transference of Academic Credits:

(please answer each question)

	Yes	No	Not Answered
1. Between individual educational areas within one institution.....	129	30	12
2. Between individual educational areas in different institutions.....	154	9	8
3. Horizontally between different institutions.....	144	10	17
4. Vertically between different institutions.....	124	29	18
5. From high school to technical/vocational programs.....	103	55	13
6. From high school to baccalaureate programs.....	94	61	16
7. From certificate and/or 1 year post h.s. programs to higher levels.....	130	27	14
8. From associate degree to baccalaureate degree programs.....	152	11	8
9. From baccalaureate to graduate programs.....	120	41	10
10. From on-the-job training programs to formal educational programs.....	123	40	8
11. From educational and/or training through working experience to formal educational programs.....	136	24	11
12. From military medical training and/or experience to formal educational programs.....	138	25	8
13. From pre-professional to professional.....	132	26	13
14. Other, Please Specify_____	12	0	159

Needs to Expand Cooperative and Coordinative Efforts in Educational Offerings as They Affect:

(please answer each question)

	Yes	No	Not Answered
15. Planning of new offerings.....	152	9	10
16. Changes in present offerings.....	152	7	12
17. Coordination with and between educational offerings within one institution.....	144	15	12
18. Coordination with and between educational offerings between different institutions.....	154	6	11
19. Avoidance of duplication in offerings.....	134	24	13
20. Identification of class openings in programs.....	130	26	15
21. Recognition of educati.. and experience not gained by formal means.....	141	18	12
22. Recognition of education and experience gained in military service.....	143	19	9
23. Introduction of academic equivalency tests in clinical skills.....	137	20	14
24. External degree establishment and implementation.....	100	39	32
25. Working with employers in establishing and implementing skill tests.....	136	2[illegible]	13
26. Provision of continuing education for practicing health professionals..	154	8	9
27. Working with employers in continuing education for health professionals	150	11	10
28. Working with employers in continuing education for health personnel at all levels.....	151	9	11
29. Other, Please Specify_____	6	0	165

VI. NEEDS FOR ASSESSMENT OF FACTORS OF INTEREST AND/OR CONCERN AS THEY AFFECT PLANNING AND EMPLOYMENT.

Please answer each question as you view the following needs:

		Yes	No	Not Answered
1.	Development by individual employers of their own independent skill tests	48	108	15
2.	Cooperative development and implementation of skill tests by different employers working together	95	62	14
3.	Joint planning and development of skill tests by employers and educators	127	31	13
4.	Joint planning and development of skill tests by employers, health personnel, educators and planners working together	148	14	9
5.	Joint planning for the introduction of new educational offerings by educators, employers, health personnel, health professional associations, health planners and consumers working together	151	9	11
6.	Joint planning and implementation of decisions to end outmoded educational offerings by educators, employers, health professional associations, health planners and consumers working together	148	11	12
7.	Joint planning and implementation of continuing educational programs by educators, health professional associations, employers, health personnel, health planners and consumers working together	151	8	12
8.	Employers conducting their own independent continuing education programs	72	83	16
9.	Cooperative planning for continuing education at all levels (on-the-job through professional)	152	7	12
10.	Identification of area of need in health care service delivery	147	9	15
11.	Development of a health manpower information bank	150	9	12
12.	Central information center for listing open positions	139	22	10
13.	Study of institutional accreditation	111	44	16
14.	Study of organizational (professional) certification	127	29	15
15.	Study of licensing statutes	128	29	14
16.	Study of registration	122	32	17
17.	Acceptance for employment of those educated and trained by other than formal means	114	40	17
18.	Acceptance for employment of those educated and trained	134	15	22
19.	Common Nomenclature	138	14	19
20.	Other, Please Specify_____	8	0	163

VII. REPRESENTATION OF RESPONDEE

Please answer each question as it applies to your response to this questionnaire.

		Yes	No	Not Answere
1.	Is your response, the official opinion of your employing institution?	9	148	14
2.	Does your response represent only your personal opinion?	127	30	14
3.	Does your response represent a combination of 1 and 2?	60	93	18

Total Compilation of Response to Questionnaire (continued)

VIII. PARTICIPATION IN CONFERENCES, AND/OR ASSISTANCE WITH PLANNING AND EVALUATION.

If you have answered any or all of the previous questions, please answer the following:

	Yes	No	Not Answered
1. Would you be interested in meeting with others who share your concerns?	156	7	8
If you answered YES to question 1 above, Would you or a designated representative(s):			
2. Attend a meeting(s) or conference(s)	145	9	17
3. Assist in planning	115	15	41
4. Assist in evaluation	112	16	43

IX. If you answered YES to any or all questions in Section VIII, please rank your preference 1 through 4 regarding implementation by placing the appropriate code numbers in the boxes below.

First Choice Total	Second Choice Total	Third Choice Total	Fourth Choice Total
Code 1.....38	Code 1.....13	Code 1.....11	Code 1.....22
Code 2.....18	Code 2.....12	Code 2.....9	Code 2.....7
Code 3.....3	Code 3.....5	Code 3.....4	Code 3.....4
Code 5.....4	Code 4.....2	Code 4.....3	Code 4.....8
Code 6.....7	Code 5.....2	Code 5.....9	Code 5.....9
Code 7.....51	Code 6.....11	Code 6.....13	Code 6.....17
Code 8.....21	Code 7.....28	Code 7.....25	Code 7.....9
Code 9.....12	Code 8.....51	Code 8.....27	Code 8.....12
	Code 9.....19	Code 9.....28	Code 9.....17

Code:

1. A general conference to include educators teaching all levels of health profession and occupations.
2. Separate and/or joint meetings of the associate and higher degree programs in allied health.
3. Separate meetings of those involved in vocational education.
4. Separate meetings of employers with clinical instructors.
5. Separate meetings of educators teaching programs outside of technical institutes, colleges and universities, such as hospitals and the like.
6. Joint and/or separate meetings of those in medicine, dentistry, veterinary medicine, nursing, pharmacy, podiatry, optometry with their allied personnel.
7. One statewide conference which would include "mini-conferences" and involve educators, employers, health personnel, planners and consumers which would report back to a statewide planning body. This to be followed later by regional and/or local conferences.
8. Regional conferences which would include "mini-conferences" and involve educators, employers, health personnel, planners and consumers which would elect one (1) representative to participate in a statewide planning agency.
9. Mini-conferences of individual organizations, institutions and/or groups, each of which would elect one (1) representative to participate in a statewide planning body.

X. Additional comments:

COMMUNICATION, COOPERATION AND COORDINATION IN HEALTH MANPOWER PREPARATION AND UTILIZATION.

Excerpts from speech delivered by: Thomas F. (Bud) Zimmerman, Ph.D.
Dean, School of Associated Medical Sciences
Project Director, Area Health Education System
University of Illinois, College of Medicine.

Communication, cooperation and coordination are vital subjects and I bring some good news and some bad news. The good news is the recognition we should; the bad news is the evidence we do not practice them. Unfortunately, the account we find in the Old Testament in the Book of Judges aptly describes our level of cooperation and preparation of health manpower and the utilization of same in the health industry. It notes that, "everyone was doing right in his own sight." I think that captures the essence of where we are at present.

My most recent experience is with the developing Illinois Area Health Education System, which has convinced me of two things. First, the gains to be realized in communicating, cooperating and coordinating are vast and worth the effort. Secondly, there are substantial problems that must be overcome. For example, we represent, in Illinois, about 70% of the state's population in four distinct regions. We are working in three broad disciplinary areas; graduate medical education, allied health education at the associate, baccalaureate and master's levels and nursing education at all levels. Institutionally, the involvement is with 29 hospitals and about 30 educational institutions. This provides excellent 'windmills'! The case for optimism is the growing awareness of all concerned, that we simply cannot afford to continue, "going it alone".

Following is a demonstration of the negative impact of not communicating, not cooperating and not coordinating. When the AHES proposal was first made to the board governing educational programs in six institutions, it was immediately apparent that this board, comprised of hospital administration, medical staff and university educatorss, had no idea whatsoever how extensive were the activities in each of the 6 institutions and certainly no awareness of what was happening in allied health education. They knew only that it was a growing problem in terms of utilization and cost.

It was found that in six hospitals there were nineteen different allied health education programs with 409 students, 533 part-time and 19 full-time faculty having varying degrees of affiliation with 38 different educational institutions. The condition was, if not chaotic, bordering closely on chaos, with a lack of consistency between institutions and levels of offerings. The goal of educational and career mobility cannot be supported without the vital foundation of an educational continuum with the segments planned together and operated conjointly and interdependently.

We are beginning to understand in a very practical way that programs of the community college do have a vital relationship and impact on the programming at the baccalaureate level; that both of these have a vital interdependence with the community hospital and that all of this must be addressed in an interdependent fashion. As a result, efforts are now being made to begin to identify the appropriate allocation of resources which will lead to coordination.

The impact of disjointed educational programming in the preparation of health manpower is manifested in disconnected care by the various professions as they serve the patient. It is also an issue of cost and it is clear that attention must be paid to the funding of educational programs.

Educational programs are, in the jargon of the day, "ripping off" clinical institutions and eventually the patient in terms of supporting educational costs. This is a stark cold statement, but much of clinical education in the allied health fields, nursing and graduate medical education is borne by the patient. There is also a limit to the number of students who can be accepted for clinical affiliation by any one institution.

The fact that the present mode of preparation and therefore the utilization of health manpower suffers dramatically due to the lack of cooperation, communication and coordination is a fact familiar to us all. Time prevents a full discussion of this broad topic, but following are three substantial problems which must be dealt with in attempting to build effective communication, cooperation and coordination.

The first is the substance of what we do in the preparation of health manpower; where and how the program should be developed. This is, "manpower intelligence". The other two are "process issues", which must be overcome if we are to communicate. These are, "institutional ego" and "professionalization".

Our approach to manpower intelligence to date has been far too simplistic. This has carried us far away from the complex nature of the information we seek. As we know, there are many different types of data which must go into the manpower intelligence effort. We are familiar with many. Examples of data are:

1. Professional 'nose count' by category.

2. Hospital job attrition numbers.

3. Budgeted vacancies.

4. "Wish trip" data. (If I had the world the way I liked it, I need ---)

5. Supply-demand data reflected in salaries paid different types of personnel.

6. Educational resources data. (the kind of material we push through the pipeline).

7. The number of educational institutions.

8. The number of accredited programs with class size, graduate output etc.

9. Economic data - This needs attention both at the 'macro' and 'micro' levels. When we look at the gross national product, we will begin to understand the health industry cannot continue to grow without some very negative impact on other sectors. This means that managing effective use of resources becomes even more critical and this re-emphasizes the absolute necessity of communication, cooperation and coordination. Those in the health industry concerned with preparation and utilization of human resources must pay heed to economic data of industry.

10. Epidemiological data - This is needed when generating program strategy and preparing manpower to meet identified community health needs in society.

NOTE: We continue to orient educational programs to episodic acute care, but we should begin to understand self-care and community care level programs as these potentially will have the greatest economic payoff.

11. Career interest data - There is a fantastic mismatch such as 300 students declaring an interest for which there are 20 class openings.

One of the bullets that must be bitten, is the balance between production for the health industry need and the provision of careers, not only for young people, but for the entire spectrum of the population. The university takes its mission of providing educational opportunities seriously and the fact that some subject majors have a tough time getting a job, does not mean that the university is going to stop teaching and encouraging students to take that major.

At the state boards of higher education, boards of regents and at legislative levels, career interest data has a very important impact. This is particularly true in a period of economic collapse, a period when we have perhaps saturated the field of public education and so much interest is turning to health careers.

12. Data representing a cross-section of health professions and institutions on national, regional and state health policy. - Lack of this data causes us to suffer a great vacuum in terms of establishing direction.

With reference to health manpower shortages, I simply state that as long as we are importing a vast proportion of our physician manpower from abroad and as long as we continue to fail to address care of the elderly, self-care and community care, we do have a substantial health manpower problem which continues to merit our intelligent communication, cooperation and coordination.

There is one flaw which affects contemporary problem solving in the health industry. This is to believe that our major problem is lack of data. Data will only enlighten the decision. We must give thought and realize that judgements must be made. There is no way we are going to accumulate enough data and thereby avoid a decision. A classic phenomenon is that should a study reveal we need 40 more of "X", 400 institutions go into business creating the 40 that are needed. We need all of the factions involved to sit down at a table and reach decisions and make judgements cooperatively. Manpower intelligence is a great sink into which can be invested vast sums of money. Efforts need to be maintained at the practical, operational level regardless of the fact that purists will be on your back.

Institutional Ego is the problem that impedes communication. The dilemma here is institutional economy, self direction and accountability. This makes it very difficult for institutions to work effectively together and communicate. Some examples are : the community hospital's relationship with the medical center with both bending over backwards to ensure maintaining their own ego.

the senior college working with the community college

the college of nursing working with the college of medicine

A possible reason for this situation is that institutions fail to recognize the ego problem and fail in knowing how to effectively deal with the situation.

Something is beginning to happen nationally which affects this situation. Possibility is that within the next ten years, as the educational resources which address the health manpower production increasingly become regarded as a public utility, dollars will flow to those institutions whose programs the public wants to buy. The institutional rigidity and ego will then be attacked and it will force changes. It appears that states will generate dollars to pay for graduate medical education. This means that state governments will be very interested in the types of education they are purchasing. Another pregnant topic is "certification of need". When you look at the national arena, you see the clashing of institutions and the conflicting courses being taken. Cooperation now, is vital.

Professionalization, or professionalism is one of the major maladies of health manpower production and utilization. All too often, professionalization has been accepted as 'the' goal, the good thing to do. While critical evaluation of the finer aspects is needed, there are also negative impacts.

One of the negative impacts noted by Dr. Lester Evans, a prominent medical educator, is what I would call a problem of insularity; the problem of becoming better at what one does. Too often this causes the professional to isolate himself from the meaning and significance of others about him to the point of defensiveness. In this very process of striving for mastery, they become islands unto themselves. Living on a professional island leads to some familiar non-productive behaviour which is very common. This can be lumped under the term, 'turf protecting", such as developing peculiar language, strange jargon, developing rites and rituals which distinguish the islands from intruders. The inhabitants of these professional islands lose touch and communication with and between each other as well as with and between professional groups. Communication frequently becomes impossible. John Spiegel, the president-elect of the American Psychiatric Association discusses another problem which is 'professional narcissism'. This is characterized by a mental state in which one has an exceedingly high idear of one's own self importance and vested interest. Unfortunately, self preoccupation characterizes much of the content of what we call professional. Spiegel likens professional organizations to trade unions, the primary agenda being to conjugate the verb, "to eat"... I eat, then you eat and then they eat.. The result is that what is delivered is less than the expectations generated by the professional groups for themselves. In the cold light of day it must be admitted that many of the propositions articulated in the name of professions are exclusionary, self-serving, outmoded and supported by incomplete and biased data.

Another negative aspect cited by Edward Shine of the Massachusetts Institute of Technology cuts through an insidious weakness called, "trained incapacity". The traditional educational model puts so much stress on the professional as an autonomous expert whom the client can trust that with the high degree of skill, high commitment to the professional ethic, we may well have trained out of most of our professionals, the attitudes and skills needed to work collaboratively.

The last negative aspect I will cite, is the "inflationary Impact". This is felt in both the escalating demands placed on individuals who wish to achieve professional status and in the cost of health care. In achieving the goal of greater acceptability, visibility, respectability, and, yes, money, professionals quickly grasp the significance of controlling the educational process. This results in continuous striving to ever elevate the educational standards and levels and in most cases without regard for the relevance to the actual world of work and content of the work.

Dr. Al. Light of the University of Chicago Medical Schools made some penetrating observations on the subject as he noted that hospitals remain the primary employer of health specialists. Salaries, as we know, consist of about three-fourths of all hospital costs. Faced with public pressure to cut rising costs, the hospitals seek to employ the lowest possible level of appropriately credentialled employees. Dr. Light states and I agree that this results in accusations that standards have been lowered. There are others who would claim that national health specialty associations are, however, being faced with an embarrassing disclosure of having pressed for unwarranted high levels of education for the work to be done. There is considerable evidence for the latter. The point is, that at a time when the cost of health care is such a major national problem, we must ask how much professionalism we can afford.

Negative impacts are important because professionalization as it presently operates does more to make communication difficult than it does to make it possible. I DO hope that these negative examples will not be accepted negatively, but rather as the fact that we are willing to confront ourselves with some reality.

On the more positive side, I would recommend that we upgrade the whole concept of what we mean by the health team. I refer to the kind of health team that embodies the principals of communication, cooperation and coordination. It is not satisfying to envision the health team at the level of an athletic event. It is too simplistic. It odes not deal effectively with all issues such as there are eleven players and this is the quarterback and so forth. You get lost in the analogy.

We must first accept some basic needs that force us to come to a team mode of operation which shows the magnitude of health need, the range and complexity of special knowledge and technology, the ever increasing diverse population that must be served and the exploding knowledge base. All of this adds up to the fact that we must make effective utilization of all of our available health manpower rather than thinking of the health team as an athletic team. What we are really talking about is a highly sophisticated spectrum of sociotechnical teams, and there are many teams. If we need a model it might be the National Aeronautics and Space Administration team and not a football team. A few of the qualities of an effective team from the field of organizational development are:

1. Mutual identity with respect to the primary task. (I would say we strike out effectively on this score.)

2. Open communication.

3. Mutual trust.

4. Mutual support. (I mean a predictable absence of hostility or indifference.)

5. A team that is managing and not avoiding conflict.

6. An effective team that is used selectively in the team mode, while recognizing that not all activity is appropriate or cost effective for team responsibility.

7. An effective team which contains members who possess a broad range of required skills to accomplish the mission at hand.

Lack of leadership may be the factor preventing team implementation. We should begin to think of leadership as functional rather than positional in responsibility. We should see leadership that will flow within the group depending upon the task and problem at hand. We should not see it tied to role or social status. We speak of dependent and independent roles. These, I suggest, are giant steps sideways. The issue is that roles should be interdependent.

It is important that there be more interdisciplinary activity so there is a vital experience between students in the various disciplines. We have cultivated a terrible assumption that has been accepted which is, "it takes one to teach one". Not long ago I sat through a very disturbing discussion on continuing education. Nursing and medicine was trying to decide whether the topic was nursing or medical education. I thought to myself that the real issue was, "let's get together on what kind of education will be effective to bring about good patient care and who cares whether it is taught by a physician or a nurse". I would further suggest that professions must reassess themselves and their accountability to society.

We could learn from the law field and the concept of "fiduciary". This is one that holds something of value for another and its benefit is the property of the other. The service provided by the health industry is for the patient, education is for the benefit of the student and ultimately the patient. Both belong to society and to each other in a fiduciary relationship. I am reminded of the experimentalists and clinicians discussing an experiment. In a cold dark dungeon is a plant growing in the one ray of sunlight that penetrates the gloom. Both the clinician and the experimentalist, after the clinician shocks the plant when it wilts, get into a big argument about who is doing the most for the plant. The plant is forgotten as the argument rages. This is very much the character and so much of the issue in which professional groups and institutions believe they are owners of their professions. Professional associations sometimes function with such great autonomy that they become confused about the issue of ownership and accountability. It is important that professionals, institutions and you and I understand that our organizations do NOT own the profession. We are caretakers of the service to be provided for the benefit of society.

As a last salvo, I would state that one of the most important things we can pay attention to, is the need for trust. I used to think in my youth, that too much stress was made on trust. However, I am ever increasingly convinced that we must deposit in each other, in other professions, in other institutions, in government, trust instead of the prevailing feelings of fear and anxiety with, "My God, what are they doing to us now?" The condition of trust will do much to positively affect and implement communication, cooperation and coordination. The reason that I feel trust is no longer naive, is that it is becoming increasingly apparent that if only for self interest and enlightenment we had best start trusting each other.

In summary, when it comes to communication, cooperation and coordination, Pogo summed it up very well when he said, "I have met the enemy and it is us!"

1/25/74
T. F. Zimmerman, Ph.D.
Excerpts from speech

mvb

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G L O S S A R Y *

The following definitions are stated for utilization at this Conference for the purpose of clarification of content during the discussion periods.

Accreditation is the process by which an agency or an organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. Accreditation shall apply only to institutions and programs.

Certification is the process by which a non-governmental agency or an association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or to use a particular title, or grants permission to institutions to perform specified functions.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

Qualifying examination is a criterion for measuring an individual's ability to meet a predetermined standard.

Equivalency testing is the comprehensive evaluation of knowledge acquired through alternate learning experience as a substitute for established educational requirements.

Challenge examination is equivalency testing which leads to academic credit or advanced standing in lieu of course enrollment by candidate.

Proficiency testing assesses technical knowledge and skills related to the performance requirements of a specific job; such knowledge and skills may have been acquired through formal or informal means.

* Invitational Conference on Communication, Cooperation and Coordination In Allied Health Manpower Preparation and Utilization, Columbus, Ohio, May 6-7, 1974. Glossary from Maryland Y. Pennell, M.P.H., Consultant, Division of Associated Health Professions, Bureau of Health Resources, Health Resources Administration, Department of Health, Education and Welfare.

Trends in Licensure, Certification, and Accreditation: Implications for Health-Manpower Education in the Future

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The title of this paper may be like the cart leading the horse. Perhaps the proper emphasis between the two anchor points of regulation and education of health manpower should be reversed, so that the title would read: "Trends in Health Manpower Education: Implications for Licensure, Certification, and Accreditation in the Future." That, however, is another direction. Here the concern is with the effect of regulatory mechanisms on education of health manpower.

Let us begin with a look at recent developments, either actual or projected, in each of the three main mechanisms for social regulation of health manpower: (1) licensure — a legal mechanism by which a governmental agency authorizes persons who have met specified minimal standards of competency to engage in a given profession or occupation;[1] (2) certification — a voluntary mechanism by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association; and (3) accreditation of educational institutions or programs, also a voluntary mechanism by which an agency or organization (unfortunately a multiplicity of agencies and organizations) recognizes a program of study or an institution as meeting certain predetermined qualifications or standards.

In addition to these three main mechanisms for social regulation of health manpower, two others are important and are assuming increasing significance. They are regulation of work settings, both external and internal, and requirements of payment programs. Trends in both these sectors of the health service system are important because they also have implications for education of health manpower. Regulation of work settings affects surveillance of quality of personnel, and requirements of payment programs affects financing of health services, including the manpower component.

All these mechanisms of social control are inter-related or interlocked, as Dr. William K.

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Selden and Mrs. Karen L. Grimm have pointed out so well in connection with their work on accreditation.[2] Thus, it may be helpful, and it will certainly avoid repetition, to extract the overall trends in regulation of health manpower that emerge from consideration of developments with respect to each mechanism of social control. For instance, all roads lead not only to Rome but to continuing education, certainly on a voluntary basis and perhaps as a legally required mechanism. The latest voice to join this chorus is the government-appointed Commission on Medical Malpractice, which released its report on April 17th after more than 18 months of study. The attempt here is to pull it all together before we turn to the implications for health manpower education.

Licensure

Licensing laws are an exercise of the police power of the state to protect the public health, safety, and welfare. As such, they were designed to specify requirements related to personal qualifications (age, residence, citizenship, and character) and to educational qualifications (course requirements, completion of approved programs, experience, examinations, etc.). While licensing laws allow persons to enter the profession or occupation on meeting the specified qualifications, if they are mandatory they require all who practice the profession to be licensed and exclude all others who do not meet these qualifications and are not licensed. Voluntary licensing laws, by contrast, do not forbid practice of the profession by non-licensed personnel but merely bar such personnel from holding themselves out as licensed, e.g., from using the title or insignia. Voluntary licensing laws have therefore been called a form of governmental certification.[3] Thus, the various economic repercussions of licensing laws contribute to the jealousy with which most licensed professions and occupations guard their jurisdictions.

In addition, licensing laws have legal repercussions that flow from the definition of the scope of functions that each licensing law contains. The physician's scope of functions is all inclusive, but other licensed personnel are authorized to perform only a segment of those functions. Fortunately, these definitions are usually couched in quite general terms, but nevertheless they specify the bounds of allowable practice. The legal effect is that liability can be imposed for overstepping these bounds, particularly if harm should result to the patient. Although such liability has been imposed in few cases, the fear of a malpractice suit or a license suspension has been sufficient to deter physicians from delegating tasks beyond custom and practice and to deter other licensed personnel from assuming increased responsibilities.[4]

Expanded insurance coverage has increased the effectiveness of the vastly expanded demand for health services as costs of services continue to rise. Proposals for use of well-trained allied and auxiliary health manpower for performance of tasks within their competence sounded the alarm on licensure for they are central to problems in licensing laws I have described. Scientific and technological developments and improved education and training made performance of many tasks by non-physician personnel both possible and safe, but still the licensing laws unreasonably blocked delegation of such tasks.

At the same time, it was recognized that the licensing laws created other rigidities out of tune with the contemporary scene. They blocked recognition of qualifications in education or experience other than those specified, often with great particularity, in the statute. They barred movement within an occupation and between related occupations by specifying hard and fast educational requirements. They discouraged mobility of health personnel across state lines because of restrictions on recognition of the licenses of other states.[5] They failed to protect the public adequately because they required no updating of qualifications. Composed in many instances of members of the profession seeking licensure, licensing boards produced segmented manpower policies, made with little representation of other professions, providers, or the public.

All these issues have been the subject of intense national debate over the last six to eight years, and as a result a number of developments have occurred or are projected.

A moratorium on the enactment of licensing laws for new categories of health personnel was supported by a number of professional

groups. Although some states have nevertheless enacted statutes licensing previously unlicensed categories, such as physical therapy assistants and speech therapists, by and large this moratorium has been observed and has certainly slowed down new licensing laws ,with added, defined scopes of functions.

More than 30 states have enacted or proposed legislation authorizing the functioning of physician's assistants. These statutes are of two kinds. One kind is an exception to the state's medical practice act that authorizes the physician to delegate routine patient care functions to allied health personnel. As of July 1972, nine states had enacted such statutes. The other kind of statute (in more than 20 states) provides a regulatory authority whereby the State Board of Medical Examiners is authorized to approve training programs for physician's assistants, to certify graduates, and to approve a physician's use of one or two physician's assistants. Only one state has enacted a licensure law for physician's assistants — Colorado in its Child Health Associate Law —and that was one of the first statutes in this field.

In addition to the physician's assistant laws, which authorize the functioning of a new kind of personnel, expanded functions have been authorized for existing licensed personnel, particularly for professional nurses and dental hygienists. Change to authorize the expanded role of the nurse has been slow in coming perhaps partly because of a division of opinion as to whether new legal authority was needed. The view of the HEW Secretary's Committee to Study Extended Roles for Nurses was that no new authority was necessary, that the nurse practitioner represented a logical extension of the functions nurses have long performed. This logical view could not prevail in the face of an opinion of the Attorney General of Arizona that the functions specified for the nurse practitioner would be in violation of the medical and nursing practice acts of that state; nor could it prevail in the face of the concerns about possible liability on the part of physicians and nurses in other states.

Accordingly, three routes have been taken or proposed to authorize an expanded role for nurses: amendment of the definition of professional nursing, as in New York State; exemption of professional nurses from the statutory prohibition on medical diagnosis and prescribing, when the diagnosis and prescribing are authorized by rules and regulations jointly promulgated by state medical and nursing boards, as in Idaho; and action by joint practice commissions, composed of representatives of the medical and nursing professions and the hospital associations, as proposed in Michigan and California.

The increasing recognition of the nurse-midwife should also be mentioned. Whereas in 1967 only three jurisdictions (New Mexico, the eastern counties of Kentucky, and New York City for deliveries in hospitals) authorized the nurse-midwife to do deliveries, today 17 states have authorized nurse-midwives to function in this capacity by statute, regulation, or opinion of the Attorney General of the state. Such legislation has just been introduced in the California Legislature by Senator Beilenson and Assemblyman Duffy.

Dental practice acts have long restricted dental hygienists to functions below their education and training. Within the last six years, however, nearly half the states (24) have amended or interpreted their statutes to allow expanded functions for dental hygienists or dental assistants or both.[8] Ten of these states now have what are called "open" dental practice acts, which permit the dentist to delegate to dental hygienists or dental assistants any procedure except those that require his skill.

Other developments in licensure consist of cautious moves toward recognition of equivalent qualifications in a few states (for x-ray technology in New York State and in California for medical corpsmen seeking to become professional nurses, candidates seeking licensure as vocational nurses, and licensed vocational nurses seeking to become professional nurses). Legal requirements for continuing education or proof of renewed qualifications as a condition of license renewal have been adopted. Such provisions are now required for optometrists, osteopaths, dentists, dental hygienists, and nurses, in a varying number of states. In California, as of 1976, both registered nurses and licensed vocational nurses will be required to inform themselves of developments in their fields,

either by pursuing an approved course of continuing education or by other means deemed equivalent.

The concept of institutional licensure, first proposed by Professor Nathan Hershey of the University of Pittsburgh has engendered considerable discussion. Under a scheme of institutional licensure, individual licensure would be retained for independent practitioners to whom the public has direct access, but persons employed solely within an institution in a dependent capacity would be regulated by extending facility licensure to cover personnel. Institutional licensure thus has two parts: (1) definition of jobs and qualifications for these jobs by health care institutions; and (2) review and regulation of job classifications, required training, and degree of supervision by a state agency accountable to the public. This proposal has disadvantages that are threatening to some professional groups who believe it may not take sufficent account of the need for inter-institutional credentialing of personnel so as to permit mobility. There is concern that the proposal may lock personnel into unique job descriptions and encourage further proliferation of occupations. Its principal advantages are that it would permit innovative and flexible use of personnel in an institutional setting, where team provision of care builds in safeguards, and add protection now lacking with respect to the many and increasing categories of personnel trained and employed by institutions and subject to virtually no controls except those of the employing institution. In a word, institutional licensure would recognize legal responsibility of health care institutions for the quality of care they provide by expanding institutional responsibility for performance of personnel.

Certification

Certification, the process of granting recognition to an individual who has met certain standards, may apply either to basic or to specialty qualifications. Registration, a term often used interchangeably with certification, is actually listing a name in a register of an agency if a person has completed certain training. Both certification and registration are intertwined with accreditation of educational programs because, as Grimm points out,[7] certification is often a shorthand means of identifying graduates of accredited programs.

While certification encourages professional attitudes and goals and was designed to provide an objective measure of competence by requiring the candidate to pass a national examination, in actuality a number of problems have been identified.[8] The basic requirement for certification is completion of an approved educational program, but the multiplicity of educational programs in different settings for the same occupation makes surveillance difficult. For many health occupations, no substitution of work experience or recognition of equivalent qualifications is allowed in place of academic qualifications for certification. Very few certifying bodies use examinations developed by professional testing agencies. In some cases, use of proficiency examinations might be a better measure of skills than written examinations. Not all certifying bodies require continuing quality of performance by persons certified, though they may require continuing membership in the association.

Many of these problems were discussed in a national conference on certification in 1971.[9] In addition, the Bureau of Health Manpower Education of the National Institutes of Health has let a contract to the Institute of Public Administration for a major study of "the complex and uncoordinated certification practices" and investigation of the feasibility of establishing a system of national certification.[10]

Accreditation

The process of accreditation of educational institutions and programs has been so thoroughly researched and analyzed by the Study of Accreditation of Selected Health Educational Programs (SASHEP) that here the discussion is limited to listing the issues that SASHEP identified and to summarizing its recommendations.

The issues are as follows:

1. Accountability of accreditation, since private agencies are functioning in a public role.
2. Structure of accreditation, since boards of accrediting bodies rarely contain lay members or representatives of other health professions or agencies.
3. Financing of accreditation, since the cost

of accreditation has been borne largely by the health professional organizations, which does not provide a sufficiently broad financial base.

4. Expansion of accreditation, since accrediting programs are proliferating as new health professions are established.
5. Research in accreditation, since little research has been done in this field and subjective judgments tend to govern decisions.
6. Relationship of accreditation to licensure and certification, since many licensing statutes require graduation from an accredited school, and similarly so for certification.

In view of its findings, SASHEP recommended establishment of an independent, broadly representative Council on Accreditation for Allied Health Education to sponsor, coordinate, and supervise accreditation of selected health educational programs and to relate accreditation to curricular development. The Council would be composed of physicians, allied health professionals, educators, representatives of institutional employers, public representatives, other health professionals, and representatives of the federal government. Thus, the recommended agency would be dominated by no single professional group.

Other Regulatory Mechanisms

These three main mechanisms for social regulation of health manpower are supplemented by other significant mechanisms. Regulation of work settings includes both external and internal regulation. Examples of external regulation are state hospital licensing laws and standards of the Joint Commission on Accreditation of Hospitals, both of which have provisions affecting qualifications of health personnel. The Professional Standards Review Organizations (PSROs) required by the Social Security Amendments of 1972 (P.L. 92-603) are a mechanism of external control by work settings. Examples of internal regulation are the constitution and by-laws of hospitals, decisions of their organized medical staffs and committees, and policies of trade unions.

Another mechanism regulating health manpower consists of requirements of payment programs, such as Medicare and Medicaid. On the theory that he who pays the piper calls the tune, payment programs may provide reimbursement of services only if they are provided by specified kinds of personnel with specified qualifications. In this way, Medicare has allowed reimbursement of allied health personnel under conditions designed to assure high-quality care, if provided incident to a physician's professional services and under the direct personal supervision of the physician. On the other hand, it is unfortunate that P.L. 92-603 amends Medicare to allow coverage of chiropractors' services effective July 1, 1973, but only with respect to treatment by means of manual manipulation of the spine and only with respect to correction of subluxation of the spine demonstrated by x-ray.

Trends in Regulation

These developments, taken together, point to several trends in regulation of health manpower. On the one hand, some of these trends consist of efforts to correct rigidities in the system that are not consonant with contemporary needs. On the other hand, these trends are designed to compensate for an excessive permissiveness that allows proliferation of new kinds of allied health personnel with variable preparation and minimal controls. These trends may be described as follows:

There is a trend towards authorizing more flexible use of health personnel. Although changes in licensing laws to expand the scope of functions of existing personnel and to authorize the functioning of new kinds of personnel have been effected only after extensive debate, these changes are here to stay. Moreover, they will probably be followed by further changes in this direction, as warranted by strengthened educational programs and increasing provision of services in organized settings where there are built-in checks on performance. Since the licensing laws had not been modified in any significant way for about 100 years before this movement started, it seems reasonable not to open the floodgates. The scope of functions of all allied health manpower appears to be widening continually, simply justified on the ground of custom and practice.

Second, and closely related to the first trend, is the trend toward credentialing new types of health personnel. As Margaret Mahoney and Sara Engelhardt point out, diversity of health manpower follows from diverse service needs.[11] The high degree of specialization in American medicine has engendered assistants trained to work in various specialties. Some form of credentialing, principally certification and accreditation of educational programs, is being sought for the many new kinds of assistants. Many kinds of technicians trained by institutions on the job (i.e., plaster cast and medication technicians), however, have no credentialing by an outside agency. One can speculate that efforts may be made on their behalf to obtain individual credentialing if some form of institutional licensure or alternate controlling mechanism is not adopted.

An increased recognition of work experience and equivalent qualifications as an alternative to traditional academic qualifications is occurring. One of the criticisms of certification is that it fails to allow substitution of equivalent qualifications. National policy, as reflected by P.L. 92-603, favors recognition of equivalent qualifications. Specific educational requirements in licensing laws may well become a thing of the past.

Another trend, closely related to recognition of equivalent qualifications, encourages lateral and upward mobility. Although there is general agreement that opportunities to move to related occupations at the same level of competence and up the ladder to more highly skilled positions are necessary, the mechanisms for facilitating these kinds of mobility are still poorly defined. Nevertheless, the trend is clear.

The possibility of the adoption of national standards and ultimate achievement of a national system of credentialing is increasing. National examinations, pioneered by the nursing profession through its State Board Test Pool Examination, and increasing use of national examinations by other professions, including medicine, may be one route to national standards. Enactment of a system of national health insurance covering the entire population would provide an opportunity for eliminating barriers to geographic mobility of personnel and for effecting a national system of credentialing, if the legislation builds in a manpower component, as the Kennedy bill does.

There is growing interest in making continuing education as much a part of a health professional's equipment as basic education. It is not yet clear whether continuing education will be handled on a voluntary basis through professional associations or whether legal requirements will be expanded. Since specialty certification is non-governmental, it is reasonable to anticipate that much of the continuing education will be required by specialty boards or professional associations. Still, there may well be an increase in statutory requirements for continuing education as well.

The trend toward a broader base for administration of credentialing would increase participation by related health professions and occupations, providers of health service, and consumers. Implementation of the SASHEP recommendations will bring together a wide range of professions and occupations in the accreditation process. The expanded legal liability of institutions under *Darling* v. *Charleston Memorial Hospital* [12] will compel increased involvement of health care providers, whether or not some form of institutional licensure is adopted. As consumers become active participants in planning and organizing health services, they will seek a voice, too, in the qualifications of personnel who are to provide those services.

Implications for Health Manpower Education

What are the implications of these trends for health manpower education and of the movement towards a more flexible system of regulating health manpower which would include increased protection for the public? This is a very important question because, basically, the best protection of the quality of health personnel is not licensure, certification, or accreditation but rather the educational preparation, both academic and practical, that each student receives.

Let us examine, therefore, the impact of these trends on the preparation of candidates for allied health occupations in the time

sequence that they face: admission to educational programs; pursuit of education and training; credentialing; and maintenance of qualifications.

It is becoming increasingly clear that all educational programs are being called on to provide multiple entry points. This means that persons with varying experience or qualfications other than traditional academic qualifications must receive recognition for their achievements. In order to effectuate such recognition, appropriate equivalency examinations must be developed. The drive in educational circles to provide increased educational opportunity through various versions of an open admissions policy and through development of the extended university with new teaching techniques for persons already in the world of work is an indication that imaginative implementation of multiple entry points is possible.

A number of important conclusions regarding conduct of education and training, flow from current trends in credentialing. Educational institutions and health care institutions must be prepared to train a broad range of personnel with different skills. This is already being done, of course, but the need for a variety of specialized skills will continue and, hopefully, periodic evaluation and rationalization of these skills will be undertaken so as to avoid excessive fragmentation. At the same time, educational institutions must assure a commonality of basic skills on which further training can be added, so that upward mobility is more than a pious hope. Thus, a core curriculum can assure basic knowledge, and articulation of other components of the educational program can provide the means for upward mobility.[13] If health personnel are to work together as a team in provision of service, they must be trained as a team. Dental hygienists and other dental auxiliary personnel are now trained in tandem with dental students in some places, and the medical school of the State University of New York at Stony Brook and the University of Nevada are engaged in innovative ventures of joint training of different kinds of health personnel. Actually, development of this approach in education will encourage the qualifications necessary to make lateral mobility a reality. A most important current trend points to the need for increased coordination of teaching and practice. Theory and practice have long been combined, but in the future, education of health manpower will require increased integration of lessons from the world of science and scholarship, with lessons from the world of practice.

As for the consequences of trends in credentialing for educational programs, that issue is as broad as it is long. If our educational programs were all of uniformly high quality, one could do away with a separate system of examinations. One could have graduation from an approved program constitute licensure or permission to practice, without further examination. This is the system in a number of countries, including the United Kingdom, where the medical schools are of uniform quality or under governmental control.[14] In the United States, our pluralistic system would seem to indicate continuation for some time to come of some form of examination, in addition to educational preparation. Therefore, educators of allied health manpower, licensing boards, the health professions, and the professional testing agencies, are addressing themselves, to devising more meaningful examinations to test competence. Such examinations, adopted nationwide, are contributing to development of national standards.

With respect to maintenance of continuing qualifications, there is no doubt that a large responsibility to devise imaginative and meaningful means of updating qualifications will fall on educational and health care institutions and on professional associations. In view of the high degree of specialization not only in medicine but in other professions, this continuing education should be in the field of the practitioner's specialty. The challenge to educational programs, health care institutions, and the health professions is to make continuing education as integral a part of the qualifications of health personnel as basic education.

In conclusion, the changes in social regulation of health manpower can remove barriers to innovations in education. One can go a step farther and state, with some justification, that changes in regulation of health manpower can serve as a tool affirmatively to encourage improved

education and training. The trends in licensure, certification, and accreditation thus open the door to advances in education. But the actual changes and advances that will take place in education of health manpower are up to the educators, the institutions, the practitioners, and the consumers.

References

1. For definitions of terms, health occupations licensed in each state, and much other valuable information and analysis, see Report on Licensure and Related Health Personnel Credentialing, DHEW Pub. No. (HSM) 72-11. U.S. Dept. of Health, Education, and Welfare. Office of Assistant Secretary for Health and Scientific Affairs, Washington, D.C., June 1971.
2. Selden WK: The Interrelationships of Accreditation, Certification, and Licensure. Certification in Allied Health Professions, 1971 Conference Proceedings, p 34. U.S. Dept of Health, Education, and Welfare. Bureau of Health Manpower Education, Division of Allied Health Manpower, Sept 7-10, 1971; Grimm KL: The Relationship of Accreditation to Voluntary Certification and State Licensure. SASHEP, Part II — Staff Working Papers, Accreditation of Health Educational Programs, p I-1. Study of Accreditation of Selected Health Educational Programs, Washington, D.C., Feb 1972.
3. Statement of Dr. William Shonick of the School of Public Health, University of California, Los Angeles.
4. Forgotson EH, Roemer R, Newman RW: Legal Regulation of Health Personnel in the United States, in Report of the National Advisory Commission on Health Manpower, Vol 2, pp 292-294, 423-428, U.S. Government Printing Office, Washington, D.C. 1967.
5. Report on Licensure and Related Health Personnel Credentialing, supra note 1 at 43. Restrictions on mobility are being eased, however, by increasing use of uniform national examinations.
6. Johnson DW, Bernstein S: Classification of states regarding expanding duties for dental auxiliaries and selected aspects of dental licensure 1970. American Journal of Public Health p 208, 1972.
7. Grimm; supra note 2 at I-5.
8. Certification in Allied Health Professions, supra note 2.
9. Certification in Allied Health, 1971 Conference Proceedings, U.S. Department of Health, Education, and Welfare. DHEW Pub. No. (NIH) 73-246, Sept. 1971.
10. News Release, Bureau of Health Manpower Education, Division of Allied Health Manpower, U.S. Dept. of Health, Education, and Welfare, February 26, 1973.
11. Mahoney ME, Engelhardt SL: Toward an evaluation system for health education. The Pharos, p 62 63 (April) 1973.
12. 33 Ill. 2d 326, 211 N.E. 2d 253 (1965).
13. Hamburg J: Core curriculum in allied health, JAMA Vol 210, p 111, 1969.
14. Roemer R: Legal systems regulating health personnel, A comparative analysis. Milbank Memorial Fund Quarterly Vol XLVI, No 4, p 431 436 ff, Oct 1968.

INTRODUCTION AND BACKGROUND

SELECTED HEALTH MANPOWER EDUCATIONAL OFFERINGS IN OHIO

This data shows changes by type of offering in selected health manpower educational programs in Ohio, between October, 1970 and November, 1973.

Included are operational programs offered in 1970, those phased out or dropped, additional new offerings, total programs operational as of November, 1973 and programs proposed for the future. Differentiation is made between educational levels in the same discipline.

The summary shows an overview. The detail of changes by type of offering and teaching institution have also been prepared.

The 1970 data was compiled as the result of a questionnaire to all educational institutions in Ohio. This was included in the Health Careers of Ohio educational brochures first published in October, 1970.

The balance of the data was obtained from response to mail questionnaires, telephone calls and researching of catalogues. Health Careers of Ohio serves as the statewide information center on health professions and occupations education and therefore information must be constantly updated. However, with daily changes occurring, there may be some changes which did not reach us by publication date.

Detail concerning student composition in type and number, retention rate, placement of graduates and other data, await available funding.

Monica V. Brown
Director

December, 1973

SUMMARY OF CHANGES IN HEALTH EDUCATIONAL PROGRAMS IN OHIO

BETWEEN SEPTEMBER 1970 AND NOVEMBER 1973

Pages 1 and 2 are offerings for which Health Careers of Ohio has brochures. Note: See page 2 for Totals
Pages 3 and 4 are offerings for which Health Careers of Ohio does not have brochures.

TYPE OF OFFERING Numbers are HCOO Codes	CERTIFICATE					ASSOCIATE					BACCALAUREATE					MASTERS					HIGHER				
	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed
001 Hospital Administration	-	-	-	-	-	-	-	-	-	-	0	0	0	0	1	2	0	0	2	1	-	-	-	-	-
002 Health Planning	-	-	-	-	-	-	-	-	-	-	1	0	1	2	0	2	0	0	2	0	-	-	-	-	-
051 Medical Assisting	0	0	2	2	0	6	0	4	10	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
052 Medical Secretarial	0	0	5	5	0	8	1	11	18	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
101 Medical Technology	-	-	-	-	-	-	-	-	-	-	37	2	0	35	0	-	-	-	-	-	-	-	-	-	-
121 Microbiology	-	-	-	-	-	-	-	-	-	-	8	1	4	11	0	9	0	4	13	0	9	0	4	13	0
151 Radiologic Technology	75	10	8	73	0	3	0	3	6	6	1	0	1	2	2	0	0	1	1	1	0	0	0	0	0
201 Dietetics	-	-	-	-	-	-	-	-	-	-	20	2	2	20	1	-	-	-	-	-	-	-	-	-	-
261 Home Economics	-	-	-	-	-	-	-	-	-	-	17	1	3	19	0	-	-	-	-	-	-	-	-	-	-
321 Environmental Health	-	-	-	-	-	3	0	8	11	6	3	0	2	5	0	0	0	4	4	0	0	0	3	3	0
401 Medical Illustration	1	1	0	0	1	-	-	-	-	-	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-
431 Med. Record Admin.	1	1	1	1	0	2	1	2	3	3	1	0	0	1	1	-	-	-	-	-	-	-	-	-	-
451 Health Education	-	-	-	-	-	-	-	-	-	-	5	-	6	11	0	5	0	1	6	1	3	0	1	4	0
501 Dentistry	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	0	0	2	0
504 Dental Hygiene	-	-	-	-	-	2	0	3	5	0	1	0	0	1	1	-	-	-	-	-	-	-	-	-	-
505 Dental Assisting	2	0	3	5	0	0	0	1	1	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
506 Dental Laboratory Tech.	0	0	1	1	0	1	0	0	1	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
531 Medicine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	0	0	4	2
561 Optometry	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0	1	0
571 Pharmacy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	0	0	4	0
581 Podiatry	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0	1	0
591 Veterinary Medicine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0	1	0
594 Animal Care Technology	-	-	-	-	-	2	0	0	2	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
701 Occupational Therapy	-	-	-	-	-	-	-	-	-	-	1	0	1	2	1	-	-	-	-	-	-	-	-	-	-
702 Occupational Ther. Asst.	0	0	1	1	0	0	0	2	2	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
721 Physical Therapy	-	-	-	-	-	-	-	-	-	-	1	0	1	2	2	-	-	-	-	-	-	-	-	-	-
722 Physical Ther. Asst.	-	-	-	-	-	0	0	2	2	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Summary of Changes..1970-1973 (Continued)

(Offerings for which Health Careers of Ohio has brochures) Continued

TYPE OF OFFERING Numbers are HCOO Codes	CERTIFICATE					ASSOCIATE					BACCALAUREATE					MASTERS					HIGHER				
	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed
751 Speech Path. & Audio.	-	-	-	-	-	-	-	-	-	-	9	0	3	12	1	8	0	1	9	0	4	0	2	6	0
801 Psychology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8	0	5	13	0
831 Social Work	-	-	-	-	-	-	-	-	-	-	18	1	16	33	1	3	1	0	2	0	2	0	0	2	0
921 Surgical Assisting	0	0	5	5	0	3	1	1	3	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
931 Respiratory Therapy	0	0	4	4	0	3	1	4	6	6	1	0	1	2	1	-	-	-	-	-	-	-	-	-	-
932 Circulation Therapy	-	-	-	-	-	-	-	-	-	-	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-
Sub-Total (Offerings on HCOO Brochures)	79	12	30	97	1	35	4	45	76	42	128	7	43	164	15	29	1	11	39	3	39	0	15	54	2
Sub-Total (Offerings not on HCOO Brochures)	48	4	6	50	0	62	4	12	70	21	13	0	4	17	6	14	0	1	15	0	6	0	1	7	0
GRAND TOTAL	127	16	36	147	1	97	8	57	146	63	141	7	47	181	21	43	1	12	54	3	45	0	16	61	2

Summary of Changes..1970-1973 (Continued)

(Offerings for which Health Careers of Ohio does not have brochures) Continued

TYPE OF OFFERING Numbers are HCOO Codes	CERTIFICATE					ASSOCIATE					BACCALAUREATE					MASTERS					HIGHER				
	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed	1970 Operational	Phased Out or Dropped	New Added	1973 Operational	Proposed
102 Cytotechnology	13	1	0	12	0	2	0	0	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
105 Medical Lab. Tech.	-	-	-	-	-	10	1	1	10	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
106 Certified Lab. Asst.	15	2	0	1.	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
107 Nuclear Med. Tech.	2	0	0	2	0	2	0	0	2	1	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-
109 Histologic Tech.	4	1	3	6	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
155 Radioisotope Tech.	-	-	-	-	-	2	1	0	1	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
221 Dietary Technology	-	-	-	-	-	1	0	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
222 Food Service Tech.	0	0	1	1	0	3	0	0	3	1	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0
227 Food Serv. Supervisor	-	-	-	-	-	12	1	0	11	1	0	0	1	1	0	-	-	-	-	-	-	-	-	-	-
351 Biomedical Eng.	-	-	-	-	-	-	-	-	-	-	2	0	0	2	1	5	0	0	5	0	5	0	0	5	0
354 Biomedical Equip.Tech.	-	-	-	-	-	1	0	1	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
355 Biomed. Instrument.	-	-	-	-	-	0	0	0	0	1	0	0	0	0	1	-	-	-	-	-	-	-	-	-	-
432 Medical Library../ Med.Communications	-	-	-	-	-	-	-	-	-	-	2	0	0	2	0	1	0	0	1	0	1	0	0	1	0
551 Physician Assistant/ Physician Associate	2	0	0	2	0	1	0	1	2	1	1	0	0	1	1	-	-	-	-	-	-	-	-	-	-
562 Optometric Tech.	-	-	-	-	-	0	0	0	0	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
563 Orthoptic Tech.	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
572 Hosp.Pharmacy Tech.	-	-	-	-	-	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
573 Pharmaceutical Tech.	-	-	-	-	-	0	0	0	0	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
615 Nurse Anesthesiology	7	0	2	9	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
771 Recreational Therapy	-	-	-	-	-	-	-	-	-	-	5	-	-	5	2	1	0	0	1	0	-	-	-	-	-
773 Music Therapy	-	-	-	-	-	0	0	1	1	0	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-
781 Rehabilitation Coun.	-	-	-	-	-	-	-		-	-	-	-	-	-	-	7	0	0	7	-	-	-	-	-	-
835 Comm. Serv. Aide/ Social Serv. Tech.	-	-	-	-	-	6	0	4	10	0	0	0	1	1	-	-	-	-	-	-	-	-	-	-	-
841 Mental Hlth. Tech.	-	-	-	-	-	6	1	1	6	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Summary of Changes..1970-1973 (Continued)

(Offerings for which Health Careers of Ohio does not have brochures) Continued

TYPE OF OFFERING Numbers are HCOO Codes	CERTIFICATE					ASSOCIATE					BACCALAUREATE					MASTERS					HIGHER				
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855 Child Care Tech./ Child Develop. Tech./ Early Childhood Educ./ Day Care Manage.Tech.	-	-	-	-	-	14	0	2	16	3	1	0	2	3	1	-	-	-	-	-	-	-	-	-	-
918 EEG Technology	3	0	0	3	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
919 Environ.Management	1	0	0	1	0	1	0	0	1	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
923 Opthalmologic Tech.	0	0	0	0	0	0	0	1	1	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sub-Total (Offerings not on HCOO Brochures)	48	4	6	50	0	62	4	12	70	21	13	0	4	17	6	14	0	1	15	0	6	0	1	7	0

Over 200 Health Careers

Ohio Needs Qualified Health Manpower Now!

One million more new positions will be available by 1975. If you want to help your fellow man, gain recognition for yourself and have a secure future with good pay in one of the more than 200 health careers . . .
Investigate for Yourself.

Physician — A man or woman devoted to the healing arts, who deals intimately with human well being both physical and mental. The physician uses scientific knowledge coupled with empathy for others to prevent and cure the diseases of mankind.

Nurse — Nursing is a service and a science. Promotion of good health, prevention of disease and care of the sick are three responsibilities of men and women in nursing.

Medical Technologist — Medical Technologists perform scientific fact-finding tests in clinical pathology, research and nuclear medicine laboratories that help track down the cause and show the way to cure and find the prevention of disease.

Pharmacist — The pharmacist is a specialist in the science of drugs. He compounds medicines and dispenses prescriptions ordered by physicians, dentists and other prescribers.

Occupational Therapist — The occupational therapist is a man or woman who uses purposeful educational and recreational activity as treatment for physical or emotional disabilities to restore good health.

Veterinarian — The veterinarian is skilled in the diagnosis, treatment and prevention of diseases in animals who protects the health of the community by: preventing the transfer of the diseases from animal to man; conserving our livestock resources; engaging in scientific research and being dedicated to the relief of pain and suffering in all creatures.

Optometrist — A man or woman concerned with the eyes who examines them and their related structures as they affect visual problems and other abnormalities. One who prescribes and adapts lenses and other optic aides.

Inhalation Therapist — Inhalation therapy is a specialty concerned with human respiration function. The inhalation therapist restores normal respiration by administering treatment ordered by a physician.

Dentist — the dentist is devoted to the prevention and healing of oral diseases. Dentistry is concerned indirectly with the health of the entire body and extends to scientific research in many areas of investigation.

Dietitian — Dietitians are specialists in foods and nutrition as they affect the health of people. They also work in food research, in industry and teaching.

Physical Therapist — The physical therapist works with patients to restore function and prevent disability after disease or injury. They help patients to reach maximum performance to the utmost of their capabilities.

Radiologic Technologist — The radiologic technologist, formerly called the x-ray technician is an assistant to the radiologist. He works with patients and x-ray machinery. There is advancement with further training and education into nuclear and radiation therapy technology.

Medical Records Science — Medical Record Librarians and Technicians prepare and preserve health information and design and maintain accurate files of health records which are so vital to help prevent, cure and treat the diseases of mankind.

The best way to know if a health career is for you, is to find out as much as you can about the career in which you are interested.

There are more than 200 health careers. The shortage of health manpower in our nation and particularly in Ohio, **will provide you with opportunity in whatever career you choose.**

Listed below are some of the many challenging health careers. Check one or several — Detach card — Drop it in the mail and we will send you information. If your chosen health career is not included, write it in below so we can send you details.

- ☐ 001 Hospital Administrator
- ☐ 002 Health Planner
- ☐ 051 Medical Assistant
- ☐ 052 Medical Secretary
- ☐ 101 Medical Technology
- ☐ 121 Microbiologist
- ☐ 151 Radiologic Technologist
- ☐ 201 Dietitian
- ☐ 261 Home Economist
- ☐ 321 Environmental Health
- ☐ 401 Medical Illustrator
- ☐ 431 Medical Record Adm.
- ☐ 451 Health Educator
- ☐ 501 Dentist
- ☐ 504 Dental Hygienist
- ☐ 505 Dental Assistant
- ☐ 506 Dental Laboratory Technologist
- ☐ 531 Physician
- ☐ 561 Optometrist
- ☐ 571 Pharmacist
- ☐ 581 Podiatrist
- ☐ 591 Veterinarian
- ☐ 601 Registered Nurse
- ☐ 621 Licensed Practical Nurse
- ☐ 701 Occupational Therapist
- ☐ 721 Physical Therapist
- ☐ 751 Speech Pathologist & Audiologist
- ☐ 801 Psychologist
- ☐ 831 Social Worker
- ☐ 911 Non-College Occupations
- ☐ 921 Surgical Assistant
- ☐ 931 Inhalation/Respiratory Therapy
- ☐ 932 Circulation Technologist

Please Print—Please Fill Out Completely

Name _____ ☐ M ☐ F
Last First Middle Sex

Address _____

City _____ State _____ Zip _____

High School _____

High School Year Grad. _____ Year of Birth _____

College: Student _____ Graduate _____

Graduation year _____

If veteran, please state branch of service _____

and Social Security number _____

100M—Rev. 73

Health Careers of Ohio

What is Health Careers of Ohio?

- **People** helping other people learn about educational requirements and opportunities for jobs in the health field.

- **People** bringing other people together who work and teach in the health professions and occupations, to discuss common concerns and find improved ways of making sure that everyone in Ohio has the best possible health care.

- **People** researching the changing patterns and needs for health personnel in our State.

- **People** sharing their knowledge by translating planning into action.

Health Careers of Ohio is People Serving Others . . .

How Does Health Careers of Ohio Serve Others?

- **By distributing** literature through the Central Information Center about health professions and occupations. The brochures include career descriptions, employment outlook, salaries, educational requirements, financial assistance and where to study.

- **By offering** programs, films and slide shows about health career opportunities to high schools, community colleges, technical institutes, colleges, universities, and voluntary organizations and groups.

- **By conducting** studies to help identify needs for health personnel as they affect educational offerings and employment possibilities.

- **By cooperating** with others in planning and conducting conferences and seminars to bring about coordination of efforts by all involved in counseling those interested in going into the health field, educating aspiring health careerists, planning for optimum delivery of health care and employing health personnel.

Why Health Careers of Ohio?

- Before Health Careers of Ohio, there was no focal point in Ohio where all those concerned with health manpower could come together. There was no central location where people interested in working in the health field could learn how to study for a health career or where to obtain information.

- In 1970, through the efforts of Ohio's leaders in the health field, Health Careers of Ohio was born.

- By 1971, Health Careers of Ohio was incorporated as a non-profit, tax exempt voluntary organization.

Facts on OHIO OPERATION MEDIHC

- **Ohio Operation MEDIHC** is part of a nationwide program designed to help men and women who received education, training and experience in health areas while in military service to utilize their knowledge and ability when they return to civilian life.

- **Ohio Operation MEDIHC** will also assist those who served in military fields unrelated to health and who are interested in pursuing civilian health careers

- **Ohio Operation MEDIHC** provides counseling and vocational guidance for veterans. **It does not provide any educational programs.***

- **Ohio Operation MEDIHC** puts employers and educators of health personnel in contact with veterans interested in pursuing health careers.

- **Ohio Operation MEDIHC** is located in Columbus, Ohio and administered by The Ohio State University, College of Medicine.

- **Health Careers of Ohio,** Columbus, Ohio is the designated agency for **Ohio Operation MEDIHC.** It is a "not for profit" organization incorporated under the laws of the State of Ohio.*

- **Health Careers of Ohio-Operation MEDIHC** does **not** charge for its services.

* Health Careers of Ohio serves as the center for distribution of information about health careers and health manpower, including qualifications and accredited educational programs.

OHIO OPERATION MEDIHC

A Resource Center For:

Veterans

You may be one of the many veterans who have had valuable education, training and experience in health areas while in the military. If so, Ohio Operation **MEDIHC** urges you to take advantage of your training and experience by directing yourself to a comparable job in the civilian health care field which is constantly demanding qualified health personnel.

Or do you first want to expand your knowledge, training and experience? And what if you were not in a health occupation and now you are interested in a health career? Ohio Operation **MEDIHC** urges you to consider one of the numerous health career opportunities in Ohio's excellent educational institutions.

How MEDIHC Serves Veterans

- Refers applicants to possible places of employment.
- Provides information on health professions and occupations.
- Provides information on educational opportunities.
- Send **MEDIHC Profiles,** a roster of applicants, which includes brief descriptions of veterans objectives, past experience, home address and phone number to employers of health personnel.
- Refers applicants, interested in employment or educational opportunities in other states, to the appropriate state **MEDIHC** offices.

If you are interested in learning about opportunities in the health field and would like assistance and guidance in finding a health job or educational program which meets your career objectives, please write or telephone us. If you are still in the military, a MEDIHC application form can be obtained from the Transition Program Counselor on your military base.

Employers and Educators

Employers, does meeting your health manpower requirements present problems periodically? Constantly?

Educators, does the number of applicants for your health careers programs fall short of your institution's desire and capacity to produce the ever increasing numbers of qualified health manpower required in your community or in other Ohio communities?

Health Careers of Ohio—Operation **MEDIHC** is striving to help improve and expand the delivery of health services in Ohio. Each month, men and women, many of whom are qualified health personnel, are separated from the military. Some professional backgrounds include patient care, clinical laboratory, planning, social services, environmental health and administration. **MEDIHC** urges you to join us in tapping this valuable manpower resource and to absorb these people into the job opportunities and/or educational programs within your organization or institution.

How MEDIHC Serves Employers and Educators

- Expedites employer requests for specific types of personnel by putting employers in direct contact with **MEDIHC** applicants having the requisite job skills, education and experience.
- Directs **MEDIHC** applicants to educational institutions which offer programs in the applicants' career objectives.
- Provides employers with **MEDIHC Profiles** published by the Ohio Hospital Association. This is a roster of Armed Forces veterans who have had education, training and experience in health areas while in the military. (Contact us if you wish to be placed on our mailing list.)

Please write or call and let us know how we can serve you better in meeting your demands for health manpower.