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ABSTRACT

Problems related to the delivery of continuing education programs in the allied health professions are examined, based on the viewpoints of allied health professional organizations, allied health faculty members, and continuing education administrative units. Problems as seen by professional organizations include: allied health continuing education (AHCE) is provided for membership as a tangible benefit; AHCE is considered an area for financial gain; AHCE approval process and recordkeeping is unique to the organization; and communication and coordination between and among allied health organizations is minimal or nonexistent. Problems as seen by allied health faculty members include: AHCE is an overload activity for faculty members; AHCE is provided by professional clinical sites and the clinical affiliation agreements may be jeopardized if allied health schools or colleges develop AHCE programs and the faculty compete with affiliated institutions; AHCE is a responsibility of the allied health faculty who should present the program content; and AHCE programs should not mix noncredit and credit students. Problems in AHCE as seen by continuing education (CE) administrative units include the following: revenue generated by AHCE activities must partially support the CE administrative staff; and the health care team is often discussed but few AHCE programs are developed to focus on this concept. Suggestions for solving problems include the following: encourage the establishment of national standards for processing AHCE program proposals and encourage allied health professional organizations to establish a uniform approval form. (SW)

PROBLEMS IN ALLIED HEALTH CONTINUING EDUCATION

Jacqueline Parochka

Introduction

By way of an introduction I'd like to identify the academic units of the University of Illinois Medical Center Campus and the relationship they have to the Office for Continuing Education in Region 1-A.

The academic units of the University of Illinois Medical Center are as follows:

1. College of Associated Health Professions
2. College of Dentistry
3. College of Medicine (subdivision)
4. College of Nursing
5. College of Pharmacy
6. Graduate College
7. School of Public Health
8. Center for Educational Development

In 1969, the University of Illinois College of Medicine reorganized into a system of component units. Three of these units, the Rockford School of Medicine, the Peoria School of Medicine and the School of Clinical Medicine at Urbana-Champaign, are formally organized schools. At each of these sites, an Office for Continuing Education was established.

Since September 1975, the Office for Continuing Education in Region 1-A at Rockford has been offering a variety of continuing education programs specifically designed for various groups of health care professionals. Most of the program offerings developed through this office are tailored to the identified needs and wants of the health professionals in the nine northwestern counties of Illinois namely Jo Daviess, Stephenson, Winnebago, Carroll, Ogle, Whiteside, Lee, Boone and DeKalb. This geographic area is known as Region 1-A.

Today's presentation focuses on problems related to the delivery of continuing education programs in the allied health professions. The views presented are not exhaustive but are representative of current problems in the field of continuing education.

The viewpoints to be considered are those of:

1. Allied health professional organizations.
2. Allied health faculty members.
3. Continuing education administrative units.

Problems in Allied Health Continuing Education (AHCE) as seen by professional organizations are:

1. AHCE is provided for membership as a tangible benefit. The provision of continuing education programs is incorporated into the national program format of virtually every allied health organization. One key point to remember however is that not all members of a professional organization are able to attend a national meeting. For that matter, they are seldom able to attend either regional or state meetings. For this reason, professional organizations need to attend to their primary function which is the dissemination of research and development results. This can best be accomplished by providing the information through the professional journals associated with the professional organization. I was encouraged to note that sometime ago AJMT had begun a continuing education program entitled "Mini Courses". Members of ASMT and/or P.A.C.E. are able to accumulate individual education units for their participation in these courses.

2. AHCE is considered an area for financial gain. Many professional organizations view continuing education programming as a money maker. What is not taken into consideration is the administrative support staff needed to offer the noncredit courses and the financial support needed to provide these activities. If it weren't for the fact that many continuing education programs are coordinated and planned by volunteers, there would not be the dollars left after the payment of direct and indirect program expenses. Hence, unless

administrative expenses are calculated as part of the program cost, referring to profits after expenses is a misnomer.

3. AHCE approval process and record keeping is "unique" to our organization. Yes indeed many allied health organizations have their own individualized approval process. The technologist Section of the Society of Nuclear Medicine has a process called Verification of Involvement in Continuing Education (VOICE), the American Society of Radiologic Technologists has Evidence of Continuing Education (ECE) and of course ASMT has P.A.C.E. to name just a few. While providing each professional organization a degree of visibility and esteem, the process is a variable from one organization to the next.

4. Communication and coordination between and among allied health organizations is minimal or non-existent. Physical Therapy, Occupational Therapy, Medical Records Administration, Medical Technology, Dietetics, etc.etc.etc., all have a similar professional organization structure consisting of elected officers, a House of Delegates, a state chapter or association with respective districts or chapters. A Constitution and Bylaw governs the business of each professional organization. Each professional organization stands as a tribute to the democratic process of government evidenced here in the U.S.A. However, learning from one another is impeded since the process of communication between and among the organizations is minimal. The American Society of Allied Health Professions serves as one possibility of bridging the gap between the allied health organizations and makes an attempt to serve as umbrella for all groups. As this organization creates a state structure, the capability of this organization to serve allied health will become solidified.

The next group of problems in AHCE will be reviewed by citing the opinions and perspectives of allied health faculty members. The first problem is: Problems in AHCE as Seen by Allied Health Faculty Members:

1. AHCE is an overload activity for faculty members. Faculty members are already stretched with teaching and research responsibilities. Oftentime continuing education is not considered a part of the promotion and tenure tract, consequently, faculty members view continuing education involvement as a lesser priority. Sometime colleges and universities are unable to pay the faculty to present the content of continuing education programs. Thus, no additional pay and no credit on the promotion and tenure tract equals no involvement in either continuing education program planning or development. Higher education first, must find ways of financially compensating allied health faculty members, especially when the program is sponsored by an allied health department or college. Second, higher education must give credit toward promotion and tenure by incorporating continuing education program planning, development and delivery.

2. AHCE is provided by professional organizations. If an allied health school or college develops AHCE programs, then the faculty competes with the professional organizations. Many allied health professional organizations are the sole providers of continuing education programs at the state and local level. Since the majority of allied health faculty are members and are oftentime the leaders of their discipline specific professional organizations, as well as other professional organizations, to offer continuing education programs through the allied health school or college places them and the school or college in competition with the professional organization. Hence, allied health faculty members view the provision of continuing education activities at the state and local level as a "conflict of interest" between the institution of higher education and the professional organization.

3. AHCE is provided by clinical sites. If an allied health school or college develops AHCE program, then the faculty competes with an affiliated institution. This may jeopardize the clinical affiliation agreements. Competing with an affiliated institution is viewed by some allied health faculty members

as more of a violation than competing with a professional organization. For this reason, allied health faculty members are reluctant to offer continuing education activities. One thing faculty members should remember is that continuing education information dispensed at a clinical facility is usually site specific. That is, the continuing education information is of an inservice nature and by definition should offer an update on procedures and policies unique to that clinical facility. Faculty members should keep in mind that there are a diversity of procedures, techniques and theories which can be compared and contrasted and thus could be offered as an educational activity to a total professional audience.

4. AHCE is a responsibility of the allied health faculty. Allied health faculty members should present the program content. If AHCE activities are sponsored by an allied health college or school, then faculty members have the perception that the content should be offered by the faculty within that school or college. This is only partially correct. An allied health school or college can hire external presenters, i.e. faculty members from other allied health programs or nationally known experts in the field could serve as program presenters. Thus, faculty members could help plan and develop the continuing education program but the content could be offered by individuals external to the allied health unit. It is of course understood that the allied health school/college would employ some quality assurance mechanism in which the program objectives, content outline and evaluation procedures would be reviewed prior to brochure development.

5. If allied health faculty members are either unable or unwilling to deliver the content, then the AHCE program should not be offered. Because of this perception, some faculty members avoid thinking of offering continuing education activities. This is a dilemma which should be addressed by allied health programs across the country.

6. AHCE programs should not mix noncredit "students" with "students" enrolled for academic credit. Allied health programs should begin to examine ways of admitting participants into graduate courses who either do not wish to secure an advanced degree or are unable to do so but who would like CEUs or some professional credit for their involvement. The University of Illinois Medical Center Campus has initiated such a process. Students may enroll in some graduate courses and may secure continuing education credit for their participation. At the outset, students are told that once hours of continuing education are recorded they can not be transferred into academic credit. In addition, noncredit students pay a nonrefundable registration charge separate from the tuition rates of the university. Finally, records for attendance as a noncredit student are maintained by Offices of Continuing Education and are not recorded by the Office of Admission and Records of the University. Hence, a special procedure has been initiated to separate credit students from noncredit students.

7. Allied Health faculty members cannot offer AHCE programs for other allied health disciplines. Allied health faculty members most commonly think of offering continuing education activities for their professional peers. There are times when programs could be developed for other allied health disciplines. For example, dieticians could offer a continuing education activity on some nutritional topic directed toward a dental hygienist audience in which the content could address the relationship between dietary intake and dental caries and gum disease. Medical technologists could present a continuing education course for nurses in which normal and abnormal laboratory results are explained and discussed. There are certainly other examples which you can think of.

8. The numbers of practicing professionals are small in number - therefore it is difficult to plan AHCE programs. This problem plagues all the allied health professions organizations at the state and local level. Continuing education programs budgeted to break even with small numbers of participants in

attendance can be costly to the individual registrant. This, however, should not be viewed as a deterant to planning continuing education activities. One way to solve this problem is to plan and develop interdisciplinary programs. Examples of universal topics needed by all allied health professionals are:

Professionalism/Socialization

Changing Values and Ethics

Interdisciplinary Teams and Professional Roles

Interpersonal Communications

Management Theory and Practice and

Quality Assurance.

The final group of problems to be examined today will be those associated with continuing education administrative units:

Problems in AHCE as seen by CE Administrative Units:

1. Revenue generated by AHCE activities must partially support the CE administrative staff. Continuing education units across the country operate under this policy. Consequently, administrative staff members tend to be apprehensive about their continued existence. Those in the field know that generating the revenue to partially sustain the staff is realistic. However, to expect continuing education units to be totally self-supporting is unrealistic. To attempt to do so would escalate the costs to the paying participants and would likely price the program out of the market place.

2. The health care team is often discussed, but few AHCE programs are developed to focus on this concept. The health care team concept is an idea which must be put into practice by the allied health disciplines. These professionals are in the best position to do so since they are organized in some department structure within institutions of higher learning. Interdisciplinary planning committees could effectively plan and offer continuing education programs which focus on the health care team concept. This process has been previously described.

3. Most AHCE programs are discipline specific. They are budgeted and dependent upon small numbers of participants in order to break even. Because discipline specific programs rely on small numbers to attend in order to break even, the professional advisory group must participate in the program planning process and must be responsible for encouraging their professional peers to attend the program. Without professional involvement and without commitment at the outset, continuing education programs and break even budgets are in jeopardy.

4. Some allied health professionals are confused when "noncredit" AHCE courses advertise professional "credit." Since continuing education programs advertise Category I credit for physicians and professional credit such as CEARPs, CEUs and HCEs, etc., program participants believe they have accumulated some academic credit which when added to other noncredit activities can be translated into academic credit. How does this occur? Program participants read the advertisement piece, note the mention of professional credit and assume that CEUs etc. are synonymous to the Carnegie unit. Consequently, they telephone Offices for Continuing Education and ask for a transcript to be sent an academic institution where they are applying for admission. These occurrences are rare but they do exist.

5. Every professional organization has their own program review form, process, record keeping system, professional credit and fee structure. No two are alike. In order for Offices for Continuing Education to secure professional credit for Med Techs, P.T.s, Medical Record Adm., Dieticians, Nurses, etc., they must complete a continuing education form which is different for each organization, must submit the curriculum plan for the program and pay a processing fee. Currently, there is no central clearinghouse for securing professional credit for a variety of allied health professionals. It is my hope that the American Society of Allied Health Professions will establish such a clearinghouse process to enable participating institutions, organizations and agencies to submit one standardized form for securing CEUs.

Suggestions for Solving Some Problems:

1. Encourage the establishment of national standards for processing AHCE program proposals.
2. Encourage allied health professional organization representatives to establish a uniform approval form contining such criteria as program prupose, objectives, time schedule, evaluation plan and presenter credentials.
3. Suggest the adoption of a single record keeping unit.
4. Recommend the development of more interdisciplinary programs when the content is relevant to more than one allied health discipline.
5. Suggest that faculty members develop the idea for an AHCE program and recommend possible presenters if unable to deliver the content.
6. Discontinue the word credit when advertising noncredit AHCE programs.

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Abstract

Notes

VIEWPOINTS FROM THREE PERSPECTIVES

A. The viewpoints to be considered
   1. Allied health professional organizations.
   2. Allied health faculty members.
   3. Continuing education administrative units.

B. Problems in AHCE as seen by professional organizations
   1. AHCE is provided for membership as a tangible benefit.
   2. AHCE is considered an area for financial gain.
   3. AHCE approval process and record keeping is "unique" to our organization.
   4. Communication and coordination between and among allied health organizations is minimal or non-existent.

C. Problems in AHCE as seen by allied health faculty members
   1. AHCE is an overload activity for faculty members.
   2. AHCE is provided by professional organizations. If allied health school or college develops AHCE program, then faculty competes with professional organization.
   3. AHCE is provided by clinical sites. If allied health school or college develops AHCE program, then the faculty competes with affiliated institutions. This may jeopardize the clinical affiliation agreements.
   4. AHCE is a responsibility of the allied health faculty. Allied health faculty members should present the program content.
   5. If allied health faculty members are either unable or unwilling to deliver the content, then the AHCE program should not be offered.
   6. AHCE programs should not mix noncredit "students" with "students" enrolled for academic credit.
   7. Allied health faculty members cannot offer AHCE programs for other allied health disciplines.
   8. The numbers of practicing professionals are small in number - therefore it is difficult to plan AHCE programs.

D. Problems in AHCE as seen by CE administrative units
   1. Revenue generated by AHCE activities must partially support the CE administrative staff.
   2. The health care team is often discussed but few AHCE programs are developed to focus on this concept.

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3. Most AHCE programs are discipline specific. They are budgeted and dependent upon small numbers of participants in order to break even.
4. Some allied health professions are confused when "noncredit" AHCE courses advertise professional "credit".
5. Every professional organization has their own program review form, process, record keeping system, professional credit and fee structure. No two are alike.

E. Suggestions for Solving Some Problems

1. Encourage the establishment of national standards for processing AHCE program proposals.
2. Encourage allied health professional organization representatives to establish a uniform approval form containing such criteria as program purpose, objectives, time schedule, evaluation plan and presenter credentials.
3. Suggest the adoption of a single record keeping unit.
4. Recommend the development of more interdisciplinary programs when the content is relevant to more than one allied health discipline.
5. Suggest that faculty members develop the idea for an AHCE program and recommend possible presenters if unable to deliver the content.
6. Discontinue the word credit when advertising noncredit AHCE programs.