

# Pioneering Allied Health Clinical Education Reform

A NATIONAL CONSENSUS CONFERENCE

## PROCEEDINGS



**The Tremont Suite Hotels  
Baltimore, Maryland**

*sponsored by*

**Department of Health and Human Services  
Health Resources and Services Administration  
Bureau of Health Professions  
Division of Public Health and Allied Health**

*hosted by*

**The Department of Medical and Research Technology  
University of Maryland School of Medicine  
100 Penn Street, Allied Health Building, Room 340  
Baltimore, Maryland 21201-1082  
<http://som1.umaryland.edu/smdmrt>**



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July 12 - 13, 1999

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**Denise M. Harmening, Ph.D., MT(ASCP), CLS(NCA)**  
*Chair and Professor*

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PROCEEDINGS



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# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Preface

**Denise M. Harmening, Ph.D., MT(ASCP), CLS (NCA)**

Chair and Professor

Department of Medical and Research Technology  
University of Maryland School of Medicine

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As Chair of the Department of Medical and Research Technology at University of Maryland's School of Medicine, it is a pleasure to present the Proceedings from this national, historic conference, *Pioneering Allied Health Clinical Education Reform*.

The logo for this conference was developed by Art therapists within the Coalition for Allied Health Leadership under a contract funded by the Bureau of Health Professions. The text added by the Planning Committee reflected the goal for this Conference. We hoped that through consensus gathering we could emerge with one vision, one voice, focused on the patient.

The conference was a national consensus conference, and was funded by the Division of Associated Dental and Public Health Professions, the Bureau of Health Professions of the Health Resources and Services Administration. The purpose of this conference was to provide an opportunity to collaborate on a strategic plan for clinical education reform, which will ensure the availability of health care professionals qualified to meet the needs of patient populations and health care service providers. Table 1 outlines the objectives of the conference.

**Table 1: Objectives**

- Define the key opportunities and challenges to preserving and enhancing clinical education and training.
- Develop recommendations to overcome barriers and maximize opportunities for clinical education reform.
- Disseminate the final blueprint to policymakers and key stakeholders.

The conference gave participants the opportunity to address and examine clinical education on a national level. We are fortunate that the Bureau has become so proactive by funding so many contracts which focus on these issues.

Three major issues are presented through keynote addresses: economically-driven changes impacting clinical education and training; overcoming barriers to clinical education and training reform; and the role of professional societies in clinical education training reform. The format of the meeting is outlined in Table 2.

<b>Table 2: Meeting Format</b>
<ul style="list-style-type: none"><li>• Three Keynote Speakers: define the major issues</li><li>• Three Reaction Panels: provide analysis and recommendations</li><li>• Three Open Forums: audience-wide discussion and consensus-gathering</li><li>• Closing Panel</li></ul>

The three-keynote speakers defined the major issues from their perspective. Reaction panels provided analysis and recommendations and a general reaction to these issues. A voice representing HMOs in the hospital sector; someone voicing the opinion of educational institutions representing both two and four-year colleges; and finally a voice from professional societies, accrediting and certifying agencies were standard presentations in the three reaction panels. In open forums, the audience voiced their opinions and reactions based on their institutional setting and region of the country.

The Planning Committee consisted of the following individuals who represented various constituencies:

- Deborah Astroth - the National Commission on Allied Health and the Implementation Task Force
- Richard Boan - National Network of Health Career Programs in the Two-Year Community Colleges
- Tom Elwood - Association of Schools of Allied Health
- Marilyn Harrington - Commission on Accreditation of Allied Health Education Programs
- Rumaldo Z. Juarez - Hispanics in Allied Health
- Virginia Pappas - Health Professions Network
- Peggy Valentine - National Society of Allied Health
- Donald Young - American Association of Health Care Plans

Participants at this meeting represented 32 states, the District of Columbia and Canada and more than 17 allied health professions, as well as physicians, educators and administrators. There were representatives from managed care organizations and hospitals, and representatives from at least 22 professional societies and accrediting agencies.

Our hope is that this basic blueprint for allied health clinical education reform will serve as a resource for both policy makers and stakeholders as we face the new millennium.



# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Opening Remarks

**Norman L. Clark, DDS, MPH, JD**

Chief, Allied Health and Associated Professions Branch  
Division of Public Health and Allied Health  
Bureau of Health Professions  
Health Resources and Services Administration

I would like to welcome each of you this morning. You are very important to this consensus conference. We want you to express your opinions and help us reach some conclusions about the direction that we should follow in the future. I would like to also thank Dr. Denise Harmening and her staff for bringing us to this point.

This is a consensus conference. That means sparks may fly. That's great! We need your ideas as we look at the difficult challenges facing allied health clinical education in the future.

At a recent meeting, Bill Gates reportedly stated, "If GM had kept up with technology like the computer industry has, we would all be driving \$25.00 cars that get 100 miles to the gallon." In response, General Motors issued a press release stating, "If GM had developed technology like Microsoft®, we would all be driving cars with the following characteristics:

- Your car would crash twice a day for no reason whatsoever.
- Occasionally, your car would die on the freeway for no reason, and you would just accept this, restart, and drive on.
- The air bag system would ask, "Are you sure", before going off.
- You would press the start button to shut off the engine."

So, you see, the sparks flew because there were varying perspectives on the issue. Perhaps, the two companies should have had a national consensus conference!

How did we get here today? Briefly, there were two national commissions on allied health that brought us to the point (Table 1). The National Commission on Allied Health, a congressionally-mandated commission under Title VII legislation, was created to provide advice to the Senate Committee on Labor and Human Resources, the House of Representatives Committee on Energy and Commerce, and to the Secretary of the Department of Health and Human Services. The focus of this commission was to assess issues relating to allied health and to the future role the allied health professions will play in the emerging health care delivery system for the 21<sup>st</sup> century.

The final report of the National Commission on Allied Health was issued in 1995. The report made twelve recommendations directing the future of allied health and four recommendations relating to education, workforce, research, and data. In addition, several white papers, testimony, and information gathered from many interested parties were integrated into the twelve recommendations (Table 2).

**Table 1: Conference Background**

- Product of the analysis and recommendations of two national task forces:
  - National Commission on Allied Health
  - National Commission on Allied Health Implementation Task Force

**Table 2: National Commission on Allied Health**

- Purpose was to provide advice to the :
  - Senate Committee on Labor and Human Resources
  - House of Representatives Committee on Energy and Commerce
  - Secretary of the Department of Health and Human Services
- Focus of the National Commission on Allied Health was to assess issues relating to allied health and the future role the allied health professions will play in the emerging health care delivery system.
- The final report of the Commission, published in 1995, made twelve recommendations directing the future of allied health and four recommendations related to education, workforce, research, and data.

Based upon the recommendations of the National Commission on Allied Health, an “Implementation Task Force” was subsequently established to develop strategies for implementing the recommendations . We have several participants in the audience who have served on the National Commission on Allied Health and on the Implementation Task Force.

The Implementation Task Force concentrated on three areas: education reform, outcomes research, and collaboration (Table 3). Three contracts are to be awarded to implement the recommended strategies. One of these contracts was designed to plan and conduct a National Conference on Allied Health Clinical Education Reform involving key stakeholders, and this is the conference. A second contract has been awarded to determine how the allied health professions can work together better; and a third contract will be awarded in mid-August that focuses on outcomes research.

**Table 3: Implementation Task Force**

- To ensure that the recommendations of the National Commission on Allied Health were carried out, the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, established an Implementation Task Force
- The Implementation Task Force was to address recommendations related to:
  - education reform
  - outcomes research
  - collaboration

***Recommendations***

- Three contracts were created and funded as a result of the recommendations of the Implementation Task Force
- One of these contracts was designed to plan and conduct a national conference on allied health clinical education reform involving key stakeholders

The desired outcome for this conference is to establish the basis for an interface between key stakeholders (Table 4). This is very, very important. We need to hear your voices and your opinions because the blueprint that you will develop here will give us guidance for the future. Your recommendations will be taken seriously and we will act upon the guidance that you provide.

<b>Table 4: Pioneering Allied Health Clinical Education Reform: A National Consensus Conference</b>
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- |  |
|--|
| <ul style="list-style-type: none"><li>• To provide key stakeholders an opportunity to collaborate on a strategic plan for clinical education/training to ensure the availability of health care professionals who are qualified to meet the needs of patient populations and health care service providers</li></ul> |
|--|

I wish you a very productive conference and good luck!





# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Planning Committee

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### CONFERENCE DIRECTOR

**Denise M. Harmening, Ph.D., MT(ASCP), CLS(NCA)**  
Chair and Professor  
Department of Medical & Research Technology  
University of Maryland School of Medicine  
Baltimore, Maryland

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**Norman L. Clark, D.D.S., M.P.H., J.D.**  
Chief, Allied Health and Associated Professions Branch  
Division of Public Health and Allied Health  
Bureau of Health Professions  
Health Resources and Services Administration  
U.S. Department of Health and Human Services

### SPECIAL GUESTS

**Jennifer Burks, RN, M.S.N.**  
Deputy Director

**Young Song**  
Program Officer  
Division of Public Health and Allied Health  
Bureau of Health Professions  
Health Resources and Services Administration  
U.S. Department of Health and Human Services

### CONFERENCE COORDINATOR

**Cynthia Carr Stambach, M.A.S.**  
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University of Maryland School of Medicine  
Baltimore, Maryland

**MEMBERS OF THE CONFERENCE PLANNING COMMITTEE**

**Deborah Bailey Astroth, R.D.H., B.S.**

National Commission on Allied Health  
Implementation Task Force  
Assistant Professor  
Departments of Dental Hygiene and Surgical Dentistry  
University of Colorado School of Dentistry  
Denver, Colorado

**Richard Boan, Ph.D.**

National Network of Health Career Programs in  
Two-year Colleges  
Chair of Health Sciences  
Midlands Technical College  
Columbia, South Carolina

**Thomas Elwood, Dr.P.H.**

Executive Director  
Association of Schools of Allied Health  
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**Marilyn S. Harrington, Ph.D., R.D.H.**

Commission on Accreditation of Allied Health  
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Dean, School of Allied Health Sciences  
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**Rumaldo Z. Juarez, Ph.D.**

Hispanics in Allied Health  
Dean, School of Health Professions  
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**Gail Nielsen, BSHCA**

Hospital Sector Representative  
Managed Care Performance Administrator  
Iowa Health System Corporate Headquarters  
Des Moines, Iowa

**Virginia Pappas, CAE**

Health Professions Network  
Deputy Executive Director  
Society of Nuclear Medicine  
Reston, Virginia

**Peggy Valentine, Ed.D.**

National Society of Allied Health  
Interim Associate Dean  
Division of Allied Health Sciences  
Howard University  
Washington, DC

**Donald Young, M.D.**

Senior Vice President for Policy and  
Clinical Services  
American Association of Hospital Plans  
Washington, D.C.

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Department of Medical and Research Technology (DMRT)  
University of Maryland School of Medicine

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**Paul Griffey, M.B.A., MT(ASCP)**

Assistant Professor

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Assistant Professor

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**Julie Archibald, B.S.**

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LAN Systems Administrator  
Graphic Artist

**Alicia Walters**

Contract Administrator



# Pioneering Allied Health Clinical Education Reform

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## Agenda

Monday,  
July 12, 1999

8:00 a.m. – 8:30 a.m.

**Continental Breakfast**

Mason Temple: Corinthian Foyer

8:30 a.m. – 8:45 a.m.

**Welcome and Introductions**

Mason Temple  
Corinthian Ballroom

Denise M. Harmening, Ph.D., MT(ASCP), CLS(NCA)  
Conference Director  
Chair and Professor  
Department of Medical and Research Technology  
University of Maryland School of Medicine

Jennifer Burks, RN, MSN  
Deputy Director  
Division of Associated Dental and  
Public Health Professions  
Bureau of Health Professions  
Health Resources and Services Administration  
U.S. Department of Health and Human Services

8:45 a.m. – 9:00 a.m.

**Opening Remarks: Conference Background  
and Objectives**

Norman L. Clark, DDS, MPH, JD  
Chief, Allied Health and Associated Professions Branch  
Bureau of Health Professions  
Health Resources and Services Administration

9:00 a.m. – 9:45 a.m.

**Keynote Address: Economically-Driven Changes  
Impacting Clinical Education/Training**

George B. Rowland, M.D., M.P.H.  
Rowland Associates

9:45 a.m. – 10:30 a.m.

**Reaction Panel: Response and Recommendations**

**Reaction Panelists**

Linda Johnson, Ph.D., R.N., Acting Director  
Associated Health Education Office  
Department of Veterans Affairs

Julie O'Sullivan Maillet, Ph.D.  
Associate Dean for Academic  
Affairs and Research  
University of Medicine and Dentistry of New Jersey

Arthur Cooper, M.D., M.S.  
Chief, Division of Pediatric Surgery  
Columbia University/Harlem Hospital  
Representing the Joint Review Committee on  
Educational Programs for Emergency  
Medicine Technicians and Paramedics

**Moderator**  
Gail Nielsen, BSHCA  
Managed Care Performance Administrator  
Iowa Health System Corporate Headquarters

**Recorder**  
Thomas Elwood, Dr.P.H.  
Executive Director  
Association of Schools of Allied  
Health Professions

10:30 a.m. – 11:00 a.m.

**Coffee Break**  
Mason Temple: Corinthian Foyer

11:00 a.m. – 12:00 p.m.

**Open Forum: Recommendations and Consensus Gathering**  
**Moderator:** Gail Nielsen, BSHCA

12:00 p.m. – 1:30 p.m.

**Luncheon**  
Tremont Suite Hotels: Plaza B (Third Floor)

**1:30 p.m. – 2:15 p.m.**

**Keynote Address: Overcoming Barriers to Clinical Education/Training Reform**  
Mason Temple  
Corinthian Ballroom  
  
Lawrence Abrams, Ed.D.  
Dean, College of Health Professions  
Thomas Jefferson University

2:15 p.m. – 3:00 p.m.

**Reaction Panel: Responses and Recommendations.**

**Reaction Panelists**  
Diane J. Youngs, B.S., RT(R), RDMS  
Program Instructor  
Diagnostic Medical Sonography

Rumaldo Z. Juarez, Ph.D.  
Dean, School of Health Professions  
Southwest Texas State University

Jody Gandy, Ph.D., P.T.  
Director, Physical Therapy Education  
American Physical Therapy Association  
Associate Dean, College of Health Professions  
SUNY Health Science Center at Syracuse

**Moderator**  
Marilyn S. Harrington, Ph.D., R.D.H.  
Dean, School of Allied Health Sciences  
University of Texas Health Science Center  
at San Antonio

**Recorder**  
Peggy Valentine, Ed.D., Interim Associate Dean  
Division of Allied Health Sciences  
Howard University

3:00 p.m. – 3:30 p.m.

**Refreshments**  
Mason Temple: Corinthian Foyer

3:30 p.m. – 4:30 p.m.

**Open Forum: Recommendations and Consensus Gathering**  
**Moderator:** Marilyn S. Harrington, Ph.D., R.D.H.

5:30 p.m.

**Reception**  
Tremont Suite Hotels: Plaza B (Third Floor)

**Tuesday,**  
**July 13, 1999**

8:00 a.m. – 8:30 a.m.

**Continental Breakfast**  
Mason Temple: Corinthian Foyer

8:30 a.m. – 8:45 a.m.

**Review and Summation of Day 1 Recommendations**  
Denise M. Harmening, Ph.D., MT(ASCP), CLS(NCA)  
Conference Director

8:45 a.m. – 9:30 a.m.

**Keynote Address: The Role of Professional Societies in  
Clinical Education/Training Reform**

Patricia Crist, Ph.D., OTR/L, FAOTA  
Chair and Professor  
Department of Occupational Therapy  
Duquesne University

9:30 a.m. – 10:15 a.m.

**Reaction Panel: Responses and Recommendations**

**Reaction Panelists**

Ann F. Sosnowski, B.S., MT  
Coordinator, Student Recruitment  
Schools of Allied Health

William Beaumont Hospital  
Lydia Wingate, Ph.D.  
Dean, College of Health Professions  
Weber State University

Harriet Rolen-Mark, M.A., MT(ASCP)  
Past Chair, ASCP-AMS  
Associate Dean, College of Health Professions  
SUNY Health Science Center at Syracuse

**Moderator**

Virginia Pappas, CAE  
Associate Executive Director  
Society of Nuclear Medicine

**Recorder**

Deborah Bailey Astroth, B.S., R.D.H.  
Assistant Professor  
Departments of Dental Hygiene and  
Surgical Dentistry  
University of Colorado School of Dentistry

10:15 a.m. – 11:15 a.m.

**Open Forum: Recommendations and Consensus Gathering**

**Moderator:** Virginia Pappas, CAE

11:15 a.m. – 11:45 a.m.

**Coffee Break**

Mason Temple: Corinthian Foyer

11:45 a.m. – 12:30 p.m.

**Closing Panel: Summary and Review of  
Final Recommendations**

**Moderator**

Denise M. Harmening, Ph.D., MT(ASCP), CLS(NCA)  
Conference Director

**Panelists**

Gail Nielsen, BSHCA  
Managed Care Performance Administrator  
Iowa Health System Corporate Headquarters

Rumaldo Z. Juarez, Ph.D.  
Dean, School of Health Professions  
Southwest Texas State University

Peggy Valentine, Ed.D., Interim Associate Dean  
Division of Allied Health Sciences  
Howard University



# Pioneering Allied Health Clinical Education Reform

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## Keynote Address

### Economically-Driven Changes Impacting Clinical Education/Training

**George B. Rowland, M.D., M.P.H.**

Rowland Associates

Thank you very much. It's a pleasure to be here today.

My role is to talk about the financial realities that impact us all in our daily work. And my job is to provide a context for your discussion and your problem solving later in the day. I have a second job, and that is to preemptively use all the material that was going to be used by subsequent speakers and to leave them without anything to talk about. And from feedback I've gotten, I think I'm going to do a good job at that.

Because I'm very acutely aware of the controversies on plagiarism, I would like to thank all those living and dead for the material I'm about to use that they developed.

As we talk through the day and we give our thoughts and opinions on what's going on in the health care field, there are some serious and significant underlying personal and philosophical issues that get cloaked in other terms. I just want to highlight them because I think it's useful to keep them in mind as you ask questions or as you consider the material. One of these and perhaps the most significant, is whether health care is a right of all individuals or whether it's a matter of a contractual relationship between the patient and the insurer. Another related fundamental belief is

who decides on the care that's provided? The physician? The patient? The insurance company? The government? How is this decision linked to who pays for this care? If an individual can decide, should he or she have some responsibility to pay for all or part of his decisions, or should he be able to write checks out of other people's checkbooks? And ultimately, who will be accountable for cost and quality?

It also would be helpful, I think, as we go through the day, to be careful of words that we use. It's very easy to say "if it wasn't for managed care, everything would be fine". But almost no one has a clear definition of what managed care is in any kind of real operational sense. It has come to symbolize the new Satan that's responsible for many of our ills. But when you've seen one managed care company, you've seen one managed care company. They are all different. They have different kinds of operational issues. They have different kinds of controls. And I think it would be helpful as you talk and as you think about these issues that you be specific as to what aspect of managed care or what aspect of the many cost control strategies, are causing the particular problem or are contributing to the problem.

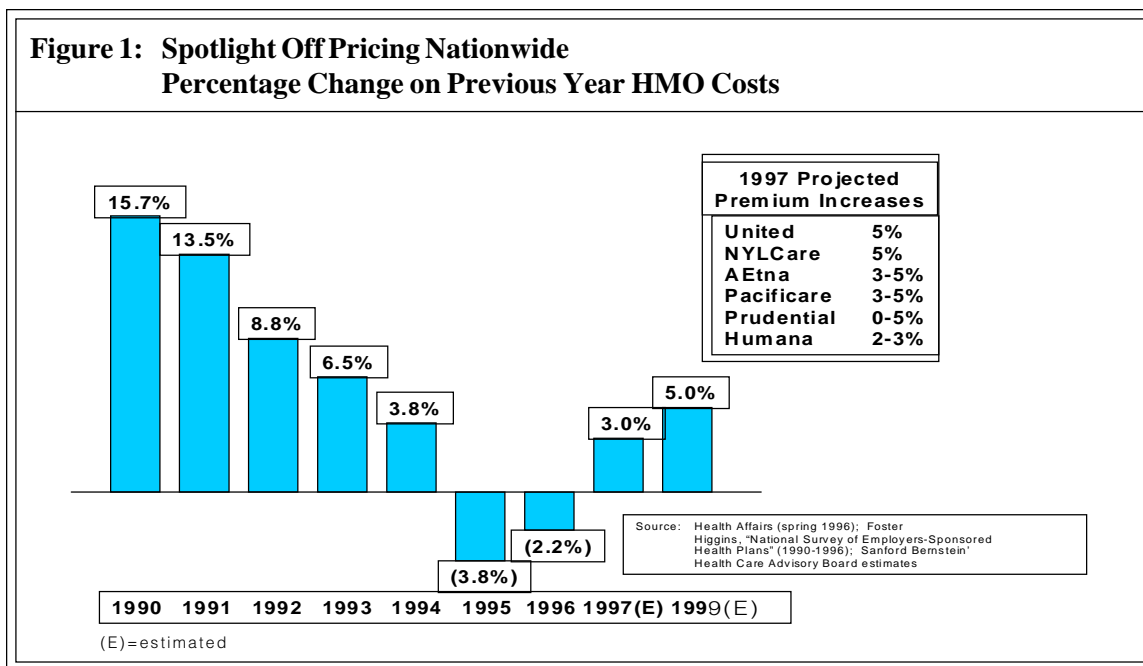
We are all here today for one simple reason, and that is that everybody who pays for care decided

KEYNOTE ADDRESS

that the cost of care was going up faster than they were willing to pay for it. This happened with employers who were experiencing 10 to 15 percent increases in their premiums. And it's happening even more significantly, although it sometimes doesn't get as much attention, on the part of the government.

As long as we had, for hospitals, "cost plus" reimbursement, and as long as we had for insurers, cost plus premium structures, there really wasn't a lot of pressure on anybody to do anything except do what they wanted to do, and have a good time doing it. But when the employers and the government said the increases have to stop, the pressure started building. That was really what stimulated the development of many of the managed care organizations that have shaped our current system and brought us to the point where we are today.

Figure 1 is taken from some of the Advisory Board material, and demonstrates the rate of increase or the percentage increase in premium structures in the '90s. It shows the rather dramatic impact of the efforts of the employers and the government, along with the insurance companies who responded to contain the rates of increase in premiums. The premiums have now begun to go up again, but there are many reasons that this is not a real surprise.



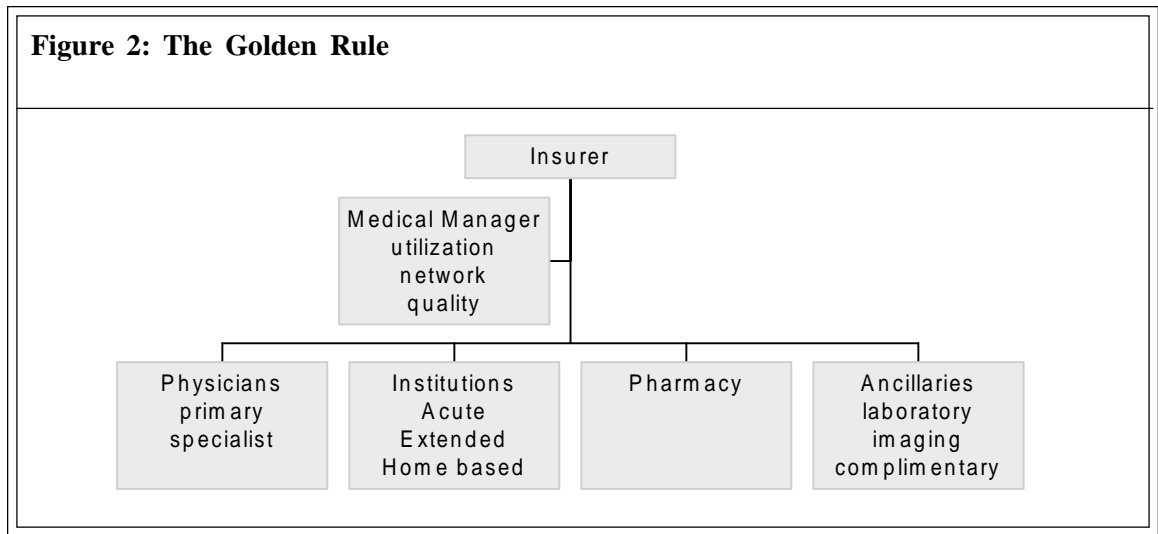
The diminished funding has created a situation where nobody's incentives are aligned. The purchasers - employers and government - want the best care at the lowest cost. The insurers are often said to want the least care at the lowest cost. Actually they really want the best care at the lowest cost also, but they are at risk, so they appear to want the least care in their attempt to contain costs. They are probably more closely aligned with the purchasers. The providers want any care at the highest cost because the cost to the insurance plan is the revenue stream for the providers. Finally, the consumers want the most care and they don't care what the cost is because they pay for almost none of it.

In this environment, the insurers are really caught in the middle between the employers who don't want to pay much, and the providers and the consumers who don't particularly care about cost, but certainly want to provide or receive lots of care.

So I don't really view the insurers as bad. I will acknowledge that some are overly greedy, that they are financially driven, and that many are only marginally competent. But I have some sympathy for their position because they are, at the moment, the ones that are "accountable" for cost and quality. Whether that should be so, I think, is a matter that we can talk about as the day goes on. Figure 2 shows the Golden Rule, and it's useful in

showing a little bit about how the money flows down. The Golden Rule, of course, is that he who has the gold makes the rules. And the insurer at the moment is the one that collects the premium dollar in most cases, and the insurer then distributes that money out to various providers to provide care to the patients or customers or consumers. And in the middle box, there is a box called “Medical Manager” which really has to do with utilization, network development, and quality. Historically, medical management has been a function of the insurance companies. Nowadays, there is at least more discussion and more interest in moving some or all of the medical management box down to a more provider-located area where the actual responsibility for cost and quality ends up in the hands of the providers, not the hands of the insurance companies. That is something I advocate with my clients, and frequently, is what I am brought in to develop. There are some good reasons to support that kind of movement.

**Figure 2: The Golden Rule**



The current reality is that within the given fixed budgets that are made available by the employers and the government, there is significant redistribution of costs, which means revenues, among and between various aspects of the medical pie. I am seeing both in the literature and personally, that for the first time, pharmacy costs on a per-member, per-month basis are exceeding the costs of inpatient care. Pharmacy costs, as you probably are aware, are the fastest growing and least controllable part of the medical care budget at the moment. And because the inpatient care has received a lot of attention in terms of concurrent review and reductions of inpatient stay and avoidance of hospital admissions, the cost of pharmaceuticals is actually exceeding that of inpatient care. That is a huge redistribution of money. Similarly, you find redistribution of money among professionals, among various kinds of professions, and between specialists and primary care physicians. That is one of the realities that occurs when you have a fixed budget that is shrinking in real terms, and everybody is trying to maintain their personal and professional income.

There has been a reduction in real costs. In the insurance model, this is achieved by a set of oppressive cost-control strategies, which I'll outline in a moment. This causes a wholesale loss of professional control on the part of physicians and other professionals in terms of the way their care is delivered.

Even with all these activities, the insurance companies have, in many cases, run out of gas in terms of being able to maintain their financial performance. They've run through their toolbox. They had a certain number of things they could do; they did these pretty well; and now their margins are falling, and many are having considerable difficulty. This is evidenced by companies beginning to pull out of less profitable markets, raising premiums, and initiating internal cost controls to improve their bottom line.

The oppressive cost-control strategies that I talked about, and you probably are more familiar with than I on a day-to-day basis, are reductions in reimbursement, which can take two forms. One



is changing the methodology of reimbursement such as moving from a cost-based reimbursement to a case rate reimbursement such as you see with DRGs in hospitals, or more recently, with Prospective Payment Systems (PPS) and skilled nursing facilities. Another is to reduce the amounts paid on the fee schedules used to pay for professional, procedural, or facility services. Another change in method is the move from fee for service to capitation payment. This has been seen in the payment for outpatient laboratory work.

In terms of fee changes, you find these in legislative or regulatory modifications which reduce DRG payments, or in a move to an RBRVS system for physicians (or fee schedule for ancillaries) often with subsequent application of withholds which are not returned.

You also see the control strategies in reduction in benefits. This can occur through formulary for pharmacy, constricted coverage of investigational treatments, and the application of "medical necessity" criteria for payment. Equally often, the issue is not a reduction in benefits as much as it is a reluctance to expand benefits. In the last year or so, we've had the introduction of lyme vaccine and Viagra - both costly but important to the patients who need them. The introduction of cholesterol lowering drugs, the "statins," have constituted a needed additional benefit which really should be used far more extensively than they are. All of these have significant cost impacts on any kind of insurance product, and the reluctance of insurance companies to cover them is just an indication again of their position in the middle between the purchasers and the providers/consumers of service.

The impacts of reduced revenues on the operating units that have to live within their budgets are typically higher productivity requirements. We see primary care physicians and other professionals under the gun to see more patients per day than they used to. This makes it more difficult to find the time among the practicing professionals to undertake teaching or research activities. This has had a direct impact on your programs. The need to see more patients also results in an increased competition among professionals because the supply/demand relationship for the particular profession has changed due to higher productivity per professional.

Every hospital and other institution that I work with is on an endless hunt to eliminate non-essential costs, and unfortunately you feel the brunt of some of those. The necessity to reduce costs is exacerbated by the virtual elimination of cost shifting which allowed the "better" reimbursement from some payers (Medicare and insurance) to subsidize less profitable services or payers.

There was a recent article in the *Boston Globe* from an academic center in which a physician listened each year to the same speech from administration as to how bad the reimbursement picture was, and every year nobody paid much attention to it and they went about their business. Somehow everything worked out. The message from this article was that for the first time, he saw that the administration was not "crying wolf" and that the things had gotten to the point where serious negative impacts were going to occur in the academic teaching programs of the hospital.

At the same time, the next day, on the news in reaction to President Clinton's pharmacy proposals, you saw the spokesman for the pharmaceutical industry whining and moaning about how any kind of cost controls on pharmaceuticals would damage their research and development efforts and impair the quality of pharmaceuticals available to the United States and its citizens over the next 20 years. The last time I looked, the pharmaceutical stocks were doing just fine.

In all of this attention to costs, there is some effort to search for quality. Some of the activities have continued validity but others seem increasingly irrelevant for improving quality. Accreditation of medical personnel is, I think, historically one of the major efforts to ensure quality. This is represented by licensing professional personnel. I'm convinced that at least for physicians, the state medical licensing activity is a waste of time and effort. I don't know about your profession, but it doesn't appear to significantly contribute to quality. And, in fact, it's often suggested that they don't even police their own licensing activities in a particularly effective way.

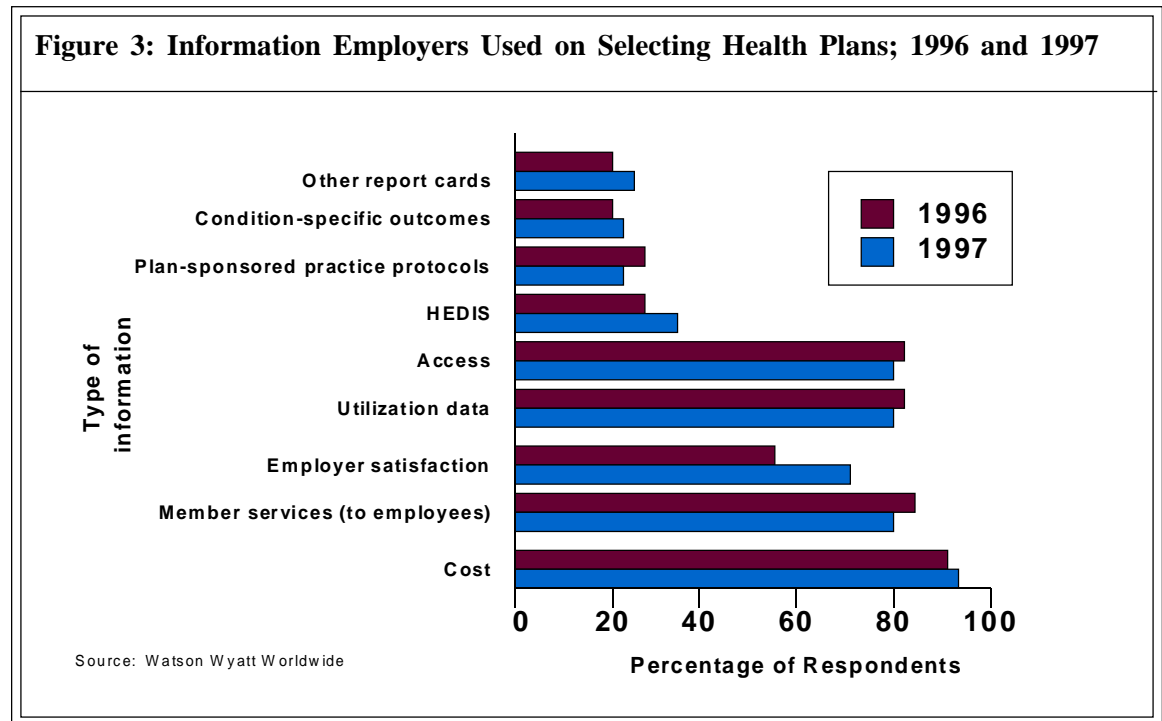
Institutional accreditation, JCHO or NCQA, is another effort that certainly has been long-standing. More recently, I think, recognizing the limitations of those kinds of accreditation activi-

ties, the development of report cards has been more prevalent. HEDIS measures when done in conjunction with NCQA have really made a significant impact in focusing on some population-based health measures that really put the insurance companies on notice, and make them work on some things that they might not otherwise work on.

Report cards for hospitals are being talked about. They are still pretty crude, limited to some acuity adjusted mortality statistics. We are beginning to see on the Internet physician report cards from some of the more progressive insurance companies who provide networks. When well done, this is certainly a useful way to present consumers with performance information and to monitor the quality of individual providers and provider units.

Finally and unfortunately, much of the “quality” is still driven by lawsuits and legislation, which is probably not the optimum way to handle complex problems in the delivery of medical services. I think the sad news is that quality doesn’t play a very big part in the health care choices made by those

**Figure 3: Information Employers Used on Selecting Health Plans; 1996 and 1997**



who are purchasing health care. Cost is still by far the most important factor that most employers use in selecting insurance plans.

In the last several years, I think there has been a lot more consideration of the word “value” which is a concept which includes both cost and quality. It is a concept I find useful in my own work even though it is often hard to quantify. It is helpful to force the discussion that balances cost and quality and marginal value added because that is likely to be more important ultimately in health care decisions.

There are four components that I see as relevant for value in health care activities. (Table 1) One

is price or cost. Now, price is different than cost, as you all know. The cost to a hospital may or may not bear much relationship to the price they charge for the particular service. The second is service. Customer service is properly receiving more attention by a public that demands greater consideration of their time and their opinions. I know that if a retail establishment, Sears or my local grocery store, had the same customer service as our local emergency department or most of the physician offices that I am familiar with, they would go out of business in a minute and a half. Competency is a concept that we’ll talk about throughout the day. I think that the public expects a certain level of competence. They

don't want to wonder whether a particular physician or particular institution is delivering competent care; the institution will need to make it as predictable as a McDonald's Big Mac®.

<b>Table 1: Components of Value in Health Care</b>
<ul style="list-style-type: none"> <li>• Cost</li> <li>• Customer Service</li> <li>• Competency</li> <li>• Outcomes Data</li> </ul>

And finally, and most difficult, is the search for and publication of outcomes data. This requires physicians, hospitals, and institutions to go beyond good food or timely service, to the evaluation of the proportion of patients that recover function and improved life. This requires longitudinal follow up and evaluation of clinical and functional outcomes. This is an emerging field but one that is going to be critical, especially as you look for relevance and value in the medical sector.

Future realities will be more of the same. We're going to be faced with continued financial constraints. The employers are not going to get more generous. Medicare plans to reduce its expenditures further. And, in fact, we're going to have to find additional money to take care of the 43 million people that are uninsured. In addition, the baby boomers are moving into the older and medically-costly age group. Part of that will somehow have to come out of improved efficiencies of what we already do.

There's going to be increased provider competition for the small financial pie. There's going to be increasing consumer demands for both service and for specific services. The population is going to continue to age, and as they age, they require greater amount of medical care. I think we'll see a diminished role of the gatekeeper in terms of a primary-care gatekeeper. And we'll see a continued growth of outpatient and home-care alternatives to inpatient services.

To some extent, the consolidation that's occurring in the HMO industry or the hospital industry represents the kind of competition for market strengths, negotiating power, and available funds that will be continuing over the next years. One

of the things that you need to do individually and as a group is to decide where you are on the food chain; and if you are on the bottom, you probably really need to do something to get moved towards the top.

I'd like to suggest three areas where there are opportunities to improve your position. One area is the issue of practice and status (Table 2). The second area which you might want to look at is the whole issue of reimbursement (Table 3). And the third issue is training and education (Table 4).

I'm not an academician. I sat on the receiving end of academia for 20 or so years, but that was quite a while ago. I don't interface a lot with the academic community in my current work. I'm much more involved in the day-to-day practical issues of hospitals and physicians. Neither do I work extensively with allied health professionals. Most of my contacts are with managed care companies, hospital administrators, or hospital administrative staff, and physicians. So I may not be totally up to date on some of the issues that you face, but nonetheless, I'll charge ahead.

<b>Table 2: Practice and Status</b>
<ul style="list-style-type: none"> <li>• Be part of value improvement effort               <ul style="list-style-type: none"> <li>–Reduce waste</li> <li>–Reduce demand</li> <li>–Track, trend, report outcomes</li> </ul> </li> <li>• Get outside the silo               <ul style="list-style-type: none"> <li>–Engage in collaborative efforts</li> <li>–Expand definition of clients</li> </ul> </li> </ul>

The whole issue with practice and status is to know where to move. Along with everybody else, I was watching the American women's soccer team, and I was reminded of a speech that Don Burwick from the Institute of Health Care Improvement gave a couple of years ago at his annual conference. The title of his speech was "Run to Space." The theme was coaching his daughter's soccer team where he tried a variety of motivating efforts to try and get this team to win, which they never did. He tried to yell at them for not scoring goals, he tried to give them chocolate bars when they got a goal, and he tried to excite the whole team by having parties if they won the game. All the usual motivating methods didn't work because they did not have the basic

competencies to win. They always ran to the ball rather than to the place the ball was going - hence the title “Run to Space”. You need to run where nobody is because that’s where the ball is probably going to go when it emerges from this little pack of kids. The two lessons from this talk were that motivation without basic competency is insufficient and that you need to anticipate where health care is moving in order to be there at the right time.

While I can’t tell you exactly where that is, I can suggest a couple of things that will be relatively enduring in terms of adding value. One is to be part of the value improvement effort, both in your individual institutions and probably more importantly at a national level through your associations and through your professional organizations. And the value improvement effort that I would have in mind is made up of three sets of actions.

One is to reduce waste. It is remarkable to me how much we do that is making up for something else that wasn’t done right. It could be the staff on the hospital floor that is looking for the lab results that didn’t somehow get up to the floor in time for the physician to pick it up in the morning. It could be somebody waiting in line for a thallium stress test, and staying in the hospital two extra days because the technician doesn’t come in on the weekend, or because it was booked that day. Waste in all its forms needs to be discovered and fixed.

Second is to reduce demand. This can be done through patient empowerment, communication, and care-management techniques.

Third is to focus on outcome and to systematically track and trend outcome data for the particular activity that is important for the success of your unit or your profession or your organization.

I think it’s extremely important to get outside the silos that often characterize the health care organization. I remember when I was in the Indian Health Service a long time ago, we had one person in our little clinic that did all the lab work, did all the x-rays, did much of the translation, and generally kept things moving. She was accountable for cost and quality for a wide array of services that were important to the clinic operation. In a larger context, the more a single group

can organize all the services that make up a particular service line and can be accountable for cost and quality, the more value they will add and the more successful they will be at delivering the product at an acceptable price.

Once the service is set, a broadened client base will help shield you and your profession from a catastrophic event such as the PPS reimbursement system for skilled nursing facilities. The potential for new clients may be quite significant. I notice around our area, many of the physical therapists are now getting into personal training activities which gives them a different kind of approach. Certainly, the amount of interest in money spent on alternative or complementary modes of therapy is growing significantly. And there are opportunities to rethink who your customers and clients are probably in every field.

Matching capacity and demand is an important issue driving reimbursement. If I recollect back, I was talking to a group of cardiologists, and we were talking about frequency of certain kinds of diagnostic tests, and we were talking about some issues having to do with the relationship between primary care physicians and cardiologists. The willingness of the cardiologists to examine their own practices and utilization and the willingness to develop guidelines that help distribute their care between primary care physicians and cardiologists is largely dependent on how many cardiologists there are in town and how hungry they are. If you have an excess capacity in any particular specialty, it really does distort and make difficult some of the work that has to get done in trying to rationalize the amount of care provided.

**Table 3: Reimbursement**

- Match capacity to demand
- Assume risk
  - Episode
  - Service line
- Redesign service delivery
  - Care management techniques

One of the most important things you can do is to look at assuming some risk, meaning financial risk, and accountability for costs and quality risks for parts of what you do. When I was with the HMO, we did capitate physical therapy. We paid

a fixed amount per member per month to a physical therapy group who was fairly entrepreneurial and fairly aggressive. There were a lot of lessons to be learned from that. One was we probably didn't pay them enough, but that was a lesson we learned a little bit later. The most profound lesson to me was that all of a sudden, the physical therapists took back control over the entire process of deciding the type, frequency, and method of treatment. Now, most of the orthopedic surgeons and some of the other physicians had trouble with this. They were used to ordering exactly what they thought they wanted to order. And we said no; you can't do that anymore. All you do is make the referral for physical therapy. Physical therapists will decide what the treatment plan should be and they decide the frequency and the kinds of modalities they'll use in performing their work. That one little example, I think, shows how you can return professional autonomy and control back to a professional group by that group assuming responsibility for costs and quality.

The other thing you can do is look at service line responsibility, which is really across the continuum. Treatment is often fragmented among the rehabilitation therapies since patients' stays are limited in the hospitals and care must be given in various settings; e.g. hospitals, nursing or sub-acute facilities and in the home. It doesn't make a lot of sense to somebody who is looking at the most efficient way to provide care to the patient. I think there's lots of room for different collaborative efforts both across therapies and across the continuum to assume responsibility for cost and quality.

And lastly, I think you can participate in redesign of service delivery through disease-management and care-management techniques and case-management. This is a huge field. There's no reason that a nutritionist or a dietician can't be the case manager for a group of diabetics. There's no reason that a respiratory therapist can't be case managers for asthmatics or people with chronic obstructive pulmonary disease. So I think there's a whole field of case management out there that is waiting to be tapped.

In terms of clinical training, you need to identify what value can you add to the institutions and organizations with which you partner in clinical training. You need to entice them to make

investments in your students and in your programs. Clearly what it takes is collaboration with local employers and providers. I don't see any way around that. We're certainly working locally with our community college on several programs in an early stage that I think are going to be very fruitful, and I think we're going to succeed in finding some value-added services that are beneficial to both parties.

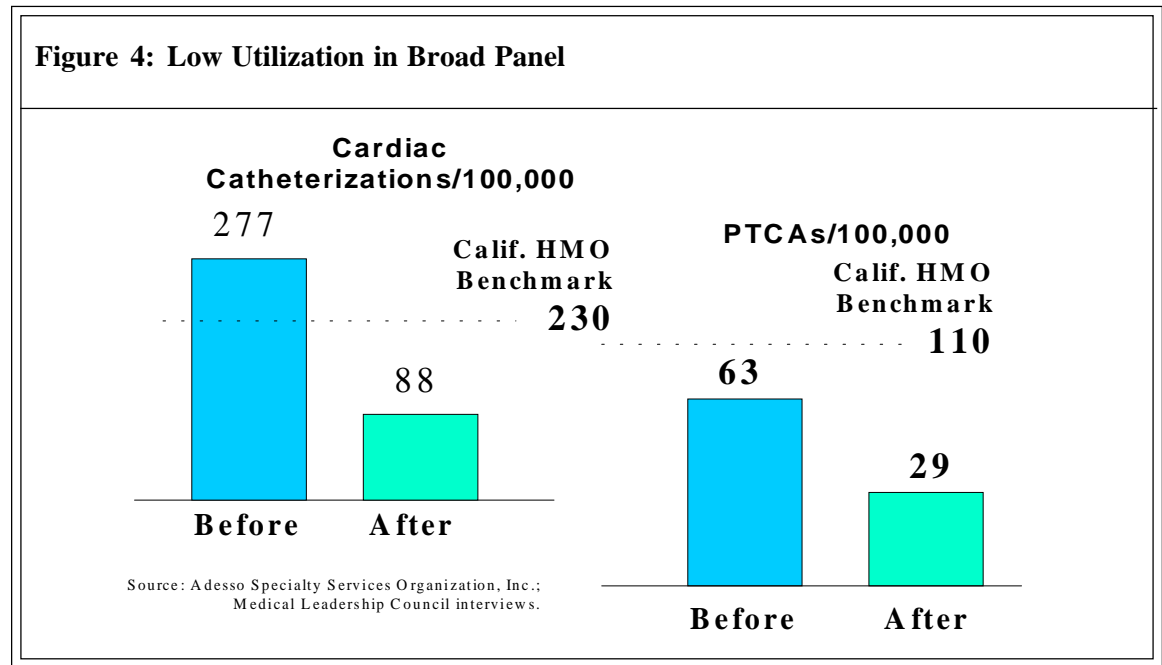
From the HMOs' standpoint, it is difficult to find a value to be added to managed-care companies through collaboration in clinical training. They don't typically employ professional staff so the benefit would be through research and outcome measurement. The partners are likely to remain the provider communities from the hospitals, the physicians, and the local health care institutions. Value added services can include outcomes and guidelines research, process improvement, quality improvement, and organization redesign. You, as academic institutions, certainly have something to contribute to the effort to rationalize the quantity and type of care with the outcome of care.

You also have an opportunity to assist institutions in recruitment, retention, placement, and continuing education for your students who are going to be in the workplace.

Figure 4 demonstrates the impact of a group of physicians - in this case cardiologists - who become accountable for cost and quality. This dramatic decrease in rates of cardiac catheterization before and after they were receiving fixed amounts for services is depicted in this figure. While the question of whether they were doing too many when they were doing 277 per hundred thousand, or whether they were doing too few when they were doing 88 per hundred thousand remains, there was no indication of adverse outcomes in the report.

If you subscribe to the Dartmouth Atlas and are familiar with Wennberg's work on small area variation, this is a dramatic example, but still not an uncommon example, of rather remarkable differences in rates of consumption to medical resources in different geographic areas. A lot of the work suggests that these are really patterns that grow up on a very local basis, based on where they were trained, local peer practices, and per-

haps supply and demand. There is nothing more dangerous than a hungry surgeon. Perhaps a hungry lawyer would be more dangerous, but certainly they are right up there together. And a hungry cardiologist behaves roughly the same way.



Finally, I do think that collaborative learning is extremely important. The workplace is increasingly collaborative these days, and unless professionals know how to collaborate and cross lines, cross disciplines, using some of the process improvement or quality improvement techniques, they're not going to be trained for the new work environment. Technical competence is necessary but not sufficient to be successful in the changing work environment of today's health care institutions.

**Table 4: Education**

- Competency based education
  - Technical
  - Collaborative learning
- Collaboration with related professions
  - Complimentary providers
- Economics and career alternatives
  - PT as personal trainers
  - Dietitian/nutrition as diabetic educators

Collaboration with related professions is particularly important. I remember spending hours on a coverage problem that should never have occurred. For some reason, the plan that I worked with in New York did not cover occupational therapy; in our particular community, all the hand rehabilitation was done by occupational therapists rather than physical therapists. We went round and round for hours and days and months as to how we were going to cover occupational therapy for hands, which was clearly medically appropriate and necessary without covering occupational therapy for all the other things that the plan did not wish to include.

This problem could have been avoided if the therapists had gotten together and said, "hey, look, we'll do your rehab and be accountable for cost and quality." That becomes an attractive package both for the insurance companies and for the profession which recovers the professional autonomy that is appropriate.

It is important that every student understand the practice context into which they're going, both in terms of the economic realities, and the opportunities to expand their career alternatives, find new customers, and grow themselves and their profession.



# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Response & Recommendations

**Linda Johnson, Ph.D., R.N.**

Acting Director  
 Associated Health Education Office  
 Department of Veteran Affairs

As Dr. Rowland said, today's health care environment is frequently seen as negatively impacting on training and education of not only allied health professionals but also all health professionals (Table 1). There is an emphasis on eliminating non-essential costs, and sadly enough, research and education are sometimes seen in the short term as non-essential costs. One of the major outcomes is reduced availability for clinical rotations. However, I believe we can look at the current situation as a glass half full or a glass half empty. There are always costs to everything, including clinical education, but there are also benefits. Sadly enough, there are not many, if any, good objective studies of the costs and the benefits. We have lots of ways to identify costs but not so many in terms of benefits. I would like to identify what VA perceives as some of the major benefits of continuing an active role in health professions education (Table 2).

<b>Table 1: Current Environment Negatively Impacts Clinical Education</b>
<ul style="list-style-type: none"> <li>• Emphasis on eliminating non-essential activities</li> <li>• Education is perceived as a cost - it uses resources               <ul style="list-style-type: none"> <li>– people</li> <li>– supplies</li> <li>– facilities</li> </ul> </li> </ul>

First is the improved clinician recruitment and retention. The clinical facility has an opportunity to recruit some of the trainees that it has educated and also recruit and retain faculty and staff. There are clinicians who really enjoy teaching, are good teachers, and like being in clinical settings that provide education. They also like the recognition of faculty appointments. From the education standpoint and from the clinical facility standpoint, it is important to recognize the clinical educators for their essential roles. There are many ways to recognize them in addition to faculty appointments. Recognition means a lot to individuals and they frequently don't get what they should.

We also need to look at the impact of clinical education on the quality of patient care. It could have some negative impact; for example, the patient has to repeat a lot of information to different kinds of trainees. However, in today's world with fewer and fewer health care providers, students can add a lot in terms of providing direct care to patients. They can't be expected to assume direct responsibility for patient care but they certainly can help out.

Another benefit of educating trainees is that those trainees that are hired after graduation in the institution where they trained will need less orientation, and this would be a major cost saving for the clinical facility.

**Table 2: Benefits**

- Recruitment of former students who will require less orientation than other new employees
- Recruitment and retention of clinical staff who enjoy teaching
- Rewards for involved clinical staff
- Improved quality of patient care due to
  - scholarly atmosphere
  - additional people to assist with patient care
- Education of future health providers is a public good and clinical facilities should be responsible.
  - Those that benefit by having trained workers should participate in their education.

In addition, the clinical facility, whether it's a hospital, an outpatient clinic, or any other setting, has an obligation to contribute to the education of future health providers in our country. The clinical facility shouldn't expect students to be trained if it won't participate. Students can learn only so much in a classroom or simulated setting. It is very important for the clinical facility to provide a setting where the students are presented with clinical realities. Clinical facilities also need to work with the professions to identify the manpower needs for the future. This is more difficult to do than one might imagine. In 1997, Department of Veterans Affairs convened a group of health professions leaders and tried to identify what VA's role would be in the future of health profession's education. We surveyed 50 professional organizations, accrediting organizations as well as professional associations, trying to determine future directions. It was amazing that very little data was available on what the individual professions thought they needed to do to prepare for the future health care needs. As a delivery system heavily involved in clinical education, VA finds it difficult to have a collaborative role with the professions when they themselves don't know where they are going.

I believe that the health care system, both the clinical and educational components, needs to thoroughly evaluate the cost and the benefits of providing clinical training for our future health care workforce. We need to determine ways to decrease the cost and increase the benefits as well as emphasize the benefits. Education for the future is a necessity for having an adequate supply of properly trained clinicians to meet future health care needs. Education is also a public good that should require contributions from a broad spectrum of our society that benefits from the educational outcomes. This means all health care delivery systems should be involved in education for the future.





# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Response & Recommendations

**Julie O'Sullivan Maillet, Ph.D.**

Associate Dean for Academic Affairs and Research  
University of Medicine and Dentistry of New Jersey

Good morning. These are my opinions on the economic impact on colleges and universities. I want you to close your eyes for a minute. Don't fall asleep, just close your eyes for a minute and think what will health care look like in 2010? And then think what allied health will look like? If your mind is totally blank, you've got to start thinking about it. Because if you think about it, education is supposed to be ahead of practice, and if we particularly, as the educators, close our eyes and don't even see a fuzzy vision of the future, then we really are in trouble. I think about it and I say practice is going to be forecasting and preventing disease and doing less treatment. The question then is, what do I do in allied health education to work there?

We're going to change because the type of care we give is going to change as well. As Dr. Rowland has discussed, we have higher clinical productivity issues out there and we have different sites of care (Table 1).

**Table 1: Higher Clinical Productivity and Different Sites for Care**

Higher Clinical Productivity	Different Sites for Care
<ul style="list-style-type: none"> <li>• reduces availability of sites</li> <li>• reduces time to educate students</li> <li>• reduces time on formal evaluations</li> </ul>	<ul style="list-style-type: none"> <li>• clients expectations different</li> <li>• space issues</li> <li>• more contracts</li> <li>• more training</li> </ul>

Clinical sites have done a fabulous job educating our students. Since allied health is very different from medicine and nursing, it is the clinical sites that tend to absorb the cost of our students. And we've sent them in as totally green individuals and said "now, you're going to make good allied health practitioners"; and they have done it, with willingness and their own time. Allied health individuals are fabulous in

promoting education. But now the question is who is going to pay for this education? Is it the practitioners that are going to have to do it on their own time, or are the sites going to be willing to pay?

Right now we have a situation, which everyone in this room knows, where we have reduced availability of sites because many sites are saying, "Sorry, I'm not in the business of education, figure out a different way of doing it." We have reduced time to educate students because of the higher productivity so that we have individuals saying, "I'd love to sit with the student and describe how to do this from scratch, but I can't do it, I don't have the time. You know, I'm spending an extra hour or two a day because of the students already. I can't spend three or four." And they have reduced time for formal evaluations which we've as well given to the clinical sites to do. We ask the sites to evaluate our students and tell us if they're competent, and then program directors sign off on their competence based on what the clinical sites say.

We have an added problem of different sites for different care. Because we're moving out of institutional care, clients have different expectations. For example, patients residing in V.A. nursing homes are willing to participate in lengthy interviews; whereas no outpatient ambulatory care patient wants to spend an hour and a half with the new allied health practitioner who is learning to interview. The change in where we give care is changing how we do clinical education.

We have space issues in the new environments. Hospitals have a lot of space. They may not say they have a lot of space, but there's generally space for training, there is space for students, there are tables and chairs they can set up. When you go into the community setting, there isn't the extra space to put the student to give them their space to work. Most people aren't designing their community centers to have a lot of space to educate all of the allied health students. We're lucky if they're training some of the medical students in their environments.

We also have more contracts so that all of us have extra work because now, rather than having one or two key sites that we're dealing with, we have 25 or 30 sites, and everyone is reading those

contracts in more detail and negotiating more with us in what's going to be in there.

And finally, we have more training, because the more clinical preceptors you have out there, the more you have to train them if you're ever going to have a quality product. So we have all sorts of issues affecting us in the college and university settings in allied health.

I always believe there are lots of solutions out there for us (Table 2). One is, I think we're going to have to change how we view clinical education so that it becomes more capstone more than basic education. I'm a skier, so I always talk about green students and black diamond trails. Well, I think we're going to send blue students out that will do blue trails, and that clinical sites will never do that green type education again. Project ahead a decade and they're not going to do the base. They may do the black diamond, but probably they'll do the blue slope education. Now, does everyone know that skiing has green, blue, and black slopes? Black is tough, blue is semi-tough, and green is easy; most of us could do green trails even if we're totally non-coordinated. We cannot send green students to do clinical education where the clinical setting is only doing blue and black diamond care and education. It is not safe.

**Table 2: Some Solutions**

- clinical education more capstone than basic education
- more student self evaluation signed by preceptor
- more simulated learning
- more clinical competency testing at academic site

Next, the students are going to have to do more self-evaluation, and then preceptors are going to have to concur, so students are going to have to learn constructive feedback, which means we have to give them the skills to assess themselves and then let the sites sign off and say, yes, I agree with this assessment. We're definitely going to have to do more simulated learning. You realize that pilots fly their first plane in the real air with you on board. That scared me. But that means that we really could simulate learning much, much better before the first time we interact with

patients. And the academic sites are going to have to figure out how they test clinical competency, so it is not just the clinical site doing that.

Now, we have a big challenge from the colleges and universities base, and I'm actually going to add a second challenge here. The first is that we have to reduce clinical costs, i.e. do more for the clinical sites, without increasing higher education costs. That's really a challenge. Every single academic institution could do a large part of the education themselves very, very well. That's why they're there. But now they have to do it without increasing their costs substantially, or we have a whole different charge system where individuals pay more for allied health education. I mean, most of us charge the same tuitions for general education courses, and maybe that needs to be different. Maybe there needs to be different costs or maybe the Bureau needs to invest more money in training students that are going into allied health to offset some of the costs because those demands are out there.

Our second challenge is to figure out how we meet market demands and don't over-produce allied health individuals. Now, we've seen medicine over-produce doctors. It would be very good if we could figure out how we have supply and demand balance, but again, you better have a vision of what's going to happen to the profession so that you can in fact make decisions on which ones are going to grow and which ones are going to shrink.

I have a few solutions for that as well (Table 3). One is we need to create more independent learners, and that's the higher ed challenge everywhere at the moment, not just for allied health. Students' progress shouldn't be measured on seat time. Students' should be participating in their own learning, and there are many students that are very resistant to this. So it's a major obstacle for us, that students like sitting there and absorbing information rather than getting into a debate and participating in their own education.

Next, we need to figure out how we share simulations, so that it's cross-disciplinary and we're all learning together. We must do this across schools because creating good simulations requires a lot of additional staff who know institutional design and technology. And if we try to do it by ourselves, the quality isn't going to be that good; we're not going to be able to afford it; and

**Table 3: Some Solutions**

- creating more independent learners
- designing shared simulations across disciplines and schools
- using computer technology and testing for skill development
- create value added projects
- make evaluation of services part of clinical education

if you're sitting in liberal arts colleges and universities, people are going to say allied health is too expensive, we can't afford it. And that may relegate many of us to just academic health science centers. Next we need to look at computer technologies; how do we use computers with students, and how do we do testing? You know, you heard the Bureau representative ask what do we do in under-served areas. There is the possibility that we can do much of the education where people do their learning in their own environment through technology, and perform competency testing when they're finished. So it's really capstone education on site and then you get people going back out to their communities. There are lots of solutions there if we're willing to say you don't have to sit in the class for eight hours a day, four days a week for your first six months, and then you have to go into clinical four days a week.

For the clinical sites, we've got to create value-added projects and we have to continue to promote students as wonderful for the clinical environment. We send in strong students to the environment, they add value and that helps with recruitment. It helps with keeping staff up to date. We can make evaluation of services part of all of our students' clinical education. We give back to the clinical sites and when the students graduate so they can in fact know how to reduce costs and how they reduce wastes, and measure their outcomes.

So with that, I'll give my three summary points. Those three points would be 1) to envision the future and find solutions; 2) to think about how you use technology to teach teams in a variety of settings; and 3) to design clinical activities that the sites will value, the students will value, and that will promote quality education.



# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Response & Recommendations

**Arthur Cooper, M.D., M.S.**

Chief

Division of Pediatric Surgery  
Columbia University/Harlem Hospital

Good morning, everyone. It's my pleasure to be here. Like my colleagues on the panel, I will be representing primarily my own views as a member of a relatively small accrediting body for a relatively small profession. I suspect that you will hear some common themes in my remarks that are similar to what you've heard others report.

I do want to begin, however, by pointing out that the profession, which the organization with which I work accredits, is a little atypical of the professions that are assembled in this room in that it is not really a health profession per se. It sits at the junction of public health and public safety and has elements of both in the training. It has a somewhat different view on our keynote speaker's initial question: "Is health care a right or a contract?" With respect to emergency medical services, the public has largely determined that it is a right. They can and should be made available for the public at large. Of course, that does not necessarily translate into the appropriate level of support for that public good.

There are also some very unique aspects to emergency medical technology as a profession. It is at the intersection of public health and public safety. Its history - grows largely out of community-based, volunteer rescue squads. This has resulted in large numbers of EMTs, and lesser numbers of paramedics being volunteers. There-

fore it is difficult to hold them accountable to any standard when they're giving freely of their own time.

As you might imagine, in such an environment, there's quite a spread between those who see themselves primarily as technicians providing a service to their communities, and those who see themselves as professionals providing services to the public. In addition, emergency medical technology is a very new profession and in a tremendous state of flux. It is a moving target in terms of planning appropriately for the future. Most of the instructors are also volunteers, not professional educators. Maintaining quality education in such an environment is a real challenge.

Salary and mobility, and to a lesser extent, professional status, are the major issues for the EMT paramedics themselves. EMTs make about \$15,000 to \$20,000 (if they are paid). Paramedics may make \$10,000 to \$15,000 or more. So for many EMTs, climbing the career ladder to Paramedic is a very large economic incentive. Yet, there's little incentive for the volunteer EMT to make that jump, as you might imagine, even though many treatments that are required for modern emergency medical technology do require the provision of the advanced life support skills traditionally within the paramedic's domain.

As a result, because we have so many volunteers, particularly at the EMT level, the wish for accreditation services is not always as strong as it might be. Since accreditation services are really the only significant guarantor of quality, given that the instructor pool is not terribly well developed, we're in a bit of a bind. What are the main issues for the employers? Cost and flexibility, and to a lesser extent, the technical level of skills that they're able to provide. HCFA is now paying less and less for ambulance services. No surprise. In addition, the ambulance world has been taken over by conglomerates in a way that the health care industry has not. Yes, there are some large health-care giants out there, but we're now facing a situation where the ambulance world is basically owned by three or four multi-national conglomerates, plus a smattering of small volunteer fire departments and rescue squads all around the nation. Neither the volunteer squads, which have no money, nor the big conglomerates, which want to make money, want to pay for accreditation services. So that impacts upon the desire of the professional to seek this additional status. Employers are hardly ready to pay the additional price for certification of paramedics for work that, in some minds, might just as well be provided by technicians at a far lesser cost rather than by para-professionals.

So what are our challenges? In terms of the actual programmatic end of things, there are limitations in terms of the clinical sites that paramedics have access to, particularly with respect to intubation training and delivery room training. These are historic stumbling blocks in this type of education, and the problems are only getting worse. In addition, there's a tremendous reconsideration of what is a paramedic. There's a study ongoing at the Ontario Pre-Hospital Advance Life Support Study, which is looking at every aspect of paramedicine and examining whether this profession provides true additional value in terms of patient outcome.

With respect to accreditation, where's the proof that we need it? We may not, but no one is willing to take the chance because there's no instructor pool out there of any quality to ensure the educational standards of accreditation are being met.

We also have an EMS education agenda for the future that the Federal Government is sponsoring,

which is seeking to reorganize and restructure the way educational standards are designed and derived to provide uniformity. And, of course, we continue to have the problem of finding appropriate medical control physicians to sign off on the competency of graduates. As revenue decreases on the clinical side of the profession, fire based services have more time on their hands because they've been so effective at preventing fires. This has caused a shift of para-medicine from the public health model to the public safety model, to training oriented rather than education oriented. This is really a very difficult problem, which has yet to be solved.

What is the reality? We are switching to terminal performance objectives and competency-based outcomes similar to other professions. How many repeats of a skill is enough to be competent? There is no data in para-medicine. At the present time, only seven states mandate accreditation and only about 20 percent of the programs are currently accredited nationally. Yet, the EMS education agenda for the future is calling for, by the year 2010, universal national accreditation, not only at the paramedic level but also the remaining professions as well.

The cost of accreditation is relatively inexpensive. It's about \$40 per student, less than about one percent of the tuition costs for the average paramedic program. So if there is value, the value of accreditation is probably pretty high because it represents a relatively small piece of the overall cost. Yet we don't have the data to prove that.

There is finally a consensus building toward the need for accreditation nationally, but that is going to require some work before it comes to fruition.

In summation:

- We have a new growing profession in a constant state of flux, which presents a moving target in terms of future planning.
- Quality education needs quality educators, and we have yet to develop an appropriate instructor pool that will meet that need.
- Accreditation standards access to educational opportunities will decrease because there are a number of schools out there that don't have the funds to improve the standards.

These are tall orders for the next decade, and I hope to learn from you and to take some information and guidance back to my group. Thank you very much.



# Pioneering Allied Health Clinical Education Reform

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## Keynote Address

### Overcoming Barriers to Clinical Education/Training Reform

**Lawrence Abrams, Ed.D.**

Dean, College of Health Professions

Thomas Jefferson University

Let me begin with a quote from Sir William Osler: “To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.”

We could probably stop there and just talk about the patient because that is essentially why we are all here today. Our clinical education responsibilities are what they are because we are trying to do something for patient care. It isn't necessarily whose responsibility it is, whether it is the hospital's, or the clinical site's, or the education program's, or the faculty's, but some day you or I might become a patient, and we should want to make sure that as much experience that the clinician has works to the advantage of the patient. That experience has to start somewhere, and I trust it should start in the clinician's educational program.

If we did not want to focus on the patient, we could just talk about the following three words: attitude, professionalism, and economics, which sum up all that we have to deal with regarding clinical education, at least in my view.

We are talking about the attitude of individuals, of agencies and organizations, both profits and non-profits. We are talking about professionalism or the lack thereof. If we want to make clinical

education work, there is no reason why we cannot make it work. Changing the words and talking about similar issues that we have been talking about for the last 20 years, as we did this morning, will not accomplish what is needed to deal effectively with clinical education. We need to take what we know has to be done, in cooperation with all the interested parties, and change that into action, not protect vested interests, not protect what we used to do, not protect what we do not yet know we want to do because we have no information to say that's going to be any better. Then, we have to deal with economics and the bottom line, whether it affects patient care or not. That is generally the attitude of everyone who is involved in the system, and that is also economics. Are we going to sacrifice the clinical education of our students for a new MRI or new CT technology, or are we going to deal with what is really important to patients, which is the responsibility we should all have in our respective positions to do what is best for patients, which is to protect what we need to do in terms of patient care.

I will not dwell that much on historical background. I will try to provide a historical overview, including many changes over the years. While the past has served us well, it doesn't necessarily mean that we should continue in the future everything we've done in the past. Change can work to

our advantage as much as it might work to our disadvantage.

Allied health programs represent a broad diversity of clinical experiences and settings. For this presentation, for example, I reviewed information from 31 different allied health disciplines, including literature from our professional organizations, from the accrediting agencies, from the certification, registration and licensing organizations, and from other constituents that are involved in the system. Although some similarities exist, essentially there are several differences. Moreover, there is very little documented research on clinical education to support what we have done in the past, what we are doing now, and what might lead to what we should be doing in the future.

Generally, the literature classifies the several types of clinical education programs into two broad categories related to patient contact. The laboratory is usually referred to as a non-patient contact setting, although we do know that that is not universal. Some laboratory personnel do have patient contact, as we know that clinical personnel are usually referred to as having patient contact. In traditional models/settings, students essentially served as staff in hospitals. This on-the-job training represented the first semi-formalization of educational training, as practiced in some hospital-based programs.

<b>Table 1: Traditional Model/Setting</b>
<ul style="list-style-type: none"> <li>• Students served as staff in hospitals</li> <li>• On-the-job training               <ul style="list-style-type: none"> <li>– first semi-formalization of education/ training</li> </ul> </li> <li>• Hospital-based programs</li> <li>• Certificate, diploma, degree programs               <ul style="list-style-type: none"> <li>– more informal, less structured experiences and evaluation methods</li> </ul> </li> <li>• One-on-one teaching models               <ul style="list-style-type: none"> <li>– hands on, direct patient interactions or experiences</li> </ul> </li> </ul>

With the advent of certificate, diploma and degree programs, more informal, less structured experiences and evaluation methods were introduced, although current trends in many allied health

disciplines include more structure and increased regulation. The one-on-one teaching models, with hands-on, direct patient interactions or experiences, provided an excellent opportunity for students to learn as well as they could during those times (Table 1). Whether this approach to clinical education is ideal now, whether it can be continued, remains to be seen. But now we are moving into other kinds of settings that I think will serve all of our clinical education responsibilities better (Table 2).

<b>Table 2: Newer Model/Setting Considerations</b>
<ul style="list-style-type: none"> <li>• Non-traditional settings               <ul style="list-style-type: none"> <li>– home care, community-based clinics, homeless shelters</li> </ul> </li> <li>• Collaborative group model               <ul style="list-style-type: none"> <li>– one instructor + 2 to 4 student peer groups; students utilize one another as resources</li> </ul> </li> <li>• Split supervision model               <ul style="list-style-type: none"> <li>– one student splits time between two sites and two supervisors</li> </ul> </li> <li>• Indirect/offsite supervision model               <ul style="list-style-type: none"> <li>– occupational therapy: six hours per week direct supervision by an OTR with indirect supervision the remainder of the 40 hour week, including supervision by a non-OT</li> </ul> </li> <li>• One year internship model               <ul style="list-style-type: none"> <li>– student is paid one-half years salary over 12 months (student rotates for six months in several supervised settings and then moves into six months of employment)</li> </ul> </li> <li>• Computer and virtual reality simulations</li> <li>• Case studies</li> <li>• Interactive ideas               <p>“Clinical skills are very different from classroom skills and demand higher levels of initiative, responsibility, flexibility, net working, time management, communication and negotiation.”</p> <p><i>Gina F. Collier and Lisa O’Connor</i> April, 1998, <i>OT Practice</i></p> </li> </ul>

Non-traditional settings are becoming much more prevalent. At Thomas Jefferson University’s College of Health Professions, for example, several of our clinical experiences now are set in

home-care, community-based clinics and homeless shelters. Both the students and faculty champion these new settings/experiences. Rather than restricting all of our clinical experiences to tertiary care centers, this diversification is working to provide our students with a more well-rounded, balanced curriculum. We also have an opportunity to use a collaborative group model, with one instructor and peer groups of two to four students, who can utilize one another as resources. We are finding that the more students can learn from each other in these groups, the more they favor that kind of clinical education. They are going to be working in teams after graduation, so they should get used to the idea of working in teams during their educational experience.

Another non-traditional approach to clinical education is the split supervision model, where a student splits the time between two sites and two supervisors. This is a value-added opportunity for most students. The expense of travelling from one site to the next, if they're not in close proximity, could work to the disadvantage of the student; however, that hasn't presented itself as a problem.

The occupational therapy literature describes the indirect off-site supervision model, where a student spends six hours per week in direct supervision by a registered occupational therapist with indirect supervision the remainder of the week, including supervision by a non-OT. This represents another of the several kinds of changes to clinical education currently in practice.

Another approach that makes some sense is the one-year internship model, where students rotate for six months in several supervised settings followed by six months of paid employment. Whether this method is feasible with the number of students that are in our programs remains to be seen. However, it does provide a concentrated opportunity for experience, and it is probably very ideal if the institutions can afford to do it. It is costly, but the return on the investment probably would work well for the student and the healthcare delivery system. It also tends to increase both the patient volume and the patient revenue.

Other options include computer and virtual reality simulations, case studies and interactive ideas. As Gina Collier and Lisa O'Connor state in *OT*

*Practice* (1998), "Clinical skills are very different from classroom skills and demand higher levels of initiative, responsibility, flexibility, networking, time management, communication, and negotiation." Now, where do we learn these clinical skills? Can they be transferred from the hospital into the classroom? Can the dexterity skills that go with the laboratory science professional be learned just as easily in a classroom situation, using the latest technology? It remains to be seen if what appear to be good ideas today will work as well as expected in the future.

There are several issues related to clinical education reform that we need to discuss. I am going to identify some general issues, then focus more specifically on the key ones.

Much has been written in the literature about issues concerning the scope of practice and core clinical competencies as defined by the various professional organizations and the state/national boards of medical/healthcare education and licensure. It is difficult to determine which point of view is best because they are very often self-serving and political. On certain issues, the professional organizations, including the accrediting agencies, stand firm until they are challenged. However, it is interesting that when they are challenged, they often tend to modify their position.

Many of the changes occurring in clinical education are driven by the increased number of programs; there just are not enough sites available for students to get adequate clinical experience. It is not that the experiences that they used to get were bad or not working, it is because of the proliferation of so many programs in several of the health professions that we do not have a choice. We have to make changes to accommodate the number of students in the system. And whether that is good or bad, remains to be seen.

There is a lack of reliable documentation regarding just how much time is needed for clinical education. Some health professions are a little bit ahead of others in this regard; but on balance, we don't really know over a long period of time precisely how much clinical education is needed for the programs that we offer. The literature does agree that the longer the clinical experience is, the better it is. But, again, it is questionable whether sufficient documentation exists to support this conclusion.



The impact of accreditation standards on clinical education addresses minimum standards and individual program flexibility. The question arises: the minimum standards are based on what? In the past, when I called some of the accrediting organizations, I was told that, well, that is just the way it has been. But based on *what* did we have those minimum standards? Some professional organizations have done a much better job than others. Although I do not wish to say that one is ahead of or better than the other, I agree with Judy's comment this morning that the American Physical Therapy Association has done an excellent job in documenting as much as they can, not only in terms of clinical education, but in terms of cost benefit and things of that nature as well. And that is helpful. We should have more activity among the professional organizations, as some of the professional organizations are trying to do, to provide us with that information.

Although we have some individual program flexibility, we still lack the outcome studies necessary to justify the individual accreditation requirements. Regarding the medical technology laboratory science professionals, NAACLS says that graduates must meet competencies outlined in the *Essentials*; there are no rules requiring clinical rotations. This prompts the question: what is the connection between board exam results and clinical practice? Is there a connection? We do not know with certainty. In fact, this day-and-a-half program could generate hundreds of doctoral dissertations that need attention. If we could get doctoral dissertations in the health professions around the country to deal with some of these issues, we might be better served than by some of the projects that people are doing for doctoral dissertations that aren't really doing much to help the system.

In occupational therapy, for example, the literature says that nine months used to be required in mental health, geriatrics, pediatrics and physical disability. Currently, there is a six-month requirement, which focuses on the age of the client served, the arena of practice (whether it is in a hospital, school or community), the acuity of injury (chronic to severe), and type of condition addressed by the setting. While these changes make a lot of sense, it doesn't mean that working for nine months in those four areas was the wrong thing to do either. By initiating innovative changes

that are in concert with the *Essentials* of their profession, academic programs in occupational therapy and its graduates have served the healthcare delivery system very well. And so we can learn a lot from what is going on in the profession of occupational therapy, as it is described in the literature.

One of the major issues that is frequently reiterated relates to the decreased staff and increased case loads in clinical settings due to mergers and restructuring. How does this situation relate to "attitude and professionalism and economics?" Considering that each of us will likely someday be a patient in a hospital, should decreased staffing and increased case loads in clinical settings due to mergers, restructuring and the bottom line be the reason why we do not have the most qualified practitioner taking care of us? I do not believe so. At Thomas Jefferson University, where I work, we are erring on the side of standards. That is, we are not making changes that will compromise patient care, no matter how reliable or economical we think they are. Although we have done things a certain way, we definitely do not just do something for the sake of doing the same thing; we also modify and change based on an evaluation of what will make a difference to our curricula and our programs. While some of the hospitals agree with us, some do not, which can be problematic, and lead to losing a site that fails to correlate with our curriculum and what we are trying to have our graduates do. Clinical education at Jefferson is essentially no different than anywhere else. We have 1,610 clinical sites worldwide, where our students get their education and that is really cumbersome to administer. Although it is difficult, we are extremely pleased with the results we are getting as reflected in the Longitudinal Study that Dr. Kevin Lyons conducts through our Center for Collaborative Research, relative to employer evaluations of our graduates. Approximately 90 percent of what we are doing continues to be supported because we survey current students and our graduates periodically for 10 years, and they tell us which part of the curriculum we should continue and which we shouldn't continue. We sometimes have more of a problem with our faculty making changes in the curriculum because we are listening to our employers, but slowly we do get the changes in place. Then we feel good about our graduates and their preparation for their professional careers. We have put

all this in place so that, relative to clinical education, we are doing something that we believe will maintain the strength of our programs and their accreditation status.

As mentioned previously, in some disciplines, such as occupational therapy and physical therapy, the proliferation of programs and students has sharply increased competition for the limited increase in clinical education training sites. For example, the Commonwealth of Pennsylvania and in our neighboring states, New Jersey and Delaware, we have 17 physical therapy programs and 16 occupational therapy programs. I don't know precisely where the responsibility lies, but it is poor management and poor planning from the professional organizations and the accrediting agencies to allow the proliferation of that many programs. There is no other place to put that responsibility. While it is true that restraint-of-trade legislation prohibits stopping a program from coming into existence, presidents and officers at universities can and should be made aware that such programs cannot survive long term. Recently, I was in a faculty club at a leading institution with a president who said that they were going to start a program, and when they couldn't get enough students, they would close it. The professional organizations are aware of that attitude. And as much as they are in a very difficult position to bring their influence to bear in order to persuade the right people, whether it is the president or the board, they have to stop the proliferation of new programs for short term, expeditious reasons. It is not working and it is adversely affecting other programs. If permitted to continue, it will also negatively affect the educational delivery system and the healthcare delivery system. There must be a way to control that.

We know from the preliminary information we have and from the Health Professions Data Collaborative (that is supported by the U. S. Bureau of Health Professions) that we have a very poor grasp on supply, a worse grasp on demand, and no grasp at all on utilization. We don't even know if the graduates of our programs are being utilized in the healthcare delivery system in the same ways they were prepared by their educational programs for entry into their respective professions. So we have to be much more responsible, and that impacts clinical education. There

is no way of getting around it. If we don't put those strong enforcements in place, we are going to continue to have problems that we can say are related to clinical education, but, in fact, we are contributing to and participating in the making of those problems.

The topic of student preparation for clinical education and training was addressed this morning. In a study completed in the field of occupational therapy, it was found that students were being sent into clinical sites without any course work in abnormal psychology or special education. The students couldn't even speak the language of the environment in which they were working. That situation has changed. After learning what the problems were from surveying the sites, the faculty and the programs corrected the situation. That is definitely a step in the right direction.

The problem of fewer employment opportunities, as stated earlier, is a direct result of the proliferation of college and university programs, which is one of the most significant contributors to the problems that we have in this regard.

Regarding risk management, which is an area with serious implications, students generally carry their own malpractice insurance plans via the college or university or hospital group policy. But many sites are also imposing other criteria in terms of risk management. Although I do not think that we currently have any major problems with an abundance of law suits (as reflected in the *College Law Digest*), the insurance companies are saying that we can anticipate problems if we do not have properly prepared students going into the clinical sites. The proliferation of programs in some disciplines clearly jeopardizes the standards of admission at institutions where tuition revenues or filling seats have high priorities. Bringing in students that are not qualified to be in the health professions programs will only serve to undermine patient care. We must be vigilant about maintaining high standards in admitting students who are capable not only to do, but to think and have the comprehension skills needed in the health professions.

Can clinical affiliation agreements really be enforced? I can give you just a very small survey. I talked to three attorneys who regularly review corporate compliance agreements, and they say,

“Absolutely not.” What is on paper sounds good, and everybody signs these agreements, even though it might take months to circulate the documents and obtain all the signatures. Yet, I’m told that they cannot really be enforced because they are so general that you can interpret whatever you want if you have a problem. But all the colleges and universities, all the programs - everybody has to have a clinical affiliation agreement. I review each of the 1,610 that I sign every year and we have our directors of clinical education in the departments review them; we have our attorneys review them and we have our insurance/risk management personnel review them also. It is a major job. Because we have not had a problem, so far, is it worth it? There is no guarantee that we won’t have a problem, even though we go through all that review. At least we have a standardized agreement that we’ve asked the clinical sites and their attorneys and their administrators to approve. So we do not impose upon them; it is a two-way agreement. Without question, the issue of clinical affiliation agreements is important in clinical education.

The evaluation process normally includes written and/or oral evaluations provided by site personnel. The educational institution faculty has the responsibility, shared or not. Legally, it is an institutional responsibility, as well as the responsibility of the student in the curriculum, to deal with clinical education. We may share it, we may be partners, but we are responsible for it.

The issue of “territoriality” deals with the concept that education “owns” the students while the service providers “own” the patients/clients. Several cases in the *College Law Digest* support this notion. Again, the educational institution owns the student, but the clinical environment owns the patients. It should be a joint, collaborative existence. It sometimes is, but not all the time.

Now, I will address the “pros” related to the clinical education issue (Table 3). The pros include: it frees the schools of the tremendous labor burden of placing and supporting students while providing clinical faculty with the opportunity for more innovation. Also, strong clinical education support should increase student recruitment. We have found that strong clinical education support does increase student recruitment because almost 50 percent of surveyed

students that had a favorable/positive clinical experience expressed interest in working at that institution, and our Career Development Center is confirming whether or not they are going to have an opportunity to work. We expect that in a few months, data for this past year will confirm that it saves recruitment costs for the hospital or the healthcare facility. This also gives them an opportunity to recruit our students before someone else does because we put in place several years ago a Career Development Center in the College of Health Professions that helps the student from day one prepare to conduct a job search, how to interview for a job, and how they are supposed to work on a job, either as a student or as an employee. We also have a career fair where we have recruiters coming from all over the United States, twice a year, to Jefferson to talk to and to meet our students and to find out what they’re interested in, which has helped our students, helped our College with recruitment, and definitely helped those hospitals and healthcare facilities that have invested in that process.

Other pros include the fact that hiring their own graduates should save clinical sites substantial recruitment costs. There are also incentives for clinical education sites/personnel, including faculty appointments and continuing education opportunities. We are very willing to do a lot to help the faculty at our clinical sites. We include them in our continuing education programs. We appreciate their teaching skills and their expertise which strengthens the knowledge base connection between our faculty and the clinical professionals. I have long been a proponent of the notion that you cannot teach what you do not do. Although our faculty don’t go back into practice as often as I would like, if at all, I am convinced that our faculty would be that much stronger if they spent more time in the clinical area every year or two to keep their clinical skills current. Whenever we have an opportunity to do things for the hospitals and the clinical personnel, we are willing and happy to do it, such as obtaining and demonstrating new technology. On the other hand, something that we *didn’t* do years ago, in response to a hospital in Philadelphia proved to be beneficial also. This hospital warned all the colleges in the area that it would stop providing clinical slots for nursing and allied health students unless the schools were willing to pay for clinical experiences. Considering the importance of clinical education for

our students, the hospital’s position was a tough thing with which to deal. So a couple of key individuals got together, got some more colleges and universities involved, and we had a meeting with the hospital administrator and with the person who made that decision. At this meeting, we said that we understand the hospital’s position, but we are also aware that the hospital is one of the leading institutions for patient care. If you really feel strongly about the change in policy, none of our programs will send our students to you, nor will we be willing to pay for it. After about 20 minutes, the hospital administrator said, “Let’s forget about it. We’ll study the issue for a couple of years, and then if it’s still a problem, we’ll come back to you.” The issue has never come back in the nine years since it was first raised.

This indicates that we can do something when we need to, if we are unified because clinical education is imperative to all of our health professions’ programs. And if we compromise those, if we compromise our standards, we are in trouble. This does not mean we can’t change what we’re doing and do it a little differently. In fact, we can and, when indicated, consider change. Even if we don’t really agree, try changes for a few years to see if it works, and then we can either change our minds, or those things can change that we tried for several years. We cannot fail to have clinical experience because a major hospital would threaten to withdraw its site unless it is paid for. Admittedly, some educational institutions around the country do pay for clinical education. While I am not a proponent of that, neither do I presume to say what you should do in your particular area. I do caution, however, that this practice can become an expense to a college or university or to a program that is beyond which it could survive, because there is no cost analysis or cost accounting approach to determine precisely how much you should pay for a student. It is a situation that could get out of hand and become a serious problem.

**Table 3: "Opinions" on the Issue - PROS**

- free schools of tremendous labor burden of placing and supporting students and clinical faculty opportunity for more innovation
- strong clinical education support should increase student recruitment
- hiring their own graduates should save clinical sites heavy recruitment costs
- incentives for clinical education sites/personnel
  - faculty appointments
  - continuing education opportunities
- presence of students should stimulate staff to stay current/sharp
- turnover of teaching staff is less than for non-teaching staff
- all of the work gets done whether or not staff are teaching
- toward the end of training, students might increase productivity
  - time of supervision offset by student’s contribution to patient care (cost/benefit)
    - students perform clerical and aid duties in general and, thus, increase patient care income in particular
    - students attend patient-related meetings

Another point in favor of clinical education is that the presence of students should stimulate staff to stay current and sharp, which we often overlook. We want to keep our clinical personnel as sharp and current as our faculty. Students strongly encourage those individuals to read their journals to find out what is current. In the literature, data have shown that turnover of teaching staff is less than for non-teaching staff, which is a cost factor. Also, the literature states that all the work gets done, whether or not the staff are teaching. At Jefferson, we never had a situation where we were told that clinical

personnel can't do their work. Somehow it gets done, and it really isn't compromised.

On the other side of the issues related to clinical education are the "cons." (Table 4) Some of these involve the lack of money, time, interest, and/or ability of clinical sites and personnel. In addition, some program departments do not have a full-time clinical education faculty person. Given the importance of clinical education, I think that is something that we all have to become more responsible for if we are going to be managing educational programs.

Other cons are the annual requirements to update the clinical affiliation agreements. Additionally, there has been an increased trend for accreditation agencies to charge a fee for each clinical site. Some opponents of clinical education hold the view that teaching decreases productivity of the clinical education/training professionals. While there might be some truth to this view, there is no definitive documentation to support it. As stated earlier, the presence of students can also be an incentive to and positive influence on clinical personnel.

In one study, the author states, "The reduction in clinical training time for students may provide immediate relief by decreasing the amount of time hospital staff spend teaching at clinical sites. However, this may be a short-term benefit if it causes an increase in the time required for new employee orientation and achievement of expected competency levels for new graduates entering the workplace." Our hospital administrator at Thomas Jefferson University Hospital and three of the other 21 healthcare facilities that comprise the Jefferson Health System have asked me to make the curriculum work so that they don't have to put in unnecessary in-service for our graduates who are not adequately prepared. They recognize that there is a learning curve, but they want assurance that the curriculum includes what it should in order to avoid an added unnecessary expense. And they're absolutely right. Although, the entire faculty in the College did not agree with me or with the hospital administrator, they did see the merit in his argument and made the necessary changes. It did not cost us anything in terms of the curriculum, it didn't cause any problems with accreditation, and we made changes that worked to the advantage of the healthcare delivery system.

Additional cons include: providing clinical education is expensive for the clinical site. While it is expensive initially, if students are prepared better, then it won't be as much of an expense in the long term. Another disadvantage is that students do little or no useful work during their initial early clinical education/training experience. The same is true for medical education and nursing education. Hospital administrators take a year of course work and a year of an internship and still require a learning curve on the job, even though they have had a year of paid internship. And they still don't know everything they need to. In fact, if you look at the curricula of the hospital administration programs around the country, most of them require only a single course in finance, yet 90 percent of their job involves finance. They don't even have their curricula in place to prepare hospital administrators properly for their responsibilities, yet they often pass judgment on everything else that goes into the hospital and the services that are provided.

Clinical sites can save money by eliminating education programs, and many are doing that. They would often rather have MRI or CT technology which generates income and generates a lot of other activity than an educational program. Until we have more data about supply, demand and utilization in the health professions work force, I think hospital administrators need to be very circumspect about removing an student clinical experience opportunities.

Technology and automation are also impacting clinical sites by eliminating the need for some jobs. And, in some areas, clinical/laboratory education is no longer a priority.

In addition, we have more competition for the limited sites resulting in only the "best students" getting the best placements, as well as the risk of all students not finding a placement. The lack of quality control that comes from schools and accrediting agencies as well as the absence of certification/credentialing for the site of clinical educators are quality control issues.

The following quote from the literature makes sense to me: "We seem to be caught in a dilemma of our affiliates telling us they would not want to hire a graduate without clinical experience but are not willing to provide the clinical experience for the students."

**Table 4: "Opinions" on the Issue - CONS**

- money, time, interest, ability of clinical sites and personnel
- some program departments do not have a full-time clinical education faculty person
- annual update of clinical affiliation agreements
- accreditation agencies charge a fee for each clinical site
- teaching decreases productivity of the clinical education/training professionals
- “The reduction in clinical training time for students may provide immediate relief by decreasing the amount of time hospital staff spend teaching at clinical sites. However, this may be a short-term benefit, if it causes an increase in the time required for new employee orientation and achievement of expected competency levels for new graduates entering the workplace.”
- teaching is expensive for the clinical site
- students do little to no useful work during their initial/early clinical education/training experience
- clinical sites can save money by eliminating education programs
- technology/automation is eliminating the need for some professionals
- laboratory/clinical education is no longer a priority

Again, on most of these issues, I consulted with hospital administrators or attorneys or accrediting agencies because I do not have the depth of knowledge or experience to be an expert on this subject. When I raised the issues, both pros and cons with them, they acknowledged the importance of clinical education. They said that they are not dealing with attitudes now. They are not dealing with anything other than finance, survival. I told them that continuing to think that way would be detrimental to their jobs because everyone, including boards of trustees, is interested in having a strong health professional being able to provide the best patient care. Yes, dollars are important, but it is equally important to know that your graduates are able to do the right thing, so that at commencement, the faculty and the administration and the university feel good about who is getting a certificate or a credential to be a health care provider.

We may want to, as one solution, maintain the ideal proven one-on-one model. We haven't yet

determined that model doesn't work. We may also consider the newer models that have been proposed. We can adjust the length and the location of the clinical experiences. We can shorten the duration of clinical rotations to accommodate more students. We can move instrumentation into the classroom. Whether you get all the skills and dexterity being supervised by the clinical professionals remains to be seen, but we can do all of those things. There is no reason why we cannot. I think they should be studied while we try to implement them.

Additional options/solutions (Table 5) include the following: we can identify more flexible accreditation and certification eligibility requirements. Accreditation agencies can be very good, especially if you include them upfront when you wish to make a change. I've had experience with accrediting agencies and organizations and professional organizations in terms of making a change that took two years, which is a very long time to obtain approval. But they finally agreed to

approve a pilot study. “We won’t hold you to what’s in place right now.” It has been my experience, then, that they’ve been very liberal, generous and objective in trying to work with the educational institutions. Ultimately, it isn’t a battle between the educational institutions and the accrediting agencies. They’ve done a great deal to help the health professions and allied health, and they are very good to work with. It requires that the communication, the cooperation, and the collaboration must be in place. That is what makes the difference. Because, after all, the accrediting agencies are us. We may have a problem with the way we relate to them, but they have been very helpful. At least the 22 different programs that we’ve had in place at Jefferson never had a major problem with an accrediting organization. We have disagreed, and it is healthy to disagree, but it has never cost us our accreditation because we disagreed. And I think we need to have that approach. It isn’t what the accrediting agencies will do or not do. They’re really very good, and they represent what we are all about.

We need to do something in order to promote collaboration and cooperation with the stakeholders. We haven’t really changed from what we’ve been doing for many years. We could consider appointing an appropriate commission, at the federal level, of educational institutions, healthcare facilities, and others, to study the issue of direct patient care and indirect care for the student learning experiences. We really haven’t done this. This conference that Dr. Harmening has put together so very well is a step in that direction, but as a result of this, we have to go at least one step further, or we are going to lose much, if not all, that we have gained here. We have to encourage the development of regional training consortiums. Some cities are trying to do that, but if we work together, if all the clinical education directors work together, we would have fewer problems with clinical education than we have right now. And we can seek and endorse and reward academic corporate clinical partnerships.

I do not believe that the managed care companies are against us. I think we have a mindset that they’re not with us, that they don’t want to support us. But where are the specific proposals that have gone to managed-care companies when they have denied educational institutions a part-

nership in trying to resolve a problem? We just *say* that they don’t want to work with us, and that they are only interested in the bottom line. We really haven’t challenged them. There are some managed-care organizations that have funded significant educational projects, although very few in allied health, more in the medical profession and nursing. Again, we really haven’t challenged them sufficiently. Why don’t we go together to managed-care organizations, some of the bigger ones with adequate resources, and say that we have a problem, we have a dilemma. Will you work with us? And I think we’ll be surprised that they might say they are interested in working with us. They want to find out, too, because what they thought was in place years ago isn’t really working now totally. I think they are more willing to be a partner in trying to resolve this problem because they, too, really have a stake in this. You might not think so, but they really do.

Another solution would be the streamlining of the clinical education process to minimize the documentation that clinical and laboratory educators must complete. It is required paperwork; we don’t have a choice. The physical therapy profession came up with the Universal Center Information Form and Clinical Performance Instrument, which seems to make sense. It would be productive and effective if we could all standardize on one instrument and take our biases away. It is like trying to get one patient insurance form. There is no reason why we can’t do it if we want to do it. If we want to be professional, I believe that something like that to start with would probably be a step in the right direction.

I believe strongly that we need to monitor and limit new program approvals. Although I have said enough about that issue, it is an embarrassment that we have the problem because we have known for years that this was going to happen. It is not new. It happened in the medical profession; it happened in other professions. We made changes years ago because we had too many nurses. Now nursing is one of the most needed health professions we have. You cannot get students into school because everyone is saying that there are no jobs, when in fact there are many jobs. The same is true with radiography. Everyone said that we have too many radiographers. Now, at least in the area where I work, equity increases were given to all the radiographers because they couldn’t

afford to lose them. And significant increases were also provided to other radiography professionals. So, we know a lot less about what we think we know a lot of, and we need to realize that. And the hospitals need to be educated about that. It isn't what we want to keep in our own domain, it is what

**Table 5: Solutions/Opinions**

- maintain ideal/proven one-on-one model
- consider newer models, including internships, technology solutions (e.g., computer simulations, “virtual” laboratory/clinic)
- adjust length/location of clinical experiences
  - shorten the duration of clinical rotations to accommodate more students in the same time period
  - move instrumentation (laboratory programs) training into the classroom setting and bring in hospital personnel to provide instruction; then, shorten the actual clinical laboratory training time
- identify more flexible accreditation and certification eligibility requirements (e.g., time, site types/locations)
- promote collaboration/cooperation among the stakeholders
  - consider appointing an appropriate Commission, at the federal level, of educational institutions, healthcare facilities, et al, to study the issue of direct patient care and indirect patient care student learning experiences
- encourage development of regional training consortiums
- seek, endorse and reward academic/corporate clinical partnerships (including contracts with managed care companies, home care agencies)
- streamline clinical evaluation process to minimize documentation that clinical/laboratory educators must complete
- PT: Universal Center Information Form and Clinical Performance Instrument
- monitor/limit new program approvals
- determine, through collaboration with employers, actual competencies required of graduates and modify curriculum as needed

we need to tell the hospital administrators and other clinical sites about what they should know. I think that we ought to establish this commission to study all the consumer, financial, and standards issues regarding clinical education and training. We should also fund comprehensive cost/benefit studies of allied health education programs. I would recommend earmarking a major percentage of all federal projects to deal just with these outcome studies and to deal with what we have been talking about for years, but not doing any-

thing about. We are just now beginning to talk about it a little bit more. And we ought to monitor and strengthen the approval process for new programs within allied health accrediting agencies and organizations. I think that also would be a major step in the right direction.

Lastly, I return to the three key terms: attitude, professionalism, and economics. We can do anything we want to do. We just have to have the right attitude, we have to be professional about it,



and we have to see that it makes sense economically. There isn't anything that has to be done that we can't do, at least from all the reading and all the time I've spent in my former and current position responsibilities. If we try to develop an attitude where I want it my way, or this way only is right, or your way is wrong, we are never going to get anywhere because what *is* right and what *is* wrong? There are a multitude of philosophy books written about what is right and what is wrong, and it doesn't make any difference at all. It is what we know has to be done and should be done. And we must do that without compromising standards. That is the key to everything: standards. We don't want to compromise standards and the students we admit into the programs. We don't want to compromise standards to get a faculty member who is less qualified than he or she should be. We don't want to compromise the investment we need to make in our health professions' programs. We should provide programs with the support they need to offer quality training. These are the keys, and standards are at the top. If we put our minds together, we can go forward from this conference, doing a great deal to improve and to make stronger our educational and healthcare delivery systems.



# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Response & Recommendations

**Diane Youngs, B.S., RT(R), RDMS**

Program Instructor

Diagnostic Medical Sonography

Mayo Foundation/Mayo Clinic

Thank you. I'm not an allied health education expert, nor am I in management at Mayo Medical Center. I do have 25 years experience in the allied health professions, 10 years as a radiographer, 15 years as a diagnostic medical sonographer, and 10 years on the academic faculty of the Diagnostic Medical Sonography program at Mayo.

With the help of our School of Health Related Sciences administrator, we came up with some reactions to Dr. Abrams' outline. Our reactions are based on Mayo Medical Center's experience and philosophy, which I will share with you briefly.

The three shields of Mayo stand for clinical practice, education, and research. The primary value is that the needs of the patient come first. Because of the diversity and the increasingly complex cases referred to Mayo, the quality of the allied health staff is very important.

Mayo expects to employ more than 20,000 allied health personnel by the year 2000. Attracting health professionals to rural southern Minnesota is no small task and very expensive. It is therefore easy to understand why Mayo considers allied health education a worthwhile and necessary investment.

Part of the Mayo experience includes hospital-based or certificate programs such as the diagnostic medical sonography program. We utilize mainly internal clinical sites. However, our physical therapy program has onboard over 200 clinical sites. Mayo programs expect close collaboration with the clinical sites and involvement in a clinical evaluation process. Our clinical sites are chosen with specific educational goals in mind, and the length of the students' rotation is adjusted accordingly. Preceptors, mentors, and clinical instructors must be appropriately certified or licensed. This harkens back to achieving the primary value of quality patient care.

Maintaining and fostering quality clinical sites is accomplished through offering continuing educational opportunities for employees. We make these opportunities convenient and accessible. Our program, for instance, provides resources and review classes tailored to sonographers pursuing advanced certification. Physical therapy participates in a multitude of continuing education opportunities, for other programs as well as their own. Tuition reimbursement makes continuing education a reality rather than a dream for many employees. So by way of example, Mayo exhibits and encourages stewardship. I think that encouraging stewardship and responsibility may be one of the most important themes to come out

of a conference such as this, because the students are potential employees for participating clinical sites.

Even with institutional support such as ours, many of our programs in the School of Health Related Sciences are experiencing difficulties (Table 1) associated with staffing shortages and program expansions meant to address those shortages. Faculty are usually recruited from the allied health staff, and it is understandably difficult to release your most experienced staff to prepare and present lectures. Program expansions, often mandated, present the challenge to optimize the clinical experience. Having enough clinical sites for all the added students is a major problem.

<b>Table 1: Barriers</b>
<ul style="list-style-type: none"> <li>• Limited dedicated faculty               <ul style="list-style-type: none"> <li>– Staffing shortages</li> </ul> </li> <li>• Mandated program expansions               <ul style="list-style-type: none"> <li>– Optimizing clinical experience</li> </ul> </li> <li>• Space limitations</li> <li>• Computer and technical equipment</li> <li>• Operational mechanisms               <ul style="list-style-type: none"> <li>– Parking, affordable housing, etc.</li> </ul> </li> </ul>

Space limitations are also an issue. Finding rooms to accommodate additional students and office space for faculty is a current problem we are dealing with. The need for additional computers and technical equipment compounds the problem. Whenever we grow, we must also consider the downstream effect this has on operational mechanisms such as parking and affordable housing. This is a very real problem we're facing in Rochester.

Our success and model suggest that any reforms that may negatively affect quality need to be approached with caution. Any of the points outlined below may serve to lessen the primary value of quality patient care (Table 2).

***Shortening quality clinical rotations.***

I think sometimes there is a perception that at a non-physician level a program can be accelerated.

***Adding clinical sites that cannot meet educational goals.***

Utilizing small rural hospitals as primary clinical

sites to accommodate additional students does not provide an equitable clinical experience compared to students at a metropolitan medical center. By using less than optimal clinical sites, we would risk losing our accreditation, which brings me to the next point.

<b>Table 2: Guarded Reactions</b>
<ul style="list-style-type: none"> <li>• Factors that affect quality of training               <ul style="list-style-type: none"> <li>– Shortening quality clinical rotations</li> <li>– Adding clinical sites that cannot meet educational goals</li> <li>– Relaxing current accreditation standards</li> <li>– Financial rewards for clinical sites</li> <li>– Computer simulation as substitute for “clinical” experience</li> <li>– Streamlining clinical evaluation process</li> </ul> </li> </ul>

***Relaxing current accreditation standards.***

Accreditation requirements may be a program's only leverage for acquiring adequate staffing and quality clinical sites.

***Financial rewards for clinical sites.***

The Mayo School of Health Related Sciences agrees with Dr. Abrams in that they are against financial rewards for clinical sites. This is a very complex issue; there are actually bidding wars going on for clinical sites, which I think is only going to, in the end, drive up health-care costs.

***Computer simulation should not be considered a major replacement for clinical experience.***

***Streamlining the clinical evaluation process.***

If streamlining means shortening the evaluation process so that specific information is not obtained, then it is detrimental. A good clinical evaluation process does take time, and perhaps a standardized evaluation process would be more in line.

The increased demand for allied health graduates have many programs, including ours, scrambling to meet the challenges of maintaining quality and quantity. Some promising changes (Table 3) include:

**Table 3: Positive Reactions**

- Blend of new methods (simulation, distance learning, etc.) with old methods
- Moving instrumentation training into the classroom setting
- Encourage regional training consortiums
- Monitor/limit new program approvals
  - for those professions with no required accreditation or licensing
- Encourage clinical site partnership
  - investment
  - responsibility
- Obtain information
  - needs of occupational groups
  - cost/benefit of training and the services rendered
  - regional needs
- Allied Health Commission may be one mechanism to provide this data

***Blending new methods with the old.***

An example would be computer simulation used as an adjunct. Distance learning is also offering some very exciting opportunities.

***Moving instrumentation training into the classroom setting.***

Certain laboratory programs that do not have patient contact can achieve this.

***Encourage regional training consortiums.***

Regional training consortiums encourage resource sharing rather than competition. Once again, distance learning provides increased opportunities.

***Monitoring or limiting new program approvals.***

We feel new programs, especially those who choose not to be accredited, or for those professions with no required licensing such as medical sonography, should be monitored. Poorly prepared allied health staff perpetuates the cycle of non-qualified clinical sites.

***Encourage clinical site partnership.***

By encouraging an atmosphere of partnership

with clinical sites, we will see more investment and responsibility.

***Obtain information.***

By obtaining information, allied health will be better equipped to address the needs of the occupational groups. Data regarding the cost benefit of their training and the services they render can be used to foster clinical site participation. Assessing regional needs makes allied health more socially responsive. An allied health commission may be one mechanism to provide this data.

Creating and maintaining a well-rounded program requires a committed investment and the support of administration, staff, and faculty. It is to everyone's benefit to invest in quality clinical education, which must be seen as a solution and not as an unnecessary drain on health-care dollars.



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## Response & Recommendations

**Rumaldo Z. Juarez, Ph.D.**

Dean

College of Health Professions  
Southwest Texas State University

First, I want to compliment and thank Dr. Abrams for such a comprehensive presentation.

Second, as you will notice from my comments, the issues I will address either overlap or restate some of the same issues that have already been mentioned by several of the speakers representing the various constituencies attending this conference, i.e., those representing the educational/ academic institutions, healthcare organizations, and health professional societies. What this illustrates is that no matter what constituency we are representing, there appears to be a great deal of convergence about the issues or problems that all of us are facing.

There are four issues that I would like to address. These are:

1. Approval of New Programs
2. Rural Minority and other Underserved Populations
3. Affiliation Agreements
4. Allied Health Legislation

### ***1. Approval of New Programs***

Based on my past experience as a member of the Health Affairs Committee of our State's Higher Education Coordinating Board, we as educators seem to be very effective at justifying our needs and requests for new allied health training pro-

grams. What is surprising is that we are able to do this despite the fact that we usually do not have access to good supply and demand data regarding the various allied health professions. What winds up happening is that educational institutions may in fact request new training programs at the urging of local or regional professional groups or healthcare providers, elected officials, or a perceived need by administrators or interested faculty in our institutions. More often than not, State Boards of Education wind up getting caught in the middle between an influential state legislator who wants a particular training program in their district and a State Advisory Board who may decide that the program is not needed. Absent from this process is any type of supply/demand health workforce data. Thus, we really don't know at the state level whether a new educational training program is needed or not, or for that matter, whether there are sufficient clinical sites and faculty to support the proposed new programs. The unfortunate outcome is that the existing training programs in the state end up competing with each other for limited clinical sites and qualified faculty.

It should give us some comfort, nevertheless, that the Bureau of Health Professions of the U.S. Department of Health and Human Services is beginning to address this issue via the creation of Health Workforce Data Centers throughout the

country. In the state of Texas, we have recently formed a Health Personnel Data Ad Hoc Committee of the Statewide Health Coordinating Council to explore ways of collecting health professions workforce data. What we have already discovered is that it is not too difficult to have access to workforce data on health professions that are licensed by the state, especially such occupations like physicians, dentists, veterinarians, psychologists, nurses, etc. When it comes to data about most of the allied health professions, however, it is not as easily accessible or collected. Some of these professions are not licensed and others, if they are licensed, have no government unit or professional association that keeps track of the number of practitioners in allied health.

So what can we do about this? I recommend that allied health professionals make their voices known and get involved with their state boards of higher education (Table 1). Become an active participant in the decision-making process that approves new educational training programs in the state and also an advocate for the collection of allied health workforce data.

**Table 1: Response/Recommendations**

- |  |
|--|
| <p><b>I. APPROVAL OF NEW PROGRAMS BY STATE BOARDS OF HIGHER EDUCATION:</b></p> <ul style="list-style-type: none"> <li>– need for the program</li> <li>– supply/demand workforce data</li> <li>– impact on available clinical education training sites</li> <li>– availability of qualified faculty</li> </ul> <p><b>II. RECOMMENDATION: Greater involvement of Allied Health Professionals in State Boards of Higher Education decision-making committees.</b></p> |
|--|

## **2. Rural Minority and other Underserved Populations**

The second issue I want to address is related to one of Dr. Abrams' points about the need for using non-traditional settings for some of our clinical education sites. A category of these non-traditional settings are located in geographic regions that have high concentrations of rural minority and other underserved populations. A significant proportion of these populations are still being left out of the loop, not only in regards to lack of healthcare services, but also in regards to being used as clinical education sites (Table 2). Located in these regions are home healthcare agencies, community-based clinics, homeless shelters, nursing homes, small rural hospitals, and migrant health centers. Specific examples in the state of Texas are communities that are located along the Texas-Mexico Border that are densely populated by a Mexican-American population. The "downside" of the proliferation of new allied health training programs is that there are fewer clinical training sites; but, this problem also has an

"upside," and that is, it is forcing many of us to look harder for these non-traditional training sites and finding them quite rewarding.

Besides serving as non-traditional clinical training sites, there are also some latent bonuses, e.g., using these sites for providing healthcare services to populations that are medically underserved and also as prime recruitment geographic areas for minority and other disadvantaged students that are severely underrepresented in the allied health professions. In the long run, students recruited from these areas are more likely to return and practice in their communities of origin and contribute toward increased healthcare services in the region.

In order to make better use of these non-traditional sites as clinical settings, we need to work closer with federally funded programs like the Area Health Education Centers and the Health Education Training Centers. In the past, AHECs have primarily been concerned with increasing the number of physicians. More re-

cently, this appears to be changing and they are beginning to address the wider needs of the health professions inclusive of allied health. These programs are being underutilized by programs in allied health. Our experience with both of these programs has been very rewarding, especially as it relates to the recruitment of under-represented populations in the health professions.

By the way of recommendations, I recommend that allied health programs expand and make better use of non-traditional clinical training sites in rural and underserved population areas. Use these sites not only for meeting the clinical education needs but also as recruitment sites for minority and other under-represented populations in the allied health professions. In addition, work closer with the Area Health Education Centers and the Health Education Training Centers in your state.

<b>Table 2: Rural, Minority, and Other Underserved Populations are Still Being Left Out of the Loop</b>
<ul style="list-style-type: none"> <li>• Rural hospitals</li> <li>• Community health centers in rural areas and inner-city neighborhoods, especially those with high-density minority populations</li> <li>• U.S.- Mexico Border Communities</li> </ul> <p><b>Recommendations:</b></p> <ul style="list-style-type: none"> <li>• Recruit students from these areas - then place these same students back in their communities of origin to do their internships</li> <li>• Work with the "What the hecs" - i.e.               <ul style="list-style-type: none"> <li>– Area Health Education Centers (AHECs)</li> <li>– Health Education Training Centers(HETCs)</li> </ul> </li> </ul>

### 3. *Affiliation Agreements*

The third issue I want to address are the affiliation agreements that are so vital to our clinical education training sites. We currently have over 600 affiliation agreements in our College of Health Professions and they are a challenge to keep up with.

Perhaps some ways to “ease the pain” of affiliation agreements are to:

- Keep them simple
- Keep the costs of the clinical site to a minimum and the benefits to a maximum
- Keep the paperwork processing to a minimum, strive for multi-year agreements, and maximize the number of allied health professions that can be included within one agreement
- Keep the clinical sites “engaged” with complimentary correspondence: don’t take them for granted after the agreements are signed

- Recognize their value and their contributions toward training the next generation of allied health professionals
- Reward them with public relations opportunities when possible
- Recognize your Preceptors
- Send letters of recognition with cc to their CEO’s
- If possible, provide “Clinical Adjunct Faculty Appointments” along with certificates of such appointments
- Maintain continued dialogue and contact with the preceptor–don’t just “dump” the intern at their doorstep
- Have the intern follow up with a thank you letter at the end of the internship
- Invite the preceptors to your organizations’ athletic and cultural events
- Socialize/train your next generation of preceptors

Table 3 outlined and summarizes some recommendations related to clinical affiliation agreements.

**Table 3: Recommendations**

- Keep them simple
- Keep the costs to the clinical site to a minimum and the benefits to a maximum
- Keep the paperwork processing to a minimum, strive for multi-year agreements, and maximize the number of allied health professions that can be included within one agreement
- Keep the clinical sites "engaged" with complimentary correspondence:
  - don't take them for granted after the agreements are signed
  - recognize their value and their contributions toward training the next generation of allied health professionals
  - reward them with public relations opportunities when possible

#### ***4. Allied Health Legislation***

The last issue I will address is allied health legislation. This is an area that I believe the allied health professions are not getting involved to the extent that we should or that we can. I recommend that we:

- Implement tax credits for healthcare organizations that serve as clinical education sites
- Revisit legislation for AHECs/HETCs for a greater emphasis on allied health professions and assistance in clinical education training sites in particular
- Ensure allied health professionals are represented in every state board of higher education





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## Response & Recommendations

**Jody S. Gandy, Ph.D., P.T.**

Director

Physical Therapy Education

American Physical Therapy Association

Thank you for the opportunity to briefly share my thoughts and reactions. As background information, please understand that my comments are being offered as the Director of Physical Therapy Education at the American Physical Therapy Association and not from the position of the profession's accrediting agency, the Commission on Accreditation of Physical Therapy Education (CAPTE).

In examining the numerous obstacles to clinical education, it is important to recognize that we are attempting to "fix" a highly complex, dynamic, and interrelated system. I am reminded of the boy who tried to stop the dike from overflowing. It seems that as soon as we attempt to plug one hole by implementing a workable solution, three more holes burst open that necessitate far more expansive and complex solutions. As a result, in reviewing Dr. Abram's presentation it is apparent that there are numerous barriers and issues that warrant our attention in clinical education. Given the myriad and complexity of these issues, it seemed prudent to attempt to provide a fundamental framework in which to view these barriers in order to develop workable recommendations. Resources used to develop these five themes included not only Dr. Abrams' keynote but also prior experiences realized from participating in education consensus-building conferences in physical therapy, and parallels drawn from re-

viewing the Proceedings from the 1997 Conference on Integrative Learning on Restructuring Health Professional's Education.

We can view the obstacles to clinical education reform as encompassing five "C's", that are as follows: (1) Competition, (2) Control, (3) Confidence and trust, (4) Change relative to attitudes, and (5) Capable of seeing a larger view or interest beyond a narrow view of a specific discipline, facility or organization. Given our time constraints, I will provide just a few examples of each to help you to understand what each "C" encompasses.

The first "C" competition, encompasses obstacles that relate to competition for qualified and competent personnel, time, money, available clinical education sites between and among disciplines, and other related resources. Competition for limited resources has become increasingly difficult given internal pressures between and among professions for qualified clinical educators and sites as well as external demands placed on the health care system by managed care and the balanced budget act.

The second "C", control, examines issues related to locus of control and decision-making authority. For example, decisions related to student progression within a curriculum, assignment of grades,

determining when learners have achieved established performance outcomes, determining when students are competent and safe to enter practice, and whether or not to develop a program, all represent control-based decisions. The obstacle posed by the issue of control is focused not only on who is responsible for making these decisions but also who is willing to relinquish control over some of these decisions. In listening to some of the comments made thus far, it is apparent that we view obstacles to clinical education differently based on our lens and locus of control. Often we attempt to frame clinical education to serve our particular need or interest. An alternative perspective might be to consider that the purpose of clinical education is to determine when the learner has satisfactorily attained established performance outcomes to enter practice at a level that ensures safe, effective, competent practitioners, as opposed to deliberating about who has control and authority over a specific aspect of learning in the practice environment.

Let's move on to the third "C," confidence and trust as it relates to clinical education reform. Confidence relates to respect and how decisions are made within an organization or profession that affect members and ultimately consumers. Trust relates to our ability to trust one another as health professions with differing interests and needs. Consider this... ideally if we had confidence and trust in each other as health professions, then we would be able to commit to clinical education reform without having every health profession represented if we viewed the obstacles similarly. Thus, no matter which disciplines were present to develop solutions, we could have confidence and trust that proposed solutions would have been made with the consideration and interest of all professions. I propose, that currently, this is not the case. If remedies were developed, it is more likely that each profession would reserve the prerogative to tweak the outcome just a little bit differently to suit its needs. This behavior is certainly understandable but perhaps does not move us closer toward addressing clinical education reform. Hence, until we move to a place where we have confidence about decision-making within our respective disciplines and trust that decisions can be made without every discipline being present, reaching solutions as a group of professions will be fraught with frustration and, more likely, a near impossibility.

The fourth "C" has to do with changing attitudes. Dr. Abrams addressed this issue in his keynote as a general, universal resistance to change. On the one hand, we may state we do not like the status quo, however, at least we know what the status quo represents. On the other hand, making the leap to an unknown, may seem attractive, and yet, we may be unsure as to how far we are willing to go to achieve a workable solution. On balance, the incentive to change must be greater than the resistance to change or inertia required to make a paradigm shift. We might ask ourselves "How urgent is the need for change?" Are we willing to delay change until the external environment drives us toward change? Dr. Abrams alluded to the fact that perhaps the accelerated change that we're all experiencing in clinical education would not have occurred so rapidly without changes in Medicare, the Balanced Budget Act, and managed care in the past six months. Perhaps without these external accelerated changes we might not be viewing clinical education in crisis and in need of reform.

The last "C", which I believe is the most important, addresses the capability to see the larger interests rather than a narrower view. Credit for the last "C" goes to Joseph Black, PhD, Senior Vice President/Division of Education at the American Physical Therapy Association. Dr. Black has shared his perspective on this issue with many persons in physical therapy through education consensus-building conferences. In essence, this means that the individual or profession is able to view the problem and solutions considering the larger interest of the profession, rather than a narrower view of a program institution or clinic. In this case it could mean the very survival of clinical education within the health care environment. To assume this posture would mean that an individual would need to set aside his/her personal bias or a particular position to find solutions that are workable for the greater good, even if the solution is not his/her preferred outcome or is not currently attainable. The example that Dr. Abrams shared in physical therapy of the development of a national voluntary clinical performance instrument for physical therapist (PT) and physical therapist assistant (PTA) students represented such an achievement. At one point, there were more than 50 different tools being used to evaluate PT and PTA student performance in clinical education. The willing-

ness on the part of academic programs, consortia, and clinical education sites to let go of any one particular instrument to develop a new uniform evaluation instrument was not an easy task. It took this profession three years to get to that position and to achieve agreement on an evaluation instrument that was both consensus-based and evidenced-based. In the final analysis, persons or organizations must believe that in anticipation of outcomes that can be achieved that serve a larger interest are worthy of relinquishing something that maybe familiar but may no longer be effective.

Finally, when considering all five “C’s,” to be able to achieve clinical education reform requires an examination of the incentives of each of the stakeholder groups that are needed to achieve workable solutions. We must clearly understand what each group brings to the discussion and what are their incentives relative to clinical education reform. If common ground can be found among all stakeholder groups, then we can begin to move toward finding mutually agreeable solutions. If, however, the incentives driving each stakeholder group is different (eg, bottom line dollars, quality product, number of students, safety, etc) then the ability to achieve consensus among all groups to achieve a common solution may be problematic.

Given these five “C’s,” I would like to offer three recommendations (Table 1).

1. Building on the earlier suggestion to establish a commission, I believe that it is imperative that all stakeholder groups involved with clinical education are convened to include students, consumers, higher education, clinical sites, managed care representatives, payors, etc. To facilitate consensus building would require the development of agreed upon assumptions to establish boundaries to focus the discussion. In addition, persons must be able to demonstrate, in advance, their commitment to achieving consensus-based solutions such as signing a covenant that describes preferred attitudes and behaviors needed to reach agreement and solutions that address a larger view. The work of this commission would be to develop a set of sufficiently broad and applicable guiding principles that each profession would be able to apply to its clinical education. Each discipline would be able to take the work of this commission

back to their respective members to enable them to achieve a sense of “buy in” with the outcomes and to offer alternative solutions that might not have been considered. This perspective is based upon principles that have been used successfully within physical therapy education to achieve widespread consensus on controversial issues. This process is intended to build confidence and trust, ensure a larger view, minimize competition, and allow for shared control.

2. A second recommendation relates to suggestions for expanding the evidence-base of clinical education that we addressed this morning. We might seek to obtain data on the “best clinical education practices” across disciplines that meet productivity standards, are cost-effective, and achieve discipline specific performance outcomes. We need to publish these “best clinical education practices” across disciplines. We also need to consider the best clinical education practices that meet the incentives of all stakeholder groups while achieving performance outcomes of learners.

A secondary study would examine the qualifications or attributes of those clinical educators who have demonstrated the best clinical education practices. As a result, education and training programs could be developed for clinical educators based on both best clinical education practices and attributes of clinical educators teaching in those programs.

A follow-up to the above study would evaluate whether or not there is a difference in the performance outcomes achieved by students when provided clinical education with persons who have completed the education and training program. The bottom line is: does research and training make a difference, and does it result in raising the standard for clinical education?

3. A final recommendation is to develop a comprehensive and systematic plan for designing, implementing, and evaluating clinical education structures that include new structures, partnerships, and changing current paradigms. This long-range strategic plan should coordinate all aspects of change to bring about clinical education reform, rather than a splintered approach that “plugs the dike” with quick short-term fixes. In summary, we need to offer recommendations

that focus on outcomes rather than control, foster confidence and trust, minimize competition and maximize cooperation/collaboration, empower persons to positively embrace change, and enable professions to value decisions that consider the larger view and interests in order to effect broad-based reform. Our future in clinical education depends on achieving these changes if we are to survive in the next millennium.

**Table 1: Recommendations**

- Establish a commission: All stakeholder groups involved with clinical education are convened to include students, consumers, higher education, clinical sites, managed care representatives, payors, etc.
- Seek to obtain data on the “best clinical education practices” across disciplines that meet productivity standards, are cost-effective, and achieve discipline specific performance outcomes
- Develop a comprehensive and systematic plan for designing, implementing, and evaluating clinical education structures that include new structures, partnerships, and changing current paradigms



# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Keynote Address

### The Role of Professional Societies in Clinical Education/Training Reform

**Patricia Crist, Ph.D., OTR/L, FAOTA**

Chair and Professor

Department of Occupational Therapy

Duquesne University

I want to thank the planning committee for the invitation to speak before this important meeting. I commend the previous speakers and the salient points they have already addressed in considering the 'pioneering of new approaches to clinical education/training.' I also am aware of the great anxiety created within me as I listened to their presentations in fear that all my main points would be taken. Seldom do I ever find myself speaking last; I always volunteer to go first. So, some of my comments will validate previous statements and recommendations while the majority will be furthering our discussion.

First, I need to create a context for the basis of my presentation:

- I do not see clinical education and clinical training as one in the same. My preference is education at this time is not just to habituate behavior but to integrate knowledge and enhance skill development as the foundation for professional reasoning.
- Please excuse my own professional socialization process if I slip and call clinical education: fieldwork.
- I do not portray myself as a scholar of professional societies but will share my perspective as a member because members are the 'engines' that run societies. I am an

active member in my own society and have had the pleasure and challenge of doing many interdisciplinary workshops to clinical educators.

- Last, I apologize for reading, as I seldom use notes. I have limited time and much to cover. This will also prevent me from side-tracking into 'preachable moments.'

I have been asked to discuss the role of professional societies in clinical education reform. The three pre-conference foci given to me were:

1. the impact of practice and core competencies;
2. the influence of accreditation standards; and
3. the potential resources for reform if the allied health professions cooperate and collaborate on the critical issue of clinical education reform. I do not come to you with expert knowledge of all the professional societies. I was told that each of you would do the tweaking as needed for the group as a whole as well as applying the issues I discuss to your own professional societies. During this 30-minute presentation, I will:

- Briefly review the context in which professional societies operate
- Describe the 8 major contributions of societies to the health of our national community followed by an expansion of our notion of clinical education stakeholders

- Then one-by-one, I will provide possible scenarios that professional societies can engage in to respond to emerging issues in clinical education
- Finally, I will call upon the unique contributions that collectively societies could make together to ensure excellence in clinical education while boldly providing cost effective, accountable, quality health-care delivery.

By the way - if I was publishing this in my own society - I would now have to do the appropriate disclaimer . . . . “The opinions expressed in this presentation are not necessarily those of the society” . . . .and so on.

Think of your professional society.  
 Got it in mind?  
*Write down the 3 most critical issues or current priorities your professional society is addressing today.*

How many of you identified specifically clinical education on your list?  
*[Authors Note: Less than 20% of audience raises their hand.]*

This is exactly my point. Even though I am speaking to the clinical education leaders in our societies, we must recognize that this is seldom a priority issue for our organizations. This issue is a secondary concern for societies and for some a ‘hot potato’ regarding assuming responsibility for clinical education. For some, clinical education is a thorn in the side of our societies’ priorities. While others have neglected clinical education, failing to note that a buried treasure awaits. From the vote just taken, only a handful of our allied health societies currently address clinical education as a priority.

So what is the role of professional societies?  
 What do members and the public believe that they do?

**THE ROLE OF PROFESSIONAL SOCIETIES**

Professional societies have been acknowledged as representing the core values of their members, contributing to, if not setting, practice standards, as well as providing leadership to health care issues and policy. Societies have facilitated the development of the work force through education

of members in the latest technologies and practice environments.

Certainly, there are as many different approaches to addressing these issues as there are health professions represented because each of our societies has its own unique ‘way of doing business.’ I will outline today how we might mobilize this diversity among our professional societies to enhance clinical education (Table 1).

<p><b>Table 1: The Role of Professional Societies*</b></p>
<ul style="list-style-type: none"> <li>• Play a major role in developing the work force</li> <li>• Provide education for new career opportunities and mobility</li> <li>• Develop resources to address issues and trends in the profession</li> <li>• Introduce, if not identify, new innovations and technologies enhancing service delivery</li> </ul>
<p><i>*Dr. Marie Reed, President, National Organization for Competency Assurance (NOCA) personal communication, May 1999.</i></p>

Professional societies are the conventional keystones uniting members with common background and interests nationally. For the most part, they are made of volunteer members who may have joined to support the collective good of the profession or may only be members as long as they get access to valued services.

Thus, professional societies are the keystone for *assessing, planning, and supporting universal clinical education issues*. The three critical components of clinical education formulate the critical questions that must be addressed during our discussion of the role of professional training reform:

What will *health sciences graduates* need to know in the year 2010?

What will *clinical educators* need to know in 2010?

What *type of sites* will provide health care in the year 2010?

Without a vision capturing our response to these questions, our responses today will re-create

today - not invent tomorrow. Regardless, first and foremost our responsibility is our recipient of care - next we must answer these questions presented here. I ask you, yesterday, did we do this in our discussions and consensus-building? Or did we only reinforce traditions? Our challenge is for each of us to stop fine-tuning the old and pioneer a new future!

### **PRECIPITATING EVENTS**

As an educator, the call for reformation of health care education and training is rooted in a variety of reports, like the Pew Commission Reports that began and continue to appear earlier in this decade. Close at hand, was the emerging 'tug-of-war' between business and humanistic approaches to caring advocated by our professions. One of the bigger players, managed care organizations (MCOs) reformed practice around cost efficiency and complained how our entry-level practitioners were unprepared to practice in these organizational contexts successfully.

Ironically, the emergence of MCOs drastically eliminated many clinical education programs seeing them as expenditures and even revenue deterrents. In essence, MCOs became their own worst enemy. How could any entry-level practitioner embrace managed care when they were not trained within this system? .... A system that was not only negligent in its clinical education responsibilities but constantly used cost efficiency as the exclusive characteristic determining quality of care; the cost/reimbursement area is very low in value for many direct service providers including students.

### **THE IMPORTANT CONTRIBUTION TO PROFESSIONAL SOCIALIZATION**

While clinical education is a major component of professional socialization for our practitioners, we cannot fully comprehend responses to reforming clinical education without also considering the supply of individuals or students who are entering our training programs. Certainly, I am in awe that the majority of my students in the classroom:

- do not remember Vietnam and some now even the Gulf War
- prefer the Internet over the library to gather information
- cannot go to college without an answering machine and microwave and
- are challenged to tell time in the classroom

because I have an antiquated clock with hands on the wall.

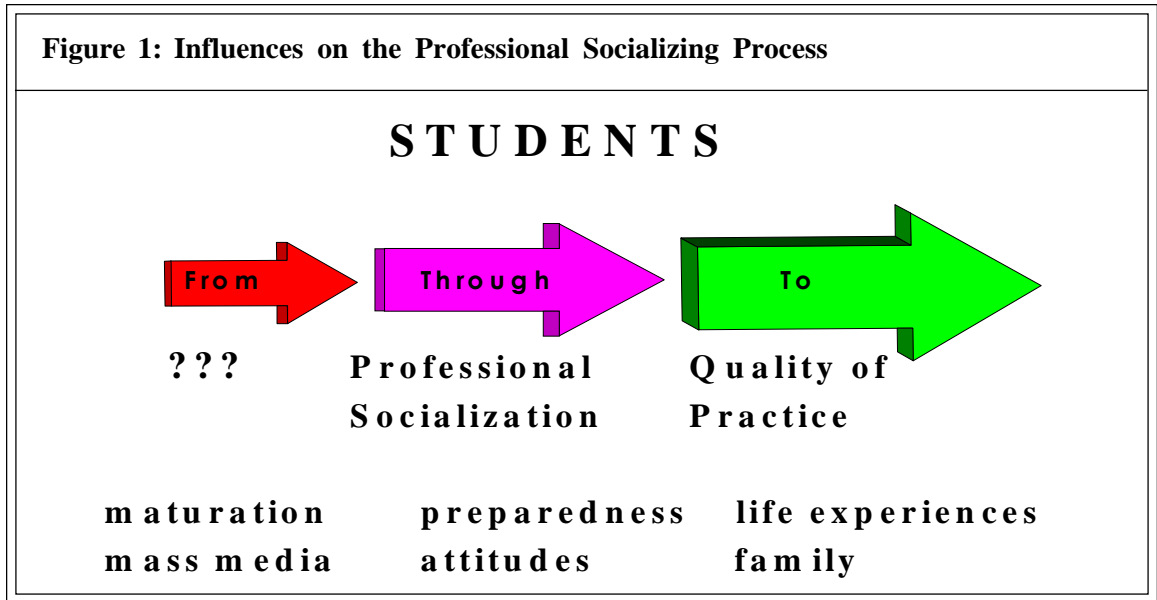
I will avoid even discussing the impact of videos, video games, South Park and MTV on their need for high stimulus entertainment-based instruction in 10 minute segments! Who would have thought that Bart Simpson would become a highly-rated family -entertainment show? ...or that 36% of students now report being bored in class.

Before you call me a cynic, let me give a few details about our students today that Hansen (1998) has gleaned from scholarly research and government reports.

- The percentage of high school graduates age 16-24 enrolled in colleges rose from 46% in 1973 to 65% in 1996. 31.6 % in 1997 received "A" grades in courses considered for college admission compared to 12.5% in 1969 and the time spent in high school homework among seniors is at an all-time low: 3.8 hours in 1997.
- 69% of full-time students are now employed compared to 36% in 1973 with slightly over 1 in 3 working 20 or more hours a week.
- 100% of colleges offer remedial programs now serving an average 20% of the freshman class.
- Only 10.6% of their mothers are fulltime homemakers compared to 33.9% in 1976. And 3 times more were from divorced families with an estimated 32% of children living with only one parent. Suicide, murder, sexual assault and other forms of violence are rising to become everyday events in our youth under the ages of 18.

Today's college students are different from what we were as students. This difference influences who we admit to our health science programs, their 'educate-ability' and ultimately what comes to clinical education. Regardless, professional socialization reflects a complex interaction of important environmental and interpersonal variables influencing clinical education students (Figure 1). These must be recognized in our clinical education reform, if we are to ensure future quality practice.

**Figure 1: Influences on the Professional Socializing Process**



**THE INFLUENTIAL PROFESSIONAL ASSOCIATION**

As a result of dynamic, external forces, our professional societies are faced with responding to the changing demands of the health care systems and the changing demographics of their membership. Association concerns include, but are not limited to:

- Matching association business with the needs of members in the trenches
- Changing reimbursement patterns and practice expectations
- Role models for new environments and practice

In planning for clinical education reform, one must always question what percentage of practitioners in a given health care discipline are currently being served as members of a given society? Estimates of member/non-member ratios are probably inflated or inaccurate if provided by the society themselves. Possibly comparison of society membership data with numbers from state licensing boards or national certification agencies might provide a more accurate estimate of the health care practitioner pool.

Societies are consistently balancing between responding to grassroots needs versus evangelizing or in some cases, ruminating over critical issues. Why is this important? In planning clinical education reform, we need to get to the individuals in the 'trenches' or the 'babble from the pulpit' will fall on deaf ears!

My suggestion is that professional societies must be one of the major 'cogs' in our training wheel, if we wish to ensure implementation of our blueprint activities. We must acknowledge that without the proactive engagement of our professional societies, we cannot move ahead.

What role will professional societies play in the future?

- proactive: facilitating, advocating and leading
- or*
- reactive: supporting, hindering or ignored

We must acknowledge that without the proactive engagement of our professional societies, we cannot move ahead. Clinical education is every practitioner's business, be they an educator or direct service provider. Thus, supporting the student training role might actually increase membership in societies if continuing education, even certification were part of membership services. At minimum, any society that distributes annual awards for commendable professional activities, should have an outstanding clinical educator award.

Members may also question the wisdom of some societies' priorities for clinical education. For instance, while I admire my own society's initiation of innovation to address the needs of our fieldwork educators through workshops, on-line self studies and news stories, I continue to question that releasing the program coordinator over fieldwork education during our most recent waves of down-sizing was wise. Of course, members



were assured that the individual’s activities were re-assigned—but then I must question who is focussing on clinical education and giving it adequate support? My fear is that the recent change in my society’s organization only buries this issue deep within the muck of society business, as no strong advocate is apparent or accountable for clinical education in day-to-day operations.

Again I return to your responses on the pop test...What importance does your society give to clinical education? How do they ‘walk the talk’ or is it just given ‘lip service?’

**PROFESSIONAL SOCIETIES & LEADERSHIP OPPORTUNITIES**

Our professional societies can be leaders in the area of clinical education. They are one of the largest and most powerful forces in the U.S. today. Their collective membership represents one of the largest, most powerful forces in the U.S. today. Some societies are trade associations while others are membership societies or professional development organizations. Thus, their ability to impart social and economic changes and benefits is insurmountable. By placing clinical education high on association agendas as a central component of all our business, clinical education reform can succeed.

**PROFESSIONAL SOCIETIES & LEADERSHIP CHALLENGES**

To be effective as a leader in clinical education reform, we must be cognizant of the public’s perception, if not skepticism, in permitting societies to lead necessary changes that benefit the public we serve. At the heart of this skepticism, is the growing public, and now organizational management tiredness, with the ‘turf wars’ between professions and the consumption of society resources to protect professional turf! Societies work quietly, giving rise to suspicions by observers that their goal is on protecting the sanctity of the profession which ultimately detracts from their ability to serve society as originally intended.

So, what do we need to do to create working as a team among respectful, responsible professionals? Our societies can extend a collective leadership role to foster team-building across professions. Clinical education reform might be one of the safest areas to demonstrate our team-building potential to the public...

**EIGHT PROFOUND ASSOCIATION IMPACTS**

Societies or associations are noted as having a profound impact on eight major areas that are worthy of noting in our deliberations (Table 2). Let me quickly read the list of association impacts as they become the foundation for the remainder of my presentation.

<p><b>Table 2: The Eight Professional Association Impacts</b></p> <ol style="list-style-type: none"> <li>1. Educating members and the public</li> <li>2. Setting and policing performance and safety standards</li> <li>3. Promulgating and enforcing codes of ethics and professional standards</li> <li>4. Conducting research and compiling statistics</li> <li>5. Political education and group advocacy</li> <li>6. Directing member talents toward community service</li> <li>7. Self-funding countless programs that relieve government of the burden</li> <li>8. Create invaluable services to the community</li> </ol> <p><i>GWSAE Report, 1997</i></p>
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**CREDENTIALING MECHANISMS FOR PROGRAMS OR INDIVIDUALS**

Before proceeding, I must acknowledge three major activities that contribute to the professions which also have an investment in clinical education reform but are not considered in traditional definitions of professional societies, but who also are major stakeholders in clinical education reform. Each is represented by their own collective groupings and boundaries of interest that must be acknowledged. I share with you, definitions of these stakeholders to seek their cooperation in this blueprint and to guide our own taxonomy and communication regarding clinical education reform.

*Licensure* gives the qualified individual the right to deliver a specific set of services in a given jurisdiction. A government agency grants permission for the individual to practice.

*Certification* ensures a uniform set of professional competence in service delivery across all similar providers. Mandatory or voluntary certification is validation for that public that an individual possesses sufficient qualifications and

knowledge to practice competently in the area certified.

*Accreditation* deals with institutions and not individual qualifications of service. Accreditation is a voluntary process assessing and giving status that predicts or safeguards performance of the institution or academic program for the public.

Each of these three credentialing mechanisms are deeply vested in clinical education reform as they require direct or standardized practice in some way. Some of these credentialing activities overlap with those of societies which hopefully could increase the support of mutual interests. Thus, the diversity of interests of societies is influenced by the critical professional activities of licensure, certification, and accreditation each of which warrants attention in our blue-print planning.

**THE POTENTIAL IMPACT OF SOCIETIES IN CLINICAL EDUCATION REFORM**

I want to return now to the role of professional societies using the eight important roles that are served by societies to delineate how these groups might focus on clinical education or training. Table 3 provides a list of these eight association impacts and potential considerations of actions regarding reforming clinical education.

<b>Table 3: The Eight Profound Impacts of Professional Societies on Clinical Education Reform</b>
<p><i>Educating members and the public</i></p> <ul style="list-style-type: none"> <li>· Setting and policing performance and safety standards</li> <li>· Promulgating and enforcing codes of ethics and professional standards</li> <li>· Conducting research and compiling statistics</li> </ul>
<p><i>Setting and policing performance and safety standards</i></p> <ul style="list-style-type: none"> <li>· Ensure educational standards specify entry-level preparation in the clinical education role</li> <li>· Assess who should ‘control/direct’ clinical education: education or practice?</li> </ul>
<p><i>Promulgating &amp; enforcing codes of ethics and professional standards</i></p> <ul style="list-style-type: none"> <li>· Certification of supervisor and training site</li> <li>· Educate regarding ethical use of students and ethical organizational behaviors</li> <li>· Maintain educational integrity of clinical education</li> </ul>
<p><i>Conducting research and compiling statistics</i></p> <ul style="list-style-type: none"> <li>· Fund studies and disseminate results               <ul style="list-style-type: none"> <li>-Government and association (single and joint)</li> <li>-Best practices                   <ul style="list-style-type: none"> <li>quality of care provided through clinical education</li> <li>supervisory effectiveness</li> <li>cost-benefits</li> </ul> </li> <li>-Model clinical education programs</li> </ul> </li> </ul>
<p><i>Political education and group advocacy</i></p> <ul style="list-style-type: none"> <li>· What about co-treatment outcomes?</li> <li>· Student-supervisor interaction</li> <li>· Interdisciplinary</li> <li>· Population-based</li> <li>· Community focussed</li> <li>· Health promotion and disease prevention</li> </ul>
<p><i>Directing member talents toward community service</i></p> <ul style="list-style-type: none"> <li>· Emerging practice environments</li> <li>· Encourage servant leadership</li> <li>· Recognize and reward clinical education activities</li> </ul>
<p><i>Self-funding countless programs that relieve government of the burden</i></p> <ul style="list-style-type: none"> <li>· Partnerships between associations</li> <li>· Common CE interests</li> <li>· Likely to practice together</li> <li>· Demonstration projects as models</li> </ul>
<p><i>Create invaluable services to the community</i></p> <ul style="list-style-type: none"> <li>· Help academic programs open new practice environments and place students</li> <li>· MCO’s: consumer education; screening</li> <li>· Students serve those who do not have reimbursement</li> </ul>

Reviewing each one provides an initial list of themes and opportunities that each society can undertake to support clinical education and may provide ideas for this consensus conference.

#### *Educating members and the public*

- *Setting and policing performance and safety standards*
- *Promulgating and enforcing codes of ethics and professional standards*
- *Conducting research and compiling statistics*

First, society members must encourage the best and brightest to come our way. I am greatly discouraged by clinical educators who in times of work stress or distress, discourage potential students, and ESPECIALLY current clinical students from pursuing their chosen health profession. We all know that this approach is frequently self-serving not to mention being, a cruel assault on one's hopes and dreams. The cumulative, long-term effect on the profession could be devastating.

Second, we need to specify the competency and outcomes from our clinical education process to ensure accountability and garner public recognition of our contribution...including the important contributions of clinical education.

#### *Setting and policing performance and safety standards*

- *Ensure that educational standards require entry-level preparation in the clinical education role before graduation*
- *Assess who should 'control/direct' clinical education: education or practice?*

Professional societies should ensure that every individual entering the profession has the fundamental knowledge to serve as a clinical educator and that serving as a clinical educator is a professional responsibility.

I'll even risk saying today that every society should not advance the status of members as experts, specialists, and so forth unless these individuals are actively engaged in mentoring junior members—especially clinical education students!

After years of reflective thinking, we must engage the long-standing debates about whose responsibility is clinical education? Education or practice? These arguments appear ludicrous as clinical education or some type of professionally supervised process in the 'real world' is critical to the long-term term viability of a profession! However, until we resolve ownership claims and avoidances we will halt progress. Several models exist within the allied health professions represented here. Can a comparative analysis provide information for us all? For instance, the contractual arrangement between the academic and clinical settings has nearly become a nightmare to both. Further, doesn't it make sense with our long-term placements that practice evaluate future practitioners for professional competence and socialization? Dependence on the academy is looking backwards and not forwards.

#### *Promulgating and enforcing codes of ethics and professional standards*

- *Certification of supervisor and training site*
- *Educate regarding ethical use of students and ethical organizational behaviors*
- *Maintain educational integrity of clinical education*

I believe that it is a travesty that, for the most part, the health care professions have relied on clinical competence and not educator competence to be the primary criteria to serve as a clinical educator. Being a clinical educator is different than being a clinician! A good clinician is not automatically a good clinical educator. Professional societies can serve the very important role of establishing universal standards across all clinical education.

Since, the role of the clinical educator seldom receives attention during entry-level education, we need to develop clinical educator training programs if not certification processes. Most importantly all accreditation standards for academic programs should include mandates for students to be prepared for the roles and functions of clinical education.

Further, certification of the clinical educator's competence is necessary but not sufficient. We must also specify the learning tasks during clinical training. Failing to do this, we leave the

student with qualified supervision but without the specific skills deemed essential for practice.

Two important considerations in our reform must be included. First, in today's health care changes, education and implementation of clinical actions that emulate ethical practice is essential. Second, we must avoid losing the educational integrity of clinical education by allowing 'on-the-job training' expectations to overtake the goal for this learning experience. Anything less would mean that we were only training our students for today's practice and not educating them for future possibilities.

#### ***Conducting research and compiling statistics***

- *Fund studies and disseminate results*
  - Government and association (single and joint)
  - Best practices
    - quality of care provided through clinical education
    - supervisory effectiveness
    - cost-benefits
  - Model clinical education programs

Our blueprint must include plans to study and disseminate information regarding model clinical education programs and 'best practices' in both current and emerging health care settings. Our societies should be encouraged to approach professional foundations as well as external funding agencies, including the federal government to support these studies. When approaching the federal government or private agencies regarding support of our direct service delivery interests, professional societies must pledge to advocate for the critical importance the role clinical education serves in ensuring qualified services to our customers.

If service providers do not provide quality services, then the need for a profession or a professional society will become defunct and as a result there will be no members to pay dues to our societies to sustain their activities!

Clinical education, using best practices and implementing model programs, are critical to serving our public responsibility and sustaining our professional interests.

#### ***Political education and group advocacy***

- *What about co-treatment outcomes?*
- *Student-supervisor interaction*
- *Interdisciplinary*
- *Population-based*
- *Community focussed*
- *Health promotion & disease prevention*

In these model programs and study of best practices, let's risk demonstrating critical outcomes from exciting possibilities such as co-treatment, and interdisciplinary clinical education to promote the emerging health care needs in a proactive manner. Further, encourage clinical education to occur in settings that are population-based, community focused, involve health promotion and disease prevention and for some, help individuals with chronic illness and disability achieve quality of life.

I advocate the importance of 'same discipline' modeling and supervision during clinical education training. Consequently, moving into these new arenas is challenging as I am not convinced that direct supervision by an 'outsider' is in the best interest of student's professional development. Thus, funding appropriate clinical education supervisors in the health care environments of the future is essential if we are going to have dramatic beneficial changes in health care delivery!

#### ***Directing member talents toward community service***

- *Emerging practice environments*
- *Encourage servant leadership*
- *Recognize and reward clinical education activities*

I have previously addressed emerging practice environments and encouragement of members to engage in clinical education as a part of professional servant leadership responsibilities.

Finally, each society needs to publicly recognize significant contributions made by clinical educators. Official recognition of outstanding clinical educators and administrative support of clinical education should be advocated by every society.

### ***Self-funding countless programs that relieve government of the burden***

- *Partnerships between associations*
- *Common CE interests*
- *Likely to practice together*
- *Demonstration projects as models*

Partnerships between associations could be cost-saving by pooling resources and reducing duplication of clinical education activities. Demonstration projects of these collaborations between societies is needed. A beginning position would be those interdisciplinary activities that naturally occur in practice as well as considering whole new interactions. The new Triallance formed between occupational, physical and speech language pathology is an example. While certainly the presidents must be politically astute during these interactions, a variety of other beneficial collaborations are initiated during day-to-day business.

### ***Create invaluable services to the community***

- *Help academic programs open new practice environments and place students*
- *MCO's: consumer education; screening*
- *Students serve those who do not have reimbursement*

Professional societies can encourage clinical education models that provide community service such as consumer education, screening and providing health-care services to those individuals who are being significantly underserved today. This creative use of students would demonstrate the efficacy of services in new health care environments as well as provide services to individuals who would benefit from our care but are not supported by the usual reimbursement sources.

In some settings, this suggestion will take student time away from the revenue-generating activities that may not be palatable. In others, this utilization of student effort may positively address the institutional mission initially, and even result in new sources of practice or revenue-generation. Remember, we all are here to “serve the greater public good”. However, I must reiterate that the 'community of interest' regarding clinical education reform is much broader than just professional membership societies.

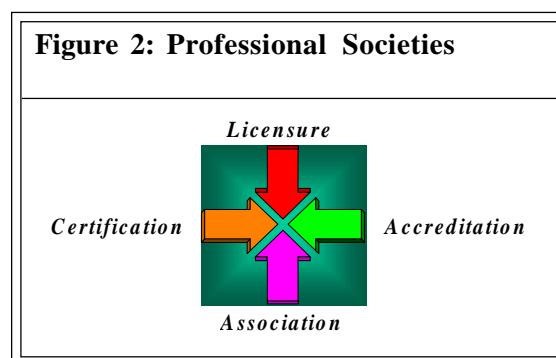
[*Author's Note:* The release of the July 30<sup>th</sup> Medicare Regulations after this conference is naïve regarding students and disastrous to health care services, in general. The new regulations indicate that student interventions are not reimbursable and that all student activities must be ‘in-line-of-site’ with their supervisor. First, who will train students if they are unable to obtain compensation for their time and costs? The long-term implication is that we will not have future practitioners prepared to practice effectively within Medicare-driven environments. Second, they have negatively impacted overall quality of care beyond that which can be delivered by professionals within the reimbursements caps set for services. The ‘line-of-site’ supervisory mandate for students significantly limits the extension of innovative use of students to deliver needed services.

The important role our professional societies play in preserving service delivery is essential, but they must always be simultaneously politically active in preserving the roles of clinical education of students to ensure qualified future practitioners.]

How did this happen with our societies as our watchdogs? We should have been proactive instead of having to be reactive.

### **MORE POTENTIAL ACTION STEPS**

Beneficial political reform will consider all of four players interested in the professional competency of entry-level practitioners and service providers as a result of clinical education outcomes (Figure 2).



With this in mind, I briefly will propose 10 more potential action steps this group could take to plan clinical education for 2010 (Table 4).

### **1. Elevate clinical education as an essential role, not an apology, gift or burden**

**Table 4: Additional Potential Actions for Professional Societies**

1. *Elevate clinical education as an essential role not an apology, gift or burden*
2. *Create funding to:*
  - re-distribute health care providers who actively train students
  - training program/stipends for training in emerging, rural and underserved areas
3. *Create an Association Cooperative*
  - centralized/uniform
    - contracting                      scheduling
    - evaluating                        reporting
    - regional consultants
    - share information and resources
    - clinical educator professional development & certification programs
4. *Coordinate use of information technology*
  - professional development of clinical educators
  - sample instructional approaches
  - bulletin board of related events
  - listserves around common interests
  - use of video-conferencing for remote supervision
  - electronic clinical education records
5. *Publications*
  - identify and pursue special issues ( an electronic journal?)
  - publicize clinical education role models for emerging areas of practice
  - panel to compile all outcome studies
6. *Declare the “Decade of Clinical Education” to place on all association agenda*
  - identify and pursue needs in ‘the trenches’
  - stimulate collaborations
  - coordinate external audience educational benefits
7. *Educational campaign for MCOs*
8. *Ensure program and reimbursement regulation watchdogs are present and collaborating*
9. *Find those who have the PASSION and let them educate!*
10. *Make clinical education practice responsibility*

We need to either create or mandate, if the later is possible, that clinical education is a responsibility of all members of the profession. Education adds new members to our family. Clinical education is a rite of passage similar to the emancipation of adolescents. We acknowledge the hard work in raising a young professional, but good parenting or supervision by a qualified clinical educator is essential for a healthy start.

## **2. Create Funding**

We should seek ways that clinical education can re-distribute health-care services to underserved populations in our country. Potentially, funding options are needed such as loan deferments. I hope that a representative from Iowa will present their *Healthy People 2010* plan to address this issue. Yesterday, AHECS & HTECS were proposed as potential partners in clinical education to underserved regions. But more importantly, our blueprint recommendations could go a step further

by not sending the entry-level practitioners alone to these underserved areas. They need qualified role modeling. Our plan should create proactive strategies to demonstrate the value of developing a cadre of experienced clinical educators in these settings who could serve as student supervisors and mentor students launching their careers in these settings.

### **3. Create an Association Cooperative**

A consortium of health providers should be convened to develop a long term plan to increase the efficiency and quality of clinical education activities. The goal is to centralize common tasks as well as share 'best practices' across the health professions.

The Health Professions Network (HPN) is one example of a group that could undertake this task of getting smaller collectives of health professions with similar clinical education processes to work together to reform clinical education. For instance, OT, PT, Speech, Psychology, Social Work, and several others have common clinical education interests ripe for discussion through a cooperative model.

On a smaller scale, my current dean of health sciences has streamlined clinical education contracting and the ease of establishing clinical education sites by simply requiring a universal contract. When a site signs an agreement, it covers all eight disciplines in our school at one time. Of course when more than one academic program trains in this site, other efficiencies and qualities could be served beyond this major process.

### **4. Coordinate use of information technology**

A panel of clinical education experts should convene with information technologists to explore new approaches to delivering traditional clinical education activities. I have listed a few here. Advancements in information technology applied to clinical education activities would clearly expand the utility and quality of student training activities.

### **5. Publications**

The Information Age clearly indicates, that the person who can access and use information most effectively, will be the winner. We need to bring clinical education into this new paradigm. Some ideas are listed below.

Ready access to related information is essential to support clinical education. Based on the groups here, why not propose that a panel be convened to compile, critically evaluate, and topically organize all existing outcome data on quality clinical education approaches across the health professions? Preferably, an Internet-based clearinghouse would be ideal to make this information readily accessible, easily searched and rapidly updated with new outcome studies. This site could be expanded to support dissemination of new training models, too. This could become a resource for clinical educators to promote involvement in training as well as provide examples of alternative approaches to supervision, student development and program development.

### **6. Declare the 'Decade of Clinical Education'**

Facilitate universal attention and development in clinical education by proclaiming the Decade of Clinical Education beginning in the Year 2000. This is a serious recommendation as the majority of future practitioners in each of our fields is likely to graduate in the next 10 years. For the most part, our entering professional groups each year are larger than previous ones, challenging the ratio of experienced to inexperienced practice resources. At the same time economic forces challenge and even hinder good clinical education.

Thus, never before has it been more important for professional societies to elevate clinical education as a primary issue. Attention to clinical education activities must be placed on the agenda of all our health professions societies, agencies, etc. Leaders and members must comprehensively address complex issues related to student training and ultimately, our real goal, the preparation of entry-level practitioners to ensure the public's demand for competence, quality and predictability in health care delivery.

### **7. Educational campaign for MCOs**

MCOs, and other collectives, need to be educated regarding the role of clinical education. A promotion campaign of sorts, needs to be launched.

### **8. Ensure program and reimbursement regulation 'watchdogs' are collaborating**

Our professional associations need to closely monitor and successfully challenge legislation or funding patterns that negatively impact clinical

education. Power through professional consortiums would have more impact than any one society could offer alone.

**9. Find those who have a PASSION to educate and let them educate!**

Identify those clinical educators who have a *passion* for student training and let them educate. Similarly, ensure they are encouraged if not rewarded by employers for engaging in professional education.

**10. Make clinical education a practice responsibility**

The last one I know varies considerably across each of the disciplines represented here. If many of the previous resources were in place that I have mentioned, then the responsibility of clinical education could move to it's rightful owner—PRACTICE! Where professional development can traject forward beyond educational foundations!

In closing, I believe we have the energy available in our professional societies to create alliances to improve clinical education (Table 5).

Table 5: Professional Societies	
<p><i>Association Partnerships / Member Alliances</i></p> <ul style="list-style-type: none"> <li>• Educational Programs</li> <li>• Related Associations</li> <li>• Health Care Industry</li> <li>• The U.S. Government</li> </ul>	

This blueprint we are creating can be the beginning of endless possibilities and new journeys.

*It is not the strongest of the species that survives,*

*Nor the most intelligent;*

*It is the one most adaptable to change.*

– Charles Darwin

For those of you who like simple answers, I apologize for frustrating you. I simply could not do this. Clinical education is not a linear, cause & effect process. In fact it is more a system—when one small drop of change falls, the ripple effect undulates to all stakeholders — a consid-

eration that began to emerge yesterday in this consensus meeting. We are being asked to adapt and lead - which we must. I observed us all “tweaking” the familiar yesterday but not much about paradigm-shifting - which I think may need to happen.

Supervised clinical education is an essential need for entry-level practitioners to be prepared for safe, quality practice. Today, I have laid numerous ideas from my own thinking for you to consider during your discussions.

Professional societies, collaborating with each other, must identify, support and replicate the ‘best practices’ in clinical education. Simultaneously, societies are called upon to address health care system demands and the professional development of our *future* practitioners—ensuring a beneficial balance between professional, scientific and humanistic values within and among the health professions. This is the primary role of our societies. I leave you with this important message:

*Excellence is never an accident.  
It is always the result of  
high intention,  
sincere effort,  
intelligent direction, and  
skilled execution.*

*It represents the wise choice of  
many alternatives.*

– Author unknown

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# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Response & Recommendations

**Ann F. Sosnowski, B.S., MT**  
Coordinator, Student Recruitment  
Schools of Allied Health  
William Beaumont Hospital

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My topic is Professional Societies from the Hospital's Perspective. Some of my points are going to be repeated from Dr. Crist's presentation simply because of the importance of some of the items she had mentioned. I am a medical technologist, so I am speaking from that perspective, although the points that I will be mentioning apply across all backgrounds and all allied health careers.

The professional societies are better equipped to identify the needs of the professions because they have the data. They have data to offer advice for the ever-changing professions. For example, the American Society of Clinical Pathologists, ASCP, surveys 1500 lab managers randomly, every other year, for information on wages and vacancies. There are ten years of data broken down into categories of: regions, disciplines, technical and supervisory levels, size of institution, and alternate work sites such as doctor's offices, clinics and the private labs. In addition, the regions further subdivide this information into the level of education such as technician, technologist and assistant. There are other laboratory surveys, such as the ASCP training program survey, wherein the program directors provide information on the number of programs in existence; number of closed and on hold programs; number of graduates; attrition rate out of the programs; job placement of graduates; and the quality of applicants. The *Advance* magazine also publishes similar data annually.

The professional societies are better equipped today because their members have their finger on the pulse of change; they come from many avenues. They come from hospitals, clinics, and private labs. Information is made available to the members on large versus small hospitals, rural versus suburban hospitals, or teaching versus research institutions. The professional societies have information coming from all these different avenues to give to their members (Table 1).

Because professional society members are in the trenches, they know the latest in disease diagnosis and management. They have experience, knowledge, and the resources needed to immediately begin curriculum changes when they are warranted. This is something that hospital-based programs are better able to do over the university programs because they can do it more quickly.

Our societies tend to be proactive rather than reactive, which Dr. Crist has mentioned earlier today. Our students need to learn professionalism and have a positive attitude about their profession. It was

**Table 1: Professional Societies are Better Equipped to Identify the Changing Needs of the Profession**

- Professional Societies, due to having many members, have their finger on the pulse of change because they come from many avenues
  - Hospital vs. clinic
  - Large vs. small hospitals
  - Rural vs. suburban hospitals
  - Teaching vs. research hospitals
- Professional Societies, due to having many members in hospitals, clinics, etc., have their finger on the pulse of change because they come from many avenues
  - Know the latest diseases, conditions
  - Know the greatest needs
  - Have experience, knowledge and supplies to immediately begin curriculum changes

mentioned yesterday that a positive attitude is one of the high points that students need to learn very early on in their education. Students need to be introduced to professional societies early in their professional education (Table 2). It is through attendance at professional symposia and meetings that students and members alike benefit. Student membership in professional societies promotes lifelong learning, and will make them aware of student scholarships if they need to take advantage of them. By involvement in their professional societies, members and students get the most up-to-date information on advances in technology and the latest testing methods. They get the latest methods of cost containment— cheaper, faster, better, which they are all going to need. As we heard Dr. Crist say earlier today, students need to know what current trends lie ahead. Students need to come out of our programs almost as if they are going to be managers themselves some day. Students should become aware of the wide range of topics that are addressed at these meetings and that these topics are chosen because they may directly effect some members.

**Table 2: Professional Societies Need to be Introduced to the Students Early in their Professional Education**

- Attendance at professional Symposia/Meetings benefits the student and all members
  - Get most up-to-date information on:
    - advances in technology/testing methods
    - latest methods for cost containment (cheaper, faster, better)
- Societies try to be proactive rather than reactive
- Learn “Professionalism” and positive attitude about their profession
- Professional journals will keep students/members up-to-date when cannot attend S/C
- Promote life-long learning
  - Networking
  - Jobs
  - Information
- Student Scholarships – often available

Professional journals are distributed to all members, even those who are unable to attend conferences. These journals have the up-to-date information that our members and students need to know.

Professional societies must make certification carry more weight. As we have heard earlier today, as well as yesterday, the PTs and the OTs are very well known to the public. This is not true of many of the other allied health programs, especially clinical lab sciences. We are not well recognized, although our certification is equitable to any of the other allied health certifications. We need to be recognized by the public. For example, when they are having a laboratory test done, they need to know that a certified professional is performing it. Maybe that is why we need licensure? This has to be made known to the government and the administrators of hospitals, insurance agencies and HMO's. Professional societies and organizations also need to do a better job of educating the public.

Similar allied health programs need to band together for greater numbers. This will bring about more recognition and preserve the quality within the profession in times of change. Look what happened with CLIA '88. We also need to band together for the sharing of information. In Michigan, the Michigan Association of Laboratory Science Educators, MALSE, consists of educators from university and hospital programs who semi-annually discuss topics related or similar to all. There is representation from all the clinical lab sciences: histotechnologists, medical technologists, phlebotomists, and cytotechnologists. Because we are similar and banded together, we can disseminate accurate information to the students and to our members. Hospital educators need to be represented on the certifying and the accrediting agencies. The hospital personnel can seldom get away to attend these meetings due to teaching responsibilities and shortages of staff. It often ends up being "who you know" that determines the make up of these agencies and committees. So, representation on the accrediting agencies and the certifying agencies tends to come from academic institutions more so. I am not saying that this is bad, but in some cases, we do tend to be a little bit underrepresented.

So in summary, the three things that I would like to impart to everyone here today, are: 1) We need to get our students into professional organizations, professional societies, earlier in their education. This should start when they are in the academic institutions, in their two-year and four-year university settings. 2) We need to bring

more recognition to some of our programs, especially in the clinical lab sciences, similar to the recognition of the PTs and OTs so that we can preserve the quality of what we aspire to. 3) In addition, we all need to be represented and accept positions on the agencies that will make the changes that will shape our profession and our students.



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## Response & Recommendations

**Lydia Wingate, Ph.D.**

Dean

College of Health Professions  
Weber State University

Thank you and good morning. I would like to begin by saying what a very great pleasure it is to participate in this important meeting and I would like to extend my compliments to our keynote speakers who have provided us with an excellent conceptual framework. As Dr. Crist indicated, one of the advantages of being at the end of a conference is that everything has basically been said. So this will not take very long.

First of all, I would like to remind you of some of the issues that Deputy Director Jennifer Burks suggested we consider during this consensus conference. Some of the issues she indicated were of importance are: the need for us to be collaborating with each other, the need to be developing effective partnerships, the need for us to be creative, the need to focus on populations including minorities and ethnically-diverse populations for which we will need cultural competence.

In addition, we need to educate our students to the concept of teams, (and that is the buzzword now), particularly interdisciplinary teams. We should be looking at new settings for training our students, in rural, inner city, and other special areas.

One of the issues raised by Dr. Crist was the future role of professional societies: Are they going to be proactive, and how are they going to become effective? It is critically important that we do become effective with our members, with

managed-care organizations, with the community, and perhaps, most importantly, with legislators. Dr. Crist also posed the questions: What will graduates, clinics, and clinical educators need to know in 2010 and what type of sites will be available at that time?

How do we achieve all of the above, answer these questions and tackle the recommendations from this conference?

You will see in some of the recommendations that we developed today in Table 1. Dr. Harmening, earlier, very effectively summarized them, so I will not dwell on them. I would, however, like to make some observations and perhaps one or two recommendations.

**Table 1: Recommendations Generated**

- Program Accreditation should be reflective of contemporary practice.
- Need for data on cost/benefit of Clin. Ed.
- Use of technology in Clin.Ed.
- Preparation & Recognition of Clinical Educators.
- Need for development of a model that accurately reflects & forecasts needs, supply & demand for Allied Health professions
- Develop state-wide consortium for Clin. Ed.

First of all, regarding the year 2010, I would submit to you that very honestly, we do not know what's going to happen in 2010, what our graduates are going to need to know, and what sites will be available. Who could have anticipated the changes in the health care system, including all of the mergers and acquisitions that have taken place in the last five years, even seven years ago, or the technological explosion? So, I am not sure anyone has the answer to that. And, with apologies to Jody, I had three "C's" to recommend; collaboration, collaboration, and collaboration is what we all need to be thinking about. And in terms of that collaboration, it needs to be between many different communities of interest. I think we need to have collaboration between our own allied health programs within our colleges and schools. I think we need to have collaboration between the professional societies, such as the Association of Allied Health Professions, and HPN that was mentioned this morning, as well as between the professional societies themselves. I also believe that we need to have collaboration between professional societies and academic programs and colleges.

What are some of the barriers that we need to be thinking about? Well, I'm afraid that as allied health educators from different professional backgrounds, we do speak with different tongues. I like the conference theme "one vision, one voice", because I think that when we achieve that goal, our legislators will be more inclined to listen to us!

I think that we need to help our legislators understand what it is we do and I think we need to educate the community. I think that we in academia, have done a very poor job of letting communities and our legislators know how we contribute to society in general and our local areas in particular.

Finally, I think the last item is probably very self-evident. We have to overcome self-interest and territoriality, which has also been alluded to today.

I would just like to leave you with a quote by John Foster Dulles, and I don't think you need me to read it for you. I'm sure this doesn't apply to anybody in this room, right?

"The meaning of success (in meeting our challenge) is not whether we have a tough problem, but whether it's the same problem we had last year!"



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## Response & Recommendations

### Harriet Rolen-Mark, M.A., MT(ASCP)

Past Chair, ASCP-AMS

Associate Dean, College of Health Professions  
SUNY Health Science Center at Syracuse

Good morning. It is my pleasure to speak to you today concerning the role of professional societies in clinical education reform.

My remarks are focused from the perspective of the professional society's viewpoint. I have done much of my professional work with the American Society of Clinical Pathologists, its Associate Member Section, and the Board of Registry. The ASCP Associate Member Section is a very large, diverse group, representing medical technologists, medical laboratory technicians, cytotechnologists, histologic technicians, histotechnologists, laboratory specialists, and clinical scientists. This gives us a broad focus across the laboratory area within the narrow focus of the clinical laboratory science arena.

In representing its professional community, any society's leadership must be two things. It must be visionary, while at the same time keeping both feet on the ground, and it must be reactive to current issues; proactive for emerging trends. This means maintaining the delicate balance between moving toward the future without a disconnect by present members. These members have a direct role in setting association agendas and this impact can be noted with the show of hands in response to Dr. Crist's "pop quiz" earlier this morning. I noted that only about 25 % of us here, many members and representatives of pro-

fessional societies, indicated that clinical education reform would be something that is a current high priority for the professional societies. This illustrates the fact that clinical education reform is but one of the challenges that professional organizations face every day.

The real strength of the professional society is its resource pool (albeit finite), of funds, member talent, and expertise to work both within and outside the discipline's silo. Several examples of proposed recommendations at this conference to date attest to the acknowledged role for the societies. For example, we've already heard suggestions for developing media to prepare clinical educators, identify and showcase best practices, and develop clinical case study media. These activities can have a positive impact on the clinical education reform movement and have been proposed as roles for the professional societies. The societies also, as already noted, play an inherent role on certification, accreditation, and licensure activities.

Dr. Crist outlined the proactive role for professional societies as facilitating, advocating, and leading. They can make their impact in educating both members and the public, promulgating, enforcing and maintaining the codes of ethics and professional standards, conducting research and compiling statistics.

So overall, the role that professional societies can have in impacting the reform is first to support clinical education and its development. The second is conducting the research (surveys of educators, employers, practitioners and other stakeholders) which forms the foundation for defining the scope of practice. The caveat is that this research must extend beyond society membership to overcome the member, non-member ratio bias.

Looking at where we've come and where we need to go for reform, I have identified three issues. The first is concerning the scope of practice. The current scope of practice, key components of clinical education and changing workplace needs must be determined and maintained. One of the key ways in which professional societies can impact clinical education reform is in the allocation of their resources, whether actual funds, member/staff talent, or by assigning it higher priority on the agenda or strategic plan. For example, the American Society of Cytopathology has developed an employer survey for use by cytotechnology programs for assessment of program effectiveness. The American Physical Therapy Association has developed the Clinical Performance Instrument (CPI). The American Society of Clinical Pathologist's Board of Registry is currently in the seventh year of a ten year longitudinal study of a 1,000 member cohort of Medical Technologists to determine scope of professional practice and career development. Therefore, the **recommendation** is that professional societies actively contribute to clinical education reform through resource allocation.

The second issue is the duplication of clinical education activities across allied health disciplines. Some examples of collaboration would be funding demonstration projects, sharing clinical education models, preparing interdisciplinary clinical case media, and using springboard foundations such as the Health Professions Network, and other professional intersociety organizations. **Recommendation:** Professional societies need to collaborate, pool resources, and reduce duplication of clinical education activities.

The third issue takes us back to our roots is the mandate to maintain codes of ethics and professional standards in the changing healthcare environment. This is one of the hallmarks of professional organizations.

**Recommendation:** Professional societies should review educational reform models to maintain ethical and professional standards as a public trust.



# Pioneering Allied Health Clinical Education Reform

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## Summary and Review of Recommendations

**Gail Nielsen, BSHCA**

Managed Care Performance Administrator  
Iowa Health System Corporate Headquarters

Remarks, in summary, regarding the hospital, health system and HMO perspective will include the ideas and recommendations voiced during the three conference segments that I believe to be of interest to hospitals, health systems, and HMOs. In addition, I will share comments from those individuals whom I interviewed in preparation for this meeting. The following are consensus points that we are taking away from this conference and that will be included in the conference report. The ideas and recommendations come primarily out of the consensus building of the first session: Economically Driven Changes Impacting Clinical Education Reform. Additional items were gathered during the remainder of our discussions. First of all, we have identified these issues: Programmatic accreditation should be more reflective of contemporary practices; data is missing on cost and benefits regarding clinical education of students; we should use technology in clinical education; and we need to prepare and recognize clinical educators.

Consensus-building identified these recommendations: Clinical education should move to outcomes based rather than processed-oriented accreditation; we should develop competency assessed by practice in addition to written examination; educational curricula and standards should be reflective of current practice analysis; and we should better anticipate future needs.

In addition, we should coordinate standards between national and state accrediting or licensing bodies and state boards of higher education. We should determine the cost effectiveness of programmatic accreditation.

We should explore innovative models that are based on performance outcomes of students as well as cost and value benefits to achieve cost neutral status. We should review policies by state and educational institutions that inhibit collaboration and sharing of resources. We should explore models of distance learning that support collaboration and sharing among schools and institutions. We should explore innovative uses of technology for clinical education.

Professional societies should develop clinical case study media including interdisciplinary which would be available to all programs. We should design systems to prepare and recognize clinical educators. Professional societies should develop media to help prepare these clinical educators. Professional societies should also develop a clearinghouse of existing models for recognition. We should promote early collaboration between clinical educators and curriculum development.

Other recommendations that we have supported: Clinical education reform should include cross-discipline and collaborative learning. Higher



institutional collaboration should be used to improve quality and reduce costs of clinical education. Evaluation of clinical services provided by students should be part of clinical education.

Considerable discussion of interest to employers surrounded the concern that health professional clinical education is not keeping pace with change. Concerns were expressed with retraining of graduates to work in a managed-care environment. The consensus recommendation was that we need to work on incentives for health service providers who would encourage their support of clinical education and training. Concerns were also voiced about clinical education and training cost benefits, and concerns that clinical sites are diminishing in numbers. Discussion also identified that we have an interest in capitated payments for various allied health disciplines.

During discussions of overcoming barriers, we explored issues of interest to hospitals, health systems and HMOs; primarily, excessive pressure continues to build in clinical sites. In discussions with hospitals and health systems, it is clear that they do understand that there are issues. They, however, have their own issues of survival under diminishing reimbursement.

We also discussed the concern that there is a dearth of information from outcome studies supporting or disputing assumptions made relative to accreditation standards. Whether they're from a patient perspective or a professional perspective, HMOs and other payers are interested in outcome standards.

We discussed the need to promote collaboration and cooperation among the stakeholders in clinical education. My recommendation is to be sure to include representatives of hospitals, health systems, and payers from the outset when conducting collaborative exercises among stakeholders.

The remaining recommendations and thoughts are coming from me from a personal perspective but also from a perspective of having interviewed a number of individuals prior to coming to this meeting and also during the Planning Committee's activities. There were a number of people, from the payer, the health system, and the hospital perspective with whom I was able to speak and to draw out their thoughts on clinical education

reform. Based on those discussions, I believe that these are good ideas. These stakeholders, however, would ask how are you going to make the recommendations happen? Who is going to take it on? Are you really willing to put some effort behind this now that you've identified and agreed in such magnitude of consensus that the work needs to be done?

How can you instill some "out-of-the-box" thinking as you go back to your colleagues and begin to work on this with your professional societies and your own individual departments? How can you make it happen? The Chancellor of Allen College in Waterloo, Iowa has identified to me that there is an organization in her community that has set a new standard for temporary placement agencies. Dr Hasek draws a correlation between that level of service and what we need to do in preparing our students for tomorrow. This placement agency has provided Allen College with temporaries who deliver far beyond any expectation that we've ever had of a Kelly Service or other temporary placement agency. The agency comes into the workplace prior to placing a temp, and reviews policy and procedural manuals and seeks to understand the responsibilities of preparing the temporary for your workplace. If you have safety policies, performance policies, dress policies, they take on the responsibility of preparing the temporary being placed. Now, that goes above and beyond the call of duty as we think of it for a temporary agency. How can we use that concept to think in a different context as we return to our own workplaces and share the issues and recommendations of this conference?

Also, I would like to share with you a perspective of a radiology administrator, about 47 years old, who, a couple of years ago, lost his 16-year-old daughter to cystic fibrosis. After her death, he decided to leave his profession and to fulfill her dream of going into public education. He now reports to me very excitedly that he loves the classroom and that he loves the opportunity to be with students and influence young minds. He also tells me that he has grave concerns about his new colleagues whom he describes as whiners and small-minded thinkers. These colleagues, he says, have lost the vision of working for the students, exciting them, and moving them forward. They have lost their desire to think of

delivering education in a whole different way. When Patricia mentioned the fact that more than 30 percent of the students are bored in the classroom, I thought of this gentleman and his newfound enthusiasm for his work.

Using new and "out-of-the-box" thinking, there are many ways that you can bring excitement into your workplace. Tools and exercises abound today. If you need some ideas, the planning committee for the Coalition for Allied Health Leadership would be glad to share ideas it has collected. ENERGIZE, think forward!



# Pioneering Allied Health Clinical Education Reform

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## Summary and Review of Recommendations

**Rumaldo Z. Juarez, Ph.D.**

Dean

College of Health Professions  
Southwest Texas State University

I will start out by quickly summarizing Dr. Rowland's concluding remarks in which he stated some of the realities that we will continue to face in the future. These are that we:

- will have continued financial constraints
- will have increasing consumer demands
- will have an aging population and
- will have a diminished role of gatekeepers

Within that context, I think much of what has been said during this day and a half of this conference is very appropriate.

It's important for all of us to leave here today thinking about the theme of this conference: "One Vision, One Voice." This type of thinking would be consistent with what our three keynote speakers (Dr. Abrams, Dr. Rowland, and Dr. Crist) shared with us. All three of them emphasized the need for collaboration. It is necessary that academic institutions from all levels (two and four-year colleges and health science centers) work toward developing collaborative models of educational programs.

Dr. Rowland recommended that we get "outside the silo," and Gail Nielsen recommended we start thinking "outside the box." In other words, we need to be more innovative and think of new ways of doing our jobs. We certainly need better linkages between two and four-year colleges and health science centers. We can continue to meet some of our individual

needs or needs of our own professions, but when it comes to the larger issues and making the larger impact, especially at the national and state levels, it behooves us to have the numbers. Let's face it, much of it boils down to how much impact we can have in terms of numbers and how well we can develop more effective collaborative models.

We also need to become more active participants in state and national legislative affairs. Possible areas for legislative action are: (1) tax credits for healthcare organizations that are assisting with clinical education, (2) reviewing AHEC and HTEC legislation with regards to how well are the training needs of allied health professions being met, (3) establishing a health commission to study clinical education training and (4) creating or developing a systematic approach for the collection of supply and demand workforce data of the allied health professions.

And finally, another issue addressed was a rapidly growing diverse population in the country and the need for the allied health professions to expand their clinical education training sites to non-traditional areas and healthcare organizations. Related to this is the need for the allied health professions to be more inclusive of the rural, minority, and other underrepresented populations in the ranks of the allied health professions.



# Pioneering Allied Health Clinical Education Reform

A National Consensus Conference

## Summary and Review of Recommendations

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I want to thank everyone, especially Dr. Harming for the opportunity to serve on the Planning Committee, and to provide closing remarks on this panel. My comments represent a personal perspective as a board member of the National Society of Allied Health. I will also share some personal observations of the conference, and then close with a few themes that emerged from the professional societies session.

The National Society of Allied Health is predominantly an African-American organization, that focuses on educational issues, clinical practice, and legislative concerns that affect minority health status. As highlighted by Dr. Juarez, there continues to be major access issues to quality health care in minority and rural communities that must be addressed. For these reasons, the National Society of Allied Health and other minority organizations play an important role in the dialogue on clinical education reform.

As allied health professionals, we pride ourselves on being the largest workforce in health care, but our presence is small in terms of decision-making in health care. We need to have a stronger voice concerning health disparities in under-served communities. Looking at the future in America, we know that a few decades from now, the current minorities will be the majority, yet we have not addressed the need to prepare more under-repre-

sented minority populations for future careers in allied health. This is important because minority professionals are more likely to work in under-served minority communities than others. Clinical education reform should be mindful of this issue and the need for cultural competency in education and practice.

A comment was made earlier regarding this conference's theme, and an analogy was made of early pioneers. We should remember that many Americans were not pioneers. The past history and life experiences of many people of color in this country included inadequate access to health care, and as mentioned earlier, access continues to be a concern in many minority communities. There were several themes that emerged from the session on professional societies and these included education, research, service, collaboration, and recruitment. Specific recommendations were presented earlier. For professional societies and other stakeholders, there is a need to fill the gaps of missing data, through outcomes research. And as Pat beautifully stated this morning, much has been done. We need to gather that information. Where the gaps continue to exist, we need to fill them. Furthermore, we must continue to prepare qualified clinical educators. I love the idea of preparing students for future clinical educator roles as part of their training, and professional society members can serve as mentors.

Fostering collaborative relationships was another theme that emerged. It is wise for educational programs to work with professional societies. These organizations can be helpful in recruiting students, and providing support in education, research, and professional services. Professional societies can provide leadership in addressing many of the issues presented today. As allied health professionals, each of us can serve as change agents. It would be interesting to follow up this group a year or two years from now to determine if this conference planted seeds of change. As Gail asked earlier, “Have we begun to think out of the box, and to what extent have we encouraged others to do the same?”

Those are my closing remarks. This has been a very good conference. We have learned much, and hopefully, we are committed to implement many of the proposed strategies as recommended.



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## Open Forum

### Introduction

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The purpose of the Open Forum was to establish an initial interface among key stakeholders in allied health clinical education and to gather consensus and recommendations. These “key stakeholders” represented an extremely diverse population of professions, agencies, and institutions. The conference was attended by one hundred, forty-eight participants, who came from thirty-two states, the District of Columbia, and Canada. More than twenty allied health professions and twenty-two professional organizations and accrediting agencies were represented. In the planning phase, the conference planning committee outlined three general categories that subsumed fundamental issues relevant to clinical education reform. These three categories, which focused upon economic factors, overcoming educational barriers, and the role of professional societies in clinical education reform, were first addressed by conference keynote speakers and reaction panelists, respectively.

Open forum sessions provided all participants with a formal setting for the exchange of ideas and the formulation of recommendations for education reform. Promoted as a national consensus conference, the goal was to attempt to define issues and generate recommendations relevant to clinical education reform that would transcend established territories and boundaries. Consensus was not determined by a pre-established threshold or ratio; nor were precise participant polling methodologies employed. Rather, consensus was conceptualized as defined by Webster’s Third New International Dictionary: “a general agreement; the judgment arrived at by most of those concerned.” Perhaps, the consensus-gathering process would be more accurately defined as a pattern of finding “common ground”.

Integral points from the keynote presentations and reaction panels were provided as a starting point for the open forum discussions. Discussion points frequently led to recommendations, and recommendations sometimes produced strategies. Areas of common ground were designed as (C), if at least 50% of participants were in agreement. Those discussion points, recommendations, and strategies that did not appear to be common among participants were designated as (NC) and those for which neither end of the continuum could be ascertained were designated (M). In a few instances, time constraints precluded a polling of participants to determine common ground, no common ground, or mixed judgments.

In the post-conference evaluations, some participants expressed concern about presenting open forum recommendations as truly “consensual”. In that light, the information presented herein should be evaluated as areas in which a majority of participants could find some common ground. Although not empirically consensual, such common themes are more likely to form the basis of any subsequent blueprint for clinical education reform.



# Pioneering Allied Health Clinical Education Reform

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## Open Forum Recommendations

### Economically-Driven Changes Impacting Clinical Education Reform

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#### **RECOMMENDATION 1**

Programmatic accreditation should be more reflective of contemporary practices (C)

#### **STRATEGIES**

- Move to outcomes based rather than process oriented accreditation (C)
- Competency assessed by practice in addition to written examination (C)
- Educational curricula and standards should be reflective of current practice analysis and anticipate future needs (C)
- Coordination of standards between national/state accrediting/licensing bodies and state boards of higher education (MC)
- Determine cost effectiveness of programmatic accreditation (C)

#### **RECOMMENDATION 2**

Complete data should be collected on cost/benefit of clinical education of students (C)

#### **STRATEGY**

- Explore innovative models that are based on performance outcomes of students as well as cost and value benefits to achieve cost neutral status (C)

#### **RECOMMENDATION 3**

Increase the utilization of technology in clinical education (C)

#### **STRATEGIES**

- Review of policies by state/educational institutions that inhibit collaboration and sharing of resources (C)
- Explore models of distance learning that support collaboration and sharing among schools and institutions (C)
- Explore innovative uses of technology for clinical education (C)
- Professional societies develop clinical case study media, including interdisciplinary, which could be made available to all programs (C)

**RECOMMENDATION 4**

Increase preparation and recognition of clinical educators (C)

**STRATEGIES**

- Design systems to prepare and recognize clinical educators (C)
- Professional societies should be tapped to develop media to help prepare clinical educators (C)
- Professional societies could develop a clearing house of existing models for recognition of clinical educators (C)
- Promote early collaboration between clinical educators and curriculum development (C)

**RECOMMENDATION 5**

Clinical education reform should include cross discipline and collaborative learning (C)

**RECOMMENDATION 6**

Employ interinstitutional collaborations to improve quality and reduce cost of clinical education (C)

**RECOMMENDATION 7**

An evaluation of clinical services provided by students should be part of clinical education (NC)





# Pioneering Allied Health Clinical Education Reform

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## Consensus Gathering Recommendations

### Overcoming Barriers to Clinical Education Reform

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#### RECOMMENDATION 1

Develop an assessment model that accurately reflects and forecasts the need, demand, and supply for the allied health professions and support of clinical sites (C)

#### STRATEGIES

- Perform needs assessment before starting new programs
- Seek advice from professional societies in regard to duplication and proliferation of programs.

#### RECOMMENDATION 2

Reduce pressure on clinical sites (C)

#### STRATEGIES

- Develop a statewide/regional consortium for clinical education.
- Explore effective methods to support clinical education, i.e., tax credits
- List elements/major items included in affiliation agreements to reduce pressure on clinical sites
- Modify assignments performed at the clinical site to better match what the clinicians provide
- Explore the use of faculty for facilitating at clinical sites

#### RECOMMENDATION 3

Develop outcome studies that support/dispute assumptions made relative to accreditation standards, *e.g.*, length of field work (M)

#### DISCUSSION POINTS

- Move from evolution to revolution and overcome turf issues.
- How can we promote collaboration/cooperation among the stakeholders?
- Can more flexible accreditation and certification requirements aid in clinical education reform?
- How can changes in academic structure facilitate clinical education reform?
- Can we expand clinical education to community-based practice to increase teaching sites?
- Can new models, such as technology solutions/computer simulations/"virtual laboratory" facilitate clinical education?
- The need to adequately prepare students and faculty for clinical education
- The need for allied health faculty and professionals to increase their involvement in legislative/policy making decisions.



# Pioneering Allied Health Clinical Education Reform

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## Open Forum Recommendations

### The Role of Professional Societies in Clinical Education Reform

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#### DISCUSSION POINTS

- Need for professional societies to acknowledge clinical education as a higher priority(C)
- The need for professional societies to be proactive in facilitating, advocating, and leading clinical education reform(C)
- Need for collaborations and partnerships among professional societies(C)
- Need for collaborations and partnerships within and between allied health schools and colleges(C)
- The need to maintain student learning as the primary focus in clinical education(C)
- Need for a collaborative role of professional societies in recruiting and promoting clinical educators (C)
- Need to develop clinical education standards, programs, and processes that support adult learner needs and lifestyle concerns(C)
- Defining the appropriate role of professional societies in determining scope of practice and core competencies(M)
- Need for key stakeholders to come together to address common interests regarding clinical education(C)
- Defining professional societies/accrediting/ certifying agencies impact on clinical education reform
- Need for professional societies to analyze the long term financing of clinical education(C)



# Pioneering Allied Health Clinical Education Reform

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## Critical Issue Survey and Results

### INTRODUCTION

The *Critical Issues Survey* polled attendees in an informal, relaxed setting during the luncheon. The survey solicited input to five questions that focused on economic factors, new opportunities and challenges in clinical education, barriers to clinical education reform, making graduates more adaptive to the working environment and the role of professional societies in facilitating clinical education and training. Input derived from the Open Forums was designed to seek out issues on which a diverse population of attendees could find common ground; while agendas and issues specific to particular professions and organizations were identified in the responses to the *Critical Issues Survey*.



1. **What are the top three economic factors impacting Clinical Education/ Training in your area?**



2. **What new opportunities or challenges have evolved in Clinical Education/ Training in your profession?**



3. **What are the top three barriers to Clinical Education/ Training Reform in your region?**



4. **What changes in Clinical Education/ Training would make graduates more adaptive to the current working environments?**



5. **What three recommendations do you have for your professional society in regard to facilitating Clinical Education/ Training?**

**1. What are the top three economic factors impacting Clinical Education/Training in your area?**

- Very low employment.
- Short-staffing at clinical sites due to unfilled positions.
- Difficulty attracting students to lower wage positions.
- PPS - huge impact on OT/PT and long-term care.
- Distance from home school to clinical agency.
- Salaries of clinical instructors.
- (Dental Hygiene) The threat of the reduction of educational standards - thus threat of creation of preceptor programs; flourish of non-accredited programs.
- Lack of dental hygiene educators.
- Hospitals receiving less money for payments thus not hiring individual when someone leaves.
- The Balance Budget Amendments and Prospective Payment System - many subacute care facilities have had to cut staff and no longer hire student programs.
- The clinical educators do not have time, have productivity demands to meet are not compensated and maybe afraid of losing their jobs to students who soon will be therapists.
- Fewer affiliates.
- Hospital cut backs resulting in fewer technologists with less time for teaching during clinical rotations.
- Willingness of CIs to take students because they don't want to train the job competition.
- Clinical staff are part time or PRN in LTC & HH.
- Fall out of BBA of 1997.
- Whether or not pay preceptors.
- Whether or not to reimburse students for travel/lodging.
- Not hiring enough core clinical faculty to adequately support the clinical preceptorship.
- Hospital sites
- Funding
- Loosing affiliates due to hospital mergers.
- Raise in Tuition costs/cost of training supplies.
- Increased demands on productivity in the clinic.
- Decreased number of jobs available.
- Managed care has affected employment.
- Employee salaries.
- Health professionals are overwhelmed and underpaid.
- Employee salaries - fewer people applying due to low wages.
- Fewer staff to do work, let alone teach/train.
- "Managed Care"
- DPPS capitation!!
- SLPs laid off .... per diem vs. salaried, etc. - no students welcome.
- Cost to the hospital in training students.
- Paying clinical sites - Pro/Con. Standardized preparation and recognition of clinical educators (who will pay) should they get money?
- Managed Care
- Institutions opting for fiscal success/survival vs. clinical education.
- Education programs - increased recognition of clinical vs. didactic education.
- Funding
- Sufficient faculty
- Recruitment
- Faculty

- Clinical sites
- Clinical education centers are inadequately staffed for patient load let alone student supervision.
- Institutional financial support for laboratory equipment and maintenance (simulators, computers).
- Manpower shortages
- Student readiness with medical exam, health lab profile; vaccinations to start clinical.
- Providing our own on-site preceptors for students.
- PPS
- RPS and long term care placements.
- Loss of FTEs and downsizing in LTC and some hospitals.
- Fewer rehabilitation opportunities for full time clinical experiences.
- Many programs competing for the same sites.
- Reimbursement issues causing demand for productivity with less staff members therefore reduction in willingness to instruct students.

**2. What new opportunities or challenges have evolved in Clinical Education/Training in your profession?**

- Distance education
- Creation of teaching methodologies that meet the learning needs of the entering students. The lack of preparation of entering students, re: independent learning and communication skills.
- Keeping schools active, many have closed.
- Encouraging clinical educators to do the training in new ways, for eg: using a collaborative model, challenging the student clinical reasoning skills.
- Creation of multi-media teaching programs.
- Little chance to use instrumentation.
- Opportunities more non-traditional (medical settings)
- Challenges less direct supervision of the licensed professional during clinical ed
- Involving preceptors enough for them to communicate problems with student performance to the program as well as to the student. Also, many preceptors are turning down students due to “not enough staff” or “not enough time”.
- The salary has increased and there are more job opportunities.
- Opportunities - Internet technology
- Challenges - changing instruments
- Opportunities - not many, in fact none!
- Challenges - to do more with less
- Opportunities - availability of info on Internet
- Challenges - more lab techniques to teach in same amount of time with fewer people
- Keeping up with delivery of service changes and keeping curriculum current.
- Lack of quality candidates to train.
- Is there a greater focus on lower level jobs and greater emphasis on preparing these individuals vs. professionals? (everything is of advanced technology now)
- Opportunities: Data Analysis  
Chief Information Officer  
Coder/Biller
- Challenges: Non-credential person being in charge of credential person.  
Vocational schools offering training in professional field for short period.  
Less funding from CE.

- Advanced clinical practice in my area of training - allowing our profession to become marketable.
  - Education
  - Administration
  - Opportunities: Distance Education, Electronic Media
  - Challenges: Manpower shortages
  - Lack of cooperation of preceptors to take students on a continuous basis.
  - Movement to using new sites where OT services have not previously existed with 2 days/week of OT faculty member salary “purchased” by the clinical site (to provide student supervision and OT services).
  - Now have a “majors fee” at the Univ. and additional fees for lab courses (helps a lot!).
  - Credentialing for PT clinical educators.
  - Discussion regarding the DPT as entry level degree
  - Direct access opportunities in 32 states
  - CPI
  - Technology changes
  - In cancellations due to clinic circumstances
  - Reluctancy to promise too far in advance because of the staff problems.
- 3. What are the top three barriers to Clinical Education/Training Reform in your region?**
- Finding clinical sites
  - Preparing for the future of healthcare vs. reactions to the current situations.
  - Availability of clinical instructors
  - Availability of clinical spaces
  - State regulations and politics that prevents teaching the full range of clinical skills needed for the students that will later move to another region. In general, lack of funding. Regarding competency education and evaluation, we are well established and not hindered.
  - Increased work load and less staff
  - No reward system for clinical educators, just more work.
  - Same as the top 3 economic factors outlined above.
  - Little incentive for additional training other than personal satisfaction and improvement.
  - Too many universities/colleges wanting the same sites for clinical education.
  - Receptiveness of the clinical staff.
  - Optimism of the clinical staff about the job market.
  - Dean of the college!!!
  - I am the sole clinical coordinator for over 100 sites.
  - Other programs competing for the same sites.
  - In the County Hospital they do not allow the student to perform evasive procedures.
  - There are too many schools that offer training quick and the cost is killing the students.
  - Distance between university and affiliates.
  - Decreased number of sites.
  - What kind of reform? How are we to change a system? We need a bigger lobby. More efforts are needed to work with Congress!
  - Only 31 accredited programs in the U.S.:
    - very little peer-teaching support
    - very few number
  - All disciplines separate. Not one body speaking for all.
  - Republican Governor
  - National Organization requirements re: hours SLP students need to obtain for certification.

- Completing degree in 2 yr. program though scope of field has grown so much.
- Cost to have more clinical instructors.
- Licensure!
- Funding for technology equipment/programs.
- Establishment of special interest groups.
- Administration support/budget.
- Language (Spanish speaking clients)
- Qualified faculty who are willing to relocate to our area.
- Limited number of in-patient clinical sties.
- Rigid, min-set, antiquated administration ideas, policies, philosophies, etc.
- Difference between standards taught didactically and the students observing limited standards routinely used in clinical practice.
- Clinical too long.
- Lack of trained preceptors willing to work w/students.
- Concern that the students will receive inadequate supervision.
- Supervisors blindly committed to training students in the same way they were trained.
- Staff turnover in local hospitals.
- Meyers.
- Lack of understanding clin-ed by institutional administrators.
- The educational programs must embrace and reform.
- Listed above as economic factors & challenges.

**4. What changes in Clinical Education/Training would make graduates more adaptive to the current working environments?**

- Additional time devoted to development of clinical skills i.e., apprenticeships.
- Creation of diverse clinical sites - which would need the condition of general or no dental (dentists) supervision in those sites.
- Always having a certified/qualified CI
- Curriculum must reflect & train student for practice
- School taking more responsibility to ensure capability
- Outlining actions needed for entry level practice
- More instrumentation for outmoded labs.
- Earlier exposure
- Flexibility with placements
- Inclusion of more administrative practice.
- Graduates need to be paid better.
- Pay more to attract better students.
- More interdisciplinary training.
- Having tracks: medical vs. educational; ped vs. adult.
- Students are ill-prepared for entry into programs.
- Cultural diversity and sensitivity.
- Find the miracle to eradicate apathy of the clinical staff (providing pt. care & education) and the students to be independent and responsible for learning.
- Completing training all up front in class then move to clinical - this is what we do now and works best.
- Changes need to occur during the didactic/academic phase first to - independence in thinking and clinical reasoning.
- Group models of supervision.
- Team approach.

- Link clinical education to initial employment opportunity
  - All the professional programs must work collaboratively with their colleges in the clinical. Survey graduates/employers and adapt accordingly.
- 5. What three recommendations do you have for your professional society in regard to facilitating Clinical Education/Training?**
- Provide information regarding changes being experienced in clinical practice/funding.
  - Provide mentors for students in clinical practice.
  - I appreciate the need for parochial organizations. However, regarding national healthcare and issues - create a dual membership, i.e., I would pay my dues to the American Dental Hygienists' Association and with that dues statement add \$25 payment that will go toward membership in a National Allied Health Organization, thus uniting the AH voice.
  - Highlight clinical educators in the newsletters.
  - Making sure that OR curriculum's reflect more current practice.
  - Taking more responsibility for some clinical education at the academic institution.
  - Look to discourage the development of more programs.
  - Review NAACLS requirements and develop something that is practical and realistic for the entry-level technologist that can be taught in 2 years.
  - Seek advice from the payors & policy makers.
  - Seek advice from the clients/consumers.
  - Preceptor workshops/seminars, esp. at the national conference level.
  - Advertising CME credits for preceptoring.
  - Limit number of new programs!!!
  - More institutions should participate in their off site training. I mean that your certif. programs that are not housed on a college campus do not monitor their students by visiting the site or they wait until the student is at the end of training to send the student for hands-on training.
  - Revise essentials to be more practical.
  - Cl. Lab Sc. Society needs to do more to raise the standards of the profession.
  - Laboratory scientists need to be recognized as scientists.
  - Need to be paid better.
  - Set-up training modules on Internet.
  - Work on obtaining grants for innovative programs.
  - Review training requirements re: hours in adult area during crisis.
  - Contact APTA @ training CI project and get in on it!
  - Keep those lobbyists aggressive on BBACF/PPS issue.
  - Add the component or title of nurse practitioner to our curriculum.
  - Changing the requirements for preceptors to allow more diversity to our students.
  - Funding
  - Determine if clinical education is part of the societies' goals and philosophies.
  - Request society divulge material to assist academic faculty with clinical faculty preparation material.
  - Promote changes to focus "entry" level upon competition of program and not require only one avenue to certification in field, i.e., surgical tech only avenue AST CAAHEP. No grandfather.
  - I think AOTA has done very well with this:  
In 1991 they produced a manual including videotape with 12-13 vignettes for clinical educator supervision - it is currently being revised.
  - New standards eliminate 1 hour specification.





# Pioneering Allied Health Clinical Education Reform

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