

Council Minutes

The Council of Allied Health in North Carolina

UNC General Administration Building, Board Room

Wednesday, January 3, 2007; 9:30 am – 12:30 pm

- I. Welcome and Introductions –Kathy Heilig, Chair
 - A. Heilig welcomes members, guests of the Council, and panelists (Craig Souza and Sue Beck were not able to attend because of family emergencies.)
 - B. Approval of minutes moved to Business Section after break

- II. Presentation: *Implications of the Clinical Doctorate in the Allied Health Professions: Workforce, Reimbursement and Scope of Practice Considerations*
 - A. Heilig introduces and welcomes panel participants representing
 1. Employers: Bill Pully, NC Hospital Association
John Sexton, Private Contractor of Audiology Services
 2. Educators: Stephen Thomas, Dean, School of Allied Health, ECU
Rick Segal, P.T., Division Chair, UNC-Chapel Hill
 3. Practitioners: Dan Dore, P.T., Duke Hospitals
Pat Roush, Audiologist, UNC Hospitals
Carol Siebert, O.T., NC Occupational Therapy Association
 - B. Pat Porter, from UNC’s Department of Allied Health Sciences and Council’s legislative liaison, introduces the topic and explains the framework for the presentation. Porter briefly summarizes the rationale for the panel presentation – moving from a private to a more public discussion with the intent to provide information on a topic that is both growing in attention and in some areas in concern. The purpose of the present panel presentation is not to debate but to inform. The Council provides a unique forum for this interchange of ideas with the goal to inform many groups: employers, educators, professionals, state agencies, others. The agenda will start with a background presentation by Erin Fraher from the Sheps Center for Health Services Research. Panelists have 5 minutes to present a summary of their perspective. The panel discussion will end with a question session for audience and panel members.
 - C. *The Move Toward the Clinical Doctorate in the Allied Health Professions in North Carolina* – Erin Fraher
 1. Fraher states that because of the expertise of its members, the Council is the perfect forum for shifting from a debate to a discussion of this issue. The result will be information from a public policy perspective that will aid in projecting future implications of the move toward clinical doctorates for the state as a whole.
 2. Fraher ends her presentation asking “what is the best use of public resources”? In connection with the workforce development initiatives being studied by several members of the Council, does the move to clinical doctorates eliminate career ladders for those dislocated/displaced workers being transitioned into health care professions? Does the ability exist for a PT/OT assistant to become a PT/OT? For those interested in this topic, investigate the approach of the Clinical Laboratory Science profession which has articulated well the reasons for moving to the clinical doctorate as a career ladder.
 - D. Bill Pully – NCHA, an employer’s perspective
 1. Agrees with both sides of the issue, but is concerned about rising health care expenditures. Are we really training the workforce needed in the future to care for the citizens of North Carolina? Huge amount of public resources will be needed to accomplish this goal. This past year, is the first year that baby boomers turn 65. It is known that health care expenditures double at age 65, and again at age 85. Coincidentally, these are the fastest

growing segments of our population. We are in the threshold of the greatest increase in health care expenditures ever seen. In an article in this morning's paper about tax reform, Senator David Hoyle commented that Medicaid expenditures represent 17% of the state budget while in 2030 they are projected to be 53% of the budget. All of us believe that policies and measures will be in place to prevent this from happening.

2. Two concerns of NCHA
 - a. Quality of care – how to overcome quality chasm cited by IOM report. Providing better quality care not only directly benefits patients but society because of savings in resources.
 - b. Efficiency – must find ways to become more efficient; must examine what tasks will stay in the hospital setting, which will be reassigned, which will be removed from the hospital.
 3. Example of PharmD and medication reconciliation problem – a pharmacy leader is an essential member of the clinical team in solving this problem. The need for the PharmD in this position created a demand for more Pharmacy assistants to dispense medication.
 4. Cannot discuss the issue of clinical doctorates without examining the dynamics of the present job market in the health professions. There are 7500 vacant jobs in NC hospitals right now. If we fail to provide education spots to train individuals for these jobs, this shortage will escalate in the future. If the goal is to produce the health care workforce for the future, then Pully asks the educators and professionals how individuals can be trained better and faster so they can join the workforce sooner.
- E. Stephen Thomas – Dean, School of AH Sciences, ECU, an educator's perspective
1. Presentation based on hand-out listing highlights from discussions of views related to issues of clinical doctorates by the Administrative Council (nine department chairs, chair of the School's Faculty Council, associate and assistant deans) in ECU's School of Allied Health Sciences.
 2. Many of these views are in accord with views already expressed today.
 3. There are 661 students enrolled in the School of Allied Health Sciences; only 1/3 are undergraduates. ECU offers a number of clinical doctorates and Ph.D. programs – has accrued experience of issues relevant to these programs (DPT, AuD, Ph.D. in Speech Pathology, etc). The move to the DPT was driven by competition from other universities. The result of this move was costly – for example, had to move away from master's level faculty.
 4. Lessons learned from move to clinical doctorate in PT
 - a. Number of applicants went down. The class accepts 30 students per year and the program lasts 3 years. In comparison, the master's class had 45 students per year and that program lasted 2 years. The total number of students over the 3-year span stays the same, but not the cost.
 - b. Caliber of applicants went up significantly as evidenced by higher GRE and GPA scores.
 - c. Higher load of field work and contracts (had to hire a full time staff to handle contracts).
 - d. Had to accommodate 3 classes: more space needed, higher operating costs.
 - e. Difficult to locate terminal degree faculty to teach.
 - f. Optimistic that higher caliber students combined with additional training may provide improvement in quality of professional produced.

F. Dan Dore – Director of P.T and O.T., at Duke Hospitals since 1985, a practitioner’s perspective

PT Profession has changed dramatically in the last 21 years. Current graduates better trained and, therefore, able to work independently sooner.

	1985	2006
Number of students in class at Duke	22 in Master’s Level Program	64 in Clinical Doctorate Program
Duration of Program	21 months	33 months
Experience in clinical setting Big difference for employer who can now place new graduates in settings where they can work independently	18 weeks	46 weeks
Fellowships & Residencies	None	Becoming standard practice. At Duke: women’s health residency, cardiovascular & pulmonary residency, manual therapy residency, sports medicine fellowship
Board Certification	None	Board Certification in: cardiovascular & pulmonary, orthopaedics, sports medicine, electrodiagnosis, pediatrics, geriatrics, neurology
Number of PT’s at Duke	32	110
Starting Salary	\$23,000	\$49,000 (2% turnover rate at Duke – low because of emphasis on professional development and continuing education).

G. Rick Segal, P.T., Division Chair, UNC-CH, an educator’s perspective

1. Has been through 2 transitions to DPT programs, one at a private institution – Emory – and another here at a public university.
2. His experience is that diversity is increased by having the doctorate program. This was the experience in Atlanta when recruiting at underserved institutions; the enrollment of minority students increased.
3. More training grants available to fund doctoral students.
4. The trend has been that the number of applications to PT programs nationally remains level. However, the number of applications to doctoral programs is higher than for the master programs. Even though it takes longer to finish the doctorate, the overall number of graduates remains the same.
5. The recruiting of faculty is a huge issue. Here at UNC there is no problem in terms of the proper training level. However, it is a problem nationally. Some people believe that this shortage can be dealt with by having those programs with properly trained faculty increase in capacity while those programs not able to recruit faculty close down.
6. North Carolina is doing a good job in the distribution of trained professionals – majority of programs are DPT, 2 are Master’s program. There is also a 30-hour rigorous up to 2-year distance education program at UNC. Some features of this program will be

incorporated into the campus program because it is a wonderful aid to collaboration and dialogue which result in solutions for patients.

7. Focus groups of employers and alumni are important in developing curriculum because can provide feedback as to what is needed by the profession for their patients.
 8. In conclusion, PT clinical doctorate programs pose problems with faculty recruitment and distribution of workforce, but these can be overcome
- H. Pat Roush, Audiologist, UNC Hospitals, a practitioner's perspective
1. In audiology, the AuD is the entry level degree. Has been practicing since 1976 and feels that the most significant change is the dramatic increase in the knowledge base and the highly sophisticated technical skills required to practice.
 2. Because of the above, the Master's degree no longer provides adequate time to train professionals.
 3. An important consideration from a patient perspective is that the consumer knows the difference between the M.D. and the AuD.
 4. According to Jack Roush, Director of Graduate Program in AuD and Speech Pathology, applications have more than doubled with higher qualified students since the onset of the AuD program.
 5. Distance education can be an efficient and effective method for those already in the profession to upgrade their degree.
 6. Another important consideration is that consumers understand the importance of hearing aids being dispensed by trained audiologists. In some states, these highly technical devices can be dispensed by anyone with a high school education and a small apprenticeship.
 7. Consumers also need to understand the difference between the role an ear-nose-throat physician plays in a medical/surgical procedure such as the cochlear implant and the role of the audiologist in hearing rehabilitation.
- I. John Sexton, Private Contractor of Audiology Services, an employer's perspective
1. Has 14 audiologists on staff in a statewide practice. The AuD resulted in a temporary shortage which is growing smaller. When seeking new employees broadened scope and recruited in multiple states and advertised on a national basis.
 2. One of the biggest concern when professions move toward more advanced credentials as entry level, is to include the legislative and licensing entities that govern the practice of the profession so that proper and timely changes can be made. Just now are the licensure boards being challenged to change the technical language and standards required to practice audiology and dispense hearing aids. Sexton chairs the Hearing Aid Licensure Board.
 3. Supports legislation that expands training programs because need larger pool of employees, and legislation that updates credentialing.
 4. Finds AuD students to be better trained with more clinical experience so require less on the job training.
 5. Feels that salaries will take awhile to increase so that graduates are compensated for their skills.
 6. Asks university training programs to help students have realistic expectations in terms of what they are facing with licensure rules that have not been updated to meet the new requirements of the profession.

- J. Carol Siebert, O.T., NCOTA, a practitioner's perspective (private practitioner, consultant, taught entry level classes for UNC's Master's program). Siebert distributed a hand-out on the "*History of Occupational Therapy Education and Standards*" and "*The Current Requirements for Occupational Therapy Licensure in North Carolina*".
1. As of Monday, January 1st, 2007, the entry level position is a Master's degree. This decision was made 8 years ago; the phase-in allowed schools to prepare and the potential workforce to be aware of the requirement.
 2. In North Carolina, licensed practitioners have degrees ranging from an Associate's degree to a Master. Nationwide as well as in North Carolina, 25% have a Master's degree.
 3. Presently, there is no discussion of requiring the entry level to be a Doctorate in OT. The emphasis in the profession is to encourage practitioners to seek advanced degrees either in OT or related disciplines, and acquire advanced clinical competencies. In part, this is because the profession needs basic research to be done but also because it needs practitioners with advanced knowledge to develop advanced clinical practice areas and to do translational research (how basic research works in real practice settings).
 4. The profession is 100 years old but from its inception, 25 months of didactic training and 9 months of clinical experience were required. The profession continues to examine the curriculum basics necessary to produce a strong, general practitioner.
 5. Over the past 20 years, there have been many changes which lead to re-examining what must be included in the curriculum. Changes have occurred in
 - a. Base of knowledge
 - b. Places where practitioners work
 - c. Systems under which the profession is practiced
 6. Practitioners no longer work in in-patient settings which offer a higher level of professional support. Today, over 40% don't work in these settings. The demands for productivity have increased, and many settings offer none or minimal contact with colleagues. The fastest growing practice area is home and community care. The 2 fastest growing population requiring OT are older adults (driver rehabilitation, aging in place solutions to modify home environment), and children and young adults living with chronic conditions. Both of these populations require either home or community care. The entry level practitioner must understand complex systems such as Medicare as well as the problem of the patient.
 7. Highest rate of turnover is in in-patient care because of the lack of opportunity to advance, to innovate, to make a direct impact on quality of life.
 8. OT services are autonomous. Legally, this means no requirement for physician's order or prescription. Services are billed independently. Must prepare entry level practitioner understand this obligation.
- K. Question and Answer Session
1. It appears that there is a need for Clinical Doctorates for higher quality patient care.

Have the outcome for patients been evaluated and have they been better?

 - a. Roush feels that it is too early to tell for the AuD. Still dealing with 4th year clinical placement for students so there is a systematic procedure assuring high quality experience for the students.
 - b. In PT, the need to assess patient outcome quantitatively has increased over the last 10 years as has the DPT. By 2009, over 99% of programs will be DPT.
 - c. Until a few years ago, productivity was the measure in clinical practice rather than patient outcome.
 - d. Thomas points out that must not use PharmD program as an example because the measure there is dispensing rather than treatment. Noticed that after development of

DPT program, level of research output skyrocketed – external funding has come in. The important issues is coming up with discoveries that impact the scope of practice, discovering new ways to treat, coming up with solutions for problems that existed and trying to implement those in terms of practice in the field. This has always been the role of the university. In recruiting faculty with terminal level degrees to teach in the DPT program, find that this faculty have the ability to conduct research and to involve the students in research that increases the scope of practice and therefore affect patient outcome. Fraher wants to clarify that the PharmD perform clinically related patient services. The data for the PharmD are just coming in. Fraher points out that the CDs are not the ones who will evaluate patient outcomes data. Data needs to be collected and analyzed much in the same manner as for nursing (for example, mortality rates versus increasing staff ratio with CDs). As the professions move forward, these studies must be incorporated. Segal points out that by including management in the curriculum, practitioners are better equipped to evaluate outcomes and collect data to be analyzed.

2. What will happen in the future?

- a. There will always be an increase in the knowledge base and complexity and sophistication of what is needed to practice. The answer now has been to increase the length and complexity of the training program resulting in a CD.
- b. There is also increased number of CEUs to maintain certification.
- c. More specialization areas through residency and fellowship programs much like in physician training. Some practitioners will remain generalists.
- d. Medicine has dealt with this dilemma by creation of advanced practice role for nurse practitioner and physician assistants. Research shows that high quality patient outcome is maintained. Allied health professions may have greater differentiation of roles with increased practice for assistants as middle level providers. Not everybody has to be trained to the same level; a higher level of training reserved to deal with more complex issues. Nursing continues to grapple with this dilemma of different levels of training.

3. Is there a national conversation going on as to criteria that define a doctorate?

- a. Sadler states that in higher education there is a great ambiguity about titles and degrees. Feels that professional associations provide guidance. This has been discussed extensively among the UNC Board of Governors who are very interested in this subject; Craig Souza is a leading proponent of these discussions.
- b. McLean brings attention to the hand-out from the Association of Schools of Allied Health Professions, a professional organization which is trying to grapple with this very issue. This is a draft of the position statement, “*Recommendations of the Task Force on Clinical Doctorates*”, drawn by a subcommittee of deans of allied health schools, that puts forth a definition of what constitutes a clinical doctorate. This definition is difficult to achieve because it might be seen as imposing restriction on other regulating bodies. For example, cannot impose regulations on what is in the realm of regional accrediting bodies such as SAS in the case of UNC; every institution wants autonomy in creating a program – faculty qualifications, number of credits required for degree, etc...The position paper basically establishes distinction between entry level doctorate and advanced practice doctorate, and establishes minimum hours required for the degree. The statement has been mailed to AH deans who are members of ASAHP, and no objections have been received. It has gone back to the Board to await further action.
- c. Pully points out that before talking about training a new group of practitioners must address the need to educate, train and produce the workforce needed in NC now. He

feels that “we are failing the people of NC”. The “we” includes other people, not just the people in this room. From an employer’s standpoint, when this becomes a legislative issue, data will be needed to prove that CDs improve patient outcome and to justify resources needed for the clinical doctorate programs. The resources are not being allocated today to meet the current need, and until that is done, he does not have much interest in seeing what else can be done.

4. Pheon Beal asks two questions: **How do you look at the clinical doctorates in light of the physician shortage? How much of this discussion is market, consumer-patient, driven?**
 - a. Dan Dore answers and also addresses comment by Bill Pully. Dore is deeply bothered by the idea that any decision to increase the supply of practitioners considers reducing the level of education. The commitment to continually improve a practitioner’s ability to treat and care for patients need not have to be concerned that by doing so cannot increase the supply of practitioners. These are two separate issues. High quality must always be a priority in providing care.
 - b. Recognizing that physicians and nurses will be in shorter supply in the future, PTs will need to rely on a greater body of clinical knowledge to treat patients who have less contact with physicians and nurses. This becomes a critical issue when there are fewer options available to patients. Every professional has the responsibility to be a stronger clinician.
 - c. Prevention and wellness are becoming strong strategies in preparing for the future shortage of health care professionals.
5. In response to Dore’s comments, Porter brings attention back to a compelling point made earlier by Bacon that practitioners will have to be better trained in this broader array of new technology and treatments. However, does everybody need to be trained at that level? Or, are we looking at career ladders and levels of training?
6. Libby Haile recommends looking at the advanced practice clinical doctorate in Clinical Laboratory Science for a different approach to this subject. The position paper can be found at www.ascls.org.
7. Speaking on behalf of rural hospitals, Heilig points out that administrators cannot find basic level practitioner because of urbanization trend – students tend to remain in areas where educated. So, access is a real issue for patients in small rural communities (which happen to be a larger percentage of the state than urban communities). The services are there but patients cannot get to these services. Heilig directs the question to Thomas: **Are the education programs doing anything in their curriculum to talk to students about entry level vs. non-entry level, location, types of setting?**
 - a. Thomas responds by saying that ECU provides a primary care orientation. The Physician Assistant program is a generalist program because of the demand for primary care in the rural areas. When a professional goes to a rural area, he/she may be the only practitioner in the area so his scope of knowledge must be inclusive. Thomas is proud that 60% of physician assistant students go into rural areas. Nonetheless, it is at times hard for students to be attracted to rural areas because hospitals in these areas lack the sophisticated equipment, technology and resources to which the students have become accustomed during training. Practitioners in rural areas have to be more creative and flexible in how they provide services.
 - b. Segal points to misconception that entry level is not a generalist. PT entry level is a generalist. Further residency and fellowship programs generate specialists. Reminds audience that UNC is using an online transition program to further train practitioners in the mountain region of the state. This same program can be adapted as an online

discussion board to provide consulting and support to practitioners throughout the state.

8. Becky Bullock comments and asks following questions?
 - a. Considering the PT training, it seems that on-the-job mentor training is now part of academic program. Is academia the best place to teach what is needed for the day-to-day job requirements?
 - b. There seems to be a chasm between educational training and the reality of practice. She finds that students often frustrated with what they are expected to do in day-to-day practice versus what they learned in academia. Should there be an examination of the entry level positions?
 - c. How much of the finite health care dollars should be spend on specialized, advanced degree programs?
9. Pheon Beal asks what will be the incentive for the private sector to train and deploy practitioners to undeserved, rural areas? What will be the incentive for a highly trained, specialized professional to work in these rural areas?
10. Lee responds that it is appropriate to define different clinical doctorates. However, the answer to these questions may lie in more fundamental analysis of new models of health care, including how health care is financed. Differentiation of care and scope of practice must also be examined. Is the justification of a DPT that this practitioner can supervise a number of well trained assistants and therefore impact a greater number of patients? What we are doing is identifying whole major system issues that need to be further addressed at a higher level. Perhaps the state of North Carolina can step forward with a model on how to integrate health care resources to meet the needs of its citizens.
11. Porter asks if we are developing doctorate programs before we consider system of care (“are we putting the cart before the horse”). Yoder follows by asking Pully what should we do if we are not training to meet the needs of the state?
12. Pully feels that we need to do more with less. If improving professional standards by way of the clinical doctorate provides added value and saves resources, and can be demonstrated to do so, then let’s do that.
13. Roush points out that audiology has a pressing need in rural areas. Legislature was passed to screen every baby in the state for hearing loss. The state mandated examination of babies for hearing loss did not account for lack of trained audiologists throughout the state to provide services for those children detected with hearing problems. The families are now traveling to various medical centers to get the services. Roush believes that the establishment of regional centers would alleviate the shortage of audiologists, and the need to have this highly specialized care in every community.
14. Nancy Porter, Dean of Nursing and Health Education at Gaston Community College, makes 3 points:
 - a. Wants to remind the audience that there is a very large group of people in the community colleges that are preparing the majority of the workforce who work at the patient level. She is concerned that this entire group is being left out of the discussion because they could certainly help fill those 7500 vacant positions.
 - b. Entry level issue in the nursing profession has been debated for over 40 years with little progress.
 - c. In speaking of workforce development, the present group has talked about the increasing quality of students at the graduate level at the four-year universities. However, the reality for many students who want to go to college is lack of preparation - the fastest growing program at the community colleges is remediation.

Nancy Porter feels that there needs to be an examination of workforce development and the entire education system.

- L. Conclusion – Pat Porter asks the audience two questions:
 1. Is everyone better informed on this topic? A show of hands demonstrates the success of the presentation.
 2. This is the first of several meetings on this topic, please let the Council know what you want to be the next topic. Looking back at issues raised at this meeting, should the next topic be:
 - a. Health Care System
 - b. Rural Health Care
 - c. How to address needs as opposed to demand
 3. Please respond. Your Council needs your input!
- M. On behalf of the Council, Pat Porter thanks the panel participants for their expertise and openness in discussing this topic. A better, more expert, more knowledgeable panel could not have been together. The Council appreciates your patience in answering questions, and your help to the Council today. Pat Porter thanks Erin Fraher who really brought this issue to the Council, and for bringing her knowledge and informing us today.

11:32 am – 5-minute break

III. Business of the Council: Discussion and Action

Approval of November 1st, 2006 Minutes – A motion was made and seconded to approve the November 1st, 2006 Council minutes. A voice vote was taken. The minutes were approved by voice vote.

IV. Reports

- A. Council Financial Report and 2006-07 Budget – Alan Brown

The Council is entering the second year of the Duke Endowment Grant. As a quick review, the Duke Endowment Grant is a two-year, \$70,000/year grant supplemented by matching funds from some members of the Council. The Duke Endowment Grant mainly covers salaries and the Shep's Center workforce studies. With approval from Duke Endowment, the grant has been extended into a third year because AHEC will cover certain expenses that occur within the next six months. These expenses have been identified by the Executive Director and the Department of Allied Health Sciences that manages the day-to-day budget of the Council. AHEC is covering these expenses with part of one-time funds allocated by the General Assembly this past May to support allied health initiatives. The funds in this one-time allocation must be used by June, 2007.
- B. Update on current AH Job Vacancy Study – Phillip Summers
 1. Data collection is finished.
 2. Discussion of newspaper versus online sources of ads
 - a. It does matter where you look for vacancies. When you start to categorize where vacancies are found, private practices are more likely to advertise in newspapers. Consider that newspaper advertising costs money, whereas online ads might be free (for example in professional association sites).

- b. Top five professions with highest vacancy differ depending on source of ad:

	Newspaper	Online
1 st	Physical Therapist	Physical Therapist
2 nd	Medical Assistant	Occupational Therapist
3 rd	Medical Laboratory Technician	Occupational Therapist Assistant
4 th	Occupational Therapist	Physical Therapist Assistant
5 th	Speech Language Pathologist	Speech Language Pathologist

3. De-duplication of data

- a. Same ad representing one vacancy may appear multiple times in time period of study. Online advertising can be seen as static. The same ad for one position may run several weeks. The same can be said of newspapers. Look at five criteria to determine if multiple ads or one static ad representing one vacant position:

Media source

Job title

Employer's name

City

Full time/Part time status

- b. If above criteria all the same, then code ads as one vacancy.
- c. Some in the audience pointed out that ads running continuously might still represent a number of positions. Agencies with high turnover rate (30-40%) tend to run ads continuously.
- d. The protocol above assumes that the job ad did not specify the number of positions being advertised. When multiple positions are advertised without specifically mentioning number, ad is coded for 2 positions. Banner ads (example, "Duke hires PTs) are not counted because do not represent a distinct vacancy.
- e. De-duplication affects certain professions more than others. EMT's tend to advertise online at association's website – same ad for the ten weeks. EMT's have a 78% chance of losing ads through de-duplication. In general, de-duplication resulted in an overall loss of 46% of ads.
- f. The impetus for de-duplication is that the goal is to count positions available, and not vacancy ads. In this manner can look at vacancy indices across professions.
(Vacancy Index = Positions/Total Number of Persons Employed)
- g. Summers has designed a database where many fields can be manipulated to get a better handle on vacant positions.
4. After combining data from both ad sources and after de-duplication, the ten most needed professions are:

Physical Therapist

Occupational Therapist

Physical Therapist Assistant

Medical Assistant

Speech Language Pathologist

Occupational Therapist Assistant

Respiratory Therapist

Medical Technician (Clarification on this profession was asked; is it Medical Laboratory Technician?)

Medical Laboratory Technologist

EMT- Paramedic

5. Sources of vacancy ads categorized after de-duplication:

Hospitals
 Staffing Agencies (difficult to trace location of positions;
 some positions may be for out-of-state)
 Private Practices
 Home Health Agencies
 Long-Term Care Facilities

6. Rank of geographic origin of open positions based on AHEC regions (once again, this is after de-duplication). Note that all these are higher than the NC index of 2.4/10,000 population. This is a good measure of where need is greatest.

Area L (4.4/10,000)
 Southern Regional
 Coastal
 Eastern

7. Analysis is nearly done, and work on Vacancy Report will start soon.

C. Federal and State legislative activity affecting Allied Health professions – Pat Porter

1. Both at the federal and state levels, the legislative bodies are in between sessions. However, just before the winter break, an extension to waive Medicaid Therapy Caps was passed. This means that Physical Therapists, Occupational Therapists, and Speech Language Pathologists can continue to receive Medicaid payments for services rendered without the limits imposed by the caps.
2. Go to www.ncleg.net to keep informed on progress of standing committees and commissions working on health related issues. Once the leadership of the houses is selected, these issues will come before the House committees. John Sexton, one of the panelists, left the Council's meeting early to attend a legislative body committee meeting on licensure and licensure changes for audiologists and hearing aid dispensing issues.
3. Heilig pointed out that the NC Register is now up and that the Occupational Therapy Licensing Board rules are there. She recommended that both Occupational Therapists and Physical Therapists investigate this site because there are some issues between these areas.
4. Bacon reported that UNC's Board of Governors included AHEC's request in the System's budget for next year. Within AHEC's request there is specific language that includes support for the Council. If AHEC receives new funding from the upcoming session of the Legislature, there will be more permanent funding for the Council. President Bowles is very supportive of AHEC, and it is just a matter of waiting to see what happens in this climate of tight financial conditions for the state.

D. Activities of the Executive Director – David Yoder

1. Heilig expressed much appreciation to Dr. Yoder for all his hard work in organizing and coordinating this morning's very informative panel discussion on clinical doctorates in allied health.
2. Allied Health Associations of North Carolina Booklet – the January, 2007 edition has been printed and is available for distribution. Twenty-nine professional associations are represented in the Booklet.
3. NGA Policy Academy – have been attending meetings as part of the Home Team. To inform the Council of the work being done by the Academy, have invited Roger Shackelford, Executive Director of the NC Commission on Workforce Development, to make a presentation on that Sector Strategy Initiative at the Council's next meeting on March 7th. A number of other Council members are part of the Home Team: Tom Bacon,

Pheon Beal, Alan Brown, Erin Fraher, Kathy Heilig, Laura Spivey, Stephen Thomas. A number of these Council members also belong to the Core Team: Pheon Beal, Erin Fraher, Kathy Heilig, Laura Spivey. The Core Team traveled to Minneapolis in November to continue work with the other states that are part of this Policy Academy.

4. Continue to work with the HealthCare Coalition and represent the Council at their meetings.
5. In early November, along with Lee McLean and Stephen Thomas attended the meeting of the Southern Allied Health Deans of Academic Health Centers in Charleston, SC. Presented Fraher workforce studies, and wants to inform the Council that these studies are used and quoted by the Deans and all member schools of the Association. Nationally, the workforce studies are well recognized and used as benchmark research.
6. Election of Council Officers in May – Heilig has appointed a nominating committee whose members are Karen Luken, Wayne Foster, and Ned Fowler. Chair and Vice-Chair are the two positions open; Alan Brown has volunteered to continue as Treasurer.
7. Symposium on June 15, 2007 at the Friday Center
 - a. As of now, the title is “*The Impact of the Allied Health Workforce on the Economic Development of North Carolina*”.
 - b. Taskforce working on program has met in December and will meet again immediately after the Council’s meeting today.
8. Yoder will be away from the Council’s office from Jan. 22nd to Jan. 31st.

V. Round Robin

A. Kim Jernigan – NC Community College Representative

To follow-up her description in the December meeting of the RFP for funds awarded by the General Assembly to the community college system, Kim distributed two hand-outs outlining the recipients of those grants. The first hand-out listed the recipients of the Allied Health Enhancement Grant, and the second hand-out the recipients of the Start-up Grants for new and innovative programs.

B. Tim Holmes, Allied Health Professional Representative for Group 2 (Rehabilitation Sciences)

Briefly discussed background of new licensing rules for Occupational Therapists; these rules now available on website. Also, mentioned optometry as a possible profession considering clinical doctorates.

C. Stephen Thomas, Dean of Allied Health Sciences School at ECU

Lee McLean will host the bi-annual meeting of the Southern Allied Health Deans of Academic Health Centers at UNC Chapel Hill in April. (To be an academic health center, an institution must have at least three professional schools.)

D. David Yoder, Executive Director

Lee McLean has been elected to the Board of the Association of Schools of Allied Health Professions. The Council congratulated Dr. McLean!

E. Erin Fraher, Director of the NC Health Professions Data System at the Sheps Center

Fraher announced that Occupational Therapists and Occupational Therapist Assistants are now represented in the health professions data system. Even though the Sheps Center had no additional resources to accomplish this, the OT Board was very well organized and helpful in providing the necessary data. Fraher and her group will now be able to use this new data to do more rigorous analysis of the allied health professions.

- F. Pheon Beal, Special Advisor to NC DHHS Secretary Hooker Odum on Workforce Development Issues
1. Thanked the Council for the invitation to become a member.
 2. Gave a quick review of her past positions (Director of Division of Social Services at the DHHS; worked on welfare reform before that).
 3. Expressed her interests in several areas: entry level jobs for individuals who lack the training and support to enter the health professions and is a firm believer in the role that community colleges play in this issue; diversity; workforce development in eastern NC.
 4. Voiced appreciation for the role of the community college system, AHEC.
 5. Expressed Secretary Hooker Odum's particular interest in filling positions in the public sector.

VI. Announcements

- A. Next Council meeting will be on Wednesday, March 7th, 2007 at the UNC General Administration Building Board Room. Roger Shackelford will be the main speaker.
- B. Last Council meeting of the school year will be on Wednesday, May 2nd, 2007 at the Friday Center. Association Presidents will have an opportunity to make short presentations.
- C. Friday, June 15th, 2007 – Save the Date! *“The Impact of the Allied Health Workforce on the Economic Development in NC”* Symposium at the Friday Center.

Meeting adjourned at 12:25 pm

In Attendance:

Members, Staff and Consultants:

Judi Ashbaugh	NC Dept. Health & Human Services; Office of Rural Health & Community Care
Thomas J. Bacon	Immediate Past Chair, Director, NC AHEC
Pheon Beal	Office of the Secretary of DHHS; Special Advisor for Workforce Development
Alan Brown	Treasurer, NC AHEC Program
Rebecca Bullock	Allied Health Professional Rep. – Group 3 – Diagnostic Sciences I
Samuel B. Clark	NC Health Care Facilities Representative
Amy Crisson	Allied Health Professional Rep. – Group 6 – Medical Sciences
Bill Croft	Allied Health Professional Rep. – Group 4 – Diagnostic Sciences II
Carolyn Cusic	NC Association for Home Care & Hospice
Wayne Foster	Allied Health Professional Association Rep. to the Executive Committee
Ned Fowler	NC Community College AH Programs
Erin Fraher	Allied Health Workforce Primary Investigator; Sheps Center for Health Services Research
Chastity Glover	NC Association of Health Care Recruiters
Diane Groff	Allied Health Professional Rep. – Group 1 – Counseling & Recreation Science
Elizabeth Haile	NC AHEC Allied Health Representative
Kathryn E. Heilig	Chair, NC Hospital Association
Tim Holmes	Allied Health Professional Rep. – Group 2, Rehabilitation Sciences
Kim Jernigan	NC Community Colleges
Karen Luken	Vice-Chair, NC Office on Disability and Health
Patrena Majette	NC Health Careers Access Program
Patricia Porter	Government Liaison
James Sadler	UNC System General Administration
Martha S. Taylor	Allied Health Professional Rep. – Group 5, Dental Sciences
Stephen Thomas	UNC System Allied Health Programs Representative
Edna Williams	NC State Education Assistance Authority
Lilly Topal	Assistant to the Council
David E. Yoder	Executive Director

Guests:

Tracey Bates	NC Dietetic Association, President
Sidette Boyce	Eastern AHEC
Faye Cobb	Winston-Salem State University School of Health Sciences, for Peggy Valentine
Dawn Grant	Eastern AHEC
Nancy Easterling	Carolinas Chapter – American Horticultural Therapy Association
Nedra Edwards-Hines	Northwest AHEC
Lee McLean	UNC Chapel Hill, Dept. of Allied Health Sciences
Brenda Mitchell	UNC-CH, Dept. of Allied Health Sciences; UNC AHEC Operations & Student Services Office
Jane Neese	For Karen Schmaling, UNC Charlotte College of Health & Human Services
Marge Ottofy	NC Society of Medical Assistants
Jan Overman	Forsyth Technical Community College
Nancy Porter	Gaston College Community College
Joshua F. Smith	NC Academy of Physician Assistants
Laura Spivey	NC Commission on Workforce Development
Phillip Summers	Cecil G. Sheps for Health Services Research, Graduate Assistant
Peggy Valentine	Dean, School of Health Sciences, Winston-Salem State University
Linda Yurko	Forsyth Tech CC; Director AH; Pres-Elect NC Society of Radiologic Technologists