Continuing Education Requirements to Maintain Occupational Therapy Licensure

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Different states use a variety of regulatory mechanisms to monitor the quality of practice in occupational therapy. The requirement for mandatory continuing education has been adopted by fewer than half of American states, but there is reason to predict that this trend will increase. This study investigates the patterns linking licensure to continuing education and recommends actions to ensure uniformity and accountability.

Literature Review

Licensure is a form of government regulation that grants persons permission to engage in a given occupation (U.S. Department of Health, Education, & Welfare, 1977). An applicant for licensure must provide proof that he or she has attained the minimal degree of competency required to ensure that the health, safety, and welfare of the public will be reasonably protected. Winston (1976) described licensing legislation as the natural outgrowth of a profession's internal standards and code of ethics. Licensing statutes set out the scope of practice by delineating services provided by practitioners. It is then illegal for unlicensed persons to perform services reserved for a particular profession.

AOTA endorsed licensure after realizing that third-party payers tended to restrict reimbursement to the services of licensed practitioners, that new state and federal laws favor licensed professions, and that licensure legally defines a profession and keeps it from being absorbed by other health professions (Johnson, 1975). Because of differences among the regulatory processes of states, AOTA provided guidance and support for each state association to research applicable state laws, acquire the support of other professions, and calculate the costs and political risks of attempting to secure licensure. For this reason, the wording of practice acts and the implementing regulations differ slightly among states.

Ostensibly, the primary goal of licensure is to protect consumers by providing high-quality service through qualified practitioners. However, critics claim that licensure decreases competition by limiting the supply of practitioners, which in turn increases costs and decreases access to certain health care services. Critics also point out that although licensure recognizes the legal right to practice, it is less successful in upholding quality of prac-
practice (Committee to Study the Role of Allied Health Personnel, 1989). This tension between recognizing the right to provide services and ensuring the quality of those services has been noted by leaders within the profession as well (Jones & Kirkland, 1984).

Continuing education is one way to increase and enhance a professional’s knowledge. The changing focus of occupational therapy’s attitude toward continuing education over the past two decades can be seen by comparing Resolution 300-71 (AOTA, 1971), which recommends specific continuing education requirements, with Resolution 540-79 (AOTA, 1979), which emphasizes the role of AOTA as a clearinghouse of information related to continuing education. Recently, attention has moved to issues surrounding the mechanisms for advanced competency recognition (Resolution 629-89, AOTA, 1989) rather than specific units of learning. Additionally, AOTA has remained committed to providing resources that enable professionals to obtain continuing education, including journals, workshops, conferences, and seminars. AOTA has maintained the stance that continuing education is a personal as well as a professional responsibility (Jones & Kirkland, 1984). As the number of states that mandate continuing education grows, the responsibility for continuing education has become less of a personal matter and more of a professional responsibility that is monitored by regulating bodies.

Although most health care professionals recognize the importance of continuing education, few write about it in their professional literature (Cook, Beery, Sauter, & DeVellis, 1987). Thus, knowledge of the procedural issues related to the administration of continuing education course work and the measurement of learning outcomes is not readily available to the average occupational therapy practitioner or to the members of the boards that regulate practice. Even the terminology regarding the measurement of continuing education experiences contains some hidden pitfalls. One example is the use of the term continuing education unit (CEU) in place of the more generic term continuing education (CE). CEU denotes that the particular unit of continuing education is being provided by an accredited institution of higher learning. Colleges and universities recognize uniform standards for the granting of CEUs, including the number of contact hours, the measurement of learning outcomes, and the maintenance of records. Guidelines regarding the CEU, recently revised by the Council on the Continuing Education Unit, have been adopted by the Commission on Colleges. The published guidelines address the areas of administration, instructional methodology, and program evaluation (Commission on Colleges of the Southern Association of Colleges and Schools, 1990). Thus, when CEUs are offered, learning occurs with the endorsement of the traditional educational system.

When education is not provided by an accredited college or university, the term CE may be substituted. Usually, CE providers must be recognized and approved by the designated regulatory body for a specific profession in each state. Nursing, for example, requires each provider of continuing education to register with the state board. The board maintains a list of organizations that provide approved educational experiences. Under such a system, AOTA as well as numerous other organizations could apply for recognition as a continuing education provider. If occupational therapists adopted this model, each state regulatory board would be free to determine the type and amount of education required as well as the specific requirements for approved providers.

Although this distinction in terminology seems a small matter, it should illustrate to the profession that the domain of continuing education has already been defined by other professions. Members of regulatory bodies as well as practitioners need to be informed about the existence of ground rules and prevailing trends. Mistakes could be costly. Placing the responsibility for approving CEs with the state regulatory boards may result in an administrative nightmare for the profession. If required continuing education is to be linked to proving increased competency, the boards of each state must carefully consider the form and purpose of such experiences. To assess the current climate regarding continuing education requirements, we completed a survey of licensure boards in May 1991. The purpose of this survey was to compile information about the continuing education required of occupational therapy personnel as a condition for maintaining licensure in the United States.

Method
A questionnaire was designed, reviewed by faculty members from the Division of Occupational Therapy, University of Alabama at Birmingham, and revised according to their feedback and recommendations. The survey consisted of 20 questions designed to quantify variables such as the following:

- Is continuing education required?
- How many years has practice in the state been regulated?
- What forms of continuing education are accepted?
- What amount of continuing education is required?
- What type of documentation is required?

A list of contact persons for the state regulatory boards was obtained from AOTA. The survey, along with a cover letter, was mailed to the regulatory boards of the 46 states that were licensed at the time of the study and to Puerto Rico. Of these areas, 41 have licensure laws, 2 have trademark laws, 2 have registration requirements, and 2 have certification requirements.

Of the 47 surveys sent out, 41 (87%) were returned. The responses concerning the number of occupational therapy programs located in the state were matched with
information from a national list of occupational therapy programs printed in the American Journal of Occupational Therapy (1990). The data were coded and analyzed with the SPSS/PC (1988). Statistical tests included frequency distributions and cross-tabulations.

Results

Of the 41 states that responded, 19 (46.3%) had continuing education requirements. Of those 19, all wrote the requirements into their rules and regulations manual, but 15 (79%) stated them in the text of the licensure bill itself. There was considerable variation in the number of years that practice in each state had been regulated, ranging from 1 to 23 years (M = 7.2 years).

Of the states that gave valid responses, 100% accept workshops, lectures, seminars, conferences, and college courses as continuing education. In-service presentations and publications are accepted by 94.7%, presentations by 83.3%, and correspondence courses by 66.7%. Research is accepted by 88.9%, clinical instructor time by 70.6%, and independent study time by 58.8%.

Because of discrepancies in the way that various boards account for the number of education units, information was translated into the number of contact hours required. The number of hours ranged from 8 to 36, showing little consistency among respondents. Two years is the standard period allotted for completion of the required number of hours; 13 (68%) of the respondents use this time frame. Other accepted time frames are 1 year and 3 years. Eleven (58%) of the respondents require the same number of hours for registered occupational therapists as for certified occupational therapy assistants: 8 (42%) require fewer units for the assistant.

Another area addressed by the survey was the frequency of submission and the forms of documentation accepted to demonstrate completing the required number of hours. Of those 19 states mandating continuing education, 14 (74%) require proof of completion of the required number of hours each time a person renews for a license (usually every 2 years). Five states, however, have adopted other strategies, including random audit, proof upon completion of a course or instructional unit, and submission upon request of the licensee board. Certificates are accepted by 100% of those states, roll sheet signatures by 73.3%, and letters from employers by 57.1%. Publication subscriptions and receipts are accepted by fewer than half of the respondents.

To determine whether a consistent pattern of continuing education requirements emerged in the states that had been regulated the longest, years of licensure, grouped into 5-year increments, was cross-tabulated with the presence of requirements. In states regulated 5 years or less, 7 required continuing education, 8 did not; in states regulated from 6 to 10 years, 5 required continuing education, 7 did not; and in states regulated for more than 10 years, 7 required continuing education and 7 did not.

To assess the effect that multiple education programs within a state might be having on continuing education, the number of baccalaureate occupational therapy programs in the state was cross-tabulated with the presence of continuing education requirements. In the 14 states that had more than one baccalaureate program, only 3 required continuing education in the state regulatory laws. However, in states that had a single program or none, 15 had some form of continuing education requirements, and 12 did not. Frequency data are reported because the chi-square values computed were found to be nonsignificant in all cases.

Discussion

The results of our study indicate that as of June 1991, fewer than half of the state regulatory bodies mandate continuing education as a condition for maintaining a license. This finding supports the contention that more attention is currently being paid to the qualifications of practitioners entering the profession than to the qualifications of those who continue to practice actively. Critics of the health professions are quick to point to this pattern when labeling licensure as more beneficial to the practitioner than to the consumer. In all fairness to occupational therapy, it could be argued that this pattern results because our profession is new to the licensure arena and is therefore in the early stages of developing measures of professional quality. However, no revealing link was found between the length of time that practitioners in a state had been licensed and the requirement for proof of continuing education. One might predict that such a pattern would emerge if newness were the strongest factor affecting development.

The problem encountered in coding the data for contact hours indicates a further difficulty within the profession. Specific regulatory boards seem to know little of the standardized measurement systems that are already in place (e.g., CEUs). For example, AOTA proposed that 10 contact hours should equal 1 education unit (Robertson & Martin, 1981). This ratio is endorsed by the Council on the Continuing Education Unit. However, these systems, though available, are not being followed uniformly by the regulatory boards surveyed. If multiple systems for measurement proliferate in the regulations of each state, it will be much more difficult to point to continuing education as proof of an underlying concern for quality practice.

Literature shows a trend among health care professions such as nursing, physical therapy, and medicine toward mandatory continuing education. The trend supports some proof of planned continuing education will be hard for the profession to avoid. Currently, it is unclear whether leadership in defining continuing education for
occupational therapy is internal or external to the profession itself. Our results suggest that the educational institutions within each state are not playing a leadership role in defining continuing education because there is an inverse relationship between the number of baccalaureate programs in a state and the presence of continuing education requirements in state regulatory laws. Perhaps the solution for these dilemmas will need to come from groups of regulatory boards working together.

The lack of the patterns that we predicted in regard to continuing education seems to indicate that the profession as a whole is still disorganized. Leadership in continuing education is not being demonstrated by the states that have been licensed longest, or by the educational communities within the states. The lack of a coherent pattern within the profession itself seems to increase the chances that the impetus for change will come from legislators or consumers rather than from leaders within the profession. Under pressure to preserve licensing, occupational therapists may be tempted to borrow educational and measurement strategies from other professions without carefully considering the underlying needs of the profession. Given the study results, it seems that occupational therapists have not yet forged a convincing link between recognition of professional status and commitment to the continuing professional advancement of the ever-growing number of practitioners.

Conclusions and Recommendations

The high rate of responses provided a solid database for the contention that there are no obvious patterns within the profession in regard to the development of continuing education requirements. This study points out a need for a universal system of measuring the type and amount of continuing education received. Our professional literature has acknowledged this need for more than 20 years. However, AOTA and the state regulatory boards have not adopted a uniform system of guidelines, even though, in our opinion, the initiation of a universal reporting system would be an advantage to the entire profession.

In addition to the concept of a universal reporting system, the other major issue surrounding continuing education is how soon requirements will become mandatory. Survival of our profession depends on our retaining and expanding our knowledge, skills, and expertise. Leadership in the continuing education arena is being exerted primarily by the members of specific state licensure boards. The literature indicates that one reason for this situation may be AOTA’s position that continuing education alone cannot ensure competency (Jones & Kirkland, 1984). On the other hand, if continuing education is not in itself a means for ensuring competency of professionals (Low, 1992), it should at least be valued as a vital means for allowing professionals to keep up with and implement current trends in an ever-changing health care system. ▲

References


