

# Appendix H: Continuing Education Needs Assessment Survey

July 18, 2000

Dear Colleague,

We are writing to you on behalf of the Workforce Development Committee of the Maine Turning Point project, a public health planning initiative convened by the Maine Center for Public Health and Medical Care Development in cooperation with the Maine Bureau of Health, the Continuing Health Education Program and other partners. Maine is one of 21 Turning Point projects funded by the Robert Wood Johnson Foundation to conduct a critical assessment of and plan improvements to the local public health infrastructure. We are writing to you because assessing the current landscape of continuing education opportunities is an essential part of this process.

The purpose of this brief survey is to help Maine Turning Point better understand the current availability and need for continuing education programs in Maine. With your help the survey will identify continuing education currently being provided and the context in which it is being delivered across the state. For the purposes of this survey, we define continuing health professions education as: a planned and structured learning activity with specific learning objectives designed for (physical and mental) health and/or associated social service workers, which is intended to enhance skills and to obtain/maintain professional licensure or certification by providing unitized documentation formatted as CEU/CMEs, contact hours, credits, certificates, or the like.

All information will be confidential. Your name and organization will not be linked with any given response in the survey. We will aggregate information from your survey with others to help provide an accurate picture of existing continuing education in Maine.

Thank you for taking the time to complete this survey. If you have any questions please contact one of us. A postage paid envelope is enclosed for your convenience. Thank you in advance for returning the survey by August 8.

Sincerely,

Kate Perkins  
Project Director  
Maine Turning Point

William Yerxa  
Executive Director  
Continuing Health Education Partnership, Inc.

# Maine Continuing Education Needs Assessment

Organizational Name: \_\_\_\_\_

1. Please indicate type of organization (Check All That Apply)

- |                                                       |                                               |
|-------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Professional Association     | <input type="checkbox"/> Hospital             |
| <input type="checkbox"/> Rural Health Center          | <input type="checkbox"/> Mental Health Center |
| <input type="checkbox"/> College/University           |                                               |
| <input type="checkbox"/> Other (Please Specify) _____ |                                               |

2. The organization is:

- Non Profit                       For Profit

3. In the last 12 months, has your organization provided continuing education for health and/or human services professionals?

- YES (Please Check Which Apply)(**Then proceed to Question 4**)
- |                                                          |
|----------------------------------------------------------|
| <input type="checkbox"/> Internal/Staff Only             |
| <input type="checkbox"/> Open to Staff of Other Agencies |
- NO (**Skip to Question 15, page 2**)

4. How is continuing education supported at your organization?

- Participants Pay a Fee                       Free of Charge for Participants
- Other (Please Specify) \_\_\_\_\_

5. What disciplines and/or job categories does your organization target for continuing education programs?

- |                                                 |                                                       |
|-------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Physicians             | <input type="checkbox"/> Nurses                       |
| <input type="checkbox"/> LPNs/NAs               | <input type="checkbox"/> Medical Technicians          |
| <input type="checkbox"/> Clinical Psychologists | <input type="checkbox"/> OTs                          |
| <input type="checkbox"/> PTs                    | <input type="checkbox"/> Administration               |
| <input type="checkbox"/> Social Workers         | <input type="checkbox"/> Other (Please Specify) _____ |
- \_\_\_\_\_

6. What is the format of continuing education program(s) you sponsor?

- |                                                       |                                                          |
|-------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Half/Full Day Workshops      | <input type="checkbox"/> Multi-Day Workshops/Conferences |
| <input type="checkbox"/> Breakfast/Lunch and Learn    | <input type="checkbox"/> Grand Rounds                    |
| <input type="checkbox"/> Film/Video                   | <input type="checkbox"/> Satellite Downlinks             |
| <input type="checkbox"/> PC/ Internet-Based           |                                                          |
| <input type="checkbox"/> Other (Please Specify) _____ |                                                          |

7. What are your standard measures of continuing education learning activity?

- Contact Hours                       Academic Credits
- CEU/CMEs                       Other (Please Specify) \_\_\_\_\_
- \_\_\_\_\_

8. Based on your standard measure(s) indicated, what is your *estimated* annual volume of training?

\_\_\_\_\_ Contact Hours (Annual Total)      Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_ Academic Credits (Annual Total) \_\_\_\_\_  
\_\_\_\_\_ CEU/CMEs (Annual Total) \_\_\_\_\_

9. If you utilize CEU/CME's, is your organization accredited as a CEU/CMU provider?

YES, (Please Specify By Whom-APA, MNA, AMA, ACCME, etc.) \_\_\_\_\_

NO

10. Does your organization receive dedicated or external funding for providing continuing education?

YES                       NO

11. Is continuing education part of your basic operational budget?

YES                       NO

12. Does your organization collaborate/cooperate with others in the provision of continuing education?

YES (Please Explain) \_\_\_\_\_

NO

13. How many staff does your organization have dedicated to planning/administration/evaluation of continuing education activities in approximate FTEs?  
(Please Specify) \_\_\_\_\_

14. Does your organization offer continuing education programs specifically in the area of Public Health?

YES                       NO

Please List Topics: \_\_\_\_\_

15. Is your organization, or are your staff, members of any regional or national groups whose purpose is to support continuing education in the health professions? (Please indicated "O" for organizational affiliation and/or "I" for individual membership)

YES                       NO                      Others (Specify)

\_\_\_\_\_ Alliance for Continuing Medical Education \_\_\_\_\_  
\_\_\_\_\_ Association for Continuing Higher Education \_\_\_\_\_  
\_\_\_\_\_ AAACE \_\_\_\_\_  
\_\_\_\_\_ Outreach Education Council for Critical Care \_\_\_\_\_  
\_\_\_\_\_ Accreditation Council for Continuing Medical Education \_\_\_\_\_

16. What type of continuing education program(s) would currently most benefit your organization's delivery of public health services and interaction with clients/customers and other public health officials?

17. Would your organization be interested in exploring a cooperative statewide listing for continuing education activities?

YES       NO

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Would your organization and/or employees benefit from continuing education training?

YES       NO

(Please Explain) \_\_\_\_\_  
\_\_\_\_\_

19. Contact Data:

Your Name: \_\_\_\_\_

Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Organizational Website (if applicable): \_\_\_\_\_

20. Would you like to receive the results of this survey?

YES       NO

21. Other organizations and/or training suppliers who should receive this survey:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

