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AHEC: A Model Adaptive Organization

AHEC: A Model Adaptive Organization

[Post 9/11/01]

By Jeffrey F. Butler, MA

Today we are told that our lives have changed forever. Nothing will be the same again. We live in a different world. We may have to restrict our freedom in order to be safe. We will have to adapt to significant changes in our familiar way of life.

Throughout our twenty-eight year history, AHEC has been an adaptive organization. We started as a program concerned exclusively with the mal-distribution of physicians between urban and rural areas and because that focus needed to be expanded we adapted our attention, to include other health professions and the diverse needs of communities. Our Federal funding has always been modest and time-limited. Because restrictive or limited funding is detrimental to sustained efforts we adapted our programs to leverage financial support from other sources.

We have adapted to changing technology for telemedicine and distance learning. We have adapted to changing definitions of health care access. As the demographics of our population change we adapt our health professions education programs to meet the needs of people with different language and culture on a community-by-community basis.

We are, in fact, so adaptive we frequently hear, "If you've seen one AHEC, you've seen one AHEC."

Is the adaptability of AHEC strength or weakness? Are we sufficiently clear about and committed to our broad mission that we can face challenges of the future in a cohesive and coordinated manner? If our adaptability is strength, could AHEC be a model adaptive organization?

AHEC: A Model Adaptive Organization

The Health Professions Education Partnerships Act of 1998 re-authorized the AHEC Program, re-stating its mission, "To enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community/academic partnerships." While the mission of AHEC has high value and relevance to the health of our nation, the real story is how our programs in diverse communities and relationships across the country have adapted and innovated to accomplish the National AHEC mission.

The last formal evaluation of the AHEC program conducted between 1988 and 1989 by the American Institute for Research identified and reported findings on "key program areas: providing outreach/access to educational opportunities; capacity building; brokerage, and management/implementation of demonstration programs and models.: The evaluation also described self-reported accomplishments in the following areas: "AHECs have increased access to health care services by teaming with delivery systems that reach the underserved…they have strengthened human service institutions by improving training opportunities and upgrading skills; they have strengthened human service institutions by improving training opportunities and upgrading skills; they have allowed once-isolated health science centers to connect more closely with their local communities; and they have allowed students and residents a chance to broaden their experiences by giving them an opportunity to explore options that weren't open to them earlier."

The question now is: how can we refine our adaptive characteristics and model those characteristics to meet the challenges of our changing world? This issue of the Bulletin will explore that question by focusing its inquiry and reporting on topics which have relevance to AHEC as an adaptive organization.

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AHEC

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Topics in This Issue

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The National Area Health Education Centers Bulletin

In his lead article for the topic 'Health Care Through Social Justice,' Mr. Pollack discusses our progress toward the social justice goal of universal health coverage. In helping to achieve health care for all, AHEC/HETC is involved in fundamental education and systems change.

Health Care Through Social Justice

By Ronald F. Pollack

Mr. Pollack is the Executive Director of Families USA, the national organization for health care consumers. Families USA seeks to ensure that everyone in the United States has access to high-quality, affordable health and long-term care.

Health care in the United States is one of the clearest indicators of how far we still need to travel on the road toward social justice. Depending on one's income, place of employment, and insurance status, America's health care system is either the best in the world or a dismal failure. On the one hand, the U.S. has pioneered some of the most impressive medical breakthroughs in the world and provides the highest-quality health care for those who can afford it. On the other hand, today there are approximately 41 million people without *any health care coverage* — more than the *cumulative* population of 23 states plus the District of Columbia — and there are tens of millions of others with very inadequate health coverage.

'As social justice and self-interest merge towards a common purpose, the opportunities to make progress improve and the will to act is strengthened.'

The people most afflicted with health coverage problems are typically those in families in which the breadwinner works in a low-wage job that provides no health care coverage. The problems experienced by those people and families are the combined result of failures in the private as well as the public sector. A brief analysis of those failures is illustrative.

Within the private sector, low-wage workers and their families are less likely to be offered health coverage through the workplace than are higher paid workers: over nine out of ten U.S. workers who earn more than $15 an hour are offered health insurance by their employer, whereas only half of those earning $7 an hour or less are offered such coverage. Even when coverage is offered, it is often too expensive for low-wage workers to purchase. On average, workers in low-wage firms are required to pay considerably more in premiums than are workers in high-wage firms. As a result, there is a huge health coverage gap between higher-paid and lower-paid working families.

Similarly, in the public sector, the health coverage safety net for many low-wage working people and families is more hole than webbing. For example, in 43 out of the 50 states, a non-parental adult – a person living alone or a childless couple – is ineligible for public health coverage, such as Medicaid, even if that adult is penniless. For adults who are parents, the median income eligibility standard for Medicaid among the 50 states is a meager 69 percent of the very low federal poverty line. Hence, many people – who work hard, play by the rules, and pay their taxes – have no place to turn to secure meaningful, affordable health coverage.

Because of these failures, tens of millions of people constantly confront unconscionable choices: either they forgo and delay needed health care or they seek such care at the risk of impoverishing themselves. Those who choose the first option are at risk of seeing a health condition worsen – often with tragic results. Those who select the second option are among the families who have made unaffordable health care costs the top reason for bankruptcies in our nation.

Unfortunately, without a national commitment and effective action to ensure health care

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Health Care Through Social Justice

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coverage for everyone, the situation is likely to get worse. As the economy deteriorates and more and more people become unemployed, the number of uninsured Americans will undoubtedly increase. Indeed, a recent Families USA analysis shows that, in the year 2001 alone, 2.2 million Americans became uninsured as a result of job layoffs. Moreover, as health care costs climb again, partially fueled by skyrocketing prescription drug costs, and as employers pass on increased health costs to their workers, the ranks of the uninsured will grow significantly.

Clearly we as a nation can do much better. As the richest country in world history, it offends any reasonable notion of social justice that we are the only nation in the industrialized world that fails to provide health coverage for all its residents. Our failures in this respect belie our nation's values of fair play.

Fortunately, there are two recent signs that should give us hope that we will soon travel down the road to social justice in health care coverage. First, as the economy weakened in 2001, more and more people began to realize that they are at risk of losing health coverage; currently insured working families, for example, now understand that they are just one "pink slip" away from becoming uninsured. As a result, the quest to secure health coverage for everyone is becoming not simply a social justice issue but a concern that promotes self-interest. As social justice and self-interest merge towards a common purpose, the opportunities to make progress improve and the will to act is strengthened.

Second, a dozen major health interest groups — which traditionally have been on opposite sides of major health policy issues and which span the ideological spectrum — have come together to promote increased health coverage. These "strange bedfellow" organizations include: the U.S. Chamber of Commerce, the AFL-CIO, the Business Roundtable, the Service Employees International Union, the American Medical Association, the American Nurses Association, the American Hospital Association, the Federation of American Hospitals, the Catholic Health Association, the American Association of Retired Persons (AARP), the Health Insurance Association of America, and Families USA. The fact that these very diverse and often conflicting organizations are prepared to promote health coverage expansions for the uninsured augurs well for the future.

If these disparate groups can work together toward the social justice goal of health coverage for everyone, people from all walks of life should be able to do likewise. We certainly should be able to galvanize the good will of the American people to achieve this long-awaited goal. And, if we succeed, it hopefully will inspire our nation to take meaningful steps on other key social justice issues as well.

Colorado AHEC

The Capstone Project:

Social Justice and Activism in Health Care

By Susan Hagedorn, RN, PhD, PNP, WHNP

Social justice is at the heart of health and health care, particularly in care of underserved urban and rural populations. Social justice and responsibility is defined as a, "… practice competency characterized by awareness of the multifactorial dimensions influencing the health of individuals, communities and societies and commitment to accessible and socioculturally acceptable quality health care for all" (UCHSC, 1997). The statement reflects the important role of health providers as social change leaders, concerned for the increasing income and rights disparities and integration of social justice into health care. It is caring, connection, commitment, making a difference, and making meaning of health and illness that inspire individuals to become health care providers. It is those same values and objectives that turn health care into social justice work.

Social justice theory and practice is an essential component of education as well as health care. John Dewey defined school as "…a genuine form of active community life, instead of a

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Dr. Hagedorn is an Assistant Professor at the University of Colorado School of Nursing. She is involved in creating numerous programs that benefit the underserved, including the homeless, battered women and children and youth at risk.

The Capstone Project

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place set apart to learn lessons." This integration of community life and education provides the opportunity for health care education to be emancipatory for both patients and healthcare providers. Through reflection and action addressing the core causes of dis/ease, health care providers become agents of social change. This emancipatory education adds responsibility and reflection to the science and caring taught in our health care education programs.

Poverty and social inequalities are significant determinants of poor health. It has been shown that there is a strong relationship between poverty and higher mortality and morbidity, and even more so when there is a large disparity in incomes, as in the U.S. (McCally et al, 1997). Conversely, societies with more social engagement and trust among community members, known as social capital, have better health indicators (Kawachi et al, 1997).

Health indicators in the United States are dramatically less favorable than those of other industrialized nations. More than 40 million individuals, including 9.2 million children in 2000, are without health insurance. Uninsured children are more than three times more likely to lack regular primary health care and more than four times as likely to delay health care because of cost. Almost six million of these uninsured children are in families with incomes below 200 percent of the federal poverty level (Children's Defense Fund, 2002).

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Colorado's Capstone Project

The University of Colorado Health Sciences Center School of Nursing's Capstone Project is a service learning project required of every UCHSC SON graduate.

Since the advent of the Capstone Project in 2000, more than 300 students have provided more than 5,000 hours of community service to at least 3,000 individuals being served by more than 50 community agencies. Students doing AHEC-sponsored rural and urban rotations have participated simultaneously in service-learning with agencies in rural and urban medically-underserved communities. Students have been mentored by a health professional in a rural community while working on Saturdays in the local church's food pantry. While providing this community service, students, in online study groups, reflect on inequities apparent in their experiences in health care.

Students tell troubling stories of patients of minority cultures being marginalized or even mistreated in some health care institutions and communities. They speak of the frustrations and effects on patients of lack of access to care, particularly related to specialty care and care in rural areas. Language barriers spark passionate debates about the acceptability and effects of monolingualism in many of our institutions, while speaking up for patient autonomy. Capstone students learn to understand and respect differences, as well as comprehend the privileged role of many health care providers. They learn, and are supported by their peers and faculty, when they stand up for patients without a voice.

Capstone students experience the dialectic that exists between the ethics of justice and ethics of care, i.e., confronting the politics of health care access for all and patient autonomy, while practicing hands-on caring and commitment, within a social, economic, and cultural context, of individuals, families or communities (Botes, 2000). Capstone students, too, learn through responsibility and reflection the role of empowerment in healthcare. Empowerment is the personal and collective understanding of the systematic causes of oppression, recognition of the desire and belief that personal and social transformation is possible and the goal towards which health care providers strive, while activism is a passionate approach to everyday activities which is committed to seeking a more just social order through the provocation, transformation and rebalancing of power (Hagedorn, 1995). Implicit in the role of the health practitioner, researcher and administrator are empowerment and activism.

The Capstone Project

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Confronted with the negative relationship between poverty and health, the University of Colorado Health Sciences Center School of Nursing (UCHSC SON) has formed a partnership with AHEC to integrate social justice issues throughout the curriculum and particularly through The Capstone Project. This service learning project is required of every UCHSC SON graduate *(see related article on preceding page).*

There are many ways, in addition to courses such as The Capstone Project, to integrate social justice into health care practice. The experience of both providing health care and social justice through community service enlivens the experience of community for students. The student learns important lessons related to barriers to health care and social services, risks related to poverty and the importance of community in resolving these and other issues. We practice social justice in rural and urban medically-underserved communities that provide culturally competent health care, where we readily offer interpreter services to our non-English speaking patients. Social justice is apparent in communities to address access issues, bring culturally acceptable care to the community rather than expecting the community to come to the hospitals. Health care students practice social justice when they struggle with care stratified for different classes of individuals. Health care administrators practice social justice when they listen to their communities and design systems that respond to community needs.

'It is caring, connection, commitment, making a difference, and making meaning of health and illness that inspire individuals to become health care providers. It is those same values and objectives that turn health care into social justice work.'

Health providers have a social responsibility to take action against social inequities that negatively impact health. [Health providers] can help improve population health by addressing poverty in their roles as clinicians, educators, research scientists and participants in policymaking" (McCally et al, 1997, 727). AHEC students and preceptors, as well as community agencies and residents, appreciate the opportunities offered by students in more than 50 communities combining health provision with community-based social justice projects. An interdisciplinary approach is needed to ensure equity in health care, environmental health and effective ethical decision-making. Therefore, social justice, empowerment and activism are at the heart of healthcare and imply an obligation for health practitioners to facilitate change that contributes to their patients' health.

Acknowledgments

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Massachusetts Statewide AHEC

Health Access Networks:

Advancing Social Justice 'From the Ground Up'

By Michael DeChiara, Tom Wolff, and Ellen Unruh

Dr. Wolff is Director, Mr. DeChaira is Director of Access Programs, and Ms. Unruh is Health Access Networks Coordinator at AHEC/ Community Partners in Amherst, Massachusetts.

The Massachusetts Statewide AHEC system and the University of Massachusetts Medical School through its Office of Community Programs are committed to incorporating both an awareness of social justice issues and the tools to address them through their health access programming. To this end, they established the MassHealth Access Program (MAP) to provide enhanced health care services to Medicaid (MassHealth) recipients throughout the state. The program includes both traditional AHEC expertise in workforce and education with programming that draws from community and field-based observations and lessons learned. All MAP programs work closely with the state Medicaid agency, AHEC offices within Massachusetts and a broad range of other stakeholders - hospitals, community health centers and community groups.

The most significant program promoting social justice is the Health Access Networks (HAN), created in 1998 in response to state agency initiatives to expand enrollment into publicly funded health insurance, such as Medicaid. In 1998, the Massachusetts Medicaid and Public Health agencies, with the support and urging of community groups and advocates, joined forces to issue health access mini-grants to community-based organizations working on health care outreach and enrollment. These mini-grants were distributed across the state in order to enroll a broad range of communities, representing a diversity of ethnic/cultural/racial groups. The mini-grants were managed in part by the MAP/ AHEC program and served as the fundamental building block for subsequent developments in increasing health care access in the state.

Health Access Networks are coordinated by AHEC/Community Partners as part of the broader MAP initiative. The Networks were created with the goal of ensuring that the mini-grant process would lead to changes in the way health access initiatives were implemented and systems change created. AHEC/Community Partners realized that the traditional grant relationship preserves the roles of state bureaucracy as funder and the community programs as funded program recipient, with neither party fully understanding nor respecting the needs and perspective of the other, nor seeking ways of working together. Health Access Networks, however, was designed to change this relationship; they have successfully established new ways of doing business with significant social justice implications.

Program Structure and Goals

The four specific HAN program goals are described below. By structuring HAN to meet these goals, the program was able to create successful mechanisms for bringing people together for increased collaboration.

Exchanging Information

HAN meetings engage all participants to share information. State agency representatives bring program and policy updates; advocates provide the broader context; and community groups report on what they are seeing at the grassroots level. By sharing this information on a regular basis and making it available to all who attend meetings or read the meeting minutes, the playing field is leveled and people have an increased sense of involvement.

Sharing Best Practices

HAN strives to promote sharing in a safe and respected setting with honest presentations. Community groups are encouraged to share recent efforts regarding outreach and enrollment, understanding that every community is differ-

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True Collaboration

HAN meetings create a strong foundation for collaboration. It is important at this point to reflect on the difference between collaboration and simple networking.

True collaboration, according to Arthur Himmelman (2001), is "a voluntary, strategic alliance of public, private and nonprofit organizations to enhance each other's capacity to achieve a common purpose by sharing risks, responsibilities, resources and rewards." By its very nature, collaboration can be a strong indicator of positive social change.

ent. What failed for one program may be "borrowed" by another and be a wild success. With clear modeling and support by the MAP/AHEC facilitators, community groups share openly, rather than simply presenting their successes. HANs have worked to highlight and disseminate these best practices, thereby establishing a validation of "ground up" expertise that can inform larger, statewide systems.

Building Linkages and Relationships

HANs meet monthly and create opportunities for people to go beyond stereotypes and learn more about the people who do "other jobs." Over coffee before the meeting or through exchanges during regular meeting segments, people come to understand and respect each other. State worker, community worker and advocate turn out to be closer than they might have expected in their concerns and their commitment.

Making Policies, Practices and Programs More Effective

Through HAN meetings, lessons and observations from the field can be voiced, respected and documented. The knowledge and understanding of front-line workers begin the powerful process of sending information "up the ladder" to policymakers. This is the beginning of an important feedback loop. Over the past few years, HANs have demonstrated the importance of field-based observations and their ability, once acknowledged and validated by state government, to affect significant systems change, resulting in improved program implementation and outcomes.

Similarly, the meetings also provide effective and vital pathways for government agencies seeking to engage the grassroots. HAN meetings provide forums where government representatives can engage community groups, to provide information or solicit ideas and comments. Increasingly, governmental bodies are using HAN meetings for interactive purposes.

Neutral Facilitation of Process

The final piece of the equation is that MAP/AHEC serves as a liaison between the state government and the communities during periods between meetings. Representatives of MAP/AHEC are in constant communication with higher-level representatives of the state agencies and with the broad range of community organizations. MAP/AHEC staff members help coordinate efforts to distribute information and coordinate trainings for community organizations on behalf of the state agencies.

Conclusion

The meaning of social justice includes not only an equality of services and means, but also an equality of voice and representation. HANS serve uplift and validate the community perspective: the voices and observations of community health care workers and others in the field. These front line people play a crucial role in the Health Access Networks, in the process of enrolling the uninsured and in informing system change around programs and policies. Including their expertise, observations, and varied perspectives has created a sincere appreciation by state government, and has instigated significant changes in programs and policies. Informing statewide implementation of health access from the ground up one crucial step toward social justice.

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Qualitative Change

Examples of changes in policies, programs, and practices that have resulted from the HAN include:

- An evolution in the Medicaid agency's overall approach to outreach, with the emphasis shifting from glossy, high-end marketing to on-the-ground local community initiatives and follow-up.
- The state agencies' eventual understanding of the need not for just community-based outreach, but also personalized enrollment assistance and follow-up with Medicaid applicants.
- Direct incorporation by state agencies of rich community feedback into a variety of health insurance programs. For example, fine-tuning the messages to be more relevant for different cultures or audiences and distributing materials in multiple languages.
- The creation of a strong foundation of community-generated best practices that have served as a resource both within and beyond Massachusetts.

The result is a transformed health access landscape in Massachusetts. The fundamental change involves the dynamics between state government and community groups.

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Collaboration is ultimately about building relationships that allow us to work together. Collaboration can be as simple as a sales or service contract between two individuals (one to purchaser, the other the provider) or as complex as a merger between multi-national organizations.

In her lead article for this topic Elizabeth Rink looks at collaboration in the context of public health.

Strengthening Patterns of Collaboration

By Elizabeth Rink, LCSW

Ms. Rink is the Health Promotion Disease Prevention Program Manager at the Benton County Health Department in Corvallis, Oregon. She is currently a doctoral student in the Department of Public Health at Oregon State University and a Health Partners Fellow with the Kellogg Foundation and the University of Illinois at Chicago School of Public Health.

Dr. Tricker is an Associate Professor in the Department of Public Health at Oregon State University.

Collaboration among individuals, organizations and constituencies is becoming essential in order to serve diverse populations and communities within a health system that is continually changing and becoming increasingly competitive for resources. Collaborations are defined as individuals from diverse backgrounds and organizations working together in a mutually beneficial way to constructively address a complex health issue by sharing responsibility, authority, and accountability for achieving results. They create a shared vision and joint strategies to address health concerns that go beyond the agenda of the members of a particular group (Rowitz, 2001).

The benefits of collaboration are many. According to Arthur Himmelman, collaborators "enhance each others capacity to achieve a common purpose by sharing risks, responsibilities, resources and rewards (Himmelman 2001). Through the collaborative process, citizens and organizations develop a unique kind of civic culture that makes their agencies, communities and regions stronger and more effective.

Collaborations are complex, at times frustrating, and, particularly in the early stages of development, time-consuming. The art of collaboration is not always easy to master. These arrangements are fraught with challenges such as turf issues, competition for funds and cultural

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The First Steps

The context in which a collaboration is formed is essential to its effectiveness. Before beginning, collaborators should:

- Understand the challenges of leadership such as who will lead and what the best leadership style is to facilitate the success
- Identify the relevant community or target population that is experiencing the identified problem or issue,
- Assess the extent to which each stakeholder will participate in the collaboration and what that participation will look like,
- Evaluate the community's capacity for change and how receptive the community is to addressing the identified problem or issue, and
- Determine where the identified problem or issue can be most effectively addressed.

Strengthening Patterns of Collaboration *(Continued)*

differences among organizations. They require a thorough understanding of the process as well as a unique set of leadership skills.

Collaborative leadership does not always come naturally to those health professionals who find themselves "at the table" with a diverse group of individuals who represent a variety of interests. It demands a unique set of skills that includes above all a commitment to improve a shared situation based on values, beliefs, and a common vision. The leadership must communicate this shared vision both verbally and behaviorally. Simply said, collaborative leaders must "walk their talk." It requires the ability to persuade individuals to conduct themselves within the established ground rules of the collaboration so that its members treat each other with mutual respect, trust and accountability. This type of leadership educates others on the collaborative process and the challenges of and strategies for community organizing, encourages people to share their ideas, identifies individual strengths and draws on these strengths, and acknowledges individual contributions. It also requires problem-solving skills and an ability to facilitate group discussion that results in agreed upon actions by the collaboration (Himmelman, 1991).

To foster and maintain collaborations at local, state and federal levels requires a thorough understanding of what collaborations are, how they are established and function as well as a strong commitment to the process. Training and nurturing collaborative leaders is a vital component of the success of collaborations, for well-prepared, strong and erudite leaders can lead people toward change. It is through learning and mastering the art of collaboration and the skills of collaborative leadership that health systems can and will be strengthened.

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Guidelines for Effective Collaboration

- *Involve all key players* so that collaborative decisions and activities will receive widespread support and recognition.
- Ensure that the collaborative's *leadership* is visionary, is willing to take risks, and facilitates change rather than directs it.
- Establish a *shared vision* of how the collaborative should progress and of the *expected outcomes* for children and families served by the collaborative partners.
- Build *ownership at all levels.* Commitment to change must be mobilized at all organizational levels of member agencies and among community members involved in the collaborative.
- Establish *communication and decision-making processes* that accept disagreement among actors as part of the process and establish ways to address conflict constructively.
- Institutionalize change by encouraging member agencies to include *collaborative goals* in their own institutional mandates and by *earmarking funds* to carry out collaborative activities.

Finally - and perhaps most important - remember that change begins with individuals, not institutions. It is essential that *agency representatives be allowed to take the necessary time from routine responsibilities to meet and interact with one another* so that trust and respect on an individual level can be generated. Personal interactions across agencies nurture trusting relationships that will sustain the growing pains naturally associated with systemic change.

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District of Columbia AHEC

Alliances and Partnerships:

Urban Academic Health Centers and AHEC

The District of Columbia AHEC Program (DC AHEC) is a unique partnership, first funded in 1998, of four academic institutions: Georgetown, Howard, George Washington and Catholic Universities, and various non-profit agencies, along with the local Primary Care Association, which serves as the AHEC host organization.

By Lisa Alexander

The earliest iteration of the DC AHEC was a loosely formed group called the "Primary Care Roundtable" established in 1995. In these early days, those who participated in the Roundtable were unaware of the AHEC model. The group consisted of academic and community-based primary care clinicians, drawn from the city's community health centers and publicly funded primary care clinics, whose goal was to enhance primary care training opportunities and increase access to primary care services throughout the city's safety-net clinics.

The group's common goal and shared vision facilitated the collaboration, but did not guarantee its success. Since this was a loosely structured collaborative, there were few barriers to dialog and mission setting. This collaborative evolved over time into the nascent Primary Care Association (PCA). Thus developed the PCA's unique ability to successfully bring together groups that, despite their common interest in primary care, had little connection with one another. The charge to the PCA's Health Professions Committee included evaluation of the AHEC model and the suitability of such a model for the District of Columbia. After becoming aware of the existence of the AHEC model and establishing its appropriateness for achieving their goal, the group began writing an AHEC grant application in November 1997.

Brother Charles McElroy, Director of Development for the Spanish Catholic Health Center, was the driving force behind the initial AHEC application. Members of the group committed countless hours to the grant-writing effort, during which ground rules and group norms were developed that ensured equitable input from all stakeholders. Everyone was held accountable for his or her work-products and submissions to the grant-writing process. Incentives to participate in the process included the deterioration of primary care services at the city's public clinics, the rising number of uninsured patients seeking to access the safety net clinics, and the escalation in the number of clinical placements sought by academic training programs in community-based ambulatory settings.

Shared challenges helped sustain the group through some difficult times. One such challenge involved empowerment and trust building. For years, the "town vs. gown" conflict had festered, as it does in many communities with community-based clinics and academic health centers. Until assurances were given about specific financial issues that directly impacted the community clinics, the AHEC proposal was in jeopardy. Looking back, this was a defining moment for the group as it demonstrated not only a clarification of the "threshold" for the clinics, but also resulted in a significant level of empowerment for the clinic directors. The decision was made to directly fund clinic enhancement and student training through the AHEC with no intermediation by the university partners. This hurdle, once crossed, facilitated a new era of trust and openness between the clinics and the academic health centers. It also became the foundation upon which the AHEC collaborative was built.

Shared power, along with a shared mission, increases any collaborative's chance of success. The four academic health centers, along with numerous safety net and public health clinics, are equal partners in the AHEC and continue to actively support the AHEC as it approaches the end of the third year.

A new dawn has arrived in the District of Columbia. Recent changes in the city's political landscape have fostered a renewed sense of hope and optimism. The establishment of the DC AHEC during such a promising time in the city's history gives an added bonus of motivation to the AHEC partners.

Ms. Alexander is Director of the District of Columbia AHEC Program in Washington, DC.

The Florida AHEC Network

Statewide Collaboration:

Success is Built on a Foundation of Trust and Respect

The Florida AHEC Network (the Network) is a unique blend of individuals and organizations committed to the core principles of AHEC. The leadership structure of the Network is a model of statewide collaboration and teamwork between allopathic and osteopathic medical schools, between public and private institutions, between federal and state funding sources and between rural and urban populations. The Network is a partnership between the Florida Department of Health (DOH) and the state's four independent AHEC programs at the medical schools of Nova Southeastern University (NSE), the University of Miami (UM), the University of Florida (UF), and the University of South Florida (USF). Community and academic partnerships are developed through ten regional AHEC centers serving the 67 counties of the state. Together, the ten centers, four program offices and the DOH form the basis of the Florida AHEC Network.

The Network began evolving during the mid-1980s when the state's first two AHEC programs were established in the private medical schools of NSE and UM. NSE, the state's only osteopathic medical school, served a predominantly rural area in central Florida, while UM served a more urban-based population with vast underserved areas. Although each was established independently, the leaders of these two AHEC programs shared a vision of developing a sustainable statewide AHEC network that would be successful beyond decremental federal funding through state funding from the Florida legislature.

The legislature recognized AHEC's potential and appropriated funds to support the fledgling two-program network and to establish a Medically Indigent Demonstration Project (MIDP), heavily based upon the principles of AHEC. The legislature also mandated the development of AHEC programs at each of the two state-funded medical schools and directed the partitioning of the state into AHEC service areas with each medical school coordinating the recruitment, training, and retention of health

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Key Design Features Critical to the Florida AHEC Network's Success:

♦ **Consensus-Based Decision Making:** From its inception, the Program Directors recognized the importance of the Network presenting a unified message to state legislators in terms of budget requests and issue advocacy. The Network's success, hinged upon the ability of its leaders to reach common ground through a process of consensus and compromise rather than by majority vote or executive rule. Regional interests would be replaced by that deemed in the Network's best interests.

♦ **Rotating Presidency:** The leadership of the Network is designed to rotate annually among the program offices. This encourages shared responsibility among the Program Directors and assures leadership from all regions of the state. With the presidency comes responsibility for coordinating Program Director meetings, statewide network meetings and regular conference calls. The locations of Network meetings shift with the presidency, which allows exposure of all AHEC members to the vastly different regions of the state.

♦ **Statewide AHEC Network Budget:** Each AHEC Program agreed to contribute to activities common to the Network. This decision to pool resources for the common advantage of all programs and to equitably divide funding between the programs also assures that each program will rise (or fall) together.

♦ **Statewide AHEC Network Committees:** Collaboration between program offices and centers is achieved through semi-annual statewide meetings. Representatives from all centers and program offices have agreed to participate on committees which use the Network structure to successfully tackle activities individual programs or centers would be unable to undertake. This has resulted in the Network being awarded significant health initiatives from state and private sources.

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professions' students and practitioners within its area. This decentralized approach allowed each program to tailor services to the needs of its region while still coordinating activities at the network level.

UF, the state's largest public medical school, received a portion of MIDP funds and, in 1990, subsequently developed an AHEC program serving the largely rural north Florida area. In 1993, US F received initial state AHEC funding, and established a program to serve the remaining west central portion of the state. Thus, the Network's foundation was set.

The real key to the success of the Network, however, rests not so much in these tangible design features but is due to an underlying foundation of trust and respect. Many Network decisions have required much debate, struggle and soul-searching. Even when things are at their most contentious the leadership views the survival of the Network as paramount and balances the best interests of the Network with the interests of the individual institutions.

Southeastern Massachusetts AHEC

Building Effective Coalitions:

Developing the Institute for Cross Cultural Competence

By Patricia A. Mc Partland, Ed D CHES

The importance of cultural competency as an essential skill for today's health care workforce has been clearly established in recent years. Utilizing a unique set of collaborative approaches that included a blend of applied commercial marketing approaches coupled with grassroots, collaborative, multicultural, and multiorganizational communication efforts, the Southeastern Massachusetts AHEC, Inc. (SMAHEC) developed the award-winning Institute for Cross Cultural Competence and the Medical Interpreter Training Program in 1994 and 1996 respectively. .

Dr. Mc Partland is Executive Director of the Southeastern Massachusetts AHEC in Marion and Program Director and Founder of the Institute for Cross-Cultural Competence.

The Institute's goal is to implement cross-cultural training programs for health and human service providers throughout Southeastern Massachusetts. The goal of the Medical Interpreter training program is to prepare students according to the Massachusetts Medical Interpreter Standards of Practice to promote uniformity across the state and to foster the development of quality medical interpreter services in hospitals, health centers and other health care agencies. Students receive three college credits when they successfully complete the 54-hour program. A wide range of organizations participated in the development of these programs.

The first graduating class of the Medical Interpreter Training Program at Cape Cod.

The Office of Community Programs at the University of Massachusetts Medical School, Central Mass AHEC/Language Link and the Merrimack Valley AHEC developed the curriculum. The Division of Medical Assistance/ Massachusetts Health Access Program funded the training. SMAHEC managed the project including hiring the instructor and lecturers, developing marketing material, recruiting the students, obtaining support from local organizations, conducting outreach activities to providers/stakeholders, implementing the training and conducting program evaluation.

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Southeastern Massachusetts AHEC

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Many agencies, hospitals and academic institutions assisted with financial support, organization of regional meetings, format design and identification of speakers, as well as marketing of the Institute.

This approach allowed SMAHEC to offer programming at minimal cost, thus employees from institutions with small training staffs and serious budget constraints could receive diversity training. Furthermore, the range of programs was wider than most organizations could implement on their own.

SMAHEC faced several barriers, including the assumption "It cannot be done." Some organizations were in competition with each other. At the same time, a few representatives were fearful of losing autonomy and were distrustful of sharing with their perceived competitors. Still others wanted total control of the programs. SMAHEC's neutrality was particularly helpful in bringing together several diverse organizations.

'. . .coalition building takes work and skill, but is well worth the effort . . . Once organizations join with a common purpose, much can be achieved.'

It took trust among the various organizational partners to build the Institute and the Medical Interpreter Training Program. Staff members communicate openly with constituents and deliver what they promise. Trust is further fostered by an open organizational process. SMAHEC obtains input regarding all aspects of program design, including needs assessment, program development, implementation and evaluation from various cultural groups. Forming multicultural coalitions and committees facilitates this input.

SMAHEC overcame the assumption that "it cannot be done" by identifying areas of interest between its own organizational goals and the goals of committee members and constituents. After establishing that there was mutual advantage to the organizations to pursue the project together it was easier for SMAHEC to seek commitment from each participating organization by negotiating specific roles.

To reduce turf issues, SMAHEC identified incentives for cooperation. During the early years of the Institute, participating organizations became eligible for SMAHEC grants, provided they developed a strong proposal and executed a sound program. This proved to be not only a valuable incentive but also an important vehicle for innovative programming. The incentives for participation were strong for the community colleges. As a result of SMAHEC involvement, both Cape Cod Community College and Bristol Community College were able to implement Medical Interpreter Training on their campus and to retain the tuition from these programs.

Members developed a sharing attitude once they were convinced that they had more to gain through collaboration. For example, many of the medical interpreter training students received scholarships because of the financial support of many organizations. In addition, the Community Benefits Advisory Council of Cape Cod Healthcare provided funding for eight students in the class and in return, those students each reimburse Cape Cod Healthcare with twelve hours of medical interpretation services upon receiving their certification. Demonstrating the importance of collaboration and sharing must be an ongoing process, since new members constantly join the committee, while long-time members sometimes relapse into old behavior patterns.

SMAHEC prevents "burning out" the membership by holding meetings only when necessary. Its board meets on a quarterly basis while its program development committee often holds teleconferences. Since staff plays a key role in promoting either cooperation or competition, SMAHEC hired personnel who believe in collaboration, know how to work with groups and have management skills. This is essential because staff do most of the actual work, such as organizing meetings, developing programs and writing grants. Volunteers often quickly lose interest in performing these responsibilities.

In summary, coalition building takes work and skill, but is well worth the effort as evidenced by the development of the Institute for Cross-Cultural Competence and the two Medical Interpreter Training Programs. Once organizations join with a common purpose, much can be achieved.

South Carolina AHEC

Partners Health Initiative:

Providing Basic Tools for Better Home Health Care

By Kathryn Smith

Partners for a Healthy Community, a nonprofit organization based in Anderson, South Carolina, has saved a four-county region more than $21 million in health care expenditures with an investment of less than $4 million.

Its Partners Health Initiative (PHI), which provides every family the basic tools to take better care of their health at home, is modeled on a 1996-99 program in Boise, Idaho.

PHI sent a copy of a self-care book, the *Healthwise Handbook,* to 146,000 homes in South Carolina and Georgia in 1999. The book is a guide to 180 common health problems, explaining how to care for them at home and when to go to a doctor or emergency room. In addition, a 24/7 nurse call line, *Nursewise Line*, was implemented and dozens of consumer workshops were held to spread the word about self-care.

Ms. Smith is Communications Coordinator at Partners for a Healthy Community and handled the marketing of the Partners Health Initiative.

The project was underwritten by 29 sponsors, the major one being the local hospital, Anderson Area Medical Center (AnMed Health). Three smaller competing hospitals in adjoining counties were also sponsors, contributing money, staff time and lending credibility in their communities. Business sponsors included four banks and an electric cooperative, that helped advertise the initiative to customers with stuffers in their statements. The state employee insurance plan was a major financial partner and played a crucial role in providing raw utilization data for evaluation. All participants were recognized in prominent advertisements run in their local papers and had their logos on the back cover of the books.

A staff of three manages this initiative by involving health care professionals, educators and volunteers at AnMed Health and the other hospitals, health departments, schools, social service agencies, businesses and private physicians to reinforce use of the books and to distribute copies to newcomers.

Key players in the PHI included Jay Buehler, MD, director of the AnMed Family Practice Center and chairman of the state AHEC Council, and Don Peace, director of the AnMed HETC and national Vice Chairman of the HETC Constituency Group of the National AHEC Organization (NAO). Both served on PHI advisory boards and oversaw the distribution of books and promotional materials to clinics they manage. To increase the recommendation of the books to patients, training sessions for the medical residents were presented by PHI.

The biggest challenge in getting PHI off the ground was dispelling distrust among the different counties and competing hospitals. The Project Director's experience in the community helped here as she had previously worked for the health department in one of the smaller counties. Despite this, it took a tremendous amount of negotiation, reassurance, and face-to-face meetings with decision makers and concessions to bring the important players on board. The start of the project was delayed by six months when it became clear it would take more time to cement commitments and buy-in. In some cases, token financial commitments were accepted with the understanding that in-kind contributions of staff time would be made. One small hospital in the lone PHI Georgia county never did come on board, so PHI staff channeled their efforts to reach consumers in this county through the health department, the public library and the county governing authority — which was a PHI financial sponsor.

After 18 months, an evaluation of self-reported consumer data found that an estimated $21 million in health care costs had been saved by helping people avoid unnecessary doctor and emergency room visits. The three-year cost of the PHI is pegged at $3.5 million. In addition, the staff has collected many anecdotal stories of potential tragedies averted by patients knowing a health problem was serious because of the book or *Nursewise Line* and seeking immediate medical attention.

Building Sustainability

Since the three-year initiative will lapse in September 2002, PHI is working with community groups and institutions in the PHI counties on sustainability, including building a healthy community organization in one county that doesn't yet have one. Sponsorships have been secured for a second order of 10,000 books so newcomers will continue getting this "toolbox" of self-help knowledge. AnMed Health has committed to continue underwriting the costs of the *Nursewise Line* in Anderson County, and the PHI staff hopes similar underwriting will come from the other counties.

New Hampshire AHEC

Diabetes Training Collaboration:

By Paula Smith, MBA; Martha McLeod, RD and Rosemary Orgren, PhD

How do people and organizations come together to work on a project? It starts with a heartfelt shared vision and a belief that shared goals can be best achieved by working together.

The New Hampshire Collaboration on Diabetes Education (NH CDE) was founded in this manner when, in 1998, the Southern NH AHEC became operational and was exploring ideas for clinical continuing education topics. Through discussions with staff of private medical practices and community health centers, AHEC staff became aware of a key statewide initiative for diabetes — the New Hampshire Diabetes Education Program (NH DEP). A program of the New Hampshire Office of Community and Public Health, the NH DEP worked with clinicians and health insurers to develop and adopt the New Hampshire Guidelines for Diabetes Care.

These guidelines described prevention and treatment protocols, summarized medication options, and provided resources for both consumers and health professionals. Packets were distributed to practices and clinicians, but, unfortunately, limited resources prevented the NH DEP from conducting follow-up to see if materials were being used. How could the Southern NH AHEC serve as a beneficial partner in this statewide program, contributing to its success and bringing its benefits to the southern New Hampshire medical community?

It did not take long for all the parties involved to realize that they could mutually benefit by leveraging their expertise and funding. Initially, the collaboration between the AHEC and the NH DEP made sense because the impact of the Program's clinical education efforts would be much greater together than either party could achieve independently, the classic synergistic effect. AHEC brought to the table its close working relationships with its community clinicians, the ability to award continuing education credits and staff program coordination expertise. New Hampshire DEP had the above-referenced guidelines, a working committee to review the curriculum, and a relationship with the New Hampshire Association of Certified Diabetes Educators (NH ACDE). Working together, they developed a two-part *"Lunch & Learn"* educational program. It took months of discussion concerning the goals, target audience, marketing and financing to build sufficient trust to ultimately offer the program. Discussions were initiated in July 1998 — the program was not marketed until March 1999.

'With any collaboration, it is important to outline the expectations and roles and responsibilities of all the parties at the outset.'

The group met on a monthly basis over these eight months. Goals were determined by reviewing the missions of each organization and having discussions about what model of program dissemination would best meet the needs of the new collaborative group and the providers in the community. An implementation plan was developed so as to best achieve the program's objectives. At each meeting activities were agreed upon by the parties and updates were provided on progress. Changes to the plan were negotiated as a group.

With any collaboration, it is important to outline the expectations and roles and responsibilities of all the parties at the outset. A procedure for implementing the program was adopted

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Ms. Smith is Director of Southern New Hampshire AHEC in Raymond.

Ms. McLeod is Director of the Northern New Hampshire AHEC in Littleton.

Dr. Orgren is Director of the New Hampshire Program Office in Hanover and has worked for more than 25 years in educational program development and evaluation. She has a special interest in aging and long term care.

by the group so that misunderstandings could be avoided. This procedure was shared with all parties and faculty. The educational program model that was developed was unique. All members of a medical practice team are invited to participate in the continuing education workshops, including clinicians, front desk, medical records and support staff. The program consists of a one-hour didactic lecture that reviews the NH Guidelines, discusses new diabetes medications and allows participants to engage in problem-based learning through case discussion. A second one-hour session was developed that was more interactive in nature. Seeking out best practices, participants discuss the patient/paper flow in their offices, and identify clinical guidelines they wish to audit through chart review. After the chart review, participants identify challenges and successes in managing patients with diabetes in their practice.

The collaboration of the NH DEP, the AHEC and the NH ACDE was expanded in the fall of 1999 when the Northern New Hampshire AHEC became operational and agreed to offer the Program in the northern counties of the state. The Northeast Health Care Quality Foundation (NEHCQF), the peer review organization for Maine, New Hampshire and Vermont, also joined the partnership, agreeing to provide support to CDE faculty. Health professionals and their patients both benefit from this collaboration, which brings additional resources and shared expertise to the program. Diabetes educators contribute clinical and teaching expertise and the NEHCQF provides resources to reimburse the educators and assists in marketing the program to hospital and primary care practices. AHEC brings its educational expertise, event coordination skills, staff, financial resources, and links to the provider community. The NH DEP provides the statewide clinical protocols and input from the NH Diabetes Advisory Board.

The CDE program continues to be successful and is now being replicated in other states. The Southern NH AHEC, with appropriate partners, is replicating this collaborative model to develop training programs on other health issues, including osteoporosis, breast health and gestational diabetes. The collaborative process lessons obtained during the development of the CDE Program have allowed the Southern NH AHEC and its partners to move forward rapidly on these new initiatives.

Making Champions, Making a Difference

Since the CDE Program began, more than 726 health professionals in 40 sites have participated in the program. Evaluations are extremely positive. Many participants have remarked that the *Lunch & Learn* program motivates practice staff to take a hard look at how diabetes patients are managed. Others have appreciated the identification of CDE as a "Diabetes Champion" who takes on the responsibility of circulating much of the information related to diabetes that enters the practice. Practice sites have also indicated that the Lunch & Learn series has made a difference in terms of implementing practice changes.

Many practices have added diabetes flowcharts to charts, while others have hung signs saying, "If you have diabetes, please remove your socks and shoes to better facilitate foot exams." Other interventions have included providing monofilaments for each provider, obtaining special prestamped stickers to record monofilament results in the chart, creating diabetes registries, and identifying charts of people with diabetes. More formal outcomes will be determined during the evaluation of the program, which is expected to occur in the spring and summer of 2002.

AHEC
The National Area Health Education Centers Bulletin

In their lead article for the topic "Expanding Competence to Serve the Underserved," the authors explore several strategies used by AHECs across the United States to increase the competency of health professionals to serve the underserved and demonstrate how AHECs have had an impact on training programs in colleges and universities.

Expanding Competence to Serve the Underserved

By Richard W. Matens, MDiv; Claudia R. Baquet, MD, MPH and Pamela K. Ezzat, BS

The recruitment and retention of a competent health care workforce is crucial to the provision of quality care for populations who have limited access to health services. Since its inception in the early 1970s, the AHEC system has been successful in enhancing the capacity of health care professionals to serve traditionally underserved populations throughout the country. Individual workforce development initiatives positively impact the quality of care that local healthcare professionals provide.

Strategies implemented by AHECs nationwide to improve professional competency in the health care workforce are numerous. The manner in which these strategies are implemented is as varied as the number of communities in which they are instituted. Four characteristics are fundamental to successful AHEC-sponsored health care workforce capacity-building initiatives (see accompanying sidebar on next page).

Caring for the Disenfranchised

The first step to care effectively for those who historically have been disenfranchised is to acknowledge and accept the diversity of cultural norms, race, ethnicity, social status and attitudes that exist in our country today. AHEC programs address this issue in several ways. AHEC staff members are represented on university clinical education committees, overseeing student educational rotations. AHEC programs also facilitate diversity seminars for health profession students to increase their capacity to address the needs of others. AHEC programs facilitate clinical rotations for students from schools of medicine, nursing, pharmacy, social work, dentistry and allied health. AHECs network with academic institutions and community-based organizations to heighten awareness of community diversity. Additionally, involvement in activities and conferences of state Offices of Rural Health provide an excellent conduit for AHECs to increase awareness and appreciation of diversity in the health care arena.

The Needs of the Underserved

A second essential step is fostering the ability to identify health needs specific to the underserved populations. One way in which this can happen is through the work of health professional caucuses facilitated by AHECs.

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Mr. Matens is Deputy Director, Dr. Baquet is Program Director and Ms. Ezzat is Clinical Education Coordinator of the *Maryland AHEC Program*

Fundamentals of Success

Four characteristics fundamental to successful AHEC-sponsored health care workforce capacity-building initiatives:

- Development of an appreciation for and sensitivity toward underserved communities;
- Identification of health needs specific to particular underserved communities;
- Enhancement of practical clinical skills as well as theoretical knowledge to meet those specific identified needs;
- Facilitation of resources that assist other agencies in providing services that develop clinical skills.

Expanding Competence to Serve the Underserved

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These groups encourage individual providers in a given discipline to discuss issues that impact the community they serve. Following closely upon the capacity to identify community needs are the AHEC initiatives designed to enhance the clinical skills, theoretical knowledge, and social experience of students and health professionals to meet specific community needs**.** Through their associations with health profession schools, AHECs facilitate clinical rotations in underserved areas that immerse students into the life of such communities. Skills, knowledge and social interaction are each important dimensions to improve the ability of health professionals to meet the needs of the underserved. Nevertheless, it is the personal integration of these three components that has the most dynamic impact upon the individual's ability to competently meet the needs of those to be served. AHEC continuing education programs respond to the identified community needs as well. In Maryland, the health professional caucuses provide the conduit for the identification of continuing education topics for each discipline. Originating the topics from the caucuses helps to ensure the quality of the presentation as well as that the continuing education programs will be relevant and well-attended.

Finally, in those cases where the AHECs do not directly provide the initiatives for workforce development to meet the needs of the underserved, they are able to facilitate the availability of resources so that provider skills may be enhanced and community needs may be met. AHECs are an invaluable networking resource that can facilitate implementation of such services by other entities. Centers are a natural "bridge" among community partners as well as between these partners and academic institutions. Due to their unique structure, AHECs are in the position to advocate for various community partners. Simultaneously, AHECs understand the roles that these partners play in the development of initiatives that enhance health care access for local constituents. AHECs also assist and support other community entities and academic institutions that directly provide such services. The significance of AHECs' technical assistance role is not to be underestimated. AHECs recognize the fact that certain community groups and agencies are experts in their field. It is not the role of the AHEC to duplicate services that are currently being provided by other entities in a region. However, what an AHEC can provide is a channel through which initiatives can be more easily achieved.

As communities become more diversified, it is crucial that local health care professionals are able to access programs designed to help them meet the needs of their communities. This is especially true for populations who have not historically been able to access quality care. The AHEC system is a community resource that enhances the professional development of local health care workforces to achieve this end. The flexibility of AHECs allows them to tailor initiatives to meet the needs of communities on an individual basis. It is this flexibility that enables the AHEC system to meet the emerging needs of an increasingly diverse population in the 21st century.

Maryland AHEC Pilot Project

An example of identification of community needs is found in a pilot project being instituted by the Maryland AHEC Program. This particular AHEC rotation utilizes the experience and expertise of local public health departments to identify a prominent health issue affecting the local community, which is then addressed by students in each of the five clinical rotations that occur annually.

Each student rotation examines the chosen issue from a different angle. However, the work of each rotation is not self-contained but builds upon the work of the previous rotation. Interaction between students in different disciplines is key to the success of this program. For example, third-year pharmacy students approach a topic in a different context than fourth-year medical students and will bring up issues that may not otherwise be considered. The community-based AHEC boards of directors who provide guidance of the center activities provide a third way in which local needs are identified and addressed. These boards mold the shape of AHECs based upon the emerging needs of their respective local community(ies).

California - San Joaquin Valley AHEC

Challenging the System:

Partnership Benefits Minority Communities

By John Zweifler, MD, MPH; Susan Hughes, MS, and Davin Youngclarke, MA

Despite an expanding supply of clinicians, many in our country face challenges accessing health care services. Twenty percent of the U.S. population resides in Health Professional Shortage Areas (HPSAs), defined as less than one primary care clinician to every 3,500 persons. Rural areas and under-represented minority communities are particularly affected. Addressing the geographic maldistribution of clinicians remains a major health care policy issue.

The San Joaquin Valley AHEC in partnership with University of California, San Francisco-Fresno Family Practice Residency Program (UCSF-Fresno) has used Border HETC, State AHEC and Federal AHEC support to develop creative programs that address the persistent disparities in health care services. No single solution is likely to solve the access to care concerns of underserved populations. AHEC has challenged medical educators to develop programs that facilitate the placement of clinicians in underserved settings. At UCSF-Fresno, we have taken a three-pronged approach to expanding the competence of the health care work force to serve the underserved: didactic training; training in underserved settings and priming the pipeline.

Didactic Training

UCSF-Fresno residents receive ongoing presentations on cultural and health care issues specific to under-represented minority groups in the Fresno area. These groups are predominantly Latino, African-American and Southeast Asian (in particular the Hmong community). Topics including linguistic competency and use of translators, caring for chronic diseases in under-represented minority populations and sensitivity training sessions designed to increase awareness and understanding of cross-cultural issues are woven into multicultural presentations given by community partners and health care professionals.

Multicultural training is incorporated into the UCSF-Fresno behavioral science curriculum. Residents receive feedback on their cross-cultural care during videotaped patient interactions and on shadowing sessions with family practice physician faculty members. UCSF-Fresno is collecting patient satisfaction information sorted by ethnicity and studying the relationships among patient ethnicity, perceptions of physician ethnicity, linguistic preferences and the appropriate use of professional and non-professional translators.

Recently, UCSF-Fresno with AHEC support met with local health care agencies to plan a community-wide conference focusing on the needs of the underserved. Participants identified multicultural issues as a top priority; speakers represented the Fresno County Board of Supervisors, the Superintendent of Schools, the Fresno County Health Services System, as well as UCSF-Fresno. Organizations serving Latino, African-American and Hmong communities as well as Native American and Southeast Asian populations prepared displays and discussions highlighting significant historical and cultural aspects of their communities. The conference was attended by more than 70 individuals representing more than 30 organizations caring for underserved populations.

UCSF-Fresno residents also receive specific training in community oriented primary care (COPC). Residents are taught to define populations in need, assess their unique health care needs, develop interventions appropriate to these communities and determine the practical impact of their efforts. Training is delivered by a multifaceted team of faculty who weave in primary care research, evidence based medicine, public health and epidemiology to improve resident understanding of population based care.

Dr. Sweifler is Program Director and Ms. Hughes and Mr. Youngclarke are AHEC Project Coordinators at the Family Practice Residency Program at the University of California, San Francisco-Fresno.

Dr. Tony Brown, left, reviews notes with second year resident Dr. Daniel Hernandez.

Training in Underserved Settings

UCSF-Fresno with the encouragement and support of the California AHEC Program, has developed several outstanding training sites in rural settings and in an urban community health center. AHEC has assisted UCSF-Fresno's development of a rural training site in Selma, an agricultural, largely Latino population in southern Fresno County. Nine residents (three from each year of training) practice alongside a dedicated group of rural faculty clini-

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California - San Joaquin Valley AHEC

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cians providing full scope family practice including surgical obstetrics.

A second rural site in the even more geographically isolated community of Firebaugh has been established with AHEC support. A bilingual, bicultural faculty member supervises residents who rotate on a regular basis to care for the largely immigrant/bi-national farm worker population in the area. AHEC sponsored activities include outreach through a mobile van stationed in Firebaugh, the development of telemedicine and teleconferencing capabilities at Selma and Firebaugh, and increased availability and accessibility of current medical information through the provision and support of personal digital assistants and access to on-line medical information. This training milieu decreases the sense of isolation and vulnerability which clinicians may otherwise feel.

Dr. Sam Leon checks a young patient.

UCSF-Fresno has forged a unique relationship with the Sequoia Community Health Foundation (Sequoia), a federally funded CHC in the city of Fresno. Family practice residents have been training at Sequoia since 1992 with assistance from AHEC. Two residents in each program year of training work at Sequoia. In addition, all UCSF-Fresno residents rotate through Sequoia (as well as Selma and Firebaugh) to experience practice in a collaborative, interdisciplinary CHC setting. UCSF-Fresno residents appreciate the emphasis on efficiency and the opportunity to interact with Sequoia staff during monthly Clinic Steering Committee meetings and monthly high-risk obstetric conferences with Sequoia obstetricians.

AHEC support enabled UCSF-Fresno to develop a network of care providing rural clinics and CHCs with on-site specialty services in the fields of mental health, geriatric assessments, and special procedural skills including sigmoidoscopy, colposcopy and OB ultrasounds. Furthermore, residents and faculty assigned to rural and CHC sites know that inpatient care and referral services through UCSF-Fresno's largest site in downtown Fresno is only a phone call away. With AHEC support, UCSF-Fresno has pursued the development of another training site in southwest Fresno where significant African-American, Latino and Southeast Asian populations have some of the worst health outcomes in Fresno County.

Priming the Pipeline

Although the proportion of ethnically diverse populations is increasing in the U.S., the number of clinicians from culturally diverse communities has not kept pace. Under-represented minority (URM) clinicians are more likely to practice in URM communities. UCSF-Fresno consciously selects residents who are more likely to practice in URM communities. However, the limited number of qualified URM students choosing health professional careers restricts the candidate pool. With AHEC support, UCSF-Fresno has established a strong partnership with the Health Careers Opportunity Program at California State University, Fresno. This partnership enables URM students to participate in a research methodology course, then to link with UCSF-Fresno residents and faculty working on community projects. Students gain experience in health care settings, interviewing patients and learning about health and disease in underserved communities. At the same time, they gain recognition by participating in presentations and co-authoring publications. These achievements, coupled with letters of support from UCSF-Fresno faculty, contribute to the matriculation of many participating students into health professional programs.

Commitment to the Underserved

UCSF-Fresno has embraced AHEC's commitment to providing a competent workforce to serve the underserved. UCSF-Fresno now requires all of its residents to participate in community projects during their three years of training. Our most recent Border HETC project will link residents and faculty with parish nursing programs for the underserved Latino community. UCSF-Fresno is continuing its commitment to involving URM college students in residency related activities. UCSF-Fresno is now expanding these activities to include a variety of early enrichment programs such as medical camps and mentorship programs for high school students. UCSF-Fresno continues to work with its community partners to identify areas of need with a special emphasis on a growing homeless population and developing other ambulatory care sites in both urban and rural settings.

AHEC support and encouragement has enabled UCSF-Fresno to develop a coordinated, multifaceted approach to serving the underserved. UCSF-Fresno is proud that 35 percent of its graduates have gone on to work in underserved settings.The ongoing support received from AHEC has been a key component of this success.

California - Drew University AHEC

Inner-City Program:

Training Culturally Sensitive Substance Abuse Counselors

By Paulette Ann Gorsuch, MFT

The California AHEC Substance Abuse Counselor Certificate and Degree Program is a collaborative effort between Charles R. Drew University of Medicine and Science, the College of Allied Health (COAH) and the Drew AHEC at the University of California, Los Angeles. It is a model training program for preparing culturally-sensitive substance abuse counselors to work with diverse client populations.

Drew University, located in the Watts-Willowbrook area of South Central Los Angeles, is in the heart of one of the most culturally diverse and socially and economically disadvantaged minority communities in the United States. The university takes advantage of its location and the complexity of its population to create an academic environment unlike any other. Innovative basic sciences and clinical and health services research programs address the health and social issues that are most profound and deepest among inner city and minority populations.

Dr. Roosevelt Jacobs

The mission of the university and the AHEC are the same: to educate health professionals who have unique skills, knowledge and commitment to improve the lives and health of the underserved.

With Federal Model AHEC funds, The College of Allied Health began the Substance Abuse Counseling program in 1992 under the direction of Roosevelt Jacobs, PhD, MPH. It began as a 12-month course leading to a certificate in substance abuse counseling and later expanded to a two-year degree in Community Health Services with a core concentration in Alcohol and Drug Abuse Counseling.

To date nearly 95 percent of program alumni obtain positions in greater Los Angeles as drug counselors and health educators. They are experts in the field of addictions.

The program is fully accredited by the California Association of Drug and Alcohol Counselors. Courses are designed for health care students who wish to prepare for diverse counseling careers in social service settings that treat substance abuse problems and family co-dependence, or for individuals who may already be employed in human services occupations and who wish to pursue advanced knowledge of job-related course work in addiction counseling. Many graduating students matriculate into a advanced degree program in multicultural psychology.

The education program uses a community-based approach to substance abuse prevention in support of the latest academic research that has supported incorporation of cultural traditions into substance abuse counseling professions. Students complete 255 hours of field work in the greater Los Angeles area.

Field research indicates a significant relationship between minority self-concept and the likelihood of using alcohol/drugs, and provides empirical evidence for the role of cultural sensitivity in teaching counseling students.

Dr. Matthew Velasquez, a senior full time faculty member and Associate Professor, believes that today's counselor must be extremely sensitive to cross-cultural issues and to his or her own prejudices and racism. In the course *Counseling the Culturally Different,* he directs students to practice self-knowledge and nurture a client's sense of belonging through a search for his or her ancestral roots.

Dr. Matthew Velasquez

Aligned with the AHEC mission, the courses are designed to provide comprehensive and continuous service to the medically underserved and to minority communities to include client advocacy for services.

The Drew AHEC believes its course curriculum not solely stimulates awareness in students at a cognitive level, but also enables students to understand feelings of helplessness, powerlessness and low self-esteem, and how these contribute to low motivation, frustration, ambivalence and apathy.

Graduates are taught to be sensitive to the rich mix of individuals with different racial, ethnic and cultural backgrounds and incorporate those variables into assessment and treatment.

Dr. Gorsuch is the Program Director for Substance Abuse Counselor Program at Charles R. Drew University of Medicine and Science, College of Allied Health.

AHEC
The National Area Health Education Centers Bulletin

In his lead article for the topic "Addressing Workforce Remedies," Mr. Henderson goes beyond the often-heard rhetoric of training more health care workers to look at systems change. He asks, "How can states be effective players in remedying health workforce shortages?"

Addressing Workforce Remedies

By Tim M. Henderson, MSPH

Changing times call for new approaches to meeting challenges. This is especially true for states in addressing current shortages in the health workforce. Such shortages are unlike past shortages, particularly because of differences in the economy and demographics of the population. An aging workforce rapidly approaching retirement in many disciplines is not being sufficiently replaced by a younger cohort of professionals. In part, this is because fewer are interested in particular professions for economic reasons, or there is insufficient training capacity to accommodate demand in other professions.

Mr. Henderson is Director of the Institute for Primary Care and Workforce Analysis of the National Conference of State Legislatures.

Physicians

With market forces and federal policy unable to address regional physician maldistribution, states must remain concerned about the return of their investments in medical education and physician recruitment and retention for profession shortage areas. A growing number of states have gone beyond traditional scholarship and more recent loan forgiveness programs (and AHECs) to tax credits, practice development subsidies, and other fiscal incentives that encourage physicians and other health professionals to locate in needy communities. Several Medicaid programs, seeking to be more prudent farsighted purchasers of care, recognize that their support for graduate medical education (GME) is a valuable tool for meeting future health care provider needs of Medicaid beneficiaries. Nearly 20 Medicaid programs now link GME payments to such state workforce goals as training more primary care providers for rural areas. Georgia's Medicaid program provides payments explicitly to AHECs for this purpose.

While several states have experimented with educational incentive programs, most initiatives are small in size and scope and ultimately have little impact on aggregate shortages. As states move into an era of more limited resources, they would be wise to invest in a major evaluation of such programs, resulting in expansion of the most successful initiatives and termination of the others.

'I suspect that finding the leadership and political will to cross traditional workforce training and regulation boundaries will be more challenging than mustering new thinking and

Nurses

Our country faces a nursing shortage, in part because fewer young people want to become nurses. Although many nursing schools are experiencing declining enrollments, others are unable to expand training capacity and must turn away qualified applicants. How can states offer these schools additional funds for faculty development and strengthen their accountability to address local workforce needs? A majority of these state-funded schools have no direct (i.e., line item) funding and rely on funds from block grants or broad-based formulas that finance higher education in community colleges and state universities. This methodology is troublesome to nursing schools because, among other things, it does not account for their inher-

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ently expensive clinical training programs and the cost of attracting qualified faculty. States must find a better means of supporting nursing education where most nurses train and work — outside of major health science centers.

Dentists

There also is increasing evidence that soon we will have a shortage of dentists — overall, as well as for low-income and medically underserved populations. For years, the dentistry profession has tightly regulated the supply of dental school graduates and the state licensing requirements for practice. Anecdotal reports now indicate there is a rapidly aging dental workforce not easily replaced because many dental schools have capped enrollments, and many states' licensing requirements are restrictive. To address these issues, should the scope of practice for dental hygienists be expanded so they may provide more restorative care and operate with less direct dentist supervision, or should there be serious consideration given to creating a new dental professional that might function more independently somewhat like a nurse practitioner? Should state licensing boards grant qualified foreign-trained dentists more licenses to practice, particularly in low-income and rural communities? For proprietary reasons, the current dentist population has little need to address the oral health needs of low-income children. What kinds of alternative education and practice models that target dental care to vulnerable populations could be effectively developed and sustained with public and private support?

Pharmacists

Recent studies suggest that the dramatic increase in demand for prescriptions cannot be met by a profession of pharmacists undergoing major change in their training and work environments. Graduating pharmacists are finding more competitive salaries in the booming chain drug industry, but a more demanding work environment there may make it difficult for these doctoral-trained graduates to apply fully their new therapeutic and counseling skills. If so, is it time for state regulatory agencies and pharmacists to standardize and expand the educational and work requirements of pharmacy technicians?

Across the Professions

In fact, many of the country's more than 200 non-physician health professions are now being redefined. For several professions, changes in their practice capabilities brought on by changes in their education and work environment are putting pressure on government regulators, policymakers and health care organizations to sort out and enforce new practice boundaries in a period of increasing "turf wars" between physicians and non-physicians. Greater market competition is pressuring health care organizations to use many health professions in different ways that create both new opportunities and additional stresses in the workplace. To reduce costs, for example, many hospitals would like to have the flexibility and authority to use certain allied health professionals interchangeably. Should state licensing agencies experiment with allowing certain health care institutions to have such authority?

Conclusion

Change is tough. Our economy, population and health delivery system are all rapidly evolving at the same time. Such evolution requires lots of reinvention and new thinking about how we train, regulate and utilize our health workforce. But, I suspect that finding the leadership and political will to cross traditional workforce training and regulation boundaries will be more challenging than mustering new thinking and reinvention. Perhaps, we should devote as much attention to cultivating a new generation of state health policy leaders as we do to new ideas.

'For several professions, changes in their practice capabilities brought on by changes in their education and work environment are putting pressure on government regulators, policymakers and health care organizations to sort out and enforce new practice boundaries in a period of increasing "turf wars" between physicians and non-physicians.'

Health Care System in Turmoil

Arizona Health Sciences Center Has a Plan

By Carlos C. (Kent) Campbell, MD, MPH, and Raymond Woosely, MD, PhD

Health care delivery in the United States is in a state of turmoil — and prospects are that the situation will get worse as the severe national shortage of health care workers continues to broaden. At the same time, the U.S. population is rapidly aging and will place an ever-increasing demand on health care services. Clearly, our nation's health will be severely threatened if we fail to contend with this looming crisis.

In all this gloom there is an important challenge for academic health science centers, and reasons for guarded optimism about the future. In Arizona we have more than our share of health care challenges: high rates of uninsured, striking rates of chronic disease such as diabetes, extremely poor health statistics for our youth. Yet there is a willingness here "to try something different"— a desire to explore new ways to deliver health care that attract capable people to the health care professions while at the same time providing better health care, both curative and preventative, for our citizens.

We have begun to develop a pilot for just such a model, which we will outline, but first some background on the current health care landscape.

Dr. Campbell is Director of the Arizona AHEC Program and Director of the Arizona Healthcare Initiative.

Dr. Woosely is Vice President for Health Sciences at the University of Arizona Health Sciences Center in Tucson.

Dissatisfaction Among Health Care Workers

Many health care providers today are extremely dissatisfied with their work experiences — and many patients are disappointed in the quality of care. Although Americans continue to spend more on health care, health outcomes have not improved in kind. The bottom line is that qualified, highly motivated people are turning away from the health professions, looking for what they perceive to be more satisfying careers.

Why is such a noble profession — the provision of health care to our nation's population — having so much difficulty attracting qualified workers? Certainly many factors contribute to this crisis. Obviously monetary compensation is an issue. But in our opinion the most important factor is that in increasing numbers, health care professionals feel great dissatisfaction in the quality of their work experience. They believe they could deliver much higher-quality health care and are disappointed in the care they actually are able to deliver in the current model.

Thus, if we are to avoid a potential breakdown of our nation's health care delivery system we must find ways to make the practice of health care a more professionally satisfying experience. We must find a delivery model that capitalizes on the unique skills the various disciplines provide, while encouraging close collaboration and teamwork to ensure high-quality care and reduced costs.

Arizona Healthcare Initiative

In response to this crisis, the Arizona Health Sciences Center has launched a statewide initiative focused on improving health care. The Arizona Healthcare Initiative is a pilot project that will combine expertise in medicine, nursing, pharmacy and public health to develop models for more effective health care through an interdisciplinary approach. The initiative will focus particular attention on health care challenges, as well as health promotion and disease prevention, in Arizona and the Southwest.

The Arizona AHEC Program is a key partner in the Initiative, because we must address the training and retaining of the health workforce if health care is to improve.

Now in its initial planning stage, this demonstration program will feature interdisciplinary teams of health care providers, including physicians, pharmacists, clinical pharmacists, nurse practitioners, nurses and others trained to perform important roles in integrated health care. Our goal is to demonstrate improved health outcomes and greater satisfaction of patients and caregivers when working in an environment of interdisciplinary team care. AHSC also will teach students of medicine, nursing and pharmacy in the methods of team care.

Because of the innovative spirit of this state's citizens, and the strong collaboration among our statewide partners, Arizona provides the perfect arena to begin this important effort. If successful, this Initiative will point the way to a healthier future for both our state and nation and get at the root source of the current shortages in health care workers.

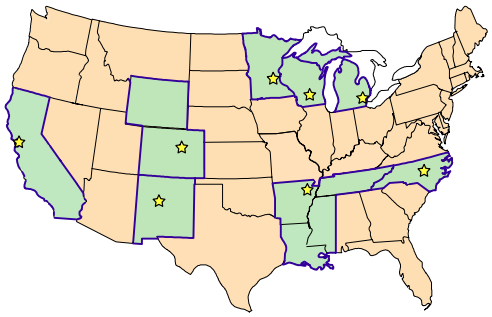
Colorado, North Carolina and Wisconsin AHECs

Partnerships for Training:

'The AHEC Bridge' is Vital in RWJ Project

By Jean Johnson PhD, FAAN, and Laurie Hodell, MS

Partnerships for Training (PFT), a national program funded by the Robert Wood Johnson Foundation, consists of eight regional consortiums of nurse practitioner (NP), physician assistant (PA) and certified nurse-midwifery (CNM) programs that are using distance education technologies and satellite campuses to extend the geographic reach of their educational programs with a goal of increasing the number of primary care providers in underserved areas of the United States. The Partnerships for Training project began in 1994 with the selection of 12 grantees for a planning phase. Eight of those grantees continued into the implementation phase. To date the project has spanned approximately eight years with an additional two years to go. The figure below shows the geographic reach of the academic institutions participating in the project.



PFT Project Sites

While large, complex projects require many inputs to be successful, the AHEC programs' contributions to the success of the PFT project are important to recognize. AHECs have been critical partners and have provided strong support to the grantee projects, most notably in Colorado, North Carolina and Wisconsin.

AHECs Provide 4 Critical Functions

- Creation of systems for learning;
- Recruitment of potential students;
- Facilitation of academic-community partnerships; and
- Support for interdisciplinary education.

This article will review the work of the AHECs in supporting this project.

AHEC Contributions to the Project

Creating Systems for Learning: In order to take programs to people living in underserved communities the academic institutions developed the capacity to offer the entire didactic portion of NP, PA, and CNM programs on-line. Creating the technology infrastructure, faculty capabilities, recruiting methods, and student support services to meet the needs of students living at a distance from campus and learning in their homes, clinical environments or local libraries has required grantees to make significant changes in the way that education is delivered.

While most grantees initially planned to deliver programs through cable networks, the rapid evolution of the Internet quickly created the opportunity to use the web as the primary educational delivery method. AHEC contributions to creating systems of learning ranged from establishing Internet access for students to identifying clinical placements in students' home communities. The AHECs also helped to establish a mentor-based support system that enhanced students' ability to succeed in rigorous academic programs taught in a non-traditional way.

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Dr. Johnson is National Program Director of the Partnerships for Training and Senior Associate Dean at George Washington University.

Ms. Hodell is Deputy Director of the Partnerships for Training Project and is affiliated with the Association of Academic Health Centers.

Colorado, North Carolina and Wisconsin AHECs

(Continued)

Examples of the work of AHEC staff members included delivering computers to students hundreds of miles away from campus, setting up the computers and teaching students how to access courses on-line. For students who did not own a personal computer, the AHECs worked out arrangements with community agencies for students to use computers. In order to support learning at the clinical site, one AHEC worked out licensing agreements for community preceptors to access medical information on line from databases such as Grateful Med and Medline at a minimal cost (another AHEC is in the process of working out a similar arrangement). In addition to benefiting the preceptors, this allowed students access information they needed to support their learning from the preceptor sites.

Recruiting potential students: The traditional methods used to enhance the primary care workforce in underserved areas (i.e., bringing students from underserved areas to universities in the hope that they will return to their home communities or requiring them to pay back loans by working for a designated period of time in an underserved area) have left significant gaps. Recognizing that qualified individuals may not be able to leave their families or jobs to access a NP, PA or CNM program, PFT has worked to fill these gaps by recruiting and educating students in their home communities. The AHECs' roots in the local communities have been instrumental in this process.

It has been important for the academic institutions to develop meaningful relationships with communities. Rather than sending brochures out to individuals who request them — hoping that some requests would come from those living in underserved areas — faculty have learned to work with agencies that are firmly rooted in communities, such as the AHECs.

The recruitment contribution of the AHECs has been remarkable. AHEC staff have worked with community health care agencies including hospitals, nursing homes, and outpatient practices to identify potential candidates for the programs. They have arranged recruitment visits in which faculty came to specific areas to meet with potential students. In some cases, AHEC staff helped potential students navigate the application and financial aid processes, often helping students apply for national Health Service Corps scholarships or loan repayment programs, or finding other funds available through their states.

Partnerships for Training Project Sites

- Duke University-East Carolina University PFT Program (North Carolina)
- Central California Community Partnerships
- Delta Health Education Partnership (Arkansas, Mississippi, Tennessee and Louisiana)
- New Mexico Partnerships for Training
- Mountain and Plains Partnership (MAPP) (Colorado and Wyoming)
- Minnesota Partnerships for Training
- Greater Detroit Area Partnerships for Training (Michigan)
- Wisconsin Program for Training Regionally Employed Care Providers (WISTREC)

Facilitating academic-community partnerships: Academic-community relationships have been strained for decades. Barriers to attaining partnerships exist on both sides. It is no secret that communities have an innate suspicion of academic programs. There is a history of "academics" taking advantage of communities for their own research or learning purposes without giving back to the communities. Communities sometimes view universities as monoliths with limited social conscience

While most health professions programs think of themselves as sensitive to the needs of communities, it is very difficult for faculty and

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Colorado, North Carolina and Wisconsin AHECs

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administrators to make the leap to real community participation. The barriers to partnering with communities are substantial. Most academic institutions have numerous communities they serve — not just one. The commute times required just to participate in a single community function are often extraordinary. Getting over the "great divide" in Colorado or to northern Minnesota in the winter can be a life-changing experience.

AHEC staff have effectively bridged the academic-community gap both in terms of distance and culture. Staff understand both academic and community values, goals and peculiarities. AHECs have translated academic policies and processes, as well as their commitment to service to communities, while reflecting back to academic programs the concerns and needs of the communities. AHECs have taken an advocacy role to put forth the health care needs of communities and then worked to bring together the community and academic programs for problem solving. The "AHEC bridge" has been a vital part of this project in helping each partner understand what needed to be accomplished in order for this program to be successful.

Supporting interdisciplinary education: The PFT program required that a substantial part of the educational process for the NP, PA and CNM students be interdisciplinary. While the need for interdisciplinary education and practice have been discussed in many forums, the reality of creating lasting educational initiatives happen is very difficult. Achieving this program goal has required each of these disciplines to change attitudes of exclusivity and to view the others as partners, not competitors.

When the program first began, none of the disciplines in any participating school had a history of working together in a meaningful way. Because of the interdisciplinary mission of the AHEC program, the state AHECs understood the challenges of interdisciplinary education. The AHEC partners were able to bring a "discipline neutral" party to the table to help negotiate some of the thorny issues such as scheduling of classes, which classes could be shared and how faculty might be best used. They were also able to help faculty step back from their disciplinary roots and look at the shared mission of improving access to primary care in underserved areas. They also assisted in finding clinical placements so that students from different disciplines could be assigned to the same clinic at the same time.

Outcomes of the Partnerships for Training Program

While the importance of the role of AHECs to the work of this project is indisputable, the proof of effectiveness is in the outcomes. To date nearly 1,000 students are either enrolled as PFT students or have graduated.

Based on the results of the first survey, completed in June 2000, the PFT program has been successful in recruiting, retaining and graduating individuals from underserved areas. Comparison data indicate that the grade point averages and pass rates on national certification exams were the same for PFT and on-campus graduates. While there has been significant concern over the retention rate of students learning through web based programs, PFT retention rates were either the same as or better than on-campus programs. In addition, there were over twice as many minority students in the PFT programs as in the on-campus programs.

The most important outcome measure is where graduates practice after completing their programs. Although initial data collection revealed some definitional problems with underserved areas, the vast majority of PFT graduates are practicing in underserved areas. PFT graduates were three times as likely to practice in an underserved area as traditional students.

As PFT winds down and projects are looking to sustain the effort initiated in this project, the AHEC program will remain the linchpin for continued success. AHECs share PFT's mission of increasing access to healthcare at the local level. Now that the educational programs are up and running, they are a resource that can help AHECs achieve their own goals. AHECs will continue to support the educational programs by identifying potential students, providing support to those students and linking academic programs to communities. In return, they will continue to benefit from the addition of primary care providers who are dedicated to improving the health of their local communities.

South Texas AHEC

It Started With the Army:

PA Program Improves Rural Access to Primary Care

By Julie Collins

Time and again, cooperation has led to improved access to quality health care for the people of South Texas. Such is the case today with a burgeoning Physician Assistant Studies Program at The University of Texas Health Science Center at San Antonio (UTHSCSA).

What began as a small cooperative program between UTHSCSA and the U.S. Army that relied on AHEC funding support has developed into a state-funded stand-alone bachelor's degree program at UTHSCSA that is set to become a master's degree program by 2003. The result is an increased number of primary care providers preparing to meet the health care needs of the rural and medically underserved areas of South Texas.

By Julie Collins
Informational Writer
South Texas AHEC

It started in the mid-1990s with a recognized need for physician assistants, or PAs, to help overcome the shortage of primary care providers in South Texas. J. Dennis Blessing, PhD, PA-C, chair of the UTHSCSA PA program, said that PAs are more often drawn to rural areas than are physicians, partly because that is where the need is, and partly because PAs are a more affordable option for small communities.

Judith Colver, PA-C, MMS, assistant professor and clinical coordinator for the UTHSCSA PA program, explained that PAs are trained to treat the vast majority of medical cases seen by a primary care physician. Although they are required to work under a physician's supervision, the physician can be physically present as little as a half-day per week and available the remainder of the time for telephonic consult.

"A PA can go into a rural health clinic and provide most of the health care needs four-and-a-half days a week, then see the more complicated patients when the supervising physician is in," she said. Therefore, PAs can offer extensive assistance to physicians already working in rural areas. They also allow communities without a local physician to recruit a doctor from an urban area who is willing to travel to the community on a part-time basis while supervising a PA full time through phone contact.

Despite the benefits PAs can offer to rural South Texas, the problem in the mid-1990s was a lack of accessible PA training programs. The only such program in the 38-county South Texas/Border Region was located at The University of Texas – Pan American in Edinburg, at the region's southernmost tip.

The late Congressman Frank Tejeda helped develop a solution. Due to military downsizing, the Army's PA program at Fort Sam Houston in San Antonio had empty seats, so Rep. Tejeda sponsored congressional legislation that enabled civilian students to train alongside military personnel in a cooperative program between the Army and UTHSCSA.

Depending upon seat availability, up to 20 civilian students per year could enter the UTHSCSA Physician Assistant Studies Program, a four-year degree program that utilized a 2+2 academic format. Students completed two years (60 hours) of prerequisite course work at a regionally-accredited college or university and then entered the 25-month program of professional studies, which entailed one year of didactic classroom and preclinical study at the Academy of Health Sciences at Fort Sam Houston, followed by 13 months of clinical supervision by the UTHSCSA School of Allied Health Sciences at locations throughout South Texas. Upon graduation, students received a bachelor of science degree in physician assistant studies from UTHSCSA and a certificate from the military that enabled them to take their certification exam.

The program began accepting students in the fall of 1995 amid high demand. More than 200 students applied for the 18 available slots in the program's first year, and applications doubled the following year.

Because UTHSCSA did not have state funding for the new program, the South Texas AHEC offered program support as well as housing costs and travel reimbursement for students going on clinical rotations in rural South Texas communities. AHEC staff also assisted the program's director in identifying the significant number of clinical training sites required by the PA curriculum.

The arrangement worked well, allowing the military to fill its vacant seats and to obtain student support services from UTHSCSA. Like

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wise, the Army provided the bulk of classroom training for UTHSCSA students and served as a credentialed body that made it possible for program graduates to obtain their certification as PAs. It also helped UTHSCSA prepare for its own future PA program by allowing faculty to gain teaching experience and the program as a whole to develop a wide variety of clinical teaching sites.

Despite the success of the joint PA program, *(see related information in box on this page)* it soon became apparent that UTHSCSA would need to venture out on its own. In 1997, the Army's PA program became the Interservice Physician Assistant Program (IPAP), admitting students from the Army, Navy, Air Force, Coast Guard and Public Health Service. The number of slots left open for civilian students dropped to two, three, or even zero per class despite an ever increasing number of applicants.

"The lack of student seats eventually drove us to start our own program, because we still need PAs in South Texas but we couldn't graduate the numbers we needed," said Ms. Colver.

The Texas Higher Education Coordinating Board granted program approval in April 2000, and that fall, with several students still completing the IPAP program, UTHSCSA admitted the first class of 20 PA students into its own bachelor's degree program. Provisional accreditation – the only accreditation a new program can receive – was granted by the Accreditation Review Commission on Education for Physician Assistants (ARC-PA) in October 2000, and full accreditation is expected by 2002.

Now the program is working towards conversion to a master's degree program by May 2003. Dr. Blessing explained that this is the trend of PA programs, and it is the more appropriate degree for PA graduates.

The master's degree program, which will accept an equal or greater number of students than the bachelor's program, will use a 3+3 academic format that includes three years of college undergraduate education followed by three years of training with UTHSCSA. After a year of basic science courses at UTHSCSA, students will be awarded a bachelor's degree. Then they will begin a year of pre-clinical, laboratory courses, followed by a year of clinical training at various South Texas sites. At the end of the program, they will obtain their master's degree and their PA certificate.

Ms. Colver said the 3+3 program was developed with South Texas students in mind. "A number of these students may not have the opportunity to complete a bachelor's degree," she said. "Therefore, we believe we will be better prepared to draw students from the region with a 3+3 program rather than a 4+2, which would require students to earn a bachelor's degree before entering the program."

Like the initial joint program with the military, UTHSCSA's stand-alone programs place an emphasis on recruiting students from South Texas to serve the medically underserved regions of South Texas.

"We recruit heavily in South Texas," said Dr. Blessing. "We hope that by choosing people from the region and training them to serve in the region we will see a large percentage of graduates remain in the region to practice."

The education program includes extensive training at rural and medically underserved clinical sites with an emphasis on culturally-appropriate medicine and use of the Spanish language. "We think it is important to the health care of South Texas that our PAs are educated to understand the region in which they will be working," Ms. Colver said.

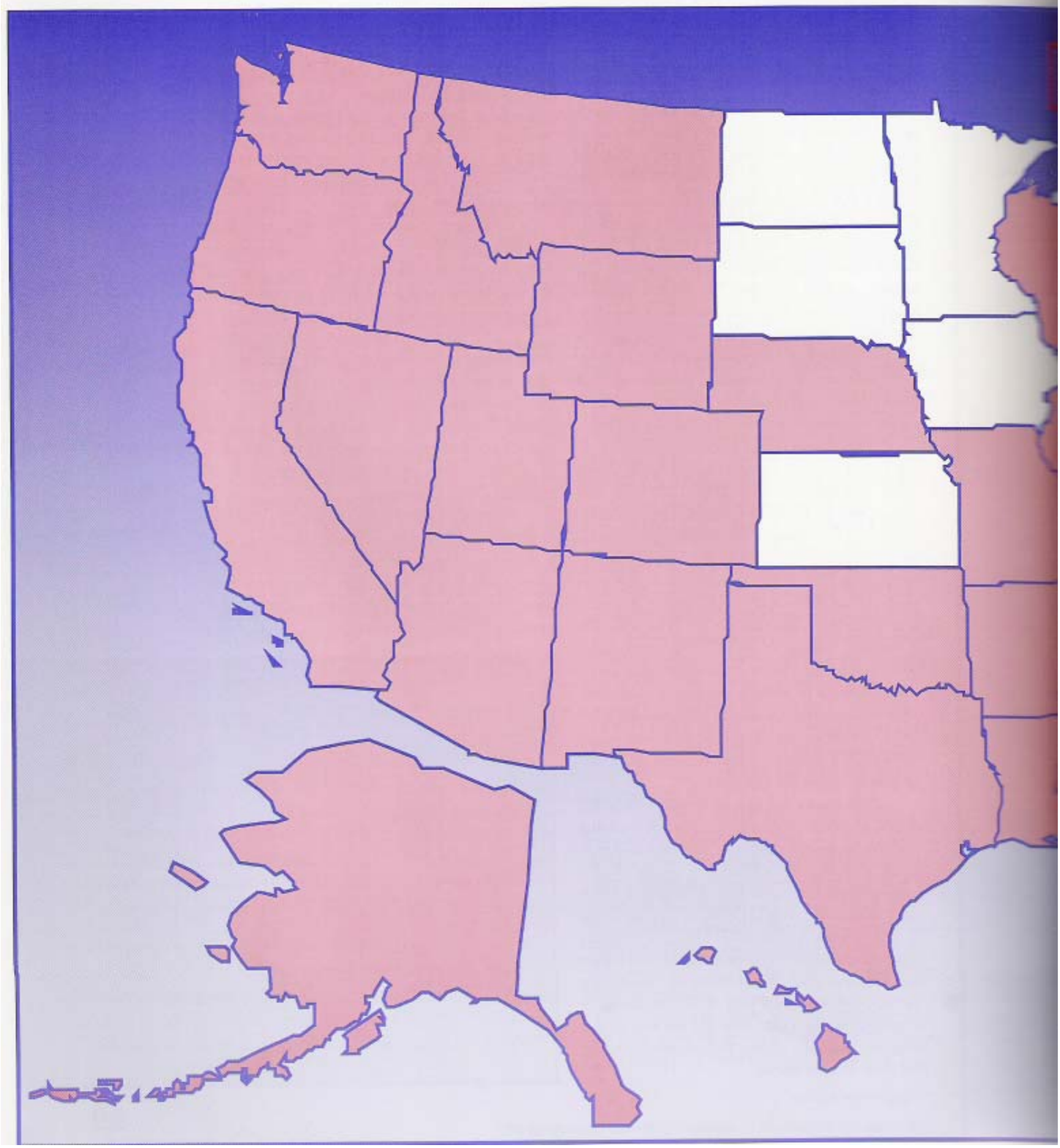
Now the communities of South Texas are anxiously awaiting a new class of graduates. "On a daily basis, we hear from doctors who have never had a PA in their office before, and they are telling us, 'I need a PA in my practice, and I need the PA here yesterday,' "said Ms. Colver.

Success Rate: Texas Style

Rural South Texas has benefited from the number of program graduates who have remained to work in the region. Since August 1995, 56 civilian students have enrolled in the program, 43 of whom have already graduated. Of those 43 students, 34 are working in Texas, 19 of whom are known to be in rural or medically underserved areas. Those graduates were well prepared to serve in rural areas, since 60 to 70 percent of their clinical training was done in medically underserved communities.

Of the 20 students who entered the bachelor's program in fall 2000, all are from Texas, including 13 from the South Texas AHEC catchment area. The 2001 entering class also is entirely from Texas, including 16 from South Texas, and 50 percent have a good working knowledge of Spanish.

The National AHE

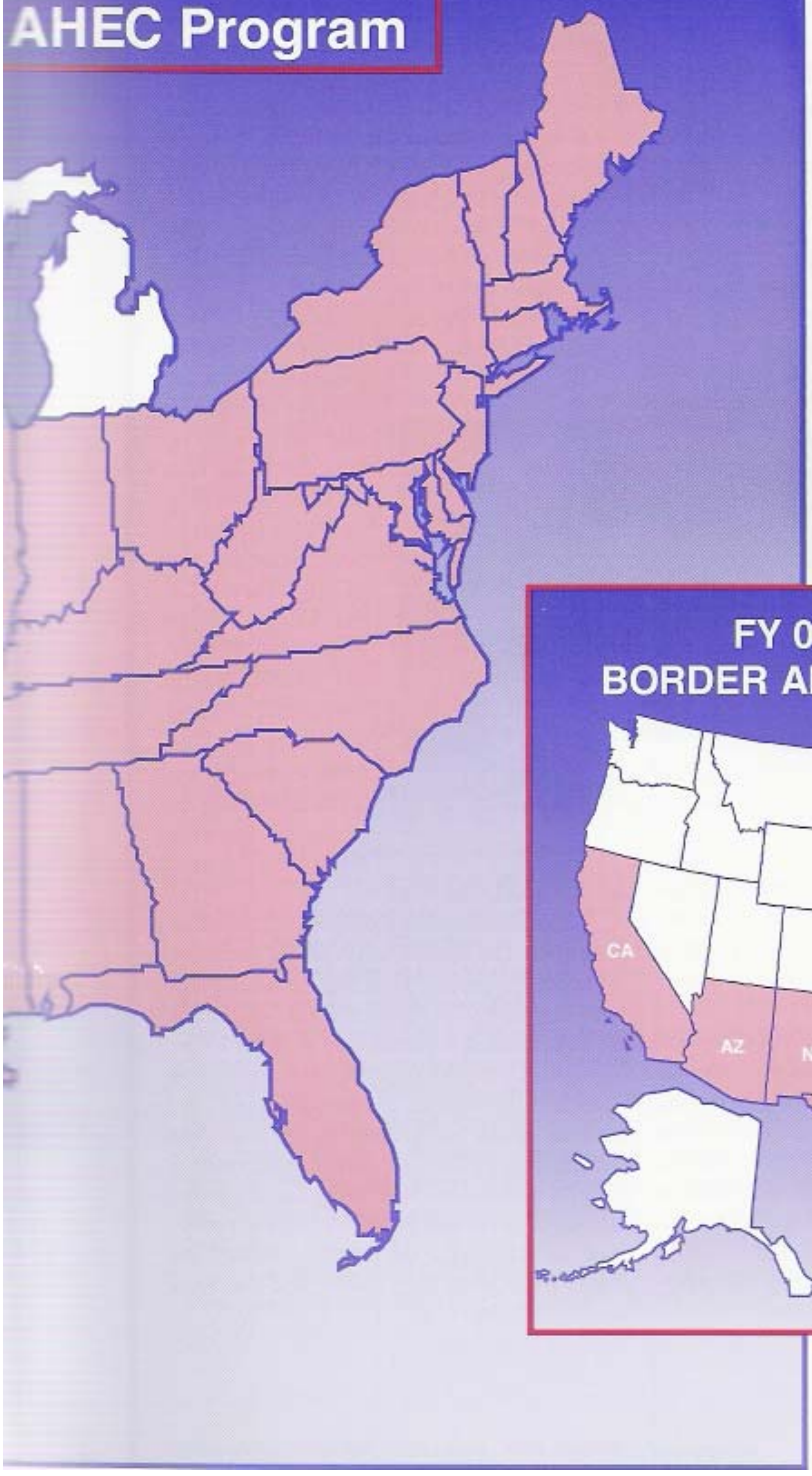


HETC Network

Building Community/Academic Partnerships For Health

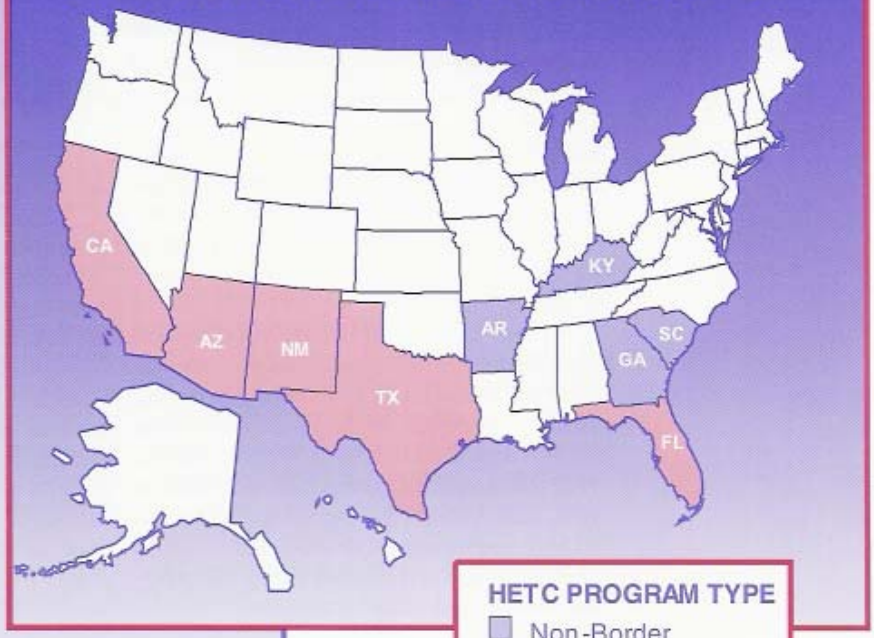
NAO
National AHEC Organization

AHEC Program



New AHEC Programs were established in September 2001 in three states: Indiana, at Indiana University in Indianapolis; Nebraska at the University of Nebraska Medical Center in Omaha; and West Virginia at West Virginia University Research Corporation in Morgantown.

FY 00 HETC PROGRAM BORDER AND NON-BORDER STATES



North Carolina AHEC

Expanding the Pipeline:

Health Careers and Workforce Diversity Project

By Bill Means and Katie Parker

The North Carolina AHEC Program recruits students into health careers to develop a stronger base of local caregivers in the state. The NC AHEC mission to improve the supply, geographic distribution, and specialty distribution of the healthcare workforce requires support for statewide initiatives specifically designed to increase racial, ethnic, and socio-economic diversity in health professions.

Several studies contend that increasing the diversity among health professions is a partial solution to improving access to care, since graduates from underserved populations are more likely to enter primary care specialties and to voluntarily practice in or near designated primary care health workforce shortage areas.

Mr. Means is Coordinator for Recruitment, Retention, and Academic Development and Ms. Parker is Program Assistant at Northwest AHEC in North Carolina.

The NC AHEC Health Careers and Workforce Diversity (HCWD) Program began in the early 1990s as several independent health careers recruitment activities. Over the years, it has expanded to include opportunities that reach students throughout their school years. Each of North Carolina's nine regional AHECs employ HCWD directors and conduct student recruitment activities.

Pipeline students have the opportunity to participate in hands-on career exploration.

The Northwest AHEC HCWD Program identifies its youth educational component as the Health Careers Pipeline Project. Northwest AHEC, located at Wake Forest University (WFU) School of Medicine in Winston-Salem, NC, selects students from a 17-county service area. Students enter the metaphorical pipeline through health careers activities designed for elementary school and continue through the pipeline through high school graduation.

The youngest students in the Northwest AHEC Pipeline Project explore health careers through The Great American Hospital Adventure: Health Careers Puppet Bunch. This program was developed by the Northwest Pennsylvania AHEC, and is being implemented in the Northwest North Carolina AHEC region with tremendous success. The program teaches kindergarten through third graders about health careers and safe behaviors simultaneously, and features eight puppets, each representing a different health profession.

A second offering for elementary students is Drew Academy. This Saturday enrichment program fosters an interest in science and math among minority male students by providing hands-on, inquiry-based learning activities. Faculty at the Wake Forest University Center for Excellence in Research, Teaching, and Learning develop learning cases, and local teachers facilitate the sessions. Each year 50 students attend Drew Academy.

The middle school component consists of two camps. The first is Camp Careers: Anatomy of Health Professions, a one-week health careers awareness camp. Northwest AHEC offers this program through a partnership with the Winston-Salem Forsyth County Schools and the Job Readiness Partnership of Forsyth County, established by the NC Governor's Job Readiness Commission. PRISM, the second middle school camp, is a two-week residential health careers awareness camp held at WFU. Students complete an Algebra 1 preparation course, an anatomy and physiology course, and tour local health facilities.

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North Carolina Pipeline Project

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Project SEARCH Academy is the high school component of the Pipeline Project. It is a two-week residential program where students participate in observation tours, life-skills workshops, journal writing, and spend 26 hours shadowing a health professional.

Northwest AHEC understands that students cannot have successful school experiences without committed and well-trained teachers. To supplement the students' experiences in the Pipeline Project, Northwest AHEC offers the Professional Series in Biomedical Sciences to high school science and health occupations teachers. Participants are introduced to the latest biomedical research at the WFU School of Medicine. They learn ways to incorporate this research into their classroom curriculum and are trained in health careers promotion and in motivation strategies for disadvantaged students.

Each of these components is important in and of itself. What makes them even more powerful, though, is the way they are integrated into a seamless pipeline, which encourages students to move from one level to the next, and ultimately into a health career. In 2001, approximately 28,700 students attended activities of the Northwest AHEC Pipeline Project. While the majority of these were participants of one-time events such as the puppet shows, 125 received more intensive exposure. Of the middle and high school students surveyed, 72% report the programs assist with health career selections. Another 84% report selecting a health career major in college.

Students in the pipeline explore many health careers, but activities are specifically designed to concentrate on professions which present the greatest opportunities for employment. Current health workforce shortages in the Northwest AHEC region include deficiencies of certified nursing assistants, registered nurses, radiologic technologists, dental hygienists, and respiratory therapists. Additionally, increases in racial and ethnic populations intensify the demand for culturally diverse healthcare professionals. By focusing attention on careers in high demand, the Pipeline Project assists in securing a sufficient health workforce for North Carolina.

The Northwest AHEC has established a core interdisciplinary team that is charged with the expansion of the Pipeline Project. This Recruitment, Retention, and Academic Development team blends the interests of students with regional workforce trends. The team challenges itself to understand health careers and workforce diversity issues from a holistic point of view as it designs and implements effective pipeline programs. These efforts ensure that as North Carolina changes and the needs of students evolve, the Pipeline Project continues to meet demands for training experiences.

It is plausible that this year's kindergartner who sees the Northwest AHEC health careers puppet show will attend a HCWD summer camp and eventually become a medical student on an AHEC community-based rotation.

Students of Drew Academy participate in hands-on and inquiry-based science and math activities.

In the year 2025, that same student could complete a NC AHEC residency training program and eventually attend a sampling of AHEC continuing education programs. In this way, when a student enters the Northwest AHEC pipeline, chooses to practice a health profession, and remains in North Carolina, the pipeline never ends. And why not? Many students trained in NC AHEC community settings as early as 1972 are now preceptors, health careers mentors, and AHEC program participants. By remaining responsive to the needs of the region and enhancing activities for students at every age, Northwest AHEC continues to focus efforts on building a well-trained, culturally diverse healthcare workforce.

North Carolina AHEC

Filling the Dentistry Gaps:

AHEC Rotations to Underserved 'An Ideal Partnership'

By Phyllis Farlow

North Carolina ranks 47th in the nation in the supply of dentists. Four of the state's 100 counties have no dentists; another 36 counties have no dentists offering services to Medicaid recipients. A recent study by the North Carolina Institute of Medicine reports 36 percent of all children entering kindergarten in the state have a history of dental caries. With statistics like these, it is not surprising that a disproportionately higher need for dental care can be found among disadvantaged groups.

As the only dental school in North Carolina, the University of North Carolina-Chapel Hill School of Dentistry (UNC SOD) is especially concerned with these statistics. As early as 1960, the UNC SOD began offering extramural rotations to senior dental students as a means to expose future dentists to the dental needs of underserved populations. These early offerings were limited in duration and scope, but the establishment of the NC AHEC Program in 1972 made a dramatic impact on the curriculum. Initial AHEC funding allowed expansion of the early extramural rotation program, and ongoing support allows continued growth.

Today the school is able to offer dozens of approved rotation sites throughout North Carolina. Qualified preceptors with adjunct faculty appointments supervise more than 63 rotation sites, spanning county health departments, community health centers, institutions for the mentally and physically disabled, correctional institutions, United States Coast Guard, Army, and Navy dental centers, and hospital dentistry programs. The NC AHEC Program supports clinical experiences in dentistry rotations as it does for other health science education programs. AHEC provides funding for school personnel, student travel and housing, and curriculum enhancement.

Rotations give students the opportunity to experience a type of dentistry that they won't necessarily see at the school or in private practice. Walking into a prison or mental institution for the first time can be an eye opener for students who have only seen patients within the "safe" walls of the UNC SOD clinics. On rotations, students learn about different health care delivery systems and have a chance to consider their roles as part of the system.

In 1999, the UNC SOD expanded extramural rotations after receiving a $230,000 grant from the Kate B. Reynolds Charitable Trust. With the funding, the numbers of preceptors and rotation sites were increased and the extramural rotations program was officially named Dentists in Service to Communities, or DISC.

North Carolina Pipeline Project UNC SOD students rate the AHEC-supported DISC rotations as one of the most positive experiences of their training. "Students find their off-campus rotations exciting and challenging," said Gene Sandler, DDS, MScD, Clinical Associate Professor with the UNC SOD. "Their patients aren't handpicked for them; they don't know what to expect when they pick up a chart. This is brand new territory; this is real-world dentistry."

UNC SOD rotations before the DISC grant were limited to junior and senior dental students and were usually completed in last summer before graduation. Typically, these students have already chosen where they plan to practice. The DISC grant extends rotation opportunities to sophomores and dental hygiene students with the goal to allow students to work with rural and underserved populations in community settings before they formulate career goals.

There are two primary outcomes of the DISC Program: it increases dental services for underserved populations by clinically treating patients, and it provides practical opportunities for students to experience the rewards of a career in dentistry that includes public service. In 2001, the second year of the grant cycle, the DISC Program worked in cooperation with NC AHEC to facilitate 46 extramural student clinical rotations in underserved settings. These students treated 1956 patients; 55 percent of the

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Ms. Farlow is the Communications Specialist for the North Carolina AHEC Program.

One source for this article was a previously published story in The North Carolina Dental Review. Excerpts are used here with permission from the author Wendy McCorkle and the UNC-Chapel Hill School of Dentistry.

patients treated were children. In monetary terms, students produced $173,769 worth of dental services.

Although UNC SOD began these rotations with the primary purpose of expanding the educational experience of future dentists, other benefits accrue as well. Preceptors, especially those located in the more rural parts of North Carolina, thrive on the interaction with students. UNC SOD reports that even though preceptors are unpaid, the school receives more requests for students than it can fill. So while students bring the latest techniques in dental education to preceptors, preceptors help students gain confidence in working on their own. It is an ideal partnership.

Only a small number of students ultimately choose careers in public health dentistry. However, community rotations where students work with underserved populations allow UNC SOD students to become more sensitive to the needs of patients with special needs or limited access to care. Extramural dental rotations are beneficial for students, their preceptors, patients in need, and the state of health care in North Carolina.

Reflections from the Dentist's Chair

Students on rotations through the DISC Program are required to keep a written and photographic journal of their community experience and write a reflective essay. The essay is an opportunity for students to contemplate the experiences from their rotations and examine the implications of these events for themselves, personally and professionally. The following are excerpts from student essays.

"Do we have the right as healthcare providers to say, 'Well this patient does not live by my moral values, therefore, this patient deserves inferior care?' I really don't think we do have that right. I can surely disagree with a patient's lifestyle from a moral perspective, but I am still obligated as a healthcare professional to provide that patient with the option of obtaining the best care possible."

"An elderly gentleman sat down in the chair. After reviewing his chart, I saw that he had cancer and asked how his treatment was going. He told me that treatment had been stopped and that he had 3-6 months to live. I was shocked because I could not believe that someone with that little time left was concerned with getting dentures. After talking with him, I learned that he had been edentulous for nearly ten years. He said that he wanted to die in comfort and 'enjoy his food during his last days on earth.' This statement was very touching. As a dentist, I know how important teeth are for a person's overall health. However, I never thought that I would be the person, a dentist, who would make a difference for a dying person."

"Before I had extracted the first tooth, Rodney was shaking all over. I can remember distinctly the shock I felt when I saw this. Was this the beginning of an epileptic seizure? Had I somehow injected the anesthetic straight into an artery? Was Rodney cold? It never occurred to me that Rodney was scared. I then felt a change in my disposition. I found myself consoling this 'hardened criminal' who all of a sudden was not so 'hardened.' My experience with Rodney taught me a great deal about a dentist's (especially my) relationship with his patient. I realized that everyone deserves your compassion and no one deserves your judgement."

The Nursing Collaborative:

Toward a Cohesive Workforce, Through Partnership

By Woody B. Hanes, RN, MSN, MEd, FNP

Turf battles and the associated lack of trust among health professions have been cited as a factor in frustrating change and reform efforts in the health care industry. Turf battles and mistrust, however, can also manifest themselves *within* professional groups and can result in a similar inertia.

In the case of the nursing profession, for example, myriad levels of entry (CNA to PhD), a jumble of employers (huge academic health centers to "mom and pop" long-term care facilities), and multiple roles (direct-care giver to cost-cutting administrator) often obscure issues of common interest to *all* nurses and can prevent the profession from speaking with one voice on issues that affect every nurse.

Woody Hanes, Program Director of the Virginia AHEC Program, served as the AHEC representative on the committee.

A group working to find common ground as the basis for action for Virginia's nurses is the Virginia Partnership for Nursing. The Partnership, established in late 1999, labors "to transform health care, by creating a nursing workforce responsive to consumer health needs." The Virginia AHEC Program serves as a vital entity in this partnership.

A committee with representatives from various nursing organizations including the State Council for Higher Education, nursing education programs and nursing and health care associations in Virginia began meeting on a regular basis in the fall of 1999. They address a decline in student enrollment in nursing programs throughout the state, a noticeable aging of the nursing workforce, and a concern by employers about ever increasing nursing vacancy rates. Any organization that was concerned about the nursing profession and was willing to meet regularly could become a committee member on a volunteer basis. Not only did community hospitals and long term care facilities sent representatives, but also regulators and public entities such as mental health agencies and correctional facilities joined the initiative. Voluntary funding supported the work of the committee, a pattern of funding that continues to this day.

'For lack of a bricks-and-mortar "home," the Partnership has created a virtual home that is always open at www.VirginianNurses.com. More importantly, any nurse at any location in Virginia is not only welcomed but encouraged to electronically "come and sit a spell."'

The committee evolved into the Virginia Partnership for Nursing, united by the common belief that Virginia was in the beginning stages of a severe nursing shortage.

By 2000, the Partnership produced its first report, which concluded that limited nursing workforce data existed. In collaboration with the Virginia Hospital and Health Care Association, nursing supply and demand data were collected from hospitals. These initial efforts resulted in work with legislators to direct the Board of Nursing to gather further data from its licensees. Efforts were also made with the legislature's Joint Commission on Health Care to study strategies to educate, train, recruit and retain nurses.

Throughout its three-year history, the Virginia Partnership for Nursing was fortunate to

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Virginia Partnership for Nursing

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have colleagues who provided essential material and service support. The Medical College of Virginia Foundation of Virginia Commonwealth University at Richmond donated fiscal accounting. Virginia Commonwealth University, along with Mary Washington Hospital at Fredericksburg, served as project leaders for the steering committee.

The Robert Wood Johnson Foundation (RWJF) also gave critical support. The Partnership applied for but did not receive competitive grant funding from the RWJF Colleagues in Caring Project (CIC). The grant application proved to be a fortunate investment of time and effort, however. RWJF CIC personnel encouraged the Partnership to join its CIC network as an unfunded affiliate member. Membership in the CIC network enabled the Partnership to obtain technical expertise, participate in CIC task forces, have committee members attend conferences without incurring registration fees and, more importantly, to share its information at the national level.

In 2001, the Partnership embarked upon an ambitious program to "flesh out" the organization's activities through a strategic planning effort. At two planning summits, participants developed strategic goals related to six issues.

The Virginia AHEC Program, along with the Virginia Nurses Association, has leadership and development responsibility for developing a strategy to *increase cultural, racial, and ethnic diversity in the nursing profession. (See related sidebar on this page.)*

Determined cooperation and creative strategies help the Partnership leverage its limited financial resources (approximately $40,000 over a three year period). For example, one partner will donate brochure design by its staff, another will provide copy, while a third will offer mailing service. It is worth noting that every strategic issue in the Partnership's plan for the future includes component based on "purely voluntary efforts" in which participants "will donate talent, time and travel." For lack of a bricks-and-mortar "home," the Partnership has created a virtual home that is always open at www.VirginianNurses.com. Any partner at any location in Virginia can access the web site and comment upon the ongoing work of the Partnership. More importantly, any nurse at any location in Virginia is not only welcomed but encouraged to electronically "come and sit a spell."

Can the Virginia Partnership for Nursing continue to avoid the internecine conflicts that potentially exist in the nursing profession? This will depend on the sustainability of the organization. The most committed of collaborators may tire without some insertion of additional human and financial resources, jeopardizing the cooperative manner in which the Partnership operates.

The Partnership, through a caring commitment to the future of nursing in Virginia, is viewed as a powerful influence within Virginia and serves as a strong voice for nursing in the health care and political area. The Virginia AHEC Program will continue to be a valuable partner in the Partnership through sharing of its health workforce development skills and expertise.

Ten Years of AHEC Experience

The Virginia AHEC Program has shared with the Partnership the knowledge it has gained from more than 10 years of experience in the area of health care recruitment and retention and supports the Virginia Partnership for Nursing in this area by:

- Collaborating with minority organizations to support recruitment and retention into nursing
- Identifying, providing, and supporting culturally sensitive continuing nursing education programs in Virginia.

AHEC
The National Area Health Education Centers Bulletin

In his lead article for the topic 'Disseminating the AHEC Model,' Mr. Baltus discusses how AHECs can further use the creativity and resourcefulness which have become their hallmarks to "market" their message.health coverage.

Disseminating the AHEC (Adaptive Organization) Model

By Dick Baltus

The thing about spending a couple decades in the same profession is, conscious effort or not, you learn things. And here, I believe, is the most important thing I've learned about marketing: If you don't have a product people want or need, all the marketing in the world won't do you any good. At least not over the long haul.

Of course, if you are fortunate enough to have a valued product, but you aren't successful at communicating with those who need or desire it, the results are just as fruitless.

So there you have it; in the span of 15 seconds, you've learned all you'll ever need to know about marketing and communication. Given the simplicity of these notions, you may find it surprising that those of us in the marketing profession can find enough work to stay busy. But the truth is, as basic as the idea seems that you have to tell people what you've got for them, often that is the last thing many product or program developers think about.

Among for-profits, that typically can be blamed on a rampant build-it-and-they-will-come mentality. In the not-for-profit sector, however, more often the culprit is a lack of resources, time or expertise. Whatever the origins, not-for-profit organizations typically are much more skilled at developing programs than disseminating information about them.

Without doubt, the AHEC organization is adept at identifying needs and developing programs to fulfill them. In the ever-shifting world of healthcare, AHECs stand as important and reliable sources of information, professional support, community outreach and training. They are of value to numerous, divergent constituents because they keep in sight the unifying goal of improved health care accessibility for everyone and are adaptable enough to follow many paths in its pursuit.

AHECs make measurable differences because they develop and provide programs based on the unique characteristics and needs of each constituent community: neighborhoods, cultural groups, students, health care providers, patients, training institutions, and so on. They begin by asking the community, "What do you need?" And they proceed, in partnership with those constituents, to develop programs that work toward filling specific needs. The resulting programs promise consumers more benefit than they require sacrifice, and evaluation and constant adjustments keep them relevant.

By seeking input from their audiences and tailoring their services to the specific needs and traits of those audiences, AHECs are almost a model in action of what is called social marketing. Almost, but not quite. Social marketing uses commercial marketing techniques to change people's behaviors and attitudes in pursuit of socially minded goals, such as improved health care accessibility. Its two key strategies are understanding and effectively communicating with target audiences.

Though effective at understanding constituent needs and responding to them through grassroots partnerships and program development, the AHEC model may not be so practiced

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Mr. Baltus is president of bbg marketing in Portland, Oregon.

'In the ever-shifting world of healthcare, AHECs stand as important and reliable sources of information, professional support, community outreach and training. They are of value to numerous, divergent constituents because they keep in sight the unifying goal of improved health care accessibility for everyone and are adaptable enough to follow many paths in its pursuit.'

Disseminating the AHEC Model

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at communicating its value. Unfortunately, even the most community-minded program must attract and hold its audience's attention to sustain long-term participation and support.

In the not-for-profit sector, this is not very easy to accomplish. Rarely are adequate resources available to fund a full-time marketing, or communications, person or even a significant marketing project. Adding this function to the already overcrowded job description of an AHEC director may be asking too much, but certainly communication needs to be an integral part of the program-planning mindset. As important as program development, funding and partnership building are, none of these activities can fully succeed without effective communication.

As a program develops, so too should a communications plan, your strategy for telling people about it. Just as community research drives program development, so too should it drive communications. How do the people who help inform your organization of the community's needs or who partner with your organization get their news? What are their values and cultural norms? What language do they speak? Where and how do they spend their time? The answer from each constituent may be different, and the program's communications plan should follow accordingly.

The lessons of social marketing should not be lost on AHEC. A product or service must be promoted, as well as designed and implemented, with constituent needs in mind. The greater the potential value of your service, the more it demands your promotional attention.

Community research — easily conducted simultaneously with a needs assessment — will suggest the most appropriate and cost-efficient promotions. You need not devote a large sum or even a burdensome amount of your time for a promotion to succeed. The key is creativity and resourcefulness, as the examples in this publication will demonstrate.

Social Marketing:

A Tool for the AHEC Toolbox

By Kelli McCormack Brown, PhD, CHES

Social marketing is "the adaptation of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreason, 1995: 7). Social marketing draws upon the behavioral sciences, communication, education, and commercial marketing theory and approach for determining the barriers and benefits that are relevant to understanding a health behavior, and then to develop a comprehensive marketing plan to encourage the audience to adopt the healthy behavior or to use recommended health services.

As the name suggests, marketing serves as the organizing concept and provides techniques for audience segmentation, product development, price analysis, and product distribution. A central component of marketing is consumer orientation, or listening to the consumer. To achieve consumer orientation, marketing theory offers social marketers a conceptual framework mnemonically known as "The 4 Ps." These variables must all be in place before bottom-line behavior change can be expected to occur:

· **Product** refers to what is being offered, that is, the benefits that consumers will gain from adopting it. The product may be a tangible commodity, a service or a practice.

· **Price** refers to the cost the consumer will have to pay in exchange for the product's benefits. This exchange may be a monetary transaction, but more commonly, is represented by nonmonetary costs, such as embarrassment, time, loss of self-esteem or pleasure.

· **Place** describes the location where services are distributed, and where consumers receive information. Place also addresses how to

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Dr. McCormack Brown is affiliated with the University of South Florida Prevention Research Center in Tampa.

A Tool for the AHEC Toolbox:

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direct messages about products so that the target audience will be most receptive to them.

· **Promotion** may include public relations, direct marketing, counseling, consumer education, social support, skills building and many other strategies to enact behavior change among the target population. A mix of channels is typically needed to reach people. It is common for mass media promotions to be equated with social marketing, but in reality, mass media is only one of many strategies used in combination to motivate behavior change, and may not be necessary at all depending upon the behavior change desired and the audience.

Six systematic phases or steps can accomplish social marketing. They are:

Initial planning phase. Existing data are used to develop a systematic plan for preliminary decisions. These data can come from a variety of sources, such as epidemiological data from local, state or federal vital statistics, or from literature reviews and projects that provide data about the target behavior and/or audience. The purpose of this phase is to eliminate options and identify decisions that still need to be made, especially the types of data to be collected in the formative research phase.

Formative research phase. In this phase potential target audiences and the realistic behaviors for those audiences are identified. Differences between audience subgroups are determined based on factors such as perceived benefits and barriers of the behavior. During this research phase factors influencing behavior through *both* qualitative and quantitative research methods are identified. Qualitative research methods such as in-depth interviews with key informants and or focus groups assist in identifying the factors that influence the target audience's behavior, whereas, quantitative data (i.e., surveys) identifies the factors with the greatest impact on the behavior. Formative research helps to the identify factors, such as previous behavior, self-esteem or knowledge, which influence behavior.

Strategy formation translates the formative research into a comprehensive strategy. During this phase the target audience and the specific behaviors to be influenced for each audience are identified. During this comprehensive strategy development it is extremely important to keep the 4 Ps (product, price, place, promotion) in mind. The data collected during the formative research phase will help in the development of strategies to maximize the benefits (product) and minimize the price (costs), as well as develop the right message for the target audience.

In the **program development** phase, materials are developed and pretested with the target audience. Information collected during the initial phases as well as data collected during formative research and strategy development are used. Information on spokespersons, placement of message, and types of materials to which the audience is receptive will guide development of materials. The key to pretesting materials to is

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The Four Ps and Six Phases of Social Marketing

"The 4 Ps" are variables that must all be in place before bottom-line behavior change can be expected to occur:

- Product
- Price
- Place
- Promotion

The following systematic phases or steps can accomplish social marketing:

1. Initial planning
2. Formative research
3. Strategic planning
4. Program/intervention development
5. Program/intervention implementation
6. Program/intervention evaluation/monitoring

make sure that the desired behavioral message is coming across to the target audience in a manner that they understand and will act upon, and at the same time ensuring that they understand the message or that they are not offended in anyway. Although pretesting concepts and materials may be time consuming it is well worth the time and costs associated with it.

Program implementation. During this phase coordination is critical. Included in implementation is the coordination of activities and interventions, as well as timing of information and materials and training of key people involved with program implementation. Sustainability is another element of program implementation.

Program evaluation/monitoring. Although this is the last phase, it must begin during the initial planning phase. When evaluating and monitoring a social marketing intervention, a change in behavior is sought, not knowledge, attitudes or perceptions; therefore, baseline behavior data is crucial to monitor the success of the social marketing intervention.

In summary, social marketing uses a systematic planning model to develop effective interventions for specific target audiences. It is based on understanding the target audience and the factors that influence the desired behavior. Behavior is the final outcome. Understanding the benefits (product) and barriers (price) of performing this behavior is key. Decisions are data-driven. Identifying the factors that influence the behavior and then developing programs and materials based on this data is critical.

Social Marketing and AHECs

AHECs across the country can use social marketing to better understand those they are trying to recruit, train, and retain for community-based health professions. In recruiting future public health professionals to serve in medically underserved areas it may be that students who have been involved with the health care or public health professions previously may have different recruiting needs than those who have never been exposed to primary health care or public health. Understanding these differences will allow AHEC to develop separate recruitment strategies for each target audience.

A key to social marketing success is maximizing the benefits and minimizing the costs. By understanding your consumers' wants and needs you can develop more systematic plans in recruiting, training and retaining community-based health professionals.

Source:
Andreason. A.R. (1995). Marketing social change: Changing behavior to promote health, social development and the environment. San Francisco, CA: Jossey-Bass.

Social Marketing Conference in Public Health

The 12th annual Social Marketing Conference in Public Health will be held June 19 – 22, 2002 in Clearwater Beach, Florida.

The conference is designed for public health professionals and health educators in a variety of settings including Centers for Disease Control and Prevention (CDC), state and local health departments, other public health agencies and non-profit organizations. Participants usually include CDC designees, program planners and administrators, health educators, health communication and health information specialists, researchers, academicians, and graduate students.

For more information go to:
http://www.hsc.usf.edu/publichealth/conted/sm02.html

The University of South Florida is also in the process of developing a graduate certificate program in Social Marketing and Public Health, the first of its kind in the United States. For information, contact Kelli McCormack Brown at kmbrown@hsc.usf.edu.

In his book, Shaping the Adaptive Organization,* William Fulmer presents a framework for thinking about the National AHEC Organization as an adaptive organization, both in terms of its history and its future. Fulmer's framework includes Landscape (the environment within which the organization functions); Learning (encouraging individual learning and organizing in a way to leverage individual learning); and Leadership (developing the capacity for nontraditional vision and skills).

NAO as an Adaptive Organization

By Carol Wolff, MA, and Charles G. Huntington, PA, MPH

Ms. Wolff is Executive Director of the Camden, New Jersey, AHEC Center and Immediate Past President of NAO.

Mr. Huntington is Associate Director of the Connecticut AHEC Program and President of NAO.

Understanding the history of an organization can be especially useful in understanding an organization's current operation and predicting how it might perform in the future.

In the beginning:
Two parallel organizations

NAO's history has included several major transitions. More than 25 years ago, the AHEC program directors were faced with the need to communicate with a unified voice to the Federal AHEC office and Congress. As a result, an informal organization called the National Association for AHEC Program Directors (NAPD) was formed. The landscape or environment within which this organization was created posed many challenges. Community-based health professions education and partnerships between academic health science centers and communities were new ideas and not well understood by host academic institutions.

Program directors, however, quickly understood the importance and value of networking and presenting a cohesive voice at the national level. They met on a quarterly basis in Washington, DC, and held annual retreats. Fulmer's third element of leadership quickly emerged.

Fortunately, competent, visionary leadership appeared at the helm of the NAPD with people like the late Gene Meyer, MD, Program Director for North Carolina AHEC program, and at the federal level with people like Cherry Tsutsumida, AHEC Branch Chief at HRSA. Although not always in agreement, both leaders possessed the vision and skills to move the AHEC concept forward. New leadership continued to emerge for the NAPD organization as it faced new challenges.

Twenty years ago, a parallel organization, the National AHEC Center Directors Association, was created in response to the needs of AHEC center directors. Center directors' issues were not focused on policy, but rather on the need to network and share resources among centers throughout the country. The environment facing most centers was one of isolation and disconnectedness. Centers functioned as community-based organizations, and communication with the academic health science centers was often a challenge. Sharing their collective experience was extremely important for AHEC center directors. This became the foundation for NACDA, which organized itself into a formal, dues-paying national organization with membership-elected leadership. Biannual national meetings to share information and experience were established along with a regular newsletter. Leadership emerged with the vision and skills to guide the organization in responding to its membership's needs. This early leadership included Jim Liest of North Carolina, Steve Meltzer of Washington and Ann Roggenbuck of Arizona.

Of note is the fact that the initial leadership of both organizations, NOAPD and NACDA, was predominately male. The gender distribution of the leadership has changed as both organizations included more female directors.

The Need for One National Organization

As the National AHEC program expanded and the HETC program was established, the utility of two separate organizations was questioned. *Could not one organization meet the needs of both constituencies?* This was not an easy transition. Some centers feared that merging into a national organization might mean dilution of their founding goals of networking and shared learning. Some program directors feared that

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Continued Growth

NAO has continued to adapt and grow since its incorporation five years ago. The charter constituency groups, Program Directors, Center Directors and HETCs, maintain primary responsibility for responding to the needs of their constituencies. Membership has increased steadily.

NAO as an Adaptive Organization

(Continued)

merger might mean a loss of control over policy issues. Some HETCs feared the loss of the identity that they were just beginning to establish. Fortunately, these groups had leaders who skillfully guided the creation of the National AHEC Organization in 1997. Pioneers during this transition were Steve Meltzer, Ida Walden, Andy Nichols and Julia Reed, to name just a few. The carefully worded articles of incorporation and bylaws responded to needs of the three constituencies; the NAO Bylaws identify as specific goals policy development, professional education and collaboration with other organizations.

NAO has made great strides in establishing itself as the recognized professional association for the national AHEC/HETC network. It has moved from an all volunteer organization to an association with professional management. New interest groups have been established (Librarians and Internationalizing AHECs) to add depth to membership. NAO organizes annual national conferences, which are state-hosted and financially supported by the Federal AHEC Branch. More recently NAO has been awarded two HRSA contracts to gather data on the national AHEC program and to produce a national AHEC resource directory.

Future

The environment within which AHECs and HETCs exist provides an ever-changing series of challenges. Be they cyclical shortages of specific health professionals (e.g., nurses), emerging health and public health issues (e.g., bioterrorism) or governmental policy directives (e.g., expansion of community health centers), NAO and its members will need to adapt their programs with an increasing degree of nimbleness. Accordingly, NAO must be structured to facilitate the adaptability of its members to an external environment that presents a continually changing array of challenges. NAO's capacity to respond to environmental changes is reflected in its ongoing strategic planning process. The strategic plan was first developed in 2001 and is actively used to organize the activities of the Board and the committees.

Leadership is the NAO's chief asset, and leadership development must be its primary activity. Organizations are adaptive primarily on the basis of their well-differentiated leadership. The NAO must foster within the national AHEC/HETC network a systems approach to leadership and provide the training and support for individuals who accept the considerable personal challenge of developing their leadership abilities. The NAO Leadership Conference in Portland, Oregon in August 2003, will provide a comprehensive introduction to leadership from a systems perspective. Additionally, through its public policy efforts, the NAO is positioning the AHEC/HETC network as a recognized national resource for addressing a broad range of health care and public health issues. Some of this important work is also being addressed by the AHEC/HETC representatives on the federal Advisory Committee on Interdisciplinary, Community-Based Linkages.

The ability of the NAO to foster the growth of the AHEC/HETC network is highly contingent on it being an adaptive organization of the type described by William Fulmer. A number of the association's current activities are consistent with the notion of an adaptive organization, but, clearly, more needs to be done. The continued ability of the NAO to serve its members requires its future leaders to recognize adaptability as a process rather than an end point.

Current NAO Activities, Expertise

Several current NAO activities are designed to foster the ability of AHECs and HETCs to learn and, importantly, to capture that learning in a way that advantages all NAO members. The NAO web site will continue to grow as a forum for the exchange of information and resources. AHECs and HETCs will be able to rely on the web site as a place to describe their current challenges as well as to share the development of relevant resources.

In order to focus the specialized expertise that exists within the AHEC/HETC network, the number and the level of activity of interest groups must increase. On the public policy front, if AHECs and HETCs are to be a bona fide national resource, then the AHEC/HETC network must become truly national in scope by fostering the development of new programs in the last few remaining states without AHEC or HETC services. Furthermore, the resources of all existing AHEC and HETC programs must be increased to the point of having sufficient reserve capacity to respond quickly to emerging national health priorities.

Finally, formal liaison relationships must be developed with additional organizations with similar policy interests (e.g., National Association of Community Health Centers, American Academy of Family Physicians).

AHEC
The National Area Health Education Centers Bulletin

Spirit of AHEC/HETC

Camden Farmers' Market

Serving the Health and Nutrition Needs of the Community

By Linda Boclair and Martha Chavis

If you were invited to a community farmers' market located in the center of Camden, New Jersey, the fifth poorest city in the nation and the first on the east coast, what would you expect to see? A few tables with a scant supply of fruits and vegetables and an occasional customer stopping by to pass the time and perhaps buy an apple or two? You've probably read that over half of the children in Camden live at or below the poverty level and that single parents head about half of the homes. You've also read that crimes abound, everything from petty theft to homicide, and drug trafficking is alive and well in Camden.

Now picture yourself walking down Broadway in Camden and approaching a farmers' market. You've accepted Camden AHEC's invitation to visit the Community Farmers' Market and you can't believe what you see. You see a vibrant market with an abundance of fresh, colorful fruits and vegetables and customers vying for the attention of the farmer and her helpers. You see a clown with balloons in the shapes of bunnies, hats and rockets and children gathered around him. You hear music in the background. But there is more; who is the young man with the stethoscope and the woman with the blood pressure cuff? Who are the youth, helping the farmer to fill the baskets with Jersey-grown apples and tomatoes and other produce? And where did they learn those customer service skills: helpful, pleasant and patient with young and old alike? A pleasant young woman in a bright orange jacket introduces herself as the nutrition consultant and welcomes you to the Market. Perhaps this isn't the same Camden that you've been reading about or perhaps your information is outdated and you are seeing the revival of Camden.

Customers buy produce and receive free vision screenings at the Camden Community Farmers' Market.

What you are seeing is one of many successful initiatives in Camden that contributes to the revival of a once vibrant city that has been economically depressed for decades. With Camden AHEC as the lead agency, a diverse group of health and human service providers, businesses, religious institutions, government entities and individuals interested in supporting the Farmers' Market came together in 1996 to form the Farmers' Market Coalition. Today the Coalition numbers 40 member organizations whose mission it is to improve the quality of life of the community by promoting good nutrition and disease prevention. This is accomplished by offering fresh fruits and vegetables, nutrition and health education, food demonstrations and screenings for diseases such as diabetes and hypertension.

Let's return to that walk down Broadway and your first impression of the Market. To answer many of the questions (i.e. who is the young man with the stethoscope and the woman with the blood pressure cuff and who are the youth and what about the nutritionist?) we need to "go behind the scenes."

The Market affords Camden AHEC the perfect opportunity to accomplish it's mission "…to improve the quality of life of the community through collaborative efforts to educate both users and providers of health services and to advocate for the responsible delivery and use of health care." A primary goal is to "bridge the gap" between the community and the health care system. Bringing the community and the health care system together involves working with the community to ensure access to high quality health care while addressing the competence of the health workforce in its ability to serve the underserved community. While Cam-

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Camden Farmers' Market

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den is rich in medical resources, including three hospitals, one Federally Qualified Health Center (FQHC), a medical school, two nursing schools and many social service agencies, services are often not reaching the community. Let's see how Camden AHEC works to promote cultural and community competence among the health workforce while encouraging youth to pursue careers in health.

'My internship at Camden AHEC was a positive experience that provided me with a better understanding of multicultural and interdisciplinary care in the city of Camden. I believe that there is a greater need for services there. I have been encouraged by this experience and will take a more active role in medical care in underserved areas.'

Medical Student, UMDNJ-SOM

Yes, the young man with the stethoscope at the Farmers' Market was a third year medical student at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine (UMDNJ-SOM). Camden AHEC's role in preparing him to serve at the Farmers' Market began during his second year of medical school with coursework and community projects developed as a collaborative effort by AHEC and UMDNJ-SOM. He learned the meaning of cultural competency and the skills required of a culturally competent clinician. He talked to migrant farm workers, uninsured Latinos and African Americans and the homeless and heard their plights in living with chronic diseases. Lack of health insurance, language barriers and the health care system's insensitivity to social and economic problems impacting the health of the underserved resulted in limited, if not nonexistent, access to quality health care. By the time he reached his third year of medical school the student was ready to serve an internship at Camden AHEC and had clearly defined goals for working with the community at the Farmers' Market. He was afforded the opportunity to learn from the community and give back to the community by educating, assessing and developing trust. He learned the relationship between nutrition and health promotion/disease prevention from the nutrition consultant and vowed to apply his knowledge in practice. He developed a more holistic understanding of how people's life styles and culture impact on their choices and health. In addition to medical students, health and human service professions students (nursing, social work, physical therapy, public health) from local colleges and universities serve internships at Camden AHEC. Evaluations by the students and their preceptors indicate a better understanding of the needs of the underserved and development of skills required of culturally competent practitioners.

Fresh produce and free vision screenings are easily available to customers at the Camden Community Farmers' Market.

'The Farmers' Market has done so much for our hospital in bringing us closer to the community, especially to the seniors, and helping us to understand the needs of the underserved.'

Nurse Educator

What could a nurse from a Camden City hospital or clinic possibly learn about the needs of the underserved by participating in health promotion activities at the Farmers' Market? Plenty. Thanks to a very supportive and active Farmers' Market Coalition, health care providers represented on the Coalition volunteer their time to provide health education and screenings at the Market. In turn, they network with outreach workers and others who have the "pulse" of the community. They see their patients who have missed or simply have not scheduled appointments and have the opportunity to re-establish contact and work through barriers to accessing services. They may have

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Camden Farmers' Market

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attended one of dozens of cultural competency training programs offered by Camden AHEC, thus furthering their knowledge of the skills needed to practice as culturally competent clinicians. They talk to Women, Infant and Children (WIC) clients and the nutrition consultant and gain a better understanding of how WIC encourages good nutrition for pregnant women and children through education and issuance of the food vouchers that the clients redeem for fresh produce at the Farmers' Market. They watch the senior citizens as they redeem their food vouchers and hear the discussions with the nutritionist about food preparation techniques to help in controlling blood pressure or lowering cholesterol. They learn of the dietary habits of Latinos, African-Americans, Asians and other cultures and the impact on maintaining healthy lifestyles. They all agree that the experience is invaluable in increasing their understanding of and ability to provide services to underserved populations. Lessons learned are shared with colleagues and frequently policies and procedures are developed and/or revised to reflect changes that result in improved services.

'...I learned that smoking and drinking and using drugs and eating a lot of fast food can cause cancer and heart problems and other diseases...and then I talked to a doctor and he told me all about what he does and how he got to be a doctor...'

Youth Advocacy Health Program Participant

The youth helping the farmer represent one of several groups of youth involved in AHEC health and nutrition programs. They are funded through the Camden Empowerment Zone and receive training from AHEC in job readiness (dress, work habits, expectations), math and public relations, communication skills, career development, health and nutrition, teambuilding and marketing. All of the pre-college (and younger) students in AHEC's programs represent underserved communities and all programs include a health careers component. Students hear presentations by health professionals, followed by question and answer sessions and field trips to hospitals, clinics, private practices, and research and clinical laboratories. Camden AHEC was a founding member of the Camden Medical Arts High School, whose mission is to prepare Camden youth to pursue careers in health care.

Promoting cultural competence and training pre-doctoral students and practitioners to work with underserved populations have been key in serving the health and nutrition needs of the community at the Farmers' Market. In addition, Camden AHEC has demonstrated community competence through it's leadership in the implementation of the Community Farmers' Market. The Market represents a marriage of economic and community development. The Market has brought life to a once depressed area of the city. Small businesses in the area have experienced increased growth, youth are employed and learn invaluable work skills, the community has a place to meet and purchase fresh produce, medical and health professions students, representing the future health workforce, learn what it means to be a culturally competent practitioner and stakeholders see the Market as a viable and important project to be expanded throughout Camden. Recently a local congressman chose the Market to launch a campaign related to food stamps, while applauding the importance of the Market in providing fresh produce and health education. The Market is also a popular site for special events, such as the celebration of National Lead Poisoning Prevention Week with emphasis on the importance of good nutrition in preventing lead poisoning in children.

In addition to recognition by the NAO, the Farmer's Market has recently been awarded The Mutual of America Community Partnership Award, representing national recognition for excellence in a project that demonstrates true collaboration among stakeholders while having a significant impact on the community served by the project.

"Camden AHEC is greatly indebted to Martha Chavis, Program Consultant, for her tireless commitment to the Farmers' Market and her determination for the Market to succeed in serving the needs of the community."

Carol Wolff, Executive Director,
Camden AHEC

Spirit of AHEC/HETC

One school – Two planets

Students Teach East Texas - Brazos AHEC Teacher

By April Heiser

I am asked each year to do health careers presentations to several classes at a local elementary school. On a Monday last October, I presented to a mixed fourth-to-sixth grade group, focusing on the techniques and "toys" health professionals use to diagnose illnesses. I had x-rays, CT scans, a sonogram, stethoscopes, and various internal body part models on display.

As I entered the classroom, students were orderly and attentive, and ready to hear all about career opportunities in the health field. As we discussed diagnostic techniques, this astute class correctly answered questions about anatomy and physiology. What is the largest bone in the body? Where would you find the smallest? What techniques and tools would we use to see the brain, bones and soft tissue of the body? The class knew that an MRI worked as a magnet and that x-rays were a special form of light. The health careers they already knew something about included psychologist, phlebotomist and various medical specialties. Their career questions were about cardiovascular surgeon, optometrist and pharmacist. I felt that I was not speaking to fourth-to-sixth graders, but to advanced high school students. We carried the conversation to a level I had not anticipated. In short, it was refreshing. I left that day feeling quite positive about the future of our health care workforce.

Then I went back on Tuesday…

As I entered this noisy classroom, the students ran to the front with their chairs to get close. I knew this was going to be more than just an interesting class when I felt a tug on my shirt, "Hey, miss. Hey, miss. Do you wanna see my fake leg?" Well of course! Who would want to miss that? I turned around to see a wiry, freckle-faced, red headed boy holding his new leg up for me to see. He whacked it a couple of times to show me it was real… or, I guess, to show me that it wasn't. He was so proud and excited about it. Always in health career mode, I fed off that enthusiasm and told him and the kids sitting next to him about the career of prosthetist/orthotist. The boy grinned from ear to ear.

As I began my regular presentation to the rest of the class, the students mentioned that they had heard of pediatricians, veterinarians, dentists and various other health careers – including "nurses who are boys."

I showed them some x-rays, which prompted the first in a series of interesting but disturbing questions. "Do any of these x-rays show a tumor?" Well, no. Most of these x-rays show healthy bones. We moved on. "Can you look at my finger? I hurt it a couple of weeks ago and didn't get an x-ray. It could be broken or it might have a tumor in it." WHAT???

Moving on – MRI's. Does anyone know about MRIs or "cat scans?" "Yeah – Wolverine had one of those in the X-Men movie!" "Cool!" Then I heard, "Do any of those pictures show a tumor?" I was beginning to see a pattern.

Finally, a student asked the big question, " What is a tumor?" I took a moment to answer the question honestly with basic medical terms and tried to make it clearer with examples and comparisons. The students seemed satisfied and I thought that maybe the tumor questions were over. We moved on to looking at a sonogram. "Where does that baby come out of?"

Oh boy, can we go back to the tumor question?

I had to end my presentation and was about to leave when several students swarmed me with questions about possible head injuries they had suffered. Some were showing me scars and telling me about their mom or aunt who was a nurse. The smallest kid in the class pushed his way through and with a very worried face he asked me, "What if I had a tumor right next to my heart? How would I know?" This final tumor question really disturbed me because he was so very serious. I asked him if he knew someone who had cancer. He said that his grandmother and grandfather had tumors and died. I told him how sorry I was, but at the same time tried to reassure him that cancer usually happens to older people. He asked if it could be healed. I told him that sometimes they remove the tumor or treat it with medicine to make it go away, but that it doesn't always work. It is had to be honest and comforting at the same time.

I left partly laughing at the weird questions from this group of kids and partly feeling very concerned about their preoccupation with cancer. When I got to my office we all laughed about the "dog" question and the "baby" question. Then I called the counselor at the school to tell her how great and inquisitive her students had been. I mentioned the numerous cancer questions and suggested that they might need someone to come and talk to them. The counselor was not surprised and explained that the boy with the artificial leg had lost his real leg last year to cancer. His classmates have been concerned and worried about him for more than a year. They try to learn everything they can about cancer. Even better, they are fiercely protective of him and are just as proud of his new leg as he is. No fourth grade teasing. No fifth grade exclusion. No sixth grade oblivion to the needs of others. They are just a quirky, curious group of kids with an enormous amount of love and concern for one of their own through the scariest of diseases.

I feel quite positive about the future of our health care workforce.

Ms. Heiser is Program Coordinator for Health Careers Promotions at Brazos AHEC, and embodies "The Spirit of AHEC."

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> ***Border HETCs located in Arizona, California, New Mexico, Texas and Florida receive one-half of HETC funds for long-term projects within 300 miles of the U.S.-Mexico border.***

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AHEC: Not Just Workforce
Enhancing the Health of the Public

AHEC Bulletin Fall 2002 Call for Articles

The "business" of AHEC has been to train health practitioners in the community away from the hospital setting. Placing practitioners in the community brings in elements of care not usually seen in a hospital setting. In secondary prevention, AHEC-trained health practitioners have the opportunity to impact the disease process soon after diagnosis or, in primary prevention, to prevent the disease process altogether. HETCs were developed with a similar but distinct mission, not only to train practitioners in community-based settings, but also to look at the most severe health issues plaguing a community and seek to impact those health problems at both the individual and the community levels through a variety of education and other supportive interventions.

The discipline of public health identifies ten essential elements that define public health practice. AHECs/HETCs respond to address the essential elements that include monitoring the health status of the community, informing, educating and empowering the community about health issues that assist public health agencies to meet these essential elements. The community needs assessment done routinely by AHECs and HETCs is conducted in order to attack health workforce issues but really accomplishes an essential public health function as well. Most often the AHEC-conducted needs assessment not only identifies workforce issues but also identifies health education and prevention needs in the community due to the lack of available workforce.

AHEC/HETC traditional goals and objectives are interwoven with the ten essential elements describing public health practice intended to improve the health of the public. Simply put, AHEC/HETC is not about workforce training and distribution, but about the health of the public.

The National AHEC Bulletin Editorial Board is interested in articles focusing on the public health activities your AHECs/HETCs engage in.

Deadline for First Draft of Articles: June 28, 2002

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Building Community/Academic Partnerships For Health

NAO

National AHEC Organization

The AHEC Mission

To enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships.

The National AHEC Bulletin is now an official publication of the National AHEC Organization (NAO). NAO will copyright the name National AHEC Bulletin, will contract for editorial services for the Bulletin beginning July 1, 2002, and will be responsible for production tasks beginning with the Fall 2002 edition.

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