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AHEC

The National Area Health Education Centers Bulletin

Volume XX, Number 2
Spring 2004

A Publication of the National AHEC Organization

A New State Perspective

By Sen. Chuck Hagel

As you know, Area Health Education Centers improve access to quality health care, and are critical to expanding the pipeline of health professionals. What is so special about AHECs is that they do this through educational partnerships with the community and academia.

Health career recruitment programs are desperately needed. For example, by next year, nearly one in ten nursing positions in Nebraska will be unfilled.

The Health Professions Education Partnership Act of 1998 funds education and scholarship programs for: primary care, dentistry, nursing, pharmacy, public health, pediatric dentistry, and other allied health professions. These programs also develop interdisciplinary and community-based linkages, including AHECs. Known collectively as Title VII health professions training programs, these are the only federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, such as rural residents, as well as to increase minority representation in the health care workforce.

(Continued on Page 3)

Fighting for AHECs

By Sen. Barbara Mikulski

As a Senator from Maryland and for Maryland, I am fighting for quality and accessible health care. That's why I am proud to support Area Health Education Centers (AHECs.) AHECs are vital health care resources, working behind the scenes to meet the day-to-day needs of our communities and the long-range needs of our nation.

The impacts of AHECs are tangible: an increased number of health professionals practicing in underserved areas, a network of community-based training sites providing educational services to students, faculty and practitioners, and ultimately, improved delivery of health care in communities all over the country.

I'm so proud of the AHECs in my home state, fighting for the health care needs of all Marylanders. AHECs meet the people where they are, whether it is underserved rural areas of Western Maryland and the Eastern Shore, or the urban communities of Baltimore. Maryland AHECs do it all: sponsoring continuing education courses, creating and maintaining professional caucuses, administering clinical education programs, and conducting academic

(Continued on Page 2)

Challenge And Opportunity

By Kery Hummel, and Kathy Vasquez

Editorial Overview

CHALLENGE AND OPPORTUNITY – two key words as this Spring, 04 issue of the National AHEC Bulletin was developed. Conceptually, the Editorial Board believed that having our partners tell the AHEC story would be timely and most appropriate.

The National AHEC Organization is honored to have our lead articles from Senator Chuck Hagel (R-Nebraska) and Senator Barbara Mikulski (D-Maryland). Their enthusiastic support for the AHEC program in general and in their respective states reflects the bipartisan nature of AHECs. Both Senators recognize that AHECs strive to improve the quality of healthcare and its workforce in the current and future healthcare delivery systems.

We also have an article from Dr. Peter Kohler, who addressed our 2003 NAO Leadership Conference in Portland, OR. Dr. Kohler describes the crucial partnership between an academic healthcare center and its community when developing an Area Health Education Center.

AHECs begin as a partnership between academia and a community of healthcare professionals. This partnership grows such that AHECs have been described as a "partnership of partnerships." Our centerfold was designed to actually list the extensive variety of partners described in each of our articles – a very impressive list. Take a close look at the lists; if you are an AHEC, perhaps you will get ideas to tap new partners. If you are a partner organization, consider the outstanding company you share and know that you are vital to the AHEC mission. If you are an elected official, we hope that you will be impressed with the magnitude of results when federal, state and local AHEC resources come together in local communities.

(Continued on Page 2)

The National AHEC Organization supports and advances the Area Health Education Centers/Health Education and Training Centers (AHEC/HETC) network in improving the health of individuals and communities by transforming health care through education. The National AHEC Bulletin is published semi-annually by NAO.

Challenge and Opportunity

Ms. Vasquez is Director of the Ohio Statewide AHEC Program, and the Medical College of Ohio Office of Rural Health and AHEC. She is the co-Guest Editor of the Spring 2004 NAO Bulletin.

Kery Hummel is Executive Director of the Western Maryland AHEC Center in Cumberland, MD, a member of the National AHEC Bulletin Editorial Board and co-Guest Editor of the Spring 2004 NAO Bulletin.

In addition, as articles were received for this issue, the topics included Student Experiences, Health Career Pipeline Development, Nursing Workforce Development, Physician Workforce Development, and Community Partnerships. As Guest Editors, we want to thank everyone that contributed articles for this issue.

We sincerely hope that all of you disseminate this issue to all of your partners, elected officials and those people in your community that may ask they question, "What is an AHEC?"

Fighting for AHECs

Sen. Barbara Mikulski

enrichment programs to attract young people into health careers.

Across the nation, AHECs build coalitions to get things done: partnering academic and clinical resources with a wide range of local, state and federal programs, and non-profit and faith-based organizations. Though the mission in each center is the same, to enhance access to quality health care, individual AHECs address the mission with positive initiatives that solve unique local needs. In rural areas, some AHECs provide health departments and hospitals with much needed telecommunications technology linking clinics to central hospitals. In some urban areas, AHECs offer no-cost health care through clinics in schools.

I am fighting to provide AHECs with $33.1 million this year. I believe the Administration's proposed budget, which includes no funding for AHECs, hampers our abilities to address the shortage of qualified and willing health professionals available to care for the nation's under-served populations. I am also working to empower men and women to consider nursing by making it more affordable and by providing opportunities for advancement. The Nurse Reinvestment Act, which I introduced in 2001, is an important start: providing scholarships to nursing students, increasing the number of nursing faculty, and offering opportunities for additional nurse education, training, and retention. I am making nursing a priority in the federal checkbook by increasing funding for nursing education programs by over $45 million in the last two years.

'AHECs are essential: intricately woven into the fabric of their regions, benefiting their communities in countless ways.'

AHECs do it all. No problem is too big or too small: geriatrics, children's health insurance, adult medical services for the poor and uninsured, promotion of interdisciplinary health practice, social services, workforce development, health workforce shortages, and education. AHECs are essential: intricately woven into the fabric of their regions, benefiting their communities in countless ways. That's why I will keep fighting for AHECs.

About Senator Mikulski

Growing up in the Highlandtown neighborhood of East Baltimore, Senator Mikulski learned the values of hard work, neighbor helping neighbor and heartfelt patriotism. Determined to make a difference in her community, Mikulski became a social worker and community activist. These experiences provided valuable lessons that Mikulski now draws on as a United States Senator.

Senator Mikulski is active on issues concerning America's seniors, women's health, veterans, and public housing. She serves on numerous committees including Health, Education, Labor and Pensions Committee (HELP), Subcommittee on Aging, Appropriations Committee, Subcommittee on Veterans Affairs, Housing and Urban Development and Independent Agencies, Subcommittee on Commerce, Justice, State, and the Judiciary, Subcommittee on Foreign Operations, Subcommittee on Transportation/Treasury and General Government, and the Subcommittee on Homeland Security, Senate Select Committee On Intelligence.

(B) ADDITIONAL OPPORTUNITIES NOT INCLUDED IN WORKSHOP REGISTRATION FEE

SPECIAL SESSIONS

Pre-registration required for all Special Sessions. Continuing Education/CME Credits and Certificates of Attendance.

I will attend the:
- ❑ **New Directors' Orientation and Box Lunch** – Sunday ..... N/C
- ❑ **Program Directors' Meeting and Box Lunch** – Tuesday ..... N/C
- ❑ **Center Directors' Meeting and Box Lunch** – Tuesday ..... N/C
- ❑ **Center Directors' Networking Dinner** – Saturday ..... $40 $ _____

	Early Registration (Received by 6/11/04)	Regular Registration (Received after 6/11/04)	
Skill Building Session – Sunday (Check one session below)	$80	$100	$ _____
❑ A) Strategic Planning for your AHEC / HETC			
❑ B) Financial Management			
❑ C) A Collaborative Approach to the Logic Modeling Process			
❑ **Certificate of Attendance** (Processing Fee) (Available to all attendees)	$10	$10	$ _____
❑ **Continuing Education/CME Credits** (Processing Fee)	$35	$35	$ _____

FAMILY / GUEST MEAL TICKETS (for family / guest of registrant)

	Early Registration	Regular Registration	
❑ **All Meal Functions**	$245	$265	$ _____
❑ **Two Evening Receptions/Aquarium**	$135	$155	$ _____
❑ **Aquarium Only on Monday night**	$10	$15	$ _____

NAO GROUP EXCURSIONS / DISCOUNTED ATTRACTION TICKETS

		# of Tickets	
❑ **Walking Tour of Annapolis**	$45	____ x $45	$ _____
❑ **Orioles Baseball Game and Bull Pen Party**	$25	____ x $25	$ _____
❑ **Fell's Point Ghost Walking Tour**	$12 Adults	____ x $12	$ _____
Three times available: (Select one) ❑ 5:30 pm - 6:30 pm ❑ 7:00 pm - 8:00 pm ❑ 8:30 pm - 9:30 pm	$8 Children 12 yrs & under	____ x $8	$ _____
❑ **Ed Kane's Water Taxis**	$5 per ticket	____ x $5	$ _____
❑ **Ride the Ducks**	$18.50 Adults	____ x $18.50	$ _____
	$12 Children	____ x $12	$ _____

All cancellations must be in writing and postmarked by July 16, 2004, to receive a full refund less a $50 administrative fee. Cancellations received after July 16, 2004, will not be eligible for refund. However, an alternate person may attend for the registrant. Refunds will be processed after the workshop. All fees are payable in U.S. dollars.

Total this page $ _____
Registration Total from Page 1 $ _____
TOTAL ENCLOSED $ _____

PAYMENT

❑ Check # _____ (Make payable to: NAO)

❑ P.O. # _____
(Purchase order payments must be received by 6/11/04. Please attach a copy of Purchase Order.)

❑ Charge (complete information below and fax to 503.244.2401 **OR** go to www.NAOconference.com to register online)
Type of Card: ❑ VISA ❑ MasterCard ❑ American Express

Account Number: _____ Exp. Date: _____
Cardholder: _____ Signature: _____
Address Credit Card is billed to: _____
Note: Credit card cannot be processed without legible, complete and correct credit card billing address.
Contact Name and Phone Number if there are questions about credit card: _____

Submit registration form and payment on or before June 11, 2004 to qualify for Early Registration special rates.
Send to: NAO, c/o EWE ME and Company, 2545 SW Spring Garden Street, Suite 150, Portland, OR 97219

NAO Workshop Registration

NAO Workshop • July 31 - August 4, 2004 • Marriott Waterfront Hotel • Baltimore, Maryland

THE EASIEST WAY TO REGISTER IS ONLINE at www.NAOconference.com
Online registration requires payment by credit card on our secure web site. Please complete one form per person.

PLEASE TYPE OR PRINT LEGIBLY

First Name _____ Last Name _____

Badge First Name (if different) _____ Title _____

Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

❑ New Director ❑ Program Director ❑ Center Director
❑ Check here if you do NOT want your information listed in the workshop attendee roster.
❑ I have a disability and will need assistance or special accommodations to participate. Please specify or call our workshop planner at 503.244.4294 x202. For TTY/Voice Needs, call 1-800-735-2258 five days prior to arrival.

_____

❑ Special Meal Requirements: ❑ Vegetarian ❑ Vegan

(A) WORKSHOP REGISTRATION FEES INCLUDE

Registration fees include workshop packet, entry to exhibit hall, poster session, workshops and general sessions, refreshment breaks, breakfast on Monday, Tuesday and Wednesday, lunch on Monday, the Sunday and Monday evening buffets, entrance to the Aquarium on Monday night, and Fun Run / Walk on Tuesday.

Pre-Workshop events include selected Sunday Sessions and Group Excursions; CEUs, CMEs and Certificates of Attendance are not included in the registration fee and must be purchased separately.

	Early Registration (Received by 6/11/04)	Regular Registration (Received after 6/11/04)	
NAO Member			
Full Workshop	$425	$465	$ _____
Three or more from same organization	$395 each	$435 each	$ _____
One-day Registration	$175	$195	$ _____
❑ Sunday ❑ Monday ❑ Tuesday			
Non-Member			
One	$525	$565	$ _____
Three or more from same organization	$495 each	$535 each	$ _____
One-day Registration	$225	$245	$ _____
❑ Sunday ❑ Monday ❑ Tuesday			
Student Rate	$175	$195	$ _____
Fun Run/Walk	N/C	N/C	

❑ I plan to attend the Fun Run/Walk on Tuesday morning
(A T-Shirt will be provided if the event is Sponsored.)
T-Shirt size: ❑ S ❑ M ❑ L ❑ XL ❑ XXL

Registration Page 1 Total $ _____

Registration Page 1 of 2

Registration form continued on next page.

A New State Perspective


Sen. Chuck Hagel

Nebraska received nearly $3 million from these programs in FY 2002, and just over $4 million in 2003. But the overall budget picture is not so rosy. President Bush's budget request for Fiscal Year 2005 contained only $11 million for Title VII programs, down from $294 million in Fiscal Year 2004. I joined 13 of my Senate colleagues in signing a letter requesting $308 million in funding for Title VII, which is equal to the FY2003 funding level. I will continue to support funding for these programs.

Nebraska was awarded its first AHEC grant in 2001, with the first center officially opening in February of 2002 in Grand Island, serving 28 counties in central Nebraska. The second center opened in January of 2003 in Norfolk, serving 22 counties in northern Nebraska.

The commitment to AHECs in Nebraska is deep. UNMC faculty member Dr. Mike Sitorius serves as the State AHEC Director and Roxanna Jokela as Deputy Director. Dorothy Anderson of my staff is a member of the Statewide AHEC Advisory Board. The state continues to provide annual support of more than $1 million for rural education and outreach programs. I'd like to share with you two of the innovative programs going on at Nebraska AHECs to enhance access to quality health care.

'Central Nebraska AHEC has aided the Nebraska Department of Education to move forward in the development of health science as a vocational area.'

Central Nebraska AHEC has aided the Nebraska Department of Education to move forward in the development of health science as a vocational area. Central Nebraska AHEC was also able to obtain $1 million grant from the Robert Wood Johnson foundation to improve communications between Latino patients and healthcare providers.

One of the best health professions recruitment tools is 'job shadowing,' where prospective students follow a health professional to learn more about the career. Because of privacy and confidentiality concerns, some practitioners and small healthcare organizations were reluctant to participate in job shadowing programs. In response to these concerns, Northern Nebraska AHEC has developed on online confidentiality and HIPAA training program to provide students with basic confidentiality training.

Recently, Nebraska has also applied for a continuing grant to support the development of three additional AHECs to cover the state. Nebraska can be proud of the work begin done by AHECs across our state.

About Senator Hagel

Chuck Hagel, Nebraska's senior U.S. Senator, was re-elected to his second term in the United States Senate on November 5, 2002 with 83% of the vote. Senator Hagel's duties include membership on three Senate committees: Foreign Relations; Banking, Housing and Urban Affairs; and Select Committee on Intelligence. Hagel is chairman of the Senate Foreign Relations International Economic Policy, Export and Trade Promotion Subcommittee and the Senate Banking International Trade and Finance Subcommittee. Hagel serves as the Co-chairman of the Congressional-Executive Commission on China.

Hagel served in Vietnam with his brother Tom in 1968. They served side by side as infantry squad leaders with the U.S. Army's 9th Infantry Division. Hagel earned many military decorations and honors, including two Purple Hearts.

A fourth generation Nebraskan, Hagel was born in North Platte, Nebraska on October 4, 1946. He graduated from St. Bonaventure High School, Columbus, Nebraska, the Brown Institute for Radio and Television, Minneapolis, Minnesota, and the University of Nebraska at Omaha.

Minnesota
Creating New AHEC Partnerships:
The Benefits of Community Engagement

Jeny Stumpf Kertz, MPP, Deputy Director, Minnesota AHEC and Lawrence Massa, CEO, Rice Memorial Hospital, Willmar, Minnesota

As a newly funded AHEC Program, the University of Minnesota sponsored a competitive process for communities to select their AHEC host. The result was a strong formation of community engagement from the very beginning.

Jeny Stumpf Kertz is the Deputy Director of the Minnesota AHEC, Minneapolis, Minnesota.

Lawrence Massa, CEO, Rice Memorial Hospital, Willmar, Minnesota.

While AHEC is more than 30 years old nationally, it is in its infancy in Minnesota. Initiated in 2002, Minnesota AHEC represents a new generation of partnerships between our communities and the University of Minnesota – grounded in a philosophy of sharing the risks, rewards and benefits of collaboration.

These new AHEC partners understand that as rural communities and higher education institutions continue to face difficult economic times, they need to work together to address common challenges. From the community perspective, stakeholders recognize the significant healthcare workforce challenges they face. They also know that direct, hands-on experience in the rural clinical practice environment and rural lifestyle helps dispel misconceptions and "myths" about perceived differences in quality and vitality. It also allows students to directly observe the needs of rural communities and get a sense of the importance of their work.

With this understanding, Minnesota AHEC has created community-university partnerships to address health care workforce concerns by engaging interested communities in the development of the regional AHECs.

Two regional AHECs were established during Minnesota AHEC's first 18 months. While physically located at local hospitals, the AHECs are actually hosted by the communities in which they reside. These host communities were selected through a competitive, community-based process that allowed communities in an AHEC region to come together and share, with their peers, their visions for leadership of the AHEC on behalf of the region as a whole. By doing so, communities actively participate in the selection process, are engaged in AHEC development and are holding the host community accountable to the commitment they made.

In northeast Minnesota, three communities participated in a forum to select their AHEC host. Participants included hospital administrators, physicians, nurse educators, business leaders, local elected officials, and academic partners. Senior leaders and faculty from the University of Minnesota and regional rural health partners also participated. Over the course of four hours, each community presented their strengths, resources, collaborations, regional involvement, creativity and innovation. At the end of the forum, participants shared their ideas about which community best demonstrated a commitment to the AHEC philosophy and ability to provide regional leadership.

In southern Minnesota, community engagement was inspiring. During early development, a small meeting planned for four interested individuals to meet with university representatives materialized into a large forum with 36 community members from the local Chamber of Commerce, hospital, county extension service and block nurse program. Each person demonstrated their personal and professional commitment to health professions education in the community.

When it was time to select a host, four communities took part. Mirroring the experience of northeast Minnesota, teams of community representatives showcased their communities, including their relationships, collaboration and commitment to provide leadership. An important realization was that they had a responsibility to go above and beyond their traditional role to not only meet

(Continued on next page)

Creative Partnerships

the HCMH Wellness Center, the Community Health Center, Home Health, Hospice, and remote sites at Mason, Johnson City, and Marble Falls, Texas.

In seeking the Community Networking Grant (CN2), the Educational Liaison was the project leader. I was tasked to bring together various elements of the Fredericksburg community to set goals and objectives in order to obtain the funding. The process involved groups from the local and county government, the schools, the hospital, local business, and the Senior Citizens' Center! The power of having a designated "facilitator" for these types of community-wide partnership efforts cannot be overestimated. While there were disagreements along the way, having one person identified and available to keep the process moving helped the community submit a successful grant.

Students in the Master of Science in Nursing program in Fredericksburg attend lectures at Texas Tech University in Lubbock via televideo conference.

I think there are, in every community, people with needs and people with resources. The problem they usually encounter is that there is no one willing to tackle the job of trying to tie everything together and match those with resources to those with needs.

My position as Educational Resource/ Distance Learning Coordinator has allowed me the flexibility to become that person for Fredericksburg and the surrounding Hill Country communities.

Dr. Don Miller, Director of the South Central AHEC, could not be more pleased with the success of the HCEP. "We look upon the Hill Country Education Project as the shining star of our South Central AHEC," he said, "and hold it out in front to be emulated by our other programs."

What we've really learned from our relationship with the South Texas AHEC is to leverage what we already have in the community to bring in what we still need. Here in the Texas Hill Country, we have taken that lesson and expanded it beyond health education. When we can bring parties to the table that may not normally work together and get them working toward a common goal for the good of the community, everyone benefits.

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Creative Partnerships

Sherry K. Snider, is an Informational Writer III, for the Center for South Texas Programs

The 2003 graduates of the Austin Community College LVN program in Fredericksburg, Texas.

held in high school classrooms. During the day, the high school students use the equipment in their classes and at night, ACC uses the labs to teach employees and, potentially, future employees of HCMH.

Once established, the success of the LVN Training Program led to a demand for additional nursing programs. Today, in cooperation with the Texas Tech University Health Science Center, the project has a BSN Program, and a Master of Nursing Program. ACC has added an RN Program in addition to their LVN Program. Since its inception, the program has graduated 35 LVNs with 12 currently enrolled. It has also produced a 70% graduation rate in the BSN program and currently has 10 students enrolled in the Master of Nursing Program. All of the students who have completed our programs have stayed in the area.

The project has also grown to include continuing health professional education. From respiratory care lectures to medicine grand rounds to EMT courses, the HCEP made possible the awarding of over 400 continuing education credits in FY 2003.

'The project has also grown to include continuing health professional education. From respiratory care lectures to medicine grand rounds to EMT courses, the HCEP made possible the awarding of over 400 continuing education credits in FY 2003.'

The nurses at our remote sites were so appreciative of the continuing education programs we were able to send them. They were never able to go anywhere for CEUs before without having to stay overnight.

The South Texas AHEC created the Educational Resource/Distance Learning Coordinator position for Hill Country Memorial Hospital as a part of its 1997 grant application. Dr. Evelyn Farmer originally filled the position. I had become acquainted with The South Texas AHEC through my work with ACC on the LVN program and, after Dr. Farmer's retirement in the fall of 1998, I applied for and was selected for the position. A large part of the reason our program has succeeded where others have not, I believe, is that we have a designated person (me) assigned to champion distance learning programs and to make sure the equipment is used and does not sit idle.

My role as Educational Resource/Distance Learning Coordinator has expanded to include not only HCMH but also the entire Fredericksburg/Hill Country community. Through the submission of successful Telecommunications Infrastructure Fund (TIF) grants, as well as a Community Networking Grant, HCMH was able to expand connectivity from the classrooms to several locations within the hospital and, eventually to our rural health clinics. At the end of FY2003, the HCEP had connections from ACC, UTHSCSA, and TTUHSC, to several sites within the HCMH,

AHEC Partnerships

their own community's needs in the health workforce, but the entire region's. Participants also knew that through this public process, the host community would be held accountable to these expectations by their colleagues.

During the forum, personal stories captured the essence of what AHEC strives to provide in rural communities, and told of the strength and commitment of these small towns to healthcare and economic vitality. In one example, a young family physician told about his move from Chicago to Minneapolis. He said that they loved Minneapolis, however, they "thought smaller town living would be even better." Following an extensive search across two states, they found a small community of about 2,500 in west central Minnesota that captured their desires.

Communities expressed that the competitive approach really motivated them and gave them a chance to showcase their strengths and offer perspectives for building a strong, lasting partnership with the University to ensure the availability of quality health professions training opportunities in their region. In the end, one of the communities was selected, but all will have a significant role in shaping the agenda for the southern Minnesota AHEC through representation on the board of directors. Communities believed that the model is truly based on regional collaboration, even though the initial steps involved direct competition.

The communities shared their creative and innovative ideas with one another as well, resulting in new friendships. Even before an announcement about the regional AHEC location was made, community members were seeking contact with new partners and colleagues who shared their commitment to health professions education and workforce development. In the end, Rice Memorial Hospital in Willmar was selected as the community host for the southern Minnesota AHEC, and has dedicated significant time and resources to provide regional leadership.

'By using an engaged public process to select the host, the communities of the region became the ones that drove AHEC development and regional collaboration rather than the University.'

By using an engaged public process to select the host, the communities of the region became the ones that drove AHEC development and regional collaboration rather than the University. In addition, participants expressed a new appreciation for the work of their colleagues and drew excitement from the partnerships and opportunities developing through AHEC. As a host community, Willmar believed that building a strong partnership with the University of Minnesota's Academic Health Center through AHEC would benefit their community and region well into the future in ways that could not be imagined at the time the host site decision was made.

When asked why communities should be interested in the newly established AHEC, one community-based family physician responded, "It's why the public has a stake in the AHEC, even though most aren't directly involved. Maybe they won't notice anything today, but we're planning ahead for 10 years from now."

As Minnesota AHEC grows, it is evident that host communities play an important role in integrating and sustaining the AHECs in the regions. Host communities have stepped forward to commit resources, personnel, educational technology and physical space. By doing so, they are also setting examples for their partners across the region to do the same. Through this type of community engagement, Minnesota AHEC is preparing for a long-term, sustainable partnership with greater Minnesota and the University – one that will endure as a resource to Minnesota communities and their families.

Oregon

A Community Partnership:

The Oregon AHEC Program

By Peter O. Kohler, M.D., President, Oregon Health & Science University

The development of the Oregon AHEC Program is outlined by Peter O. Kohler, President of the Oregon Health & Science University. The AHEC is considered a strong partner to the health center in addressing health care issues for Oregoneans.

Peter O. Kohler, M.D., is President of the Oregon Health & Science University

Like many other predominantly rural states, Oregon has long struggled with the issue of access to health care for its rural citizens. Three out of every four incorporated municipalities in Oregon is rural, and residents in these communities have a higher incidence of: 1) chronic disease, 2) overall mortality, 3) low birth weight infants, 4) inadequate prenatal care, and 5) death from accidental causes than their urban counterparts.

In the late 1980s, rural Oregon was experiencing a severe shortage of physicians that exacerbated the already fragile state of health care in their communities. Physicians were leaving small-town Oregon for a variety of economic and social reasons, including low pay, high malpractice premiums, isolation, and lack of support from their communities. It was clear that dramatic steps were needed to improve retention.

'It was clear during the recruitment that establishing an AHEC (Area Health Education Center) program in Oregon, was among our highest priorities.'

In 1987, Drs. Lowell Euhus and Scott Siebe of Enterprise, Oregon, found themselves exhausted by the demands of their rural practice. They assumed (correctly) that they were not the only overworked rural physicians in Oregon. After initial discussions with state legislators, they developed a survey and mailed it to other doctors throughout Oregon, finding that almost 50% of rural physicians planned to relocate out of their communities within five years.

Armed with that information, a group of concerned health care professionals, led by Dr. Euhus and Dr. Siebe, convened a rural health conference in Joseph, Oregon, in 1988, to discuss the findings and public policy implications of the survey. The symposium was extremely well attended, with public and rural health advocates from around the state, as well as medical educators and state legislators. The conferees came up with a list of suggestions to improve recruitment and retention of rural physicians and thereby improve health care in those areas of the state that needed it most.

As Oregon's only academic health center, the top priority at Oregon Health & Science University (OHSU) is to meet the state's need for health care professionals. Efforts to change the curriculum and reverse a dramatic decline in primary care physicians were already underway when I was recruited to OHSU from the University of Texas Health Science Center in San Antonio in 1988. It was clear during the recruitment that establishing an AHEC (Area Health Education Center) program in Oregon, was among our highest priorities. We were optimistic that my experience with AHEC and rural outreach in Texas and Arkansas would help facilitate the development of similar programs at OHSU. We began to talk about OHSU as a 96,000 square mile campus, covering all of Oregon – a concept that was embraced by the faculty and staff. OHSU has a proud

(Continued on next page)

Texas

The Hill Country Education Project: A Lesson in Creative Partnerships

By Doris Spraggins, M.Ed., Educational Resource/Distance Learning Coordinator, Hill Country Memorial Hospital and Sherry K. Snider, BA, Informational Writer III, Center for South Texas Programs at University of Tezas Health Science Center San Antonio

In 1996, with the impending closure of a health professions training program in rural south Texas, a crisis was averted when a variety of community resources were organized by the AHEC to continue local training. The result was not only immediately felt by retaining that training program, but has developed into a broad-based network for a variety of health professions education.

I had no idea the chain of events I was setting in motion at the initial meeting with the South Texas AHEC in 1996. What began as a meeting to discuss video-teleconferencing lines for distance learning has grown into what is, today, the Hill Country Education Project (HCEP). From its beginning as an Licensed Vocational Nurse training program in Fredericksburg, Texas, the partnership has grown to promote health professions training throughout the Texas Hill Country. The project works to reduce health professional shortages in this rural community by developing educational programs in nursing and other health professions and is a cooperative effort among area groups, including the South Texas AHEC The Center for South Texas Programs, The University of Texas Health Science Center San Antonio (UTHSCSA), Hill Country Memorial Hospital (HCMH), Austin Community College (ACC), The Texas Tech University Health Science Center (TTUHSC), Fredericksburg Independent School District (FISD), Gillespie County, and the City of Fredericksburg. AHEC is a key participant in the collaboration through continuing the quality of services provided in the area. Fredericksburg depends upon UTHSCSA/AHEC for support in the use of highly technical equipment for service delivery to students.

In 1996, I was working as a site manager for Austin Community College (ACC). The institution that taught Hill Country Memorial Hospital's LVN Training Program had to leave Fredericksburg due to budget cuts and the hospital was looking for a replacement institution. As a rural hospital, HCMH had found the best way to ensure an adequate supply of LVNs was to "grow their own" so continuation of the LVN program was imperative. The South Texas AHEC was a member of the advisory group that ultimately selected ACC to continue the LVN program. ACC was willing to take over the LVN Training Program, but only if the community would provide classroom space, the distance learning equipment, lab space and equipment, etc. Despite the difficulties in meeting ACC's conditions, the hospital found a way to bring the program to Fredericksburg.

The Central Fredericksburg Independent School District provided the classroom space and renovations and laboratory equipment was something the hospital was able to supply, but the distance learning equipment was out of their realm of expertise. That is when the call went out to the South Texas AHEC. UTHSCSA and the South Texas AHEC agreed to provide the T-1 connection and video teleconferencing equipment necessary to start up the program, as well as the technical expertise to operate the system effectively.

We ended up with space in the high school, with nursing lab equipment purchased by the hospital. The hospital also purchased the equipment for college anatomy and physiology courses [which are prerequisites for the nursing program] to be

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Doris Spraggins, M.Ed. is the Educational Resource/ Distance Learning Coordinator at Hill Country Memorial Hospital

Expecting the Best

many obstacles for limited English proficiency populations. Although Latinos represent the most rapidly growing population in the state, this group is medically underserved. On average, 79 percent of people in the United States saw their doctors in the past year. Available data suggest that there are several counties in North Carolina where less than one-third of Latinos have visited a primary care provider during the year. Coastal AHEC's *Expecting the Best* program allows participants to develop language skills and a knowledge base that will help them interact with the medical community, make appropriate health-related decisions, and act as active participants in their own health and well being.

The idea for *Expecting the Best* began when certified nurse midwives affiliated with Coastal AHEC's Department of OB/GYN and New Hanover Regional Medical Center encountered communication difficulties with their patients who had limited English proficiency. "Many of our patients are Hispanic women - 70 percent in Pender County alone - who speak little or no English." says Mary Slawter, CNM. *Expecting the Best* grew out of this concern. "We started with the intention of having a health education group at our health department using interpreters, and the idea evolved into a statewide collaborative program that taps into existing community college resources to help ensure program sustainability," says Sandy Diehl.

The March of Dimes recognized the project's great potential and provided seed funding for the idea through a multi-year grant. Support for implementing *Expecting the Best* within ESL classes grew through recognition that understanding the health care system, arranging and participating in clinic visits, and adhering to treatment orders all depend on an individual's ability to understand English. While *Expecting the Best* is designed to improve preconceptional health among women with limited English language skills, the curriculum focuses on such universal foundations of health as accessing/understanding health care, nutrition, and exercise and fitness. Both men and women have attended and enjoyed classes during the pilot stage of *Expecting the Best*. As one student wrote on her evaluation, "I like to learn new words and I like learning about the food pyramid. I'm learning how to eat healthy." With lessons that specifically address important health care components such as how to make a doctor's appointment, how to understand prescription information, and how to have a healthy diet, *Expecting the Best* addresses problems that impede health for individuals with limited English proficiency. *Expecting the Best* has been piloted in three North Carolina counties, and nine additional counties will join in piloting in the summer and fall of 2003.

Expecting the Best is being implemented in existing ESL classes at North Carolina community colleges, and new classes are forming through partnerships between community colleges, health care institutions, and community-based organizations. These partnerships provide an integral link between the unique resources of academic centers and those of the community, while helping to ensure the sustainability of the program. The final curriculum is expected to be available statewide in 2004. The program complements North Carolina AHEC's mission to address the unmet needs of our state. It offers a broader focus, addressing the needs of consumers as well as the needs of health care providers by proiding a foundation for health education, language, and customs that will enable better communication and understanding. For more information, visit the program's website, www.expectingthebest.org.

"We started with the intention of having a health education group at our health department using interpreters, and the idea evolved into a statewide collaborative program that taps into existing community college resources to help ensure program sustainability."

Oregon AHEC

tradition of community service but, to that point, had not been widely perceived as a statewide resource. That was something we were determined to change, and the timing was right.

The list of recommendations that had come out of the rural health conference in Joseph included a rural provider tax credit, funding for AHECs, and additional resources for the state's Office of Rural Health, which was relocated to the OHSU campus. These three items were the key provisions of an omnibus rural health bill passed by the state legislature in 1989 In April, 1990, OHSU received its first three-year, $2 million federal grant to start an AHEC program.

'The AHEC funding allowed OHSU Medical School to implement a mandatory six-week rural rotation for all third-year medical students. This had a big impact on students, exposing them to general practice and rural living.'

OHSU was already in the process of changing its curriculum to develop more family physicians. The AHEC funding allowed OHSU Medical School to implement a mandatory six-week rural rotation for all third-year medical students. This had a big impact on students, exposing them to general practice and rural living. Surveys have long shown that providers frequently locate in the communities where they received their training, and we (correctly, as it turned out) believed that exposure to the quality of life in small-town Oregon would prompt some students to settle there after graduation.

The development of the AHEC program also brought OHSU closer to Oregon's health care providers and the communities they serve. It has provided a means to ascertain health care needs on the ground and in person, supplementing statistical data. AHEC has helped guide OHSU in being more responsive to the needs of health care professionals, students and the citizens of Oregon. AHEC is well positioned to provide feedback to the University regarding how we deliver education programs and services to rural Oregon. We are proud that we've built these connections to communities through AHEC, and that our emphasis on rural and community health care has been instrumental in reshaping the distribution of care in Oregon.

'AHEC has helped guide OHSU in being more responsive to the needs of health care professionals, students and the citizens of Oregon.'

AHEC is a strong partner to the academic center as we address the multitude of issues that confront health care in the United States. AHEC has a valuable role to play in achieving a well trained health care workforce for the 21st century. The leadership shown by AHEC programs in Oregon and around the country provides an example of local decision-making and advocacy that makes a real impact on our communities. Oregon is not alone among states in facing difficult financial times. Here, as elsewhere, the future success of the AHEC program is going to depend on creativity in identifying and securing new sources of funding. As we face this challenge, we can take inspiration from past successes. Oregon's AHEC program was borne of an act of creativity, a grass roots movement that changed health care in our state forever. We have accomplished much, but there is more work to do.

New York

An AHEC Experience:

Rural Dentistry, AHEC, and a Student's Perspective

By James F. Gleason, 2nd Year Dental Student, University At Buffalo School of Dentistry

A young dental student provides an account of his mind opening experience through a clinical education program sponsored by the Western New York Rural AHEC.

James F. Gleason, is a second-year dental student at the University At Buffalo School of Dentistry

I spent the first eight years of my life living in South Buffalo, New York, a place where the space between the houses was exactly the width of one car plus two swipes of a lawn mower. Everything I ever wanted was within the distance that my two little legs could carry me. Then, when I was eight, my dad got a promotion and moved the family out to Fredonia, New York. Coming from Buffalo, Fredonia seemed about as "Podunk" as one could possibly imagine. Our new house was surrounded by farmland, and we had a barn in our backyard. For the three years that we lived there, I despised the fact that I lived in "the country." Fifteen years later, while sitting down to write this article, I realized why I hated Fredonia so much: I lost my perspective. Eight months ago, I was fortunate enough to get it back.

Over the summer, through the courtesy of the Western New York Rural Area Health Education Center (R-AHEC), I had the privilege of partaking in a summer externship that introduced student health professionals to rural communities. Being a dental student, I was placed in the office of Dr. Tim Stanford. Over the next few weeks the experiences that I had in his office opened up more than my eyes to the world of rural dentistry; it opened up my mind as well. The care with which he treated patients astounded me. In school, we had always been told that the people that sit down in our chairs are more than just a set of teeth to treat. But without seeing an actual patient, this lesson can be easily trivialized. Seeing Dr. Stanford work quickly solidified this lesson and value in me for life. His patients could never tell me how good his work was. None of them have the expertise to properly evaluate it. Yet they never ceased to praise him about the gentleness and attention that he showed them.

'As a requirement of the R-AHEC program, each week all of the students in all of the participating disciplines gathered for an interdisciplinary meeting. Inevitably, each student in the program, whether a future physician, pharmacist, physical therapist or obstetrician, came to the meetings with new stories about the abrupt change they noticed between the health care they had seen all their lives and the care given in these rural communities.'

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North Carolina

High Expectations for *Expecting the Best*

By Sally C. Scott BSN, RN, Graduate Student, The University of North Carolina at Chapel Hill School of Public Health and Project Consultant, Coastal AHEC

Starting from identifying health literacy as a significant issue among individuals with limited English proficiency, Coastal AHEC has partnered with several organizations to address local issues. The author discusses key community partnerships.

The label on the prescription bottle reads, "Take one pill twice daily with meals until finished. Do not drink any alcohol while taking this medication." These simple instructions may be clear to many of us, but to someone with limited English language skills, this vital health information may be lost. More importantly, if the label is not clearly understood, a serious adverse reaction could occur.

Poor health literacy may lead a person to take medicine incorrectly. This issue has recently received attention because of the financial costs associated with the consequences of limited health literacy. These costs arise from unnecessary doctor visits, emergency room use, missed appointments, overdoses and incorrect use of medicine, and other errors that stem from an inadequate ability to read and understand instructions contained on prescriptions, appointment slips, insurance forms, informed consent documents, and health education materials.

To address the serious gap in health literacy among the growing number of individuals with limited English proficiency, Coastal AHEC in Wilmington, North Carolina in partnership with the North Carolina March of Dimes, the North Carolina Community College System, and the North Carolina Department of Health and Human Services has developed an innovative program to improve health literacy, functional literacy, and communication skills. *Expecting the Best* is the state's first health and wellness curriculum for English as a Second Language (ESL) students. "This is an exciting program because of the great need for better health communication and the number of people who may benefit from it," says Sandy Diehl, MPH, Project Director of *Expecting the Best*. Because low literacy and English language proficiency are frequently cited as barriers that prevent individuals from receiving the health care they need, ESL classes were selected as a natural environment for implementing the *Expecting the Best* curriculum. "The North Carolina Community College System is excited to participate in this project" says Katie Waters, state coordinator of ESL programs. Over 40,000 adults attend community college ESL classes annually.

Over the last decade, North Carolina has experienced rapid immigrant growth, including a 400% increase in Latinos. Eight percent of households in North Carolina report speaking a language other than English at home. While the majority of these households speak Spanish, almost 20 percent of the remaining households speak languages that may not be served by existing translation or interpretive services. This points to a need for an innovative, comprehensive health education approach to serve the growing multicultural population in North Carolina. According to Merry K. Moos, RN, FNP, MPH, "*Expecting the Best* is a wonderful opportunity . . . to learn English in the context of healthy lifestyle choices and, as such, it may have a lifelong impact on language skills and health status."

Today's healthcare system poses

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Sally C. Scott BSN, RN, is a Graduate Student at The University of North Carolina at Chapel Hill School of Public Health. She is also a Project Consultant, for the Coastal AHEC

Connecticut

The Eastern Connecticut AHEC Multicultural Health Task Force

By Amy Hanoian Fontana, MA, Community Education Specialist, Connecticut Poison Control Center, University of Connecticut Health Center Co-chair Multicultural Health Task Force

The Connecticut Poison Control Center, the Mohegan Tribal Health Department, and the Eastern Connecticut AHEC have created a Multicultural Health Task Force that is providing language interpretation and translation services educating the population on health care services.

Amy Hanoian Fontana, MA, is Community Education Specialist, for the Connecticut Poison Control Center and is the University of Connecticut Health Center Co-chair Multicultural Health Task Force

Have you ever ventured into a new relationship with an individual or an organization and something just clicked? This is what happened when two inspired, but budget and time strapped individuals from the Connecticut Poison Control Center and the Mohegan Tribal Health Department joined forces with the Eastern Connecticut AHEC (EC AHEC). Our relationship is turning out to be a good match and our coming together is resulting in more success than any one entity could achieve on their own. Here is our story.

The Northeast Multicultural Health Task Force was born on May 29, 2003, after a chance meeting. The motivation for our joint venture was a perceived lack of coordination of multicultural health services and knowledge of these services in Eastern Connecticut. Central to the work of the task force are language service opportunities, providing effective, useful health information, serving as a source for reliable multicultural health resources, and networking. Above all, we strive to be a group that takes action.

In the short time that the Task Force has existed, we have had significant accomplishments. With EC AHEC leading the way, we conducted a needs assessment of group members to determine expectations out of the group and what they perceived were the important issues and the primary goals. Results showed that language interpretation or translation services, educating the patient population on health care services, influencing system's change/policy/legislation, and provider education (cultural competence/training) are important to our members. EC AHEC was also instrumental in securing and administering two mini grants in less than six months. These mini-grants entitled, "The Translation of Medical Information Initiative", produced the translation and development of brochures, medical information, and school health forms into Haitian Creole and Chinese. The role that EC AHEC fulfills on the Multicultural Health Task Force is one of coordination and support. ECAHEC contributes invaluable resources, knowledge, and experience to the group. The insight that EC AHEC brings to our new partnership is a great bonus.

Our Task Force, composed of multicultural leaders, meets once a month for networking opportunities, education and business. These interactions are priceless, and we have AHEC to thank for their continued support and encouragement. In the upcoming year, the Multicultural Health Task Force intends to strengthen the coalition by increasing awareness of the task force, expanding membership and continuing to identify healthcare needs resulting from existing cultural diversity and the influx of new culturally-diverse residents to the area. Many thanks to Eastern Connecticut AHEC for all of their hard work!

'In the upcoming year, the Multicultural Health Task Force intends to strengthen the coalition by increasing awareness of the task force'

A Student's Perspective

When my time was up in Dr. Stanford's office, he asked me if I might like to get a little more insight into what rural dentistry was like in the small town of Springville, New York. One phone call later, and I found myself observing the work of orthodontists Dr. Paul Ziarnowski and Dr. Victor Bochaki. Not surprisingly, I found that they treated their patients with the same care and respect as did Dr. Stanford. For starters, their office had only five operatories in it, and each of them was in a private room. In every urban orthodontic practice I've seen, there have been at least twice as many chairs for that many doctors, and the idea of private operatories was unheard of. I watched firsthand as Dr. Ziarnowski talked to his patients and their parents about how their family was doing, how the crops were coming up on the family farm that year, and even saw him sympathize when a patient told him about a tragic car accident that had recently claimed the life of two family members.

'...if we as a society are ever going to be able to appropriately serve such underserved regions, more will have to be done to better inform and expose students going into the various health care disciplines.'

Obviously, I attribute the standard of care that I saw in Springville to the fact that it is a rural setting. It is not that I think that such care cannot be found in urban or suburban settings. But in Springville, I found it to be the rule rather than the exception . And I was not the only one to make this observation. As a requirement of the R-AHEC program, each week all of the students in all of the participating disciplines gathered for an interdisciplinary meeting. Inevitably, each student in the program, whether a future physician, pharmacist, physical therapist or obstetrician, came to the meetings with new stories about the abrupt change they noticed between the health care they had seen all their lives and the care given in these rural communities.

From the changes that I noticed in myself and in my colleagues at these meetings, I think the R-AHEC program did more for us participants than we could have ever imagined or hoped for. Rural areas tend to be grossly underserved, and so much of that is based on stereotypes and inferences that are completely unfounded. Many professionals think that rural areas cannot sustain a successful practice or that their practice will suffer because it is in a rural setting. Others simply think that a rural setting does not provide enough outside of a practice in terms of entertainment and family living. Being a participant in the R-AHEC program, however, showed me that none of these assumptions are true. Yes, rural living is a bit different than city life. Yet that can be just as much an asset as anything else. The R-AHEC program allowed me, and I'm sure the other students, to experience rural life from the inside looking out. It let us dispel any preconceived notions we may have had.

In the end, if we as a society are ever going to be able to appropriately serve such underserved regions, more will have to be done to better inform and expose students going into the various health care disciplines. Surely, more education and the opportunity for direct personal experience will not work in all cases. Yet, from what I've seen, it doesn't always take much to change someone's misconceptions...just a little chance for a potential major change in perspective. A simple rural externship sponsored by AHEC, what a wonderful professional growth opportunity for me!

Student Perspectives

Missouri

Their Dreams Are Our Mission

By Joycelyn Hubbard, student at Metro Academic and Classical High School , St. Louis, Missouri and Nazly Guzmán-Singletary, Health Professions Program Coordinator, ECMO AHEC

A high school student's personal connection to the health career opportunities provided by the East Central Missouri AHEC is described. By making the most of AHEC programming she is developing the resources to support her educational goals.

Joycelyn Hubbard is a senior at Metro Academic and Classical High School in St. Louis, Missouri

Nazly Guzmán-Singletary, is the Health Professions Program Coordinator for the East Central Missouri, AHEC, St. Louis, Missouri

Joycelyn Hubbard is a bright, articulate senior at Metro Academic and Classical High School in St. Louis, Missouri. She excels inside and outside the classroom. She is not only an avid soccer player but also a painter, sculptor, and writer whose poems have appeared in two collections—"A Celebration of Young Writers" and "My Sisters' Voices—Sisters of Color Speak Out." In addition, she aspires to become a physician. She hopes to attend Xavier University of Louisiana, an institution with a great academic reputation and an excellent tradition of preparing African-Americans for medical school.

'When we help students achieve their dreams of becoming primary care providers who will address the needs of underserved communities and eventually become preceptors themselves, we accomplish our mission.'

Though Joycelyn has not always known she wanted to become a doctor, she says that "for as long as I can remember I have been interested in the field of medicine." Several of her relatives are nurses and she was introduced to the profession at an early age. Later, as she learned that she had an aptitude for math and science, her interest grew. Her attendance at a Saturday scholars program at Washington University cultivated that interest even furthered. Shortly after attending the program, Joycelyn contacted East Central Missouri AHEC (ECMO AHEC) after being referred by a family friend, a nurse practitioner at the office of Joycelyn's primary care physician.

During the past two years, she has taken full advantage of the support AHEC offers potential physicians. Among the activities Joycelyn cherishes most is the wide exposure to the field of medicine. The AHEC Career Enhancement Scholars (ACES) Primary Care Resources Initiative for Missouri (PRIMO) Summit, a mini-medical camp held at the University of Missouri-Columbia, has strengthened Joycelyn's commitment to become a doctor. She had the opportunity to live on campus, tour the facilities, visit a cadaver lab, shadow different health professionals and interact with other students with similar career goals. Joycelyn says that the medical camp gave her "the experience of actually being in medical school."

As an ACES student, Joycelyn has attended several workshops organized by

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Cuturally Competent Workforce

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such as cultural competency in education, alternative medicine, and risk management related to medical interpretation. In 2000 we developed and began offering a program called "Enhanced Cultural Competency using Simulated Patients from Diverse Cultures". This Lunch & Learn training, often offered on-site at area medical practices during lunch time, provides clinicians with problem based learning cases portrayed through role play of trained "actors" from different cultures. This educational experience offers providers the opportunity to experience cultural interactions and learn different health beliefs that affect any provider-patient communication.

'Through this partnership we have been able to provide tremendous training opportunities for health professionals.'

Most recently the Coalition's collaboration with SNHAHEC is enhancing the state's workforce by training medical interpreters. Manchester and Nashua, two of the state's larger cities, are experiencing tremendous growth in non-English speakers. In Manchester alone over 74 languages are spoken in the school system. Health care providers in the area were struggling to meet the needs of their non-English speaking patients. To respond to the need, the NHMHC and the SNHAHEC wrote a grant to the NH Endowment for Health to develop a Medical Interpretation Services Program. This initiative is improving access to care for non-English speakers by not only building upon the skills of bilinguals, but also teaching health professionals how to work with interpreters. In this comprehensive training program we also offer training to consumers through the Coalition's Woman to Woman Program, a home based peer education program. In these sessions, consumers are informed about their rights to a medical interpreter and learn about the NH health care system. This program is also embarking on coordinating an innovative statewide strategic plan for medical interpretation. In addition, together we are developing a communication strategy for informing health care organizations and providers about the importance of medical interpretation and how to incorporate interpreters into health care delivery systems.

These Graduates (above) of the NH Medical Interpretation Training Class: "The Art of Medical Interpretation," will contribute to building a more culturally competent workforce in New Hampshire.

By forming this partnership we are able to leverage the expertise of each organization. The Coalition brings its experience with the community, curriculum design, and faculty, while the AHEC supplies its faculty, a network of health care organizations and continuing education credits. Together we hope to achieve systems change within the state, assisting health care providers in meeting the needs of their communities. We believe that this collaboration has allowed us to leverage resources, and fill a niche that was not being addressed. We now are looking to collaborate further by developing enrichment programs that will encourage minority youth to pursue careers in health care. Without this partnership, neither organization would be as strong in meeting the needs of the community.

New Hampshire

Building a Culturally Competent Workforce to Improve Access to Health Care

Jazmin Miranda Smith, MEd, Executive Director, NH Minority Health Coalition, Manchester, New Hampshire

Compatible missions and approaches to community-based programs inspired a partnership to develop a range of educational offerings centered around cultural competency.

Since 1993, the New Hampshire Minority Health coalition has worked as a community based grass roots organization in Southern New Hampshire. Its mission is "to identify populations in the state with barriers to accessing appropriate health care, to advocate for adequate and appropriate services and to empower these populations to be active participants in their own health care." The Coalition has continued to grow over the past decade to meet the needs of the increasing diversity in the southern part of the state. NH has changed dramatically over time. According to the Census Bureau's 2000 Census, New Hampshire has doubled the number of residents who are ethnic minorities. "Census figures also show that New Hampshire's Hispanic population has nearly doubled since 1990 and its Asian population increased by 70.5%. In Nashua alone, the Hispanic population grew 123.8%."

Jazmin Miranda Smith is the Executive Director of the New Hampshire Minority Health Coalition, in Manchester, New Hampshire

'Our partnership with the Southern New Hampshire AHEC has been invaluable in moving the issue of cultural competency to the forefront in (the state).'

The Coalition realized that it could not advocate for underserved populations on its own. Although the focus of the organization was primarily on empowering consumers, it became apparent that a reduction in health disparities or increased access to care would not be possible without reaching out to health professionals. Without an understanding of culture and the dynamics of difference, providers in NH were ill equipped to meet the needs of their increasingly diverse patient populations.

The opportunity to share these needs came about through discussions at an early meeting of the Southern NH AHEC's Local Advisory Board. These meetings are forums during which Advisory Board members can share their insights about community needs. Our partnership with the Southern NH AHEC has been invaluable in moving the issue of cultural competency to the forefront in NH. The collaboration between the two organizations has matured over the past 6 years, allowing us to build the trust necessary to work so well together. Each organization brings passion and a commitment to serving the underserved in NH. The staff at each understands that by supporting the efforts of the other, not only do we both win, but the community thrives.

Through this partnership we have been able to provide tremendous training opportunities for health professionals. Our annual program, Diversity in Motion, offers training each spring on a variety of subjects

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Our Mission

ECMO AHEC. At a workshop designed to introduce students and parents to the process of acquiring financial aid, Joycelyn and her mother were able to better assess the monetary cost of a medical education, learn about the federal student loans, scholarships and other resources available. Joycelyn assessed the overall value of the workshop when she said "being the first child in my family to go off to college this was a great workshop… [It] … gave us an idea of what colleges and medical schools would cost."

Another workshop, held at Saint Louis University School of Medicine during National Primary Care Week, offered the opportunity to hear panels of healthcare professionals and medical students speak. She strongly identified with one student and was glad to see "an African-American woman from the same kind of environment [she] came from." The parents in attendance greatly appreciated the insight that the medical students provided and praised ECMO AHEC's efforts in providing outstanding programming, preparation for college, and encouragement and advocacy for the children. Summarizing the experience, Joycelyn called the workshop "an eye-opener."

"With the help of the ACES program, I knew that I didn't have to give up on my dreams of being a physician and that there is help along the way." Joycelyn Hubbard

Joycelyn is grateful for the difference that ECMO AHEC is making in her life. She recognizes that the support, resources and follow-up provided by AHEC are not readily available elsewhere. Joycelyn points out, "AHEC has resources that my school does not offer." An example of such a resource is the ACT preparation workshop organized by AHEC. Of this ACT workshop Joycelyn has said: "This gave me an idea of what skills I needed to improve on the ACT test. This was significant since it offered me something that my school did not provide. The ACES program allowed me to attend this course for free."

Recently, Joycelyn joined the Missouri AHEC effort to advocate for continued funding of AHEC programs. Testifying in front of the Missouri State Legislature in Jefferson City, Joycelyn spoke about her experiences with AHEC. As she eloquently highlighted the many opportunities she has had since joining AHEC; Joycelyn emphasized that these were experiences she would not have otherwise had.

Because of Joycelyn's determination and her participation in ECMO AHEC, it does not require much imagination to picture Joycelyn a few years from now as a medical student who will address another group of AHEC students and their parents. At ECMO AHEC, we are pleased to enhance the lives of our students; students such as Jocelyn Hubbard who, when she graduates from college, will be the first in her immediate family to earn a four-year degree. When we help students achieve their dreams of becoming primary care providers who will address the needs of underserved communities and eventually become preceptors themselves, we accomplish our mission.

'ECMO AHEC is one of seven regional AHEC centers that work in collaboration with the Saint Louis University School of Medicine, Kirksville College of Osteopathic Medicine, the University of Missouri School of Medicine, and local communities to form the statewide Missouri AHEC (MAHEC). ECMO AHEC serves St. Louis City and five surrounding counties, working to encourage the dreams of minority and other underrepresented students to become healthcare professionals.'

Vermont

School Collaboration:

Champlain Valley AHEC, Vermont

By Janet Hatin, and Beth Hunter Jette, seventh grade teachers at Missisquoi Valley Union Middle School

Through AHEC partnership the science curriculum of this middle school has been substantially enhanced. By garnering student interest in science, the AHEC and school have progressed to the next level, exposing students to a variety of health careers.

Ms. Hatin is a 7th grade science teacher at the Missisquoi Valley Union Middle School in Swanton, Vermont.

Ms. Hunter Jette is a 7th grade math teacher at the Missisquoi Valley Union Middle School in Swanton, Vermont.

Missisquoi Valley Union Middle School (MVU), in Swanton Vermont, sits in the heart of Franklin County, which is a picturesque rural, farming community located in the Champlain Valley region. Many of the MVU students face challenges to attain higher education and transitions to sustainable careers. The rural location of MVU limits students' exposure to the vast array of health careers that are available to them at the local hospital in the southern reaches of the county or at the tertiary care teaching hospital 45 minutes away. The farming industry employs a significant portion of the population, many of them migrant farm workers whose children change schools regularly. Economic disparity is prevalent and 26% of middle school students participate in the free and reduced lunch program. Native Americans of Abenaki descent and students from other racial minority groups make up 17% of the middle school population. From the MVU high school graduating class of 2001, 53.2% are first generation college students. A dedicated team of teachers, with the assistance of the Champlain Valley Area Health Education Center's (CVAHEC's) Microscope and Dissection Kit Lending Program, is giving students hope for their future and a glimpse of Health Careers.

Champlain Valley Area Health Education Center lends microscopes and dissection kits to schools in Addison, Chittenden, Franklin and Grand Isle Counties in Vermont. As a result, students have the equipment available to approach scientific investigations from a whole different angle. The microscope and dissection kits contain a curriculum that aligns with the national science standards, as well as materials for a unit on microscopy and dissection of frogs, worms and crayfish. In addition to providing the kits, CVAHEC staff coordinates health careers presentations, and field trips to health care sites or the University of Vermont's College of Nursing and Health Sciences and College of Medicine. All of these resources, the equipment and experiences with health professionals, assist students in developing the skills and interest necessary to join the health care workforce.

Janet Hatin, 7th grade science teacher and 15-year veteran at MVU declares that, "the Microscope and Dissection Kit Lending program fills a need for hands-on science in middle school classrooms. The integration of hands-on applications is developmentally appropriate and crucial for advancing student learning and continued interest in science at a pivotal age. The cost of the materials provided by this program would be prohibitive to participating schools. Without the equipment we would have no choice but to use paper labs."

'CVAHEC makes it possible for teachers to reach outside of the school for resources, establish community partnerships and develop relationships with health professionals.'

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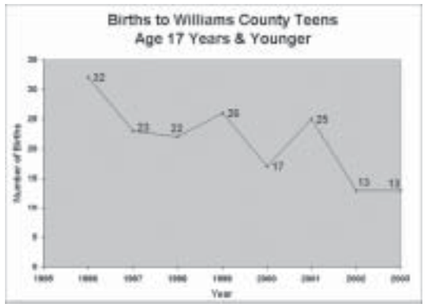
Connecting the Community

High school students perform vignettes on various teen issues which are presented to every 8th grader in the county. BAHEC founded the Williams County Teenage Health Issue Task Force in 1990.



The Task Force has also been very instrumental in getting the use of the "Baby Think It Over" simulated infants into all schools in the county. They survey both the students and parents about the Baby Think It Over experience. 94% of the parents were glad that their child had this school assignment and felt it made a positive difference. 79% of families that responded said that there was an increase in parent child communication about having a baby while a teen. Student comments included "I have learned that being a parent is not as easy as it looks. I only have it for the weekend, just imagine having that baby for the rest of your life! No friends or education – what a life" and "This project did have an impact on me because before I wanted to have a baby and now I don't want anything to do with one – at least not at my age."

The Older Adult Task Force was also founded in 1990 and is made up of multiple agencies and individuals. Once a year a health related educational event is held for older adults with over 350 attending. Topics have included health fraud, diabetes, heart, medications, and community resources.

The group surveys and interviews seniors to find out their concerns and needs on a regular basis. The high cost of medications was a common and frequent concern heard by the task force. They compiled data and identify resources in a brochure to help seniors find different venues to lower prescription costs.

Seniors participate in a Rainbow of Wellness, a health-related educational event, organized by the Older Adult Task Force.

BAHEC has connected the Williams County community by setting up cost effective and effective partnerships for discussion, education and developing plans of action to address health issues. Without their support and enthusiasm, many of these issues may never have been addressed in such a comprehensive and multifaceted manner. BAHEC is a vital resource for improving the health of Williams County.

'BAHEC is a vital resource for improving the health of Williams County.'

Ohio

Bryan AHEC: Connecting the Community

By Jean Wise RN MSN, Health Commissioner, Williams County Health Department, and Bryan AHEC Board Member

In Northwest Ohio, the Bryan AHEC has been a catalyst for developing partnerships among community organizations to address local issues. The author discusses key community partnerships.

In Williams County Ohio, BAHEC (Bryan Area Health Education Center) has been the unifying force for healthcare issues. As an RN, local health officer, and Board member of BAHEC, I have witnessed their ongoing successes in working with local health related issues and bringing together the right people and agencies to develop local plans to address these concerns.

Williams County is located in the northwest corner of Ohio, bordering Michigan and Indiana. Primarily a rural county, 75% of the land is in farming. Population in 2000 was 39,000. Bryan is the county seat where BAHEC is located serving five Ohio counties.

Jean Wise RN MSN, is Health Commissioner for the Williams County Health Department in Ohio. Wise is also a BAHEC Board Member

Examples of health related areas BAHEC has engaged the community in is women's health, teens' health and older adult issues. Nationally, Women's Health Month is emphasized every September. Locally BAHEC has been one of the driving forces to develop a theme and educational event for the local county. Health care issues addressed have been osteoporosis, STDs, and violence prevention. BAHEC helps to bring together local health care providers, the Extension Office, and Sarah's House (violence prevention education) to discuss how best to increase awareness and educate the community about women's issues.

The unique approach BAHEC takes is to develop a comprehensive, countywide awareness of the selected women's health issue. The local daily newspaper has printed full-page educational articles and the schools have permitted us to conduct contests (for example, which class drinks the most milk) to hanging educational posters on STDs in the locker rooms. Letters are mailed to multiple women's groups to educate and encourage adult women to talk with younger women about these issues. Displays appear throughout the county during September – at the fair, at each community's library and health care providers' waiting rooms.

'BAHEC has been one of the driving forces to develop a theme and educational event for the local county. Health care issues addressed have been osteoporosis, STDs, and violence prevention.'

BAHEC was the founder of two multi agency health issue driven networking groups. The Williams County Teenage Health Issue Task force was started in 1990. This group is composed of individuals and agencies who work with teens and addresses issue of teen pregnancy prevention, STDs, and drug and alcohol abuse. 2004 marks the 13th year this group has organized vignettes performed by high school students on various teen issues which are presented to every 8th grader in the county.

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School Collaboration

Students at MVU have participated in the Microscope and Dissection Kit Lending program for five years. Each year the program expands, enhancing the students' experience. The Firebirds Team, one of two 7th grade teams at the school, has incorporated the microscope and dissection curriculum, health professions speakers, and a trip to the University of Vermont into the classroom experience for approximately 100 students served each year. Participation in the program creates a focus and facilitates a future vision for many students at MVU. One student remarked that before the program, " they didn't even know what hematology was."

Beth Hunter Jette, 7th grade teacher and Firebird team leader feels that for MVU, the dissection kit and microscope lending program has energized the teachers to incorporate real world learning and careers into the classroom. Hunter Jette states, "CVAHEC makes it possible for teachers to reach outside of the school for resources, establish community partnerships and develop relationships with health professionals. Teachers see the benefits to students, especially those from disadvantaged backgrounds. The program encourages mentorship and a connection to positive adult role models. Students have been given the opportunity to work with a surgeon, a hematologist, a veterinarian, and many different fields of nursing. Students are exposed to careers and professionals that they otherwise may not have known existed. For instance, not many students knew what a cytotechnologist did before the director of the Cytotechnology Program at Fletcher Allen Health Care visited the classroom. For students whose exposure to higher educational opportunities is limited, the trip to the University of Vermont (UVM) gives them exposure to a university environment in a nurturing manner. It enables students to develop aspirations for a college or technical education. The fun, inquiry based learning model engages students in their own learning. For many, this opportunity creates a reason to come to school each day. Teachers hope this enthusiasm translates into a decrease in truancy."

A preliminary year-end evaluation demonstrates that the program achieves the goal of linking disadvantaged students to careers in health. Analysis of student's qualitative responses on a post field trip reflection sheet indicated that the majority of students could identify and describe each career presented and could link middle school science coursework with necessary preparation for each career. Furthermore, the students could identify the level of higher education required for each career pathway with some students stating the requirement for 'good' academic performance as a necessary step to entrance into health professions training. Student comments on the evaluations represented an overwhelmingly positive experience on a university campus, describing the trip to the University of Vermont most often as 'cool' and 'fun,' with students expressing an interest in attending college and possibly UVM, following the field trip. Additionally, comments such as, "feeling like they were older or already a member of the college campus" demonstrated a possible sense of empowerment among a number of students that will be further explored in future evaluations.

Seventh grade students of Ms. Hatin's lab class work on an experiment with a hematologist.

The speakers, equipment, and trip to the University of Vermont create a continuous, enriching experience throughout the academic year. The entire experience helps students link high academic performance and science learning to future careers. For many students the hands-on approach helps them develop a vision for the future, a purpose for learning and a reason to come to school each day. The collaboration of Champlain Valley AHEC and Missisquoi Valley Union Middle School has helped to make the Microscope and Dissection Kit Lending Program a real success.

Florida

Rural Students Take Health Careers in SSTRIDE

By Sarah Joslyn, Sophomore, Tufts University

In rural Taylor County, Flordia, Doctor's Memorial Hospital actively supports Rural SSTRIDE (Science Students Together Reaching Instructional Diversity and Excellence), a pre-college program offered by the Florida State University College of Medicine and Big Bend AHEC. Rural SSTRIDE offers a combination of classroom and hands-on experience to local students interested in pursuing a health career.

Doctors' Memorial Hospital in rural Taylor County, Florida, is taking an active role in the futures of the area's medically-minded high school students.

The hospital has stepped forward to provide local students interested in pursuing a health career the chance to participate in Rural SSTRIDE, a pre-college program offered by the Florida State University College of Medicine and Big Bend AHEC. Rural SSTRIDE (Science Students Together Reaching Instructional Diversity and Excellence) offers a combination of classroom and hands-on experience.

The brand new 48-bed hospital in Perry, Florida, the Taylor County seat, is providing classroom space, lecturers, mentors, and computer access for students participating in an after-school version of the Rural SSTRIDE program.

"A lot of these students don't have the idea that they can move forward to a community college, let alone to a four-year institution," said Gwendolyn Ford, director of community and rural outreach for the Florida State University College of Medicine (FSU). She hopes Rural SSTRIDE will change the mind-set of rural students.

"We are expanding the scope of things the students do," said Jim McKnight, CEO of Doctors' Memorial Hospital.

The hospital welcomed the program as a way of helping fill its own needs for laboratory technicians, nurses, physicians, and other health-care professionals. Participating students shadow health professionals and help doctors and nurses by transporting patients and delivering necessary supplies. Students also take an anatomy and physiology course, as well as integrated instruction in math, science, English, and preparation for the FCAT and SAT tests.

Jared Bradshaw, a senior at Taylor County High School, participated in the program last year and plans to return for the upcoming school year.

Sarah Joclyn is a sophomore at Tufts University.

A lot of these students don't have the idea that they can move forward to a community college, let alone to a four-year institution," said Gwendolyn Ford, director of community and rural outreach for the College of Medicine. She hopes Rural SSTRIDE will change the mind-set of rural students.

* * *

"We are expanding the scope of things the students do," said Jim McKnight, CEO of Doctors' Memorial Hospital.

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Our Indispensible Partner

JoAnne Jorgenson, RN, MPH, is the Deputy Health Director for the Fairfax County Health Department

that they test and train our bilingual staff thereby giving us much needed, ongoing, internal capacity. They not only agreed, but also adapted the teaching schedule to meet our needs and created supplemental programs adapted specifically for us. We have been so pleased with the quality of their work and their flexibility that, during the height of our training needs, we co-funded a training position at AHEC.

'AHEC doesn't just enhance our system, it's a critical part of its ability to function smoothly. It doesn't just fill some gaps, it's part of the foundation upon which we build.'

But the partnership doesn't stop here. In 2000, when the first round of the infrastructure-building Community Access Program (CAP) grants became available, we knew we wanted to apply and we knew that doing so without our AHEC was unthinkable. In 2002, when the Robert Wood Johnson Foundation Hablamos Juntos grant opportunity was announced, AHEC was a key partner right from the start of conceptualizing the application.

We were awarded both grants and in both cases, AHEC was and continues to be a critical part of that success. For our CAP grant, AHEC led the way in our CME programs on cultural competence. When our "streamlined eligibility" system became a reality, AHEC made sure that the necessary documents were translated into the needed languages. When CAP began its work with Community Health Workers, AHEC connected us with other CHW programs. As part of the Hablamos Juntos grant, AHEC is not only our training partner but also provides ongoing consultation and project management support.

We're not the only ones who benefit from their work. All of the region's health departments rely on the Northern Virginia AHEC for these services. So does the state health department. And the state's Office of Newcomer Services. And the Virginia Primary Care Association. And the list goes on. AHEC doesn't just enhance our system, it's a critical part of its ability to function smoothly. It doesn't just fill some gaps, it's part of the foundation upon which we build.

Yes, we've seen just one AHEC. We think it's the best one.

Virginia
Northern Virginia AHEC:
Our Indispensible Partner

By Elita Christiansen, MA, MPA, Assistant Vice President/Community Health & Cultural Competence, Inova Health System and JoAnne Jorgenson, RN, MPH, Deputy Health Director, Fairfax County Health Department

When the Northern Virginia AHEC began in 1996, the center asked the community of providers what challenges they were facing. Along with the responses came the basis for a synergistic partnership between a system the county health department and NV AHEC to address the language barriers in health care.

Just a few years ago, our [Northern Virginia] AHEC didn't exist. Today, it is such a critical part of our local health system we wonder how we ever got along without it.

"Northern Virginia" refers to a four county, five city region immediately west and south of Washington, DC. It is home to nearly two million people. Fairfax County, where we are located, rates among the highest in the nation in income and education levels. But those averages are deceiving, for they mask some significant challenges to providing health care. There are vulnerable populations here, however, they are masked by the averages. For example, approximately 35% of the County's population is un- or under-insured. There is no public hospital in the area, so for over fifty years, the creative partnerships between Inova Health System (a not-for-profit system) and Fairfax County Health Department have been the backbone of the local health care "safety net."

Elita Christiansen, MA, MPA, Assistant Vice President/Community Health & Cultural Competence, Inova Health System

But even with our mutually creative solutions to providing cost effective care for these patients, there was still one challenge that we couldn't sufficiently address on our own: language barriers. About 200,000 Northern Virginians speak English "less than very well" and over 150 different languages are represented. Our focus was providing quality clinical care in an environment of decreasing revenues and increasing needs, which meant increasing competition for fewer available dollars. Given that communication and trust are the bedrock of quality health care, our providers and patients had to be able to communicate with one another. We knew that "language access" had to be addressed, and we turned to the Northern Virginia AHEC for assistance.

It has been said that, "When you've seen one AHEC, you've seen one AHEC." Although this must make it hard to give a simple explanation of what AHEC is, it also means that AHECs have the flexibility, if not the mandate, to adapt their federal and state missions to meet the needs of their communities. This is exactly what our AHEC did, and it's the key reason why it has become such a critical part of our system.

When the Northern Virginia AHEC opened its doors in 1996, it started by surveying providers all over the region and asking, "What are the top challenges you face? How can we best support you, particularly in your work with vulnerable populations?" The top answers were consistent: we need trained health care interpreters, cultural competence education, and translated documents. AHEC listened. It focused on building those programs. And it made the services responsive to both our workforce and our financial needs.

For example, one of the first things it did was to create an interpreter service, providing trained bilingual individuals to bridge the communication gap between providers and non-English speaking patients. We pay for some of the service, but much of it is provided via private, local grants and Ryan White funding that AHEC has received. When we saw what a difference language proficiency testing and interpreter training made, we approached AHEC with the idea

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SSTRIDE

"It allowed me to see what it was like to be out there," Bradshaw said. "I've actually decided to be a pediatrician because of it."

Bradshaw will apply to FSU for his undergraduate education, having been influenced by the knowledge of the medical school and its professors that he gained from Rural SSTRIDE. He later plans to apply to FSU's College of Medicine and thinks he might like to be a candidate for Doctors' Memorial Hospital's scholarship program, which targets local students who promise to return to Perry to work in the health-care field.

"It allowed me to see what it was like to be out there," Bradshaw said. "I've actually decided to be a pediatrician because of it."

McKnight hopes Rural SSTRIDE and the scholarship program will help the county cure chronic shortages of nurses, technicians and physicians by forging a connection between students and the health care system of Taylor County.

Rural SSTRIDE meanwhile will continue to expand to other counties over the next two years. A course has already begun for the 2003-2004 school year in Madison and Okaloosa counties, and the program will expand to Gadsden and Jackson counties programs in 2004 and 2005, respectively.

Rural SSTRIDE grew out of an outreach program begun in 1994 under the FSU Program in Medical Sciences, in which 30 students a year completed their first year of medical school at FSU and then transferred to the University of Florida for the remainder of their medical education. A partner in FSU's outreach programs from the beginning, Big Bend AHEC continues to work with the FSU College of Medicine to bring SSTRIDE to new communities.

Since its inception, SSTRIDE has served more than 500 students in grades seven through 12. Of the 65 SSTRIDE students who have graduated from high school thus far, 80 percent have chosen health professions majors in college. In addition, more than 90 percent of the college-level students who have participated in SSTRIDE as mentors are now either in medical school or practicing medicine.

Students at Fairview Middle School in Tallahassee learn about the skeletal system with help from their SSTRIDE mentor, Uchenna Ikediobi (left), a pre-med student at Florida State University.

Arkansas

The Arkansas MASH Program After 10 Years:

Healthy, Effective, Well-Founded

By Audie Ayer, Editor, Front Porch magazine, Arkansas Farm Bureau and Ken Moore, Public Relations Department, Arkansas Farm Bureau

The Arkansas MASH (Medical Application of Science for Health) program started in 1987. After five years the program had outgrown it funding source. Working together with the Arkansas Farm Bureau and the Mentorship Partnership the MASH program was able to survive and for over ten years the MASH program has provided youth with health care experiences.

Audie Ayer is the Editor of Front Porch magazine, a publication of the Arkansas Farm Bureau

Ken Moore works in the Public Relations Department for the Arkansas Farm Bureau

In 1987, Eddie Maples got an idea for a two-week medical enrichment program for high school students. He called it a "Medical Application of Science for Health" or "MASH" Program. The first one was conducted that June.

After five years his idea had taken off, and the 6 programs offered by the AHECs in the state were successfully attracting students and exposing them to a variety of health-care career opportunities.

Maples, who is associate director of the Pine Bluff Area Health Education Center (AHEC), had used a state grant to set up and run the program. When the money dried up, however, a new funding source had to be found. That's when Arkansas Farm Bureau stepped in.

"In 1992, we lost our (Arkansas) Department of Education funding because MASH had grown too large," Maples says. The program had outgrown its funding source. So, Farm Bureau helped form the Mentor Partnership, a dedicated group of corporate and organizational sponsors who help keep the MASH program financially viable. "There were only a half dozen programs at that time," Maples says, "and we wanted to expand the program to reach more students. We couldn't have done that without Farm Bureau and the Mentor Partnership buying into what we were doing and saying, `We're not going to let this die.'"

Dr. Charles Cranford wholeheartedly agrees. He has been Executive Director of the AHEC Program at the University of Arkansas for Medical Sciences (UAMS) for the past 18 years. "In 1992, we entered a crisis stage for the MASH program," Cranford recalls. "It was at that time Ken Tillman and Arkansas Farm Bureau saw this as an opportunity to form an important relationship among UAMS' AHEC and Rural Hospital Program, Farm Bureau and rural communities." Tillman, Farm Bureau's coordinator of Rural Health programs, approached companies such as Arkansas Blue Cross and Blue Shield, the Arkansas State Chamber of Commerce, Associated Industries of Ark Inc. and the Electric Cooperatives of Arkansas to form the Mentor Partnership. Others that joined the partnership included the Arkansas Academy of Family Physicians, Community Health Centers of Arkansas, and Baptist Health Systems. Tillman calls the Mentor partners "committed" and says they "maintain steadfastness for the program."

The money generated that first year of the partnership allowed the MASH program to continue and grow. This past summer, all seven AHECs and 19 rural hospitals hosted a program.

Maples says 16 years ago he couldn't even begin to envision how successful his idea would become. Five years into the program, 162 students had participated. In

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Partnership That Works

framework at USC, which had previously designed the rotation as two months in duration. The format for the two month long educational experience is slightly different for the USC medical students, but the two medical schools utilize the same educational objectives to guide this educational program. Thus, students from the two medical schools are able to participate in a clerkship site sponsored by the other school and interact with students from the other medical school.

The contributions of the SC AHEC HPS coordinators have increased as the relationship between the SC AHEC and the medical schools has deepened. Their primary function is still to serve the students. They arrange student housing in many rural communities and orient the students to the communities. They work with the Education Directors at both medical schools to assist with the placement of students. The HPS coordinators act as a bridge between the students - an all-important step in helping sustain the momentum for the students' community-oriented projects. Similarly, the HPS coordinators provide continuity when students identify and visit patients who had previously been seen at home by students during previous rotations. The HPS coordinators visit the students in their community practices on a regular basis and are available to provide students with encouragement and assistance.

Medical student participating in a community-oriented health fair in western South Carolina.

The SC AHEC HPS coordinators now play a primary role in recruiting new rural community preceptors. As a result of their in-depth knowledge of the communities in which they actually live and work, they are vastly expanding the reach of the two medical schools. Over 55 rural communities in 36 of South Carolina's 46 counties are opening their hearts and resources to students. These numbers continue to grow! And since many of the medical students are from South Carolina, these rural communities are now enjoying the pleasure of seeing local students "come home" to learn and to give back to their communities. The students have been very pleased about the opportunity to work with physicians in their hometowns.

The HPS coordinators have also begun to work more closely with the AHEC Family Medicine Residencies. Coordinators assist with the problem-based learning experiences. They help organize and schedule skill-building activities when their assistance is requested. All efforts are focused on maximizing the quality of the students' learning experiences.

The HPS coordinators' contributions to the clerkship continue to expand. The last several years has seen an increase in the number of SC AHEC Family Medicine Residency graduates becoming preceptors in the Family Medicine/ Rural Clerkship. The HPS coordinators are the vital element that links these graduates to the clerkship in all regions of the state.

In summary, the partnership between the SC AHEC system and the state's two medical schools has led to an innovative, gratifying addition to the education of more than 200 third year medical students each year. Not only has this program given the students an opportunity to expand their clinical skills, but it has also enabled them to contribute in significant ways to the health and well-being of people residing in rural, underserved communities. This partnership has been a win-win situation for everyone involved, and all look forward to continuing this program for many years to come.

Enthusiastic comments on the SC AHEC rural rotation experience:

Student: "I was made to feel as a valued member of the practice and community."
Preceptor: "Student presence in the practice benefits staff and patients - morale in practice is higher when students are present. Gives me a better sense of mission. Like academic stimulation that comes with teaching. Patients like to see fresh faces."
Student: "She (the preceptor) made me think independently, as if I were the doctor. And so, I rose to the occasion. I felt like my being there actually mattered."
Preceptor: "Gives the practice a positive public recognition. Students have a positive effect on community health."
Student: "Great advice and assistance. Great housing. Thanks!!!"
Upstate AHEC HPS coordinator about a current 4th year medical student: "I was very pleased that one of last year's clerkship students so enjoyed his clerkship experience at the Family Medicine Rural Residency in Seneca that he is interviewing to enter their residency program next year!"
Student: "I learned much more about the depth of patients' needs when I visited their homes. The home visits showed me what a tremendous opportunity existed for impacting lives beyond the chief complaint at the clinic."
Student: "Loved the one-on-one contact with the physician - able to learn so much! One of the best, sharpest learning curve rotations!"
Student: "I've learned that even as a third year student I can make a difference in a community."
Current Family Medicine resident in Charleston: "My wonderful rural clerkship experience was the major factor in my deciding to go into Family Medicine."

inspiring educational program. The four AHEC regions in South Carolina now each employ two fulltime HPS coordinators. Students return to their campuses at the completion of each rotation with enthusiastic comments about the enjoyment and satisfaction they derived from working in rural, underserved communities. The HPS coordinators regularly travel to hear the students report on the outcomes of their community projects, many of which have resulted in major improvements in the health care provided in rural communities. For example, this collaborative effort led to a $1,000,000 grant from a community foundation to establish a Diabetes Education Center in a rural community. The work of the students and the HPS coordinators contributed greatly to the successful application for these funds.

Another example of a positive outcome from a student-initiated project is the "Right Way to Health" Campaign that arose in another rural community. As part of an initiative to raise awareness of the health implications of obesity and to help individuals make lifestyle changes, a walking path was constructed on the grounds of the local community hospital. This exercise path resulted from the collaborative energy of the medical students and community volunteers, all with the common goal of contributing to improving the health status of the residents in this rural community.

To make a five-year story brief, the bottom line is that the DRPCC has been a very successful educational program. In fact, during the academic year 2002-03, this one-month clerkship was rated #1 by the medical students among all third year clinical rotations at MUSC. As a result, the decision was made at MUSC to merge the DRPCC with the required one-month family medicine clerkship to form the two-month Family Medicine/Rural Clerkship. Beginning in July 2003, all MUSC medical students spend two months in a rural community. This change at MUSC aligned the clerkship with the

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the summer of 2003, more than 375 students from almost every region of the state were selected and exposed to the possibility of medical careers. "We now have twice as many qualified applicants than we have space," he says. "We are able to take 25 students, primarily rising seniors, from Pine Bluff and neighboring counties and see many of our MASH graduates go on to pursue a health-related career. I am very pleased with its success."

Count Dr. H. Marks Attwood among the enthusiastic supporters of the MASH/Mentor program, too. He is a family physician from Rison (population 1,258), Director of AHEC Pine Bluff, and serves on Farm Bureau's Rural Health & Safety Committee. Without MASH, he says, interesting young people in the medical field would be much more difficult - and getting them to return to a rural community to practice would be almost impossible. "I've always said you cannot pay someone enough money to practice in an area they don't want to live and raise a family in," Dr. Attwood notes. "No matter what the financial incentives are, you can't take someone who's not acquainted with life in a small town and expect them to stay if they don't have a vision for meeting the healthcare needs of that community. And that is the ultimate goal: to address the shortage of doctors, nurses, pharmacists and others in the smaller towns of our state."

'In the summer of 2003, more than 375 students from almost every region of the state were selected and exposed to the possibility of medical careers.'

Rebecca Boyd Totty of Rison attended the second MASH program at AHEC Pine Bluff in 1988. Today, she works as a pharmacist in her hometown and a relief pharmacist in two neighboring communities. "MASH exposed me to all types of therapy, surgery, lab work, and primary care medicine. But in the end I decided I wanted to be a pharmacist. High school students who know me have said they want to go into pharmacy, but my first advice to them is to attend a MASH program. Then decide if that's what they really want to do."

Attwood credits Farm Bureau at the local level with much of the MASH program's success.

"That's where (they) play such an important role, in identifying and sponsoring their local students to attend a program. Not only do they help pay their (students') way, they truly `mentor' and encourage them to hang in there, especially if they choose to make this their life calling."

MASH graduates are surveyed the year they graduate from high school to determine to see if they're enrolled in a health careers education program or already practicing a health career. Respondents noted that approximately 60% were majoring in a health-related field in college or already a practicing health professional. Dr. Yvonne Lewis, AHEC Associate Director for Education, manages that survey data and tracks MASH graduates who apply for and are accepted into one of the many colleges at UAMS. She also serves on the UAMS College of Medicine Admissions Committee.

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"We just can't say enough about how the business and medical community across the state, and the individual county Farm Bureaus have all embraced this program. Without their support, Mentor/MASH certainly would not be as successful as it is now."
-- Ken Tillman, Arkansas Farm Bureau

Arkansas MASH

"I'm pleased to see that many of our applicants include MASH as part of their portfolio to demonstrate their passion for medicine at a young age," she says. In the 2002-03 academic year, there were three MASH graduates in the UAMS Graduate School, five in the UAMS College of Health Related Professions, 15 in the UAMS College of Medicine, 14 in the UAMS College of Nursing, and 16 in the UAMS College of Pharmacy. Severe shortages in nursing and other fields remain, but school counselors are attempting to channel students in those directions.

"We are gratified (the MASH/Mentor Program) meets such an obvious need," Tillman says, "and that (the Mentor members) see their participation as very meaningful by becoming a pipeline for medical providers and provider systems for rural communities." This year, the Mentor Partnership is 10 years old, and Arkansas Farm Bureau's state convention included special recognition of participating members. "We just can't say enough about how the business and medical community across the state, and the individual county Farm Bureaus have all embraced this program. Without their support, Mentor/MASH certainly would not be as successful as it is now."

Although an extensive statewide network of MASH programs is now functioning, there's room for a few more. "It's been our goal not to require students to drive more than 30 miles to attend one," Lewis says, "and we've almost achieved that. "But we need to find someone in the Mena area who shares our vision and is willing to make it happen. Mena is located between Fort Smith and Texarkana and will certainly fill a void for students in that region." Other expansion possibilities include Conway and Monticello.

Cranford says it's rare for one entity to assume another's fund-raising duties to support a program administered by a third party (in this case, UAMS). "This is a wonderful example of leadership that goes above and beyond what you normally see and is a model for the rest of the country," he says. "We'll always be indebted to Farm Bureau for capturing the vision; resuscitating this program, and helping it expand statewide."

This article first appeared in the November-December 2003 issue of Arkansas Farm Bureau's Front Porch magazine

"MASH exposed me to all types of therapy, surgery, lab work, and primary care medicine. But in the end I decided I wanted to be a pharmacist. High school students who know me have said they want to go into pharmacy, but my first advice to them is to attend a MASH program. Then decide if that's what they really want to do..."
Rebecca Boyd Totty, attended the second MASH program at AHEC Pine Bluff in 1988 and is now a pharmacist.

South Carolina
A Statewide Partnership That Works

Submitted by Jeanne Oglesby, Staff Coordinator, MUSC Family Medicine/Rural Clerkship; Donna Kern, MD, Co-Director, MUSC Family Medicine/Rural Clerkship; C. Scott Lamar, MD, Director, USC Family Medicine/Rural Clerkship; Sandra Kammermann, MS, EdS, Site Education Coordinator, USC Rural Clerkship; Alexander Chessman, MD, Co-Director, MUSC Family Medicine/Rural Clerkship; David Garr, MD, Executive Director, South Carolina AHEC.

"The South Carolina Rural Health Association is proud to honor the Deans Rural Primary Care Clerkship as its recipient of the Outstanding Community Health Project Award (February 2003). The outstanding work being done by the leaders at MUSC, USC, SC AHEC, as well as the rural physicians which whom the students work, is an impressive testimony to the dedication and enthusiasm all these people have for the importance of providing all medical students in South Carolina with an excellent experience in rural medicine."

Jeanne Oglesby is the Staff Coordinator for the MUSC Family Medicine/Rural Clerkship

In 1996, the Deans of South Carolina's two medical schools met to discuss how they could collaborate on a joint educational initiative. South Carolina has a large rural, underserved population, and both Deans wanted to provide medical students with the opportunity to learn about and address some of the significant health care needs in our state. This gave rise to the Deans' Rural Primary Care Clerkship (DRPCC).

The two medical schools are both situated in urban areas-the Medical University of South Carolina (MUSC) in Charleston and the University of South Carolina (USC) in Columbia. Neither school had a sufficient number of clinical sites nor the infrastructure to provide rural experiences for all their students. It became clear that a partnership with the SC AHEC would be strategic for creating a successful educational program. The faculty coordinators for the DRPCC met to articulate the goals, objectives, and to develop the curriculum for this educational experience. The plan was to eventually have all third year medical students spend one month in a rural community, and the first cohort of 19 students at MUSC each volunteered for a one-year pilot of the rotation which began in July 1998.

The SC AHEC staff worked closely with the representatives from the medical schools to arrange for the housing and to orient the students when they arrived in their rural communities. The students saw patients in the offices of their physician preceptors, rounded in the hospital with their preceptors, made home visits, and helped develop community-responsive health projects using the principles of community-oriented primary care and continuous quality improvement.

The one-year pilot was very successful, and the DRPCC was instituted as a requirement for all third year medical students in July 1999. An emphasis during the initial years of the DRPCC was to prepare the students to help improve the care of people with diabetes residing in the rural communities. Students visited people in their homes who were living with diabetes and helped identify improvements the patients would like to make in the control of their diabetes.

The two medical schools collaborated on grant applications to two foundations that helped fund the DRPPC. The money was used to pay for the services of the faculty leaders and SC AHEC health professions student (HPS) coordinators, and some funds were used for student housing and travel.

This joint venture between the SC AHEC and the faculty from the two medical schools has resulted in a most gratifying,

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health of valley citizens.

The SJV AHEC and UCSF-Fresno isare employing several models of care to train its residents to manage chronic diseases. Second year Family Practice residents are assigned to work one half-day per week with UCSF-Fresno faculty member David Pepper, M.D. seeing patients referred for asthma education and management. Patients and primary care residents are instructed in asthma prevention strategies, and taught to manage patients in accordance with "Best Practice" standards established by the National Institute of Health, National Heart, Lung, and Blood Institute. Primary care residents work closely with health educators and respiratory therapists as part of a collaborative interdisciplinary team approach to health care delivery.

'The AHEC funding partnership has been critical in allowing UCSF-Fresno to train its residents to care for underserved and culturally diverse populations with asthma and Hepatitis C.'

In order to reduce Fresno's high asthma rates, we must first understand its causes. UCSF-Fresno faculty are playing a lead role in investigating potential contributors to the Valley's high asthma rates including pesticide exposure and air pollution. This population-based public health approach should reap community-wide dividends. In contrast to the consultative management strategy for asthma described above, primary care residents are instructed to manage Hepatitis C patients in their own community-based health centers with guidance from selected UCSF-Fresno faculty. Primary care residents are taught to manage Hepatitis C in the context of their own continuity practice. Primary casre residents also follow patients with Hepatitis C referred to their continuity clinics, in effect learning to provide specialized care much like a consultant.

By training primary care residents to care for Hepatitis C patients, UCSF-Fresno in partnership with AHEC is filling a major void in clinician services. Hepatitis C is a hidden epidemic affecting close to four million Americans, almost four times the number of patients with HIV. The number of people in the Valley requiring Hepatitis C care would swamp already busy gastroenterology practices. UCSF-Fresno primary care residents are taught to recognize patients at high risk for Hepatitis C, conduct a progressive, comprehensive diagnostic work-up including judicious use of laboratory studies and appropriate utilization of liver biopsies without the necessity of gastroenterology consultation. Appropriate selection of candidates for treatment include screening for known side effects such as depression are incorporated into a Hepatitis C worksheet developed in conjunction with UCSF-Fresno primary care residents. Collaboration with UCSF-Fresno's sponsoring institution pharmacy ensures the availability of the most cost-effective medications and treatment regimens for Hepatitis C UCSF Fresno's indigent population.

In addition to learning to manage individuals with chronic diseases, UCSF-Fresno primary care residents participate in projects which address the health care needs of communities as a whole. Population-based projects include staffing an asthma camp for young asthmatics and providing community education presentations on stroke and high blood pressure under the auspices of the American Heart Association.

The UCSF-Fresno Family Practice Program is proud to be a partner with the SJV AHEC. The AHEC partnership has been critical in allowing UCSF-Fresno to train its residents to care for underserved and culturally diverse populations with asthma and Hepatitis C. This training will enable UCSF-Fresno graduates to provide comprehensive high quality cost-effective management for these dibilitating chronic disease in rural and underserved community-based settings.

Florida

The Florida Keys AHEC and Community Hospitals…

An Extraordinary Academic/Community Partnership to Improve the Southernmost Nursing Shortage

By Kim Bassett, RN, MBA, BSN, C.N.A.-BC, Chief Nursing Officer, Lower Keys Medical Center, Key West, Florida; Coleen Dooley, ARNP, MSN, Director, Nursing & Allied Health Program, Florida Keys Community College, Key West, Florida; Sondra Fuchs, BSed, RN, Assistant Vice President of Nursing, Mariners Hospital, Tavernier, Florida; and Susie Martenson, RN, CEN, MS, Chief Nursing Officer, Fishermen's Hospital, Marathon, Florida

The unique geography of the Flordia Keys has resulted in an innovative community partnership for nursing workforce development that allows students to receive their entire nursing education in their home communities.

The unexcelled beauty, tropical breezes, crystal blue waters and the only living coral reef in the continental United States beckon thousands of visitors each year to the Florida Keys. Yet, the unique geography of the Keys creates significant health care accessibility challenges for the year round residents who call paradise home. In order to appreciate the challenges that we, as nursing directors, face on a daily basis, one must understand the geographic isolation and the current economy of the Keys. The Florida Keys are a 120-mile long ribbon of small islands extending from the southeastern tip of the Florida peninsula to Key West. The only access into and out of the Florida Keys is a two-lane, heavily traveled highway that contains 43 bridges. The drive from Miami, the closest city on the mainland, to Key West, the southernmost city in the Florida Keys, takes from 4 to 6 hours on this congested road. With the exception of Key West, the Florida Keys have no commercial air service and no public transportation system. Tourism provides the major source of employment for local residents.

The topography and lack of public transportation make it necessary to duplicate every civic service at 3 different sites – Key West for the lower Keys, Marathon in the middle Keys and Tavernier or Key Largo in the upper Keys. This geographic isolation coupled with the highest cost of living in the state of Florida makes recruitment and retention of nurses and other health care professionals in the Keys particularly difficult.

We have had a close relationship with the Florida Keys AHEC (FK AHEC) since its creation 15 years ago. Either as members of the Board of Directors or as community partners, we have worked together to address these health care access challenges. One of the major successes of this partnership has centered on advancing and supporting the nursing profession in the Keys. Over the years, this partnership has truly enriched nursing education as well as met significant health needs in the Keys. Recently, the increasingly urgent stories of the number of practicing clinical nurses falling to a critical level throughout the Florida Keys challenged this partnership to once

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Susie Martenson, is Chief Nursing Officer of Fishermen's Hospital, Marathon, Florida

Florida Keys AHEC

again look at what could be done to affect the nursing recruitment outlook.

To respond to this impending crisis, the FK AHEC offered to support and work with the Florida Keys Community College (FKCC) to expand the nursing program throughout the Keys. Part-time instructional staff were added with FK AHEC support and, best of all, an interactive Videoconferencing Distance Learning System was installed to link three separate classrooms in Key West, Marathon and Tavernier together for instructional purposes. The geographic expansion of the nursing program to the Middle and Upper Keys allowed students to receive their entire nursing education in their home communities and led to an immediate increase in enrollment for the program. The FK AHEC also assisted the nursing program in identifying clinical training sites in the small communities of the Middle and Upper Keys so the students no longer had to travel the long distances to Key West to complete their education. The previous 180-mile round trip to the community college 90 miles away in Key West discouraged most potential students from the Upper Keys from even applying to the FKCC Nursing Program. With this major barrier removed, applications and enrollments have since doubled.

(pictured l-r) Sondra Fuchs, BSed, RN, Assistant Vice President of Nursing, Mariners Hospital, Tavernier, Florida; Kim Bassett, RN, MBA, BSN, C.N.A.-BC, Chief Nursing Officer, Lower Keys Medical Center, Key West, Florida; and Coleen Dooley, ARNP, MSN, Director, Nursing & Allied Health Program, Florida Keys Community College, Key West, Florida.

'If it were not for FK AHEC, these kids would never have experienced a healthcare setting from the working side.'

Mariners Hospital in the Upper Keys community of Tavernier offers a good example of how much this expansion has meant to a small, rural hospital and community. Mariners, a 42 bed, acute care hospital, agreed to participate in the nursing education program by serving as a clinical site for the community college nursing students. This has allowed the small hospital to showcase its facility and pass on the knowledge and skills of its staff to the next generation of nurses. Nursing staff report that students challenge them to think and provide a constant reminder that no matter how busy, with a student by your side, shortcuts are not acceptable. Everyone benefits, the mentoring nurse, the student, and most of all, the patients. The best and the brightest from this Upper Keys community now enter the FKCC nursing program; and, as these new nurses graduate, they are recruited to work in the hospital where they received their clinical training.

Without FK AHEC support, the expansion of the Nursing Program could not have happened. While the expansion of the nursing program has had a major impact in easing the shortage of nurses, the AHEC expanding access to professional continuing education and working to increase health career recruitment programs in the local school system has also played a part in this continuing success story. Required licensure education on domestic violence, HIV, and

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California

San Joaquin Valley AHEC:

Partnering to Assure Primary Care Management of Chronic Diseases

By John Zweifler, M.D., M.P.H., Chief, UCSF-Fresno Department of Family and Community Medicine, Fresno, California

A community partnership benefits citizens of the San Joaquin Valley in the management of chronic disease. The University of California San Francisco Fresno Family Practice Program and the San Joaquin Valley AHEC have collaborated for 30 years on this clinical rotation program.

One of the first partnerships in the country between an AHEC and an academic institution began in 1974 when the University California San Francisco (UCSF) Fresno Family Practice Program and the San Joaquin Valley AHEC (SJV AHEC) teamed up. This relationship has endured to this day and has contributed to the training of many of the primary care providers now working in the region. Currently, UCSF-Fresno trains 33 primary care residents in community-based rural and urban settings caring for Fresno's underserved and culturally diverse populations. UCSF-Fresno has been fortunate to receive SJV AHEC funding to support its mission of training primary care residents to practice in the Central San Joaquin Valley's many rural and underserved settings. This years SJV AHEC grant emphasizes caring for underserved populations with chronic diseases, in particular asthma and Hepatitis C.

Kevin Hamilton, RRT, Patty Burton, RRT, and UCSF-Fresno faculty member David Pepper MD provide asthma education and care in collaboration with UCSF Fresno Family Medicine residents as part of their disease management training supported by AHEC.

Our longstanding partnership with the SJV AHEC allows our primary care residency program to develop innovative strategies to train new physicians.

The UCSF-Fresno Family Practice Program is establishing Primary Care Disease Management programs to train primary care residents and address the health care needs of underserved populations in California's Central San Joaquin Valley. The Central San Joaquin Valley is a largely agricultural region with the city of Fresno as its urban hub.

Poverty and unemployment rates are well above the national average. The Central San Joaquin Valley's largest ethnic group, Latinos, suffer disproportionately from diabetes and its related complications. Extreme air pollution, worse than the Los Angeles air basin, places all San Joaquin Valley citizens at risk for respiratory conditions including asthma. High rates of infectious diseases including Tuberculosis, HIV, and Hepatitis C plague our Valley. Like many underserved communities, access to specialty care is limited, therefore, the training of primary care providers to manage chronic illness is critical to improve the

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the GT curriculum, although convincing the CNAs to sign-up for the course took some work. For many, this was their first college-level class and they expressed concern regarding their abilities. In addition, they had to be willing to juggle work, school, and their home life, since many of the CNAs were parents.

The GT program has had a tremendous impact on the CNA turnover rate at the LTC facilities in which it was implemented. As of March 2003 the first pilot class had a turnover rate of 62% two years after the course was completed. The second pilot class had a turnover rate of 43% after 1.5 years. These figures are less than half of the annual estimated turnover rate for CNAs in Oklahoma of 135.5%!

As a result of the success of these pilots, the NEAHEC and TCC sought further funding to continue and expand the GT program. A partnership comprised of TCC, NEAHEC, the Oklahoma Department of Human Services-Aging Services Division, the Alzheimer's Association of Oklahoma and Western Arkansas, and the Tulsa Area Agency on Aging developed and submitted a grant application to the U.S. Administration on Aging and was awarded an Alzheimer's demonstration grant.

The grant proposed a two-component model for improving the quality of care for individuals with Alzheimer's disease and/or related disorders and their families. The first component was to identify minority and underserved populations in rural communities in need of services such as education, respite care and referral. A care consultant was made available to families to perform an assessment and to identify their needs. The second component addressed the training needs of CNAs in rural LTC facilities. This component provided the opportunity to expand the existing GT program to other rural facilities.

As of the end of 2003, six more GT training classes had been completed, training 32 additional Geriatric Technicians, bringing the total number of GTs trained in the program to date to 47. In a March 2004 follow-up with the students, 78% (32) of the GTs who were located (41) were still employed at the same LTC facility. By the end of June 2004 another six GT classes will be completed with two additional adjunct faculty added for training.

In summary, the NEAHEC, along with its collaborating partner organizations, has, through the development of the Geriatric Technician program, become a leader in addressing the national problem of the recruitment and retention of certified nursing assistants/aides.

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One of the major successes of this partnership has centered on advancing and supporting the nursing profession in the Keys. Over the years, this partnership has truly enriched nursing education as well as met significant health needs in the Keys.

medical errors is now available at accessible sites and convenient times for practitioners throughout the Keys, and for those who don't have time to attend a conference, home study packets have recently become available. Through the efforts of FK AHEC, satellite dishes have also been obtained and installed throughout the Keys in the past two years, so that all areas can now benefit from televised programs.

Also through our collaborative efforts, youngsters now realize that both educational and career opportunities exist in their own communities. Two one-week-long Nursing and Health Careers Summer Camps for high school students were added to the continuum of health career promotional programs available in the Keys in the summer of 2003. The Camps were developed by the FK AHEC, in collaboration with FKCC, the 3 local hospitals in Key West, Marathon and Tavernier, and many community partners. Fishermen's Hospital in Marathon and Lower Keys Medical Center in Key West hosted and participated in the 2003 Health Careers Camp. The Camps provided a wonderful opportunity for the kids to learn about the many aspects of nursing in a hospital setting, and for hospital staff to share their experiences. If it were not for FK AHEC, these kids would never have experienced a healthcare setting from the working side. Camp participants now know that the Florida Keys can provide them with a wide variety of health career opportunities, as well as an abundance of support and encouragement to help them achieve their goals.

The commitment of all of us to join together to solve a community problem – an alarming decrease in the number of nurses in the Florida Keys – is resulting in an easing of the nursing shortage in the Florida Keys and will ultimately bring about an increase in access to health care services in the Florida Keys. Fundamental to our success has been the leadership of the FK AHEC in bringing together diverse community partners to pool their resources. The greatest benefactors are the citizens of our communities. We are proud to be a part of this extraordinary academic-community partnership.

'Fundamental to our success has been the leadership of the FK AHEC in bringing together diverse community partners to pool their resources.'

'The commitment of all of us to join together to solve a community problem...resulted in an easing of the nursing shortage in the Florida Keys.'

Wisconsin

Creation of Free Clinic Benefits for Homeless Individuals and Families

By Stephanie Genz RN MSN Assistant Professor, Viterbo University, La Crosse, Wisconsin and Judy Talbott RN MHA MS Assistant Professor, Viterbo University, La Crosse, Wisconsin

CARING, Inc. provides nursing students with an invaluable learning opportunity while meeting the healthcare needs of a medically underserved population. Developed as a collaborative effort between the Southwest Wisconsin Area Health Education Center (SWAHEC), Viterbo University School of Nursing, and the Salvation Army in LaCrosse, WI, the program utilizes senior-level nursing students from Viterbo University to provide health education and health screening for clients of the Salvation Army.

Through the collaboration provided by Southwest Wisconsin Area Health Education Center (SWAHEC), Viterbo University School of Nursing faculty had the opportunity to create a new community partnership with the La Crosse County Health Department and the Salvation Army. This partnership has afforded nursing students powerful learning opportunities while meeting the healthcare needs of an underserved population.

The richness of the learning opportunities for senior-level nursing students to medically serve the poor at the Salvation Army has grown into a collaborative effort resulting in CARING, Inc., a clinical rotation in community health. During community health clinical rotations, health education presentations and health screenings for the clients of the Salvation Army are conducted.

Since the program's inception SWAHEC has contributed $50,000 in financial support to this project. Without SWAHEC's generous support, the needs of a vulnerable population and the unique student learning opportunities would not have been realized. SWAHEC regional staff also provided educational resources and opportunities for further student development. The goals and objectives of the CARING, Inc. Project is a programmatic example of AHEC's mission to increase health care access to underserved populations by the recruitment and training of medical profession students.

Stephanie Genz is an Assistant Professor at Viterbo University, in La Crosse, Wisconsin

Judy Talbott is an Assistant Professor at Viterbo University, in La Crosse, Wisconsin

The Nursing Student Clinic

CARING, Inc. became a reality in September 2000 and is housed in a dedicated room at the Salvation Army Shelter in La Crosse. The nursing student clinic was designed with three primary objectives. The first was to provide on-site health resources for individuals receiving services at the Salvation Army. The literature clearly identifies the homeless as a population experiencing not only numerous and complex health conditions, but also numerous barriers to receiving medical care. For example, a common yet significant barrier to healthcare for the homeless has been identified in the literature as access to providers. Viterbo University Community Health nursing faculty felt that a free on-site nursing clinic would begin to address this barrier to care.

The second objective for creating a student nursing clinic was to provide nursing students with a clinical rotation that would provide an opportunity to work with a medically underserved and vulnerable population. The clinical experience with CARING, Inc linked with classroom theory

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New Opportunities

The GT program is designed to provide collaborative learning experiences in a variety of LTC settings. The GT program is taught in the LTC facility, utilizing whatever space is available for a classroom. The facility also becomes the clinical training site where the TCC faculty spend time teaching the CNAs new skills and supervising students. The GT program represented the first time that TCC Division of Nursing faculty taught on-site at small rural healthcare facilities. Students receive concentrated instruction in the physiological and psychological aspects of aging, the care of individuals with Alzheimer's disease and related dementias, restorative care, and aging with disabilities. The curriculum also includes team-building skills to emphasize group process and the role of interpersonal communication so important in caregiving, and workgroups that promote quality care for older adults and their caregivers.

Benefits for the LTC facilities:

- Improved patient care,
- Increased communication between the licensed and unlicensed staff,
- Increased retention rates and an associated reduction in new employee training costs,
- Reduced training costs for existing staff since the program was provided on-site, and
- Creation of a pool of CNAs who may wish to further "climb" the nursing career ladder.

Benefits for the CNA's:

- Increased confidence in their care-giving skills,
- Improved interpersonal communication skills,
- Improved leadership skills,
- Increased job satisfaction, and
- Increased interest and confidence in continuing their education.

In developing the curriculum, the NEAHEC and TCC settled on a "fast-track"curriculum to be completed in eight weeks and which would be offered on-site at the LTC facility rather than in a traditional college classroom in the hope that this would entice those entry-level CNAs employed in the LTC on a full-time basis to seek further professional education.

Despite these opportunities for the LTC facilities, there were still a few challenges to overcome. First, staff scheduling had to be reviewed and rearranged to permit the CNAs to attend the class. Because the class was held on-site and the TCC faculty worked with the LTC facility to arrange a time that best met the facility's needs, this challenge was easily met.

The second challenge was acceptance of the GT program by the licensed nursing staff. Initially there were concerns on the part of the licensed nursing staff about how the GT program would affect the retention of their own positions and what this would mean for their job duties and responsibilities. As they observed the CNAs in the GT program developing new skills and gaining the ability to perform higher-level patient care and clinical tasks, they realized the benefits of having the GT on board and accepted the GT as a vital part of the patient care team. The licensed nurses now had additional time to perform even higher-level clinical tasks such as patient assessments, patient education, and documentation. In addition, in an unanticipated benefit, the GT program improved the working relationships between the licensed nurses and the GTs, and a mutual respect for each respective discipline's contributions to the care of the elderly developed.

As a result of the GT program's advanced training, the LTC facilities made several positive changes. Each CNA that went through the GT program received a wage increase upon completion if they agreed to remain employed at the facility for a designated period of time. This was a tangible acknowledgement of their increased knowledge, skill, and abilities. A new team approach to care evolved in which the GT felt more knowledgeable and empowered to contribute to patient care. Both LTC facilities involved with the program added a GT to their clinical staff meetings and many GTs became involved in patient care committee work for the first time. In addition, the GTs became more confident and comfortable in talking to the family members of patients.

In the pilot classes, 15 CNAs completed

New Opportunities

CNAs. At the time (and currently) Oklahoma required 75 hours of CNA training, which was equivalent to the minimum federal training requirement. The proposed advanced training program would focus specifically on the care of older adults, especially individuals with Alzheimer's Disease or related dementias, and result in certification of the CNA as a Geriatric Technician (GT).

The TCC staff first raised the possibility of a GT training program at a Northeast AHEC (NEAHEC) advisory board meeting, on which the TCC was represented. The TCC had been having difficulty funding and gaining community support to initiate the GT program. Because NEAHEC had previously established key relationships within several communities and had a long track record of support and mutual trust in these communities, NEAHEC staff was able to bring two local, rural LTC facilities to the table to discuss the proposed GT program - Sequoyah Point Living Center, located in Owasso and Inola Healthcare Center, located in Inola. NEAHEC provided the key linkage between the local communities and their health care institutions and TCC that made the implementation of the GT program possible. Without NEAHEC's first-hand and detailed knowledge of both the needs and the staff of the LTC facilities and the TCC, these varied entities would not have able to work together in an environment of trust and mutual cooperation on the GT program.

The GT program directly addresses the following factors that contribute to CNA turnover as noted in recent national studies:

- Adequacy of training,
- Methods for managing workload and schedules,
- Opportunities for career advancement,
- Respect from administrators,
- Organizational recognition,
- Workloads and staffing levels,
- Clarity of roles, and
- Participation in decision-making.

During the initial meetings curricular goals and objectives were developed and a needs/benefits analysis for the LTC facilities and TCC was conducted. As a result of these meetings the LTC facilities and the TCC agreed to proceed with the pilot GT program if funding could be identified. NEAHEC agreed to utilize a portion of its continuing education money to support the pilot GT program because in the absence of NEAHEC providing its financial support the project would not have moved forward due to the financial constraints of the LTC facilities and TCC.

The GT program consists of 320 hours of classroom and clinical instruction that provides 6 hours of college credit which can be applied to other degree programs, and, just as importantly, recognition of advanced training in geriatric care. NEAHEC provides the CNAs with health career information and information on other opportunities for advancement. In addition, GT program graduates aspiring to enter the TCC LPN or RN programs can use their GT coursework to meet some prerequisite requirements for admission into these nursing programs.

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'NEAHEC provided the key linkage between the local communities and their health care institutions and TCC that made the implementation of the GT program possible. Without NEAHEC's first-hand and detailed knowledge of both the needs and the staff of the LTC facilities and the TCC, these varied entities would not have able to work together in an environment of trust and mutual cooperation on the GT program.'

Benefits for the Homeless

provides nursing students with a practical orientation to meet the medical needs of a disenfranchised population. In addition, Viterbo University faculty identified the Salvation Army as an ideal practicum site to mentor and role model for students as it provides a hands-on learning opportunity with a vulnerable population.

The third objective of CARING, Inc was to establish an ongoing academic-community partnership with the potential for expansion to include students in other health disciplines. This objective is met through periodic collaborations such as dietetic students from Viterbo University who partnered with the nursing students and provided a diabetes prevention and management clinic. Included in this joint effort were diabetes and cholesterol screenings as well as general nutrition information related to wellness.

CARING Inc. is staffed two days a week with three to four senior level nursing students, and a minimum of one nursing faculty member and one public health nurse. Clinic hours are scheduled over the noon meal on Tuesdays and the evening meal on Wednesdays. This schedule offers the maximum opportunity for clients to access services since it is the most populated times of the Salvation Army. Evening hours in particular provide access for families with school age children and adults working day jobs, while more single individuals and elderly are served during the day time hours. Since CARING, Inc began, over 2,000 patient contacts have been made which include health screenings, referrals, follow-up activities and health education. Patients have been screened for hypertension, diabetes, cholesterol, tuberculosis, and mental health issues. The health screenings have yielded over 400 referrals for further medical care that might otherwise have gone undetected. Referrals also consist of those for parenting skills, housing, and nutrition.

Nursing Student Experience

The nursing clinic rotation was evaluated through a collaborative effort between SWAHEC and Viterbo University, School of Nursing. The increase of students' knowledge and skills were found to occur in primarily three realms. First, it was demonstrated that students developed a contextual understanding of people who are poor. One student stated, "These are everyday people who were thrown a curve ball in their lives and now they have to struggle through it. The experience (at the nursing clinic) has opened my eyes and given me more respect for people who are struggling." Second, students became acutely aware of their nursing knowledge assets and deficits. One student expressed, "... I'm not as incompetent as I thought I was... I actually do know something!" Yet another student described a client as having problems with the healthcare system and the student felt blamed. The nursing student professed: "I didn't know how to react!" Finally, student understanding and value of public health nursing increased as demonstrated by 80% of the students who participated in the research would consider community health nursing as a career. The opportunity to teach and learn while caring for the clients of the Salvation Army has provided a priceless opportunity for students and faculty to explore important topics such as cultural diversity, issues related to healthcare access, and the nurses' role in patient advocacy.

(from l-r) Sarah Peterson, RN, BSN, LaCrosse County Health Department; Stephanie Genz, RN, MS, Viterbo University; Judy Talbot, RN, MH, MS, Viterbo University; and Cinda Todd, Social Worker, Salvation Army.

"...The experience (at the nursing clinic) has opened my eyes and given me more respect for people who are struggling."

The Salvation Army nursing clinic is recognized by the community as a valuable component of the regional health care system. The success of the clinical rotation has resulted in it becoming a permanent part of the Viterbo University nursing curriculum. This clinical rotation is financially sustained through grant funding and in-kind support from all three partners. It is through the AHECs that the impetus for increasing access to health care is accomplished by creating new partnerships to develop such programs as CARING, Inc.

Oklahoma

The Northwest Oklahoma Healthcare Education Coalition-A Grassroots Effort

By Andrew Fosmire, MS, CTRS, Executive Director, Rural Health Projects/NwOKAHEC

Northwest Oklahoma, in an effort to address the nursing shortage, developed a Coalition involving area hospitals, local schools of nursing, and the Northwest Oklahoma AHEC. With the success of this collaboration, the Coalition will look at other workforce shortages in their region.

The Northwest Oklahoma Healthcare Education Coalition was founded to increase the quality and quantity of qualified nurses available to practice in the hospitals of Northwest Oklahoma. Since it's inception in 2000, close to $450,000.00 has been raised by the coalition, with almost $50,000 in cash dispersed to students attending six different schools of nursing. Much of the available cash was raised by private donations from physicians practicing in the area. This spring will see the first graduates who received funding from the coalition. How did this innovative idea come in to being?

Andrew Fosmire, is the Executive Director, Rural Health Projects for the NwOKAHEC

History of the Coalition

The Coalition began as a discussion on a hospital floor between two Enid, Oklahoma physicians who were concerned about how the shortage of competent, well-trained nurses had begun to affect their ability to practice medicine. Instead of just being concerned or complaining to hospital administrators, they chose to address the situation themselves and began discussing ideas and feasibility with a local nursing instructor. They knew a long-term solution was needed not "just a band-aid" that would only help in the short term. From these conversations, the Coalition came into being.

In the spring of 2001, Rural Health Projects, Inc./Nw Oklahoma AHEC (RHP/NwAHEC), an independent not-for-profit agency, was asked to join the Coalition to assist in the development of the Charter, policies and application process. As a part of the Coalition's formation, three subcommittees were established: marketing, finance, and education. Members and chairs for each committee were appointed and an action plan was developed for each committee to pursue. These committees then worked separately to accomplish their goals; the full Coalition met whenever there were problems to be resolved or the goals were accomplished. The major goals identified at that time were:

- Recruit and educate at least twice the number of nursing students currently being educated locally.
- Develop a career ladder that would allow various health care workers to become registered nurses without unnecessary repetition and delay.
- Increase clinical experiences of the Baccalaureate-nursing student.
- Raise funds to assist these students with tuition so they would not be required to work full time, allowing them to graduate in a timely manner.

The marketing committee developed a marketing plan to spread the word about the Coalition. NwAHEC assisted the marketing committee with recruiting materials, presentations to potential students and intensive job shadowing events within the hospitals. Career ladder concepts were developed.

The education committee drafted a revised curriculum that would provide a career ladder to the BSN level for the CNA, the CMA, the certified surgical technician, the EMT and paramedic, the LPN, and ADN. Northwestern Oklahoma State University proposed the major curriculum changes to the Oklahoma State Board of Nursing and the Oklahoma State Department of Higher

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Oklahoma

New Opportunities for the CNA in Oklahoma --

Improving Retention and Quality of Care

By Lisa Watkins, RN, MS; Pat Fitzgerald, MA; Kindell Peters, MS

The Northeast AHEC, along with its collaborating partner organizations, has, through the development of the Geriatric Technician program, become a leader in addressing the national problem of the recruitment and retention of certified nursing assistants/aides.

The recruitment and retention of certified nursing assistants/aides (CNAs) is a national problem. According to the American Health Care Association, the national vacancy rate for CNAs is 8.5% and the annual turnover rate for these positions is 71.1%. Rural freestanding facilities have the highest turnover rate at 76.4% when one compares urban and rural areas and takes into account hospital affiliation. Oklahoma's CNA vacancy rate, at 8.5%, is comparable to the national rate, however the annual estimated turnover rate in Oklahoma is the highest in the country at 135.5%.[1]

Since CNAs provide the majority of care in long-term care (LTC) facilities, CNA vacancies and turnover have a huge impact on the continuity of care for residents of these facilities. The Centers for Medicare and Medicaid Services estimate that CNAs provide an average of 2.1 hours of patient care per resident per day compared with 0.7 hours by LPNs/LVNs and 0.7 hours by RNs, totaling an average of 3.5 hours of patient care per day on a national basis. In Oklahoma, CNAs provide an average of 2.0 hours of patient care per resident per day with LPNs at 0.8 hours and RNs at 0.5 hours, for a total of 3.3 hours.[2]

Research demonstrates that increased staffing and training improves quality of care and reduces complaints, violations of federal standards and violations that cause actual harm to residents of LTC facilities.[3,4] Experts recommend a total of 4.55 hours of patient care per resident per day in these facilities.[5] The U.S. Department of Health and Human Services (DHHS) cites two (2) hours as the preferred minimum daily amount of patient care that should be provided by CNAs to each resident. Forty-two percent (42%) of Oklahoma nursing homes did not meet this standard. In these homes state inspectors found an average of 7.9 violations of federal health and safety standards compared to an average of 5.3 violations for homes meeting HHS patient care standards. In addition, 25% of homes not meeting the HHS standards were cited for actual harm violations compared to 16% in homes meeting the standards.[6]

These issues led the governor of Oklahoma to create a Continuum of Care Task Force in 2000. The Task Force analyzed problems related to the care of the elderly by convening multiple community meetings and making site visits to a variety of LTC facilities. In 2001, a draft report recommended:

- Improved staffing and training of elder care providers, especially nurse aides
- An increased focus on improving the quality of care, and
- Expanded protections for the ulnerable and elderly.

In response to these recommendations, the Tulsa Community College Division of Nursing (TCC) sought to develop an advanced training program for

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provide a great supportive environment for the activities of the Northwest Oklahoma Healthcare Education Coalition as the work of the Coalition meshes very well with the AHEC mission.

RHP/NwAHEC's offices are leased from Northwestern Oklahoma State University, and are located on the Enid Campus. The Board Room, classrooms with distance learning technology and other ancillary services are available as a benefit of this arrangement with the University. Years of experience with community activation, event organization and management, public relations, public speaking, and marketing skills are already on staff. RHP/NwAHEC has been the lead organization in offering many educational and recruiting events with the same structure as required by the Coalition. The RHP/NwAHEC service area is the 19 northwestern counties of Oklahoma, many of which are frontier counties. RHP/NwAHEC is constantly increasing its presence within extended regions of its service area.

What is next for the Coalition

The success of the Coalition is demonstrated by the 27 BSN level nurses graduating this year from Northwestern Oklahoma State University as opposed to the 12 graduating in the class of 2002. As a result of this success and the level of involvement by this AHEC center, NwAHEC was asked to assist the Coalition in meeting the next identified need/challenge, the skills labs at the nursing programs. The problem is the age of the equipment in these skills labs, and the cost of replacing or purchasing state of the art equipment in this time of very tight budgets in public education. The direction the Coalition chose was to develop a "community" nursing skills lab. This lab will be used by the LPN, ADN and BSN programs as well as the hospitals to train student nurses, practicing nurses and to help bring lapsed nurses back into the profession. NwAHEC has submitted a substantial grant for equipment to an in-state foundation that is very interested in the project, with the stipulation that NwAHEC will retain ownership of all equipment purchased with the funds and ultimately manage the lab. The nursing schools have committed space for the lab, labor and materials for remodeling, staff, equipment and funds for maintenance. The hospitals have also committed to donating equipment, technicians for maintenance, and staff for clinical education. The goal is to have the lab up and running for students in the fall semester of 2004.

There are many new challenges ahead for this Coalition. At a recent meeting, Dr. Robert Hoffmann, one of the two founding physicians stated that "although nursing remains a concern, there are many other areas in our medical facilities that are experiencing a shortage of personnel." Then he added, "The Coalition should look at ways to assist them as well." This unique collaboration demonstrates that it only takes a handful of dedicated professionals to make an impact that will be felt for years to come.

'Fortunately, the Oklahoma AHEC activities of coordinating rural clinical training and recruitment to health careers provide a great supportive environment for the activities of the Northwest Oklahoma Healthcare Education Coalition as the work of the Coalition meshes very well with the AHEC mission.'

Education. These sweeping changes were not only approved but were applauded for their innovation.

The finance committee's task was to raise money and pledges from local physicians and local health care facilities. By spring of 2001, under the leadership of one physician, over $100,000 had been raised. The fiscal challenge, though, was to raise enough money so that the coalition would be able to finance, using the interest only, about 30 students a year in the program. This would provide adequate funds for subsequent years and additional students, and allow for a self-perpetuating forgivable loan fund.

'The Coalition began as a discussion on a hospital floor between two Enid, Oklahoma physicians who were concerned about how the shortage of competent, well-trained nurses had begun to affect their ability to practice medicine.'

By the fall of 2001, with large donations from two local medical centers in Enid, Oklahoma that were matched dollar for dollar by the Sisters of Mercy, an endowment of nearly $390,000 was established for the loan fund. The cash on hand was sufficient to award 30 full academic year scholarships to students attending four different schools of nursing in Northwest Oklahoma. In the spring of 2002, five additional semester scholarships were awarded. To date 45 nursing students have received $48,750 in "scholarships" to attend six different programs. These "scholarships" should be referred to as forgivable loans to reflect the agreement the student makes with the Coalition. A long-term goal of the Coalition is to raise $1,000,000 for an endowment to be held by the Enid Community Foundation.

How the "Forgivable Loans" work

The student signs a contract with the Coalition stating they will repay the Coalition for each year of tuition received by working anywhere in a medical facility within Northwest Oklahoma other than a physician's office, proprietary home health agencies, private duty practice, research, federal facilities, industrial or summer camp nursing. If the student does not maintain passing grades, withdraws from nursing school, fails to pass boards, or does not gain employment in the specified area and facility, then the loan is considered due and payable. If this situation occurs they must repay any awarded funds to the Coalition. The template for this contract came from the very successful Oklahoma Physician Manpower Act.

All the work completed up to this point has been done by volunteers who have donated their time, and with office supplies donated by Northwestern Oklahoma State University and the two lead physicians. The two original physicians continue to provide the leadership in all aspects of this activity and they have found administering the Coalition a daunting task with their busy surgical practices. This led to their decision to request Rural Health Projects/NwAHEC, to take over custody of available cash funds, be a clearing house for applications and eventually assume the administrative duties of the coalition. This AHEC Center was a logical choice because the independent status and long history of working with all the partners of the Coalition.

Rural Health Projects, Inc., NwAHEC

Rural Health Projects, Inc./NwAHEC is entering its 15th year of existence, having been established in 1989. In 1992, it became a 501(c) 3 not-for-profit corporation. This was brought about in the final year of federal start up funds from the National AHEC grant. By becoming a private not-for-profit organization the Governing Board felt that RHP/NwAHEC could better serve their community than becoming a division of an educational institution, and functioning only as an AHEC. Fortunately, the Oklahoma AHEC activities of coordinating rural clinical training and recruitment to health careers

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