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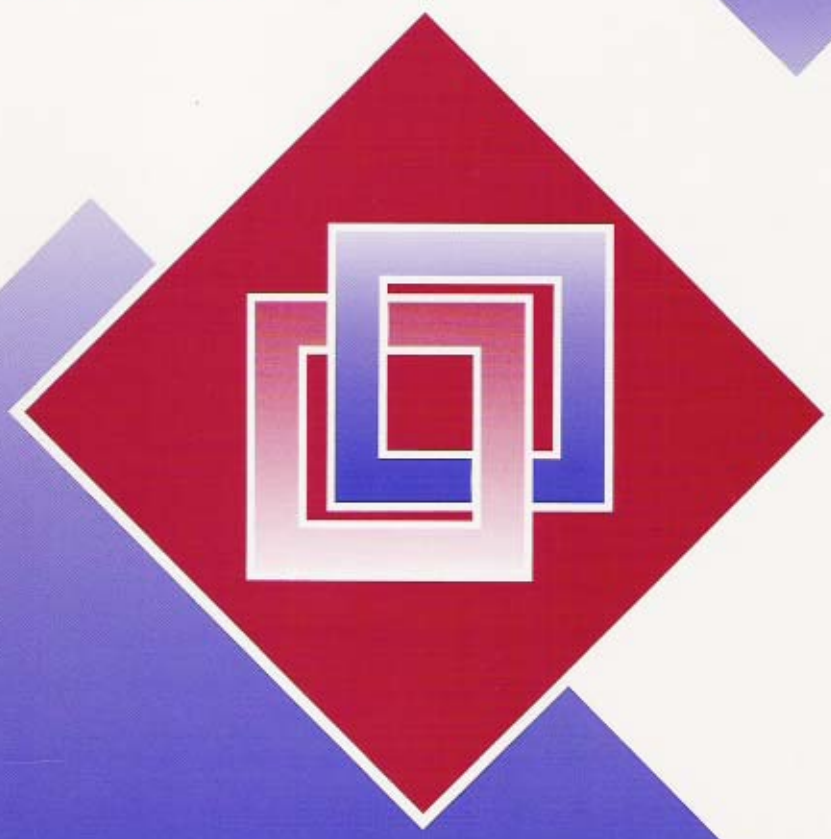

Expanding the AHEC Mission

Health Care Workforce Policy Development

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In This Issue

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AHEC

Volume XVIII, Number 1
Summer 2001

The National Area Health Education Centers Bulletin

Health Care Workforce Policy Development

Persisting and Emerging Challenges: Expanding the AHEC Workforce Mission

By Shirley A. Weaver, PhD

We invite you to the second in a two-part series focusing on health care workforce issues. The question Assistant Surgeon General, Dr. Sam Shekar, posed in the first part ("Re-examining the AHEC Workforce Mission" Autumn/Winter 2000), continues to resonate: "We can spend millions of dollars to build clinics, but if there are no health care professionals available to provide services, what good does it do?"

In the first issue we celebrated our 30 years of creative and diligent workforce efforts by describing how AHECs have helped the academic health centers to respond to the health workforce needs of the communities AHECs serve. We also re-examined that work in light of fast-moving changes in the health care environment, and challenged AHECs to look beyond the traditional ways in which they have educated and trained health care providers.

In This Issue

In this issue we step back another pace. We examine emergent workforce challenges that promise to be long standing and universal and, hence, a threat to state and federal policies geared towards improving access to health

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Sen. Angela Monson

The Most Pressing Concerns

Oklahoma State Senator Angela Zoe Monson kicks off this workforce edition by urging us to action on three key areas: admission policies and practices, cultural competency training programs and licensure and scope of practice policies. Senator Monson has a unique perspective on health care issues. As a policymaker and President-Elect of the National Conference of State Legislatures she believes that states truly are where the action is in terms of health care reform and of providing high quality, appropriate health care to every individual. As a private citizen, she affirms her commitment to positive, quality change in health care. ..... **Page 3**

Dr. Edward O'Neil

The 'Strategic Frontiers'

Edward H. O'Neil, PhD, Professor of Family and Community Medicine and Dental Public Health Director at the Center for the Health Professions at the University of California, San Francisco, describes the growing crisis in the health care professions. He examines the forces contributing to this crisis — including the aging of the population, stresses on health care delivery organizations, the values placed on health care careers and developments in technology. He challenges AHEC programs across the country to realign their programs to help address the current and future shortages. ..... **Page 7**

Mr. Edward Salsberg

Greater Collaboration Needed

Edward Salsberg, MPA, Director of the Center for Health Workforce Studies at the School of Public Health at the State University of New York at Albany, recognizes AHEC's successes in establishing linkages between academic centers and communities and facilitating training — particularly interdisciplinary training — in community based settings. He points out AHECs' tremendous potential to be viewed by state policymakers as a resource ready and able to support these policymakers on health workforce issues. He urges AHECs to share workforce data relevant to issues that could inform policymakers' decisions. ..... **Page 10**

Mr. Stephen Tise

Ms. Marilyn Biviano

Supply and Demand Projections

Mr. Stephen Tise and Ms. Marilyn Biviano of the Bureau of Health Professions help us make sense of some of the issues affecting the current shortage in the field of health care delivery, including the labor intensive nature of the work and attempts to reduce costs all along the way. Their careful analysis of projected demands on key career fields (nurses, pharmacists, physicians and therapists) is coupled with information on the latest research underway to link the demands on each of 20 health care occupations with opportunities to increase supply of health care workers. ..... **Page 13**

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care. In turn we ask the implied question: Has AHEC embraced this larger, long-range issue in its workforce mission?

We specifically call your attention to an article by *Dr. Andy Nichols,* to whom this edition is dedicated. This 1993 speech is dated only by its reference to then-current political health policy events. Dr. Nichols' call for workforce planning remains as cogent today as it was then — providing testimony to Senator Monson's argument. Further, the introduction by Dr. Nichols' daughter and professional colleague, describing his legislative success in Arizona provides insight into the importance of integrating workforce planning with health care access policy changes.

In the **four lead articles** we are oriented to national health care workforce issues and their political context, which provide the framework for AHECs' workforce mission. *Senator Angela Monson* offers the unique perspective of a state legislator/policymaker. She highlights the "disconnect that exists between initiatives that call for access and expansion of coverage, and initiatives that bring into (or limit) the health care workforce the type and number of providers that we need to meet the mission." *Dr. Edward O'Neil* outlines "strategic frontiers that AHECs can begin to emphasize to help address the challenges in the years ahead." *Steven Tise* and *Dr. Marilyn Biviano* help us understand the factors affecting health workforce supply and offer the current demand projections for each of the major health occupation categories. Their projected double-digit increases in demands in each of the health occupation categories makes concrete the workforce challenges that lie ahead. *Mr. Edward Salsberg* brings into sharper focus the challenges and opportunities for AHEC involvement in workforce policy development at the state level. These articles point up some of the contradictions extent in U.S. workforce policy development: federal or state policymakers focus singularly on health care access, while access is dependent upon an available workforce; governmental policymakers react to "fix" manifest problems, while workforce issues are cumulative, long term and complex; AHECs are charged to focus on workforce issues at the community and/or health professions education program levels, while workforce issues are, in fact, expressions of larger social policy. The articles also suggest that an opportunity exists to expand the federal AHEC workforce mission, in order to play a purposeful role in statewide workforce policy development.

'It is clear that workforce challenges are expressions of the larger, more complex social, economic and geopolitical context of health care in the U.S.'

The **second section** of the *Bulletin* focuses on the currently most prominent workforce challenge: the nation-wide nursing shortage. In this section we describe different levels of nursing workforce planning in which AHECs are involved. AHEC's such as *California*, have long-standing formal roles in nursing workforce strategic planning. Others, such as *New Hampshire,* are assuming important roles in new planning initiatives. The *Colleagues in Caring* initiative, a major Robert Wood Johnson Foundation national nursing workforce project, offers several important insights for AHEC. First, it suggests that the perception of the nursing profession is that AHEC's multi-disciplinary mission can not adequately support (its) single profession agendas. Second, on the other hand, it suggests that AHECs can play a collaborative role in sustaining such training programs.

The **third section** focuses on Community/Migrant Health Centers (C/MHCs) and the National Health Service Corps (NHSC) – the primary vehicles for federally supported health care for the underserved. The examples presented here offer a glimpse into the many and varied collaborative relationships between AHECs and C/MHCs and the NHSC. AHEC-C/MHC collaborations have led to a wide range of successful workforce recruitment, training and retention programs — from staff training to formal graduate medical education programs. Some AHEC programs, as witnessed by the *Illinois* program, have served as the state coordinator the NHSC SEARCH recruitment program. Regrettably absent from this discussion, however, is evidence of AHEC/CHC/NHSC collaboration in workforce planning at the national level.

Dr. Weaver is director of the Maine Statewide AHEC Program and Chairperson of the National AHEC Bulletin Editorial Board.

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Section I:

Health Care Workforce: The Most Pressing Concerns

By Senator Angela Zoe Monson

The following is excerpted from an address given by Senator Monson in December 2000 at the Health Workforce Conference 2000: Building a Foundation for Health Care in the 21st Century*, co-sponsored by the Health Resources and Services Administration and the National Conference of State Legislatures.*

Recently I participated in a discussion with state legislators and executive branch staff on health care issues. One of the elements of this discussion was the frequent mistrust between the federal government and state governments. So, I think that this conference is a great example of how there is not always a bad relationship between these two branches of governments.

I know you are committed to positive, quality change in health care; so am I.

I want to frame my comments from a state legislator's perspective and, here or there, I will take off my state legislator's hat and put on "Angela's personal commitment hat."

States truly are where the action is in terms of health care reform. This is not to disparage the work of Congress, but we at the state level really have been the laboratories of public policy. We're close to people; we get the letters and the phone calls. And we try to respond as quickly as we can.

But we share the same goals with you, the same vision – to provide high quality, appropriate health care to every single individual in this county. If we're able to do that, not only do we create healthy individuals, but also we create healthy communities. We create healthy states. We create a healthy nation.

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Senator Monson is an Oklahoma State Senator. She is President-Elect of the National Conference of State Legislatures and Chairperson of the National Health Service Corps Advisory Committee.

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The **fourth section** touches on workforce issues that are gaining national visibility: public health, mental health and underrepresented minority health professionals. *Christine Gebbie* describes the first comprehensive effort to estimate the public health workforce since the 1970s, which is an important first step towards framing an approach to continuous enumeration of public health workers. The *North Carolina AHEC* has been involved in mental health workforce needs assessments and development for 15 years. Their experience calls to our attention the incredible demands on this sector of health care — demands that require continuous appraisal of workforce needs. *The California Health Workforce Study* of participation of underrepresented minorities in undergraduate medical education points up the negative influence of anti-affirmative action policy. These brief glimpses serve to call AHEC's attention to these critical workforce issues.

The final sections of this edition present specific projects that address local/regional workforce issues. These projects help us to distinguish workforce issues unique to specific areas from those that are universal; e.g. the nursing shortage. They also serve to remind us of the many dimensions to developing a workforce to meet all health care needs.

It is clear that workforce challenges are expressions of the larger, more complex social, economic and geopolitical context of health care in the U.S. The increasing demand for more and different health care services drives the need for more and different providers. We are seeing increasing attention being given to meeting the needs of the millions of citizens who currently do not have, and/or can not afford, full access to health care. We also anticipate that our aging, and more affluent, "baby boomer" population will be making high health care demands. And, as the Surgeon General has emphasized, preventive and health promoting services must be expanded, as they are the long-term key to improved health and quality of life. Ironically, despite the high profile of these health care *access* problems, health care *workforce* continues to be a missing link in health care policy formation, at both the national and state level. This absence of planning for health care workforce development concurrent with health access policy formulation poses continuing challenges and new opportunities for expanding the AHEC workforce mission.

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To accomplish this goal requires our attention on three key areas: admission policies and practices, cultural competency training programs and licensure and scope of practice policies. Reaching the goal also requires the participation of two very important people: the patient and the practitioner.

It's not rocket science. If we don't have the patient who is a participant in the process, then it doesn't work. If we don't have the practitioner there to provide the care, then it doesn't work.

Unfortunately, many of our policies, programs and practices have removed one or the other, and sometimes both, from this very simple scenario.

We take the patients out of this process by creating limited access to health care services, either through financial stress or, simply, lack of health insurance. We take individuals out of the marketplace by saying: "You have no access to becoming a healthy individual because you do not have the financial means to access the care that's necessary."

We've created policy restrictions at the state and, to some extent, at the national level, and even in the private marketplace, in terms of what's covered and not covered — what actual services people have access to. We have created a scenario in which these policies have restricted coverage and access to such an extent that we can't help but expect an unhealthy population.

We've removed practitioners from this simple scenario. We've reduced the pool. We've reduced the flow in the pipeline.

First, we've refused, at the state level, to appropriately fund graduate medical education.

As I look at the budget for the state of Oklahoma, I sometimes want to cry. Outside of limited support of our medical colleges, we give a very, very small amount of the state budget to the support of graduate medical education.

Second, we are creating biased entry admission policies, sometimes by court order, that restrict who is in the applicant pool and limits who gets graduate medical education.

At the beginning of this HRSA-sponsored Health Care Workforce Conference, Dr. Claude Earl Fox said that we want practitioners to look like the communities within which they serve. That is becoming more and more difficult because of the admission policies at many of our medical training facilities.

This bears repeating: the assault on affirmative action and the restrictions placed on who is entering health care training programs has, as a result of legal cases and court rulings, created a situation where the diversity in the applicant pools for health professional training programs is reduced, thus reducing access to professionals that look like, and understand, the communities in which they work.

Third, we've created practice site choices and incentives that do not encourage, or even allow, practitioners to go where they are needed. From a policy perspective, we have not provided incentives that create the distribution we need.

We've always assumed it will happen automatically. Unfortunately, many of those things don't happen automatically. And when, with an eye to making policy changes, we look at restructuring access to practitioners, when we look at contractual kinds of relationships, states have been slow to respond, saying it is a private sector responsibility.

But we have created (or allowed) contractual situations to occur that limit networks in managed care or that simply mandate overburdensome credentialing requirements — therefore restricting who is in the pool or who is in the network. Or we've created (or allowed) licensure requirements to be put in place that really restrict and limit folk who are practicing and providing care in many states.

We have done a number of things to expand access, but we've also done a number of things that limit access. So now we have an opportunity, in partnership with federal, state and local governments, to assure that we are working together to achieve one hundred percent access and zero percent disparities.

We have an opportunity to recognize the disconnect that exists between initiatives that call for access and expansion of coverage, and initiatives that bring into (or limit) the health care workforce the type and number of providers that we need to meet the mission.

If we are going to assure an adequate workforce, whether in numbers, distribution or competency, then we are going to have to work on all fronts. We cannot continue to pass the buck and say it's someone else's responsibility. This Health Workforce Conference is

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about one of the crucial aspects to making sure it works — providing the necessary information.

The effort on the part of HRSA to provide state-based data is a great start. We need it; it is vitally important. We need to know who is practicing where, not just the geographical area, but the actual clinical setting. We need to know who is being served and who is not. And we, as policymakers, all need to ask the question: Why does maldistribution exist in some areas? Only through collaboration and the dissemination of data can we even begin to ascertain the answer to the question, and then, put in place the appropriate public policy. If we are going to address and work on this issue, we need to create the opportunity. Creation of opportunity sounds simple, but we don't focus on it as we should.

Again, I go back to admission policies and practices. If we don't create policies and practices that allow a diverse pool of folk into the network, we will never have an opportunity to make sure that the health care workforce looks like the communities in which they work.

We have to create cultural competency training programs. That means exposure. We have to make sure that people from rural areas have an opportunity to be exposed to urban areas. But we also have to make sure that urban folk have an opportunity to be exposed to rural areas of practice. If we don't create the opportunity, if we don't create the exposure, people will continue in their own individual vision.

"Creating opportunity" may be a hard subject for policymakers, but we really must look at licensure and scope of practice policies. These are hard issues and we don't like to address them because we don't like to be involved in those fights.

We give the responsibility to licensure boards to devise scope of practice guidelines. Then, when they sometimes put in place fairly restrictive policies, we, as elected officials, too often become engaged only when the dialogue is heightened to a level that we cannot ignore, and we believe that we have no option but to create a new public policy.

But if we are going to do it and do it effectively, we really have to look at and evaluate appropriately academic programs and the training given in those programs. We have to have the guts and the courage to deal with scope of practice issues. We're going to have to review licensure policies and regulations, and tell our licensure boards: this policy is too restrictive, it is inappropriate.

We're going to have to take a look at "any willing provider" legislation for networks. I am not advocating this per se, but I am saying that when networks and managed care are limited to the extent that people don't have access, then we, as public policymakers, have a responsibility.

If we think access is important, we must work to make sure that it is there and available for the people who are uninsured. It extends to the use of alternative medicine — other ways of providing care. If the practitioners who feel comfortable in their environments won't go to areas that need to be served, then we must — through scope of practice, alternative medicine and other creative mechanisms — create an opportunity for people to receive services.

It can be done. I am not saying just to send folks out. The appropriate training, the appropriate academic programs, will allow practitioners to provide care in the appropriate fashion.

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'We have an opportunity to recognize the disconnect that exists between initiatives that call for access and expansion of coverage, and initiatives that bring into (or limit) the health care workforce the type and number of providers that we need to meet the mission.'

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This a hard issue for states to deal with. It is much easier for us to expand Medicaid. It is much easier for us, as elected officials, to change policy regarding insurance regulations. But it doesn't matter, it doesn't count, if we expand coverage to include every single person in the state of Oklahoma and the workforce is not in place to meet the needs of those individuals. It simply does not matter.

If we are going to be successful, we have to recognize the partnership that must exist between state policymakers, federal policymakers and local policymakers. The Department of Health and Human Services' initiative to empower communities, to create partnerships within communities, is so vitally important.

We, as policymakers, must recognize that we have a responsibility to identify and finance workforce issues. We are going to have to create mechanisms to pay for graduate medical education, to provide the opportunities, to recruit, to provide the support once people are placed in settings that may not be the "best" because they don't offer the amenities that one might get in a urban area.

We have to recognize we have a responsibility to provide support and make sure that the feelings of isolation are not so great. As Chairperson of the National Health Service Corps Advisory Committee, I believe NHSC has demonstrated the capability of meeting many of these kinds of workforce issues, but the funding is not there. If the support, the reauthorization and the re-appropriation are not there, the program will not be able to meet the objectives set out for it.

The Corps has shown that it can diversify workforces. The Corps has demonstrated that it is possible to place people in communities and in settings where many others don't want to go.

These challenges before us are not insurmountable. We have too many examples and too many demonstrations of where and how it can work. We simply have to take a look at them. If we are truly committed to our ultimate goal of providing access, providing appropriate high quality care, then we are going to have to work hard. We are going to have to take on the hard challenges. We are going to have to look at reimbursement rates from a state level and at incentives and disincentives that exist there.

It is all about commitment. It is all about the establishment of priorities, about advocacy work, about providing the right kinds of information. And then, working hard to make sure that workforce profiles of our state are not just placed on the shelf, but are actually pulled out and used by public policymakers, when they make the appropriate decisions about graduate medical education funding and about distribution of providers throughout the state.

These actions all rest on our commitment — and to the answer to the question: are people really entitled to high quality, appropriate health care?

If you answer that question "Yes," then you have, and I have, an individual responsibility to work toward that end. Do payers have a responsibility to make sure that incentives and mechanisms put in place for payment for health care services are appropriate, and that disincentives are not created which discourage practice in rural areas, or in certain urban settings and with certain populations? I think the answer is Yes, payers – public and private – do have that responsibility.

And then, ultimately, what role is government really going to play? Is it a public responsibility? Is it a private responsibility? We have to answer these hard questions because the answers to those questions move us to act. They move us to take certain actions, if we believe that there is an appropriate role for government at the national, state and

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AHEC's Valuable Emphasis

The Area Health Education Center Program has also shown its value in providing young professionals with exposure to rural and underserved communities. The community-based training experiences that are encouraged and facilitated by the AHECs show the student that the "less desirable" practice sites offer rich rewards and opportunities for making an important difference in people's lives.

The AHEC's emphasis on health career education for youth, especially minority youth, offers a hope that, over time, the pool of applicants to health professional training programs will be as diverse as the communities needing them.

The 'Strategic Frontiers' in the Health Professions Crisis

By Edward H. O'Neil, PhD

It is increasingly evident that there is a growing crisis within the nursing and allied health professional community. While most of this crisis is a function of number, there is also a dawning realization that the ways in which professionals and workers are employed, the set of skills and competencies required and the regulations that guide work and practice are all part of the overall crisis of health professional workers.

The causes for these dislocations are varied, and many of the most important trends are external to health care itself. But these trends are shaping the new ways in which health systems, educational programs, labor unions and professional groups must respond. These patterns offer important new clues to how AHEC programs across the nation will need to realign their programs for success in the future.

A recent study by the American Hospital Association showed that "hospitals find themselves facing both immediate and long-term shortages of personnel." These were not limited to nurses, but included all types of allied health, entry level clerical and custodial personnel as well. A 1998 study by the University of California-San Francisco Center for the Health Professions concluded that there was a looming and structural shortage of health care workers in the allied and auxiliary fields. A more recent study by the Center for the Health Professions has pointed to a similar shortage in nursing that runs the gamut of nursing employment.

'There are several strategic frontiers that AHECs can begin to emphasize to help address the challenges in the years ahead. These include better information about needed changes, improved sequencing of education and work experiences, and improvement in the quality of health in the workplace.'

Forces Impinging on the Health Care Workforce

Demography: These shortages are being driven by a confluence of powerful forces, many of which are beyond health care. Perhaps the largest forces, and ones certainly obvious across health care and society, are the changes taking place in the U.S. population.

First, that population in general is aging. This means that health care workers — all health care workers — are aging along with the general population. For example, the average age of registered nurses (RNs) in California is 49, but this is no more alarming than trends in other professions. The fact is that the U.S. workforce is aging, and older people

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Dr. O'Neil is a Professor of Family and Community Medicine and Dental Public Health Director at the Center for the Health Professions at the University of California, San Francisco.

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local levels, to assure that the workforce, the health care workforce, is in place.

To meet our ultimate goal of the provision of high quality appropriate health care for every single person in this country, it really is up to us to create in Congress, in our state legislatures and in county and city governments, the kind of priorities that need to be created.

It's up to us to do the work. We as state legislators can't pass the buck. The challenge is before us all; the opportunity is before us. So I encourage us all to work hard to make sure our ultimate goal is achieved.

I can't think of anything else that is more important and more valuable than assuring that every single person in this country has access to quality and appropriate health care that's necessary. I appreciate the opportunity to work with you on this challenge.

The 'Strategic Frontiers'

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will be doing more of the work than in the past. For professions such as nursing and other allied professions where the entry age has grown older, or in which the work is so physically demanding that it can't be done by those of a certain age, the workforce will be even more constrained.

A second feature is the size of the aging cohorts that represent the Baby Boom. As this 76 million-plus generation ages past 60 they will, of course, begin to consume more health care and utilize more health services. As this demand grows it will meet the inevitable crush for more workers. We have few models of possible variation in that demand. We hope that the Baby Boomers will be healthier and more focused on self care, but we know that we are, as a population, more obese than ever and use more health care than ever before.

Related to the demographic reality of the growth of the Baby Boom is the decline of the size of the cohorts that immediately follow the Boomers. This age group will produce a workforce gap that will be hard to overcome. Workers in this age group are already the hottest commodities around, and industry outside of the health sector is already pretty blunt about the impending war for talent.

Success in the future will not mean merely filling the coffers; success in a rapidly changing technological environment and in an age of shrinking entry cohorts will mean the ability to attract and retain workers that have the very best technological and interpersonal skills. The reality is that if an employer is having difficulty attracting such workers today, the challenge will grow dramatically in the future.

A final demographic reality is the movement from a mainstream, Caucasian majority culture to a multi-cultural reality that blends a rich and very diverse set of ethnic and cultural minorities. Last year, California joined Hawaii and New Mexico as non-majority states for the entire population. If one looks at the under-15 population, however, the majority returns, but as Latino. Coupling this change with the aging population means that it will be essential to accommodate these new realities in any effort to build an adequate health care workforce for the future.

Health Care Organizations: The second major force impacting health care is the continued stress on health care delivery organizations. For most of the post World War II period, hospitals, clinics, health plans, colleges and schools for training lived under the regime of a growing industry (from five percent of GDP in 1960 to 14 percent in 2000) that did not have much external accountability.

For the past decade or so, unevenly across the country, the "system" of care has moved to become more accountable for cost and outcomes. This adjustment has stressed and will continue to stress the system. This stress has trickled down into the workplace in many different forms: perceived shortness of physician exam time, reduction in middle managers in hospitals, more stressful patient care loads, more competition between and among professional groups and, in general, more demanding environments and fewer resources. This has made employment in health care less fulfilling, more contentious and filled with more stress than ever before. Therefore, health care organizations have become less desirable as places for initial employment and less able to retain employees.

Values: The third force is one of values. Two value shifts are driving most of the action. First is the value women place on nursing as a career. While the profession has historically benefited from the focus by women on nursing (by artificial exclusion from other professions), that constraint has clearly been lifted, and women are free to choose other careers. What should be said is that women might still choose nursing or other allied professions, but clearly are not doing so; they must see some flaws when comparing these traditional careers to other fields.

The other relevant value shift is between generations. The values of "Generation X" are no better or worse than those found in a large health care system, they are just different.

Technology: Finally, there is the general shift in the way we work. As the nature of employment and institutional life changes, pushed on by the drive of information technology, health care has been more or less left behind. This need not happen. But it will require a repositioning of institutions of health care to be more consistent with a workplace that is faster, flatter and more flexible than most health care settings are currently.

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The 'Strategic Frontiers'

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Realignments Necessary: The Role of AHEC

All of these drivers present an enormous challenge to health care systems and professionals alike. As they begin to make accommodations to these realities, there are several strategic frontiers that AHECs can begin to emphasize to help address the challenges in the years ahead. These include better information about needed changes, improved sequencing of education and work experiences and improvement in the quality of health in the workplace.

First, at the local level better signaling mechanisms need to be put in place between work and education. Much of the misalignment in numbers, skills and work structures has come about by failed communication between the two.

AHECs are uniquely positioned to collect and analyze data related to this mismatch. Much health care regulation and data are made and assembled at the state level. However, systematic data collection and analysis of the sort that looks across professions and is richly informed from practice and health organizational settings are not done well in any state in the union.

Without such data and analysis, the response of policymakers and institutional decision makers, not to mention students and prospective students, is hopelessly befuddled. The relationship with education, employers and state policymakers of most AHECs creates a brilliant context for creating such an initiative. Although such a shift to data collection and analysis would be a departure for many AHECs, one might argue that without mounting such an effort the AHECs will have little chance for successfully meeting their traditional obligations, much less really impacting health professional education and work.

Link Training and Working: Several analyses of current workforce problems and opportunities suggest more rational sequences of training and work. Often called career ladders or early entry programs, these efforts are, at the heart, a rethinking of the artificial separation of work and training.

Efforts that bring work and education together are relevant in K-12 programs, traditional professional training and career improvement approaches for existing professionals. While these initiatives offer great benefit to student, health professional, employer and training programs, they are not as openly embraced as they might be. Often what is needed is a best-practice assessment and dissemination of models, which work with practical information, and assistance as to how the partners might come together to meet each other's needs. Again, AHECs are uniquely well positioned to assist in such a brokering process.

Create a Better Working Environment: Another challenge facing the creation of a sustainable health workplace is building supportive and humane work environments. One recent study of California nurses found that the work environment contributed most significantly to job satisfaction, or the lack of it, surpassing compensation in importance. The reality is that many health care workplaces need to be remade in order to be more supportive of the health care worker. This will mean building new organizational structures, reskilling the work teams, particularly in non-clinical, organizational skills, and redesigning reward and incentive structures. Because they are directly charged with improving the quantity and quality of the health care workforce, it seems unlikely that AHECs will be able to avoid addressing such a central issue, if they are to remain relevant.

'Every work setting and every education program will need help in realigning the way in which their work is to be done. AHECs across the country could and should play a major role in each of these opportunities for change.'

Workplace improvement efforts must integrate practitioners and teachers. As important as realigning new training programs is, it is also necessary to leverage knowledge available from the work environment in order to retrain and advance the existing workforce. Every work setting and every education program will need help in realigning the way in which their work is to be done. AHECs across the country could and should play a major role in each of these opportunities for change.

Greater Collaboration Needed Between States and AHECs

The following is excerpted from an address given by Mr. Salsberg in December 2000 at the Health Workforce Conference 2000: Building a Foundation for Health Care in the 21st Century*, co-sponsored by the Health Resources and Services Administration and the National Conference of State Legislatures.*

By Edward Salsberg, MPA

Although there are many variations among states and among AHECs, most share a fundamental goal of fostering a responsive health professions education system that produces the number and types of health professionals with the appropriate skills needed to provide high quality care. Yet greater collaboration is needed between states and AHECs, especially on the development of a cohesive state health workforce policy.

Many states have not developed or articulated a health workforce policy or plan. In addition, many AHECs are focused on the specifics of offering a more effective education to specific health professionals rather than on policy development.

Finally, AHECs have been created and funded by the federal government and they tend to focus on the concerns of their funding agency. Increased collaboration between states and AHECs, especially as it relates to policy development, could have many benefits to the states, AHECs and the public.

Mr. Salsberg is the Founding Director of the Center for Health Workforce Studies at the School of Public Health at the State University of New York (SUNY) at Albany.

Shared Goals

States have not assumed responsibility for comprehensive health workforce planning; however, they regularly respond to specific concerns and problems related to the health workforce. For example, states have historically been concerned with shortages and the maldistribution of health professionals, especially when these conditions create access problems for state residents. To a lesser extent, states have also been concerned with the skills and competencies of health professionals; this is seen in policies related to such issues as primary care and geriatrics. Many states have also been concerned with the lack of ethnic and racial diversity of the workforce when it is compared to the state's general population.

AHECs have historically conducted programs to better prepare health professionals to serve underserved populations and to be better prepared to provide quality services. The focus has been on improving the actual training and education rather than making or changing policies. However, AHECs have designed and implemented the types of programs that help achieve the kinds of outcomes that state officials seek.

Although states have a major interest and stake in health professions, there are several significant constraints on state action. First, states generally do very little workforce planning of any type.

Nationally and at the state level, the Bureau of Labor Statistics and state Labor Departments generally provide the public with forecasts of supply and demand by occupation, including job openings, which often influence career and job choices. However, these tend to be rough estimates, especially when applied to any specific locality, and these activities are limited in scope.

Thus, a state Labor Department may forecast a shortage of registered nurses, but this provides no guidance on what types of nurses with what set of skills should be produced by what types of schools.

Second, states have traditionally stayed away from attempting to mandate curriculum. The academic community strongly resists any government interference. Thus, while some states have mandated family practice or rural rotations at their public medical schools, states generally avoid requiring changes in curriculum or educational approach at public or private institutions.

Third, most legislators and state officials have limited expertise in education and training or assessing the quality of care. Often, specific professions and special interests will go to the legislature or other state officials requesting a change in scope of practice or expanded health insurance coverage for a specific occupation or set of services. Government officials have a very difficult time assessing the often conflicting arguments of different professions and interest groups.

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Greater Collaboration

(Continued from Page 10)

AHEC Roles and Responsibilities

In general, the overriding mission of AHECs has been to encourage an education and training system for health professionals that would produce health professionals well prepared to provide quality services to high need populations. To do this, AHECs have focused activities on: establishing linkages between academic centers and communities; encouraging and facilitating training in community-based settings; and promoting interdisciplinary training.

Barriers to Collaboration

One of the barriers to collaboration is the different focus of state policymakers and AHECs. Of necessity, state policymakers tend to focus on the major statewide workforce needs and statewide policies, such as those mentioned above. AHECs, on the other hand, tend to be much more focused on specific education and training activities. AHECs also tend to be more focused on local and regional workforce needs rather than statewide.

Another important factor may be that AHECs are often heavily supported by the federal government and look to the Bureau of Health Professions for direction and guidance. States are not generally involved in any way with the Bureau in deciding the priorities or directions for the AHECs. States are not in the loop. (This is not to say that individual AHECs don't work with state policymakers.) Thus, states are often unaware of what AHECs may have to offer to assist in addressing state health workforce concerns. AHECs, of necessity, need to make sure they respond to the concerns of the federal agency that supports their operations.

Areas for Collaboration

There are several areas of potential collaboration between AHECs and states on health workforce development. It is important to recognize that in order for AHECs to be viewed as a resource, the data or experience they share must be relevant to the state's policy agenda. Typically, state policymakers focus on emergent health workforce issues that require immediate attention, such as a general nursing shortage.

Identifying priority local health workforce needs: AHECs are active with local communities around workforce education and training needs. This information can be very valuable to state policymakers. This may require AHECs to more systematically assess community needs and to pass this information on to state policymakers in an organized manner.

Role models and best practices: AHECs have real world experience in providing socially responsive education and training. Given the interests of state policymakers, better information on what works and doesn't work is critical. Maintaining longitudinal data on program outcomes (e.g. the number of graduates retained in a community or the number of graduates accepting jobs in underserved communities) could be very persuasive to state policymakers. Dissemination of the experience of AHECs across a state, i.e. with other organizations in the state (educators, health care providers, state policymakers) as the audience, is very important.

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'It is important to recognize that in order for AHECs to be viewed as a resource, the data or experience they share must be relevant to the state's policy agenda. Typically, state policymakers focus on emergent health workforce issues that require immediate attention, such as a general nursing shortage.'

Roles and Responsibilities

(Continued from Page 11)

Assisting in the development of reimbursement policies for education and training: Many state officials and legislators recognize the importance of training in ambulatory settings and many are struggling with how to structure and support such training. The experience and knowledge of AHECs could be shared with state policymakers. AHECs could assist in the design of reimbursement policies for training in ambulatory settings.

Linkage with state supported health professions education programs: As noted above, in many states, the public colleges and universities are the major source of health professions education within a state. AHECs could explore partnerships with state colleges and universities in their effort to develop health education and training programs that prepare clinicians to provide culturally competent care to the underserved.

Data collection: More and more states are recognizing the need for base line data on the supply, demand and distribution of health professionals. AHECs can assist in this effort.

AHECs have a strong commitment to understanding health workforce needs at the local level and, to that end, often collect and analyze local health workforce data. There is potential for sharing these data with state policymakers, in order to help inform their decisions on state strategies to address emergent workforce needs.

AHECs have tremendous potential to support state policymakers on health workforce issues. In order to realize this potential, it is critical for AHECs to understand the state policy agenda as it relates to the health workforce and to share data relevant to the issues that could inform policymakers' decisions. *(See related box below.)*

Specific State Roles and Responsibilities of Health Professionals

States have many diverse roles and responsibilities related to the health professions. Although each state is different, these roles usually include some or all of the following.

- ***Support for state universities and colleges***. In many states, the majority of health professionals are trained in state supported educational systems. Some states also subsidize private higher education.
- ***The regulation of the professions*:** States determine the requirements of licensure and the scope of practice for health personnel. While states sometimes rely on national voluntary credentialing guidelines, states generally have the power to determine the entry requirements and scope of practice.
- ***Reimbursement policies for Medicaid and other payers*:** States often decide which professionals are eligible for what level of reimbursement for what services. While states are fully responsible for these policies for Medicaid, legislatures also often consider mandating private insurance coverage for a particular profession or service.
- ***Special programs, projects and grants*:** Many states have authorized special initiatives to address specific concerns, such as rural health and loan repayment programs and scholarships to encourage practitioners to locate in underserved areas. Many of these programs are targeted to, or impact on, health professionals.
- ***Initiatives related to quality of care, outcomes and medical errors*:** Quality of care is a growing concern among states, with many taking steps to increase state oversight. Many states are exploring steps they might take to improve the quality of care. While not usually directly related to the education and training of the health personnel, in the long run, the link between health professions education and outcomes is likely to get greater attention.

Making Sense of Supply and Demand Projections

By Stephen Tise and Marilyn Biviano, PhD

In 1998, the health care workforce accounted for 9.3 million jobs –about seven percent of the nation's employment. Health care employment has grown 18 percent over the past ten years and is expected to grow 28 percent in the next ten years, double the projected growth rate for all occupations.

Health care delivery is labor intensive, as evidenced by the high proportion of the labor force employed in the delivery of health care. Health care labor cost affects the total demand for health workforce as well as the composition of the health workforce.

For example, in attempts to reduce health care costs, employers are hiring the least expensive health care worker capable of providing a given health care service. Over the past ten years, the employment of non-physician clinicians has increased by more than 18 percent. Also, new occupations have been born. For example, to reduce the labor costs associated with dispensing prescriptions, pharmacy technicians have become increasing prevalent in retail pharmacies.

'According to the Department of Labor's Bureau of Labor Statistics, employment growth for the health occupations will be double the employment growth for the nation as a whole. Employment projections for the health occupations are demand projections and vary substantially.'

The demand for each of the health workforce occupations is a derived demand — derived from the demand for health care services. The size and composition of the population (the consumers of health care services) is a major driving force for health workforce demand. The number of consumers and their age distribution are fundamental determinants of demand for the health workforce.

As the size of the population grows, the total health care needs will grow accordingly. And, the more elderly the population is, the more health care per person is needed. Disease prevalence, medical and technological advances, and health professional range of responsibilities also have an effect on health workforce demand.

As with demand, there are a number of factors affecting health workforce supply. Chief among these are wages, anticipated job availability, advancement potential, the practice environment, the number and size of training programs, proportion of full-time workers, attrition rates (including retirement age) and workforce age distribution. Another factor related to supply and access to health care is the distribution of an occupation. Whereas there may be an overall adequate supply of health professionals, they may not be working in underserved areas.

The following is a brief discussion of the supply and demand of nurses and pharmacists that exemplify how demand and supply issues can result in shortages.

Pharmacist Shortage: While the overall supply of pharmacists has increased in the past decade, with the average annual growth rate surpassing the population growth rate, the demand for pharmaceutical care services has grown more rapidly. Between 1991 and 2000, the number of active pharmacists in the United States increased by 14 percent, from 172,000 to 196,000, while the population grew by only nine percent. The number of active pharmacists per 100,000 population, a standard measure of supply, increased by five percent, from 68 per 100,000 in 1991 to 71 in the year 2000.

This relatively minor increase in supply, however, was vastly outpaced by an increase in demand increasingly evident in the past two years. This increase in demand for pharmacists is caused by increases in prescription drug volume and the expanded roles and responsibilities of today's pharmacists. This increase in demand is evidenced by demonstrably increased vacancy rates and difficulties in hiring.

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Ms. Biviano is Acting Director of the National Center for Health Workforce Information and Analysis, Bureau of Health Professions.

Supply and Demand Projections *(Cont. from Page 13)*

As a result of these developments, the Congressionally mandated study, *The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists* concluded that there is currently an acute shortage of pharmacists in the U.S. The shortage is termed "acute" because its onset is relatively recent, its severity significant, and its occurrence not clearly expected.

Nurses: Between 1990 and 2000, the number of registered nurses (RNs) increased from 1.8 million to 2.2 million — that's a 23 percent increase. However, the nurse-to-population ratio grew only ten percent during that same period.

Again, missing from this one-sided picture of the nursing workforce supply is increased responsibilities and volume of work for nurses that translates into increased demand. While there is no convenient measure of the increased responsibilities and volume of work in nursing care, anecdotal evidence from a wide variety of sources suggests that increased hospital patient acuity, the aging population and advances in medical science and technology have increased demand for nursing care significantly.

Currently, there is not a documented national shortage of nurses. However, there are several shortages reported at the state and local levels. California has the lowest RN-to-population ratio of any state and is facing a shortage of RNs largely because of its rapid population growth. Based on California's projected population, researchers from the University of California at San Francisco (UCSF) Center for California Health Workforce Studies, estimated an additional 43,000 RNs will be needed by 2010. Nursing school enrollments in California have declined by ten percent between 1992 and 1997 and California is heavily dependent on nurses trained in other states and outside the country.

The long-term national shortage of nursing is largely caused by the aging of the nursing workforce and the lack of young people going into nursing. The proportion of nurses under the age of 35 declined from 41 percent in 1988 to 18 percent in 2000. Further evidence of the aging nursing workforce is the dramatic increase in the proportion of RNs 45 and older — from 35 percent in 1980 to 51 percent in 2000.

Projections of national supply and requirements for RNs by the Bureau of Health Professions Division of Nursing indicate that a national shortage beginning about 2007; that shortage is expected to worsen through the year 2020.

Health Workforce Employment Projections

According to the Department of Labor's Bureau of Labor Statistics (BLS), employment growth for the health occupations will be double the employment growth for the nation as a whole. Employment projections for the health occupations are demand projections and vary substantially. Population growth, again, is a fundamental driver affecting demand for all health professions.

The growth in the number of elderly, however, will affect the demand for some occupations more than others. For example, hearing impairments and the incidence of neurological disorders are more prevalent in the middle aged and elderly population. Reflecting the large increase in the middle aged population by 2008, the projected growth in employment for audiologists is more than 36 percent.

Provided below are the U.S. BLS employment projections for the major health professions occupations and a description of what is driving the increase.

Physicians: For physicians, BLS projects an employment growth of 21 percent (for the period 1998-2008). The projected growth is due to three factors: 1) the growing and aging of the U.S. population; 2) new technologies that require more intensive treatment — more tests, more procedures and more conditions that are treatable; and 3) the continued expansion of the health care industry.

Dentists: Employment of dentists is expected to grow at a relatively slower rate — three percent for the period 1998-2008 — than most health professions. As the baby boomers age, the demand for complicated dental services such as bridges will increase substantially. However, dental care for the younger population will focus more on preventive care, much of which will be delegated to dental hygienists.

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Supply and Demand Projections *(Cont. from Page 14)*

Pharmacists: The BLS projects eight percent growth in employment of pharmacists by 2008. The BLS recognizes the aging of the population and the facts that older persons consume more prescription drugs than younger persons and that scientific advances will result in increased demand for prescriptions. However, the BLS demand projections are dampened by the expectation that pharmacies will increase their use of automation and pharmacist technicians. *Comm*ent: *The BLS projections may have underestimated the increase and continued increase in the volume of prescription drugs used.*

Registered Nurses (RNs): The BLS projects 22 percent growth in employment of RNs by 2008. The projected increase is due to the aging of the U.S. population and the associated increase in needed health care, the technological advances in patient care (which permit a greater number of medical conditions to be treated) and an increased emphasis on primary care. *Comment: The BLS projections may have underestimated the increase in nurse staffing needed to care for the increase in patient acuity.*

Therapists: Projected growth for this group of occupations (includes physical, occupational, respiratory therapists; speech language pathologists and audiologists; and others) averages 33 percent by 2008. The large projected increase is due to the following factors: 1) the aging of the U.S. population and associated increase in injuries, surgery and disabilities; 2) medical advances allowing people to survive debilitating strokes and accidents and in need of therapy; and 3) increased outpatient therapy. The projected increase in employment is tempered by insurance limitations for reimbursement.

Health Technicians and Technologists: Projected growth for this group of occupations averages to 25 percent (and ranges from -17 percent to 45 percent) by 2008. The projected increase is due to the aging of the U.S. population and associated increase in use of diagnostic procedures as well as technological advances resulting in more treatment and diagnostic procedures.

Health Service Occupations: Projected growth for this group of occupations (includes nursing aides, home health care and personal care aides, and others) averages to 36 percent — the highest projected growth for any group of health occupations. The large projected increase is due to: (1) increased long-term care needs of an increasingly elderly population; (2) medical advances that in turn increase rehabilitative care requirements; and (3) financial pressure on hospitals to release patients as soon as possible.

Completing the Story – Looking at Supply

The BLS employment projections give an estimate of future demand for the health workforce occupations. To anticipate health workforce shortages, estimates of future supply for those health occupations also are needed. It is very difficult to estimate supply — some of the major drivers of supply cannot be determined in advance with any degree of certainty. For example, relative wages and working conditions are very important factors affecting supply.

The Bureau of Health Professions' National Center for Health Workforce Information and Analysis and the Regional Center for Health Workforce Studies at the State University of New York at Albany are beginning a project to conduct a health workforce supply and demand analysis for approximately 20 health care occupations. Staff will conduct an investigation for each health care occupation, project employment demand and supply and identify potential shortages. Once potential shortages or problem areas are identified, a more in-depth investigation would be conducted.

For additional information about the Center's research activities,

visit the web site http://bhpr.hrsa.gov/healthworkforce

Andrew W. Nichols, MD, MPH 1937 - 2001

A Life of Work Envisioning the Future

By Catherine Nichols, MA

One of Andy Nichols' last and most important legacies for Arizona was to write and pass a state ballot initiative (Proposition 204 or *Healthy Arizona 2*) that ensures the right to health care coverage for approximately 350,000 Arizonans. The fight for passage of the initiative characterized Andy's efforts on behalf of the poor, the vulnerable, the needy.

After his April 19 death, Arizona Governor Jane Dee Hull renamed the newly enacted initiative the **Senator Andrew Nichols Comprehensive Health Insurance Coverage Act.**

The legislation uses tobacco settlement monies to shift the eligibility for Medicaid in Arizona up from 33 percent to 100 percent of the Federal Poverty Level (FPL). Together with a premium sharing program for Arizonans up to 200 percent of FPL that Andy had successfully implemented, most Arizonans will now be able to afford good health coverage through the Arizona Health Care Cost Containment System (AHCCCS) – Arizona's Medicaid.

Not incidentally, Prop 204 guarantees continued funding of six established preventative health care programs for ten years including: Women-Infant Care (WIC); Healthy Families; Healthy Start; medical research; teen pregnancy prevention and the Arizona AHEC for rural health education.

In the last meeting Andy organized, he called together leaders and employees of state agencies and county health departments to discuss the impact of the recent expansion of Medicaid on the workforce. Although he passed away three days before the meeting took place, everyone attended and continued the process: maintaining the commitment to address the issues of access, realizing that the key is a workforce able and prepared to facilitate the process.

As states take the steps forward to incorporating larger populations into their health systems, preparing the workforce must be part of the plan.

Andy Nichols' vision for Arizona was to eventually provide a model for the nation with an inclusive cost-effective state system that provided quality efficient health care for all. He understood well how central workforce planning is to that vision.

Ms. Nichols, daughter of the late Arizona AHEC Program Director and Arizona State Senator Andrew W. Nichols, is a doctoral student at the Florence Heller School for the Advancement of the Studies of Social Welfare of Brandeis University.

The Role of The AHECs in National Health Care Reform

By Andrew W. Nichols, MD, MPH

"The hallmarks of health care reform are improved access to health care, decreased cost of services and higher-quality health care. If the effectiveness of any program is to be judged by its impact in these three critically important areas, then the national AHEC program has reason to be bullish about its future." In the summer 1993 issue of *The National AHEC Bulletin,* Dr. Eugene Mayer makes the case for AHEC as a part of health care reform. In the three parameters mentioned (improved access, decreased cost and higher quality), AHEC has been and continues to be a significant player.

Dr. Nichols made this presentation during the 121st annual meeting of the American Public Health Association held in San Francisco, California, in October 1993. His remarks, pertinent then, are even more significant today.

With reference to improved access to health care, this is the raison d'etre of AHEC. That is, the AHEC movement was established to improve the access of medically underserved areas to health care through educational intervention. AHEC meets this need in a variety of ways, including student and resident placements in medically underserved areas during their period of training, continuing education for health care professionals already in the field and the recruitment of minority and other medically underserved youth into health careers. Numerous national evaluations and state-by-state reports of experience

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National Health Care Reform (Continued from Page 15)

with AHECs suggest that it is meeting its goal in promoting access to health care.

The role of AHEC in reducing the cost of health care is somewhat less clear, yet comes into focus through the AHEC emphasis on primary care. It has repeatedly been demonstrated that hyper-specialization has been a contributing factor in the spiraling cost of health care delivery. By attacking this problem through emphasis on training of primary care physicians and mid-level practitioners, AHEC is clearly making a contribution, although indirectly, to the solution of this problem.

Third, and finally, AHEC has a clear and convincing role in relation to health care quality issues. The continuing education function of AHEC is directly tied to quality of service delivery. Somewhat haphazard in the past, this function is increasingly being codified as AHECs become vehicles for transmitting new medical knowledge. Of all the AHEC functions, information dissemination may well be one of the major new frontiers for an expanding AHEC program.

Current proposals for national health reform have been driven largely, if not exclusively, by concern over the need to contain health care costs. Reforms growing out of a motivation for cost containment carry within them the seeds of limited access and poorer quality. The reason is simple. To distribute health care to all the people is professionally demanding and cost consumptive. Likewise, the maintenance and pursuit of quality will always be more expensive than the alternative. Yet, it is the essential ingredient of a successful health care system.

A comparison chart of eight programs for National Health Care Reform evaluated by the American Public Health Association (APHA) in November 1991 ranked each plan on 13 different parameters. It is significant that none of these plans considered was credited by the APHA for paying any attention to education and training of health workers. (This was the only parameter not covered by at least one of the plans). Recruitment and retention of health personnel are essentially not a part of most current national health care thinking and , unless inserted by groups such as the national AHEC community, are likely to be afterthoughts in the process.

More recently, the Clinton Health Security proposal does pay some attention to this important area, although it does so at the margins. While virtually invisible in public discussions of the Clinton Health Care Reform plan, it contains within it a section on health care professional development, recruitment and retention. This is found in the section entitled "Creating a New Health Workforce" and says the following:

"Programs are needed that also support Priority Health Training Programs designed to improve the supply, distribution and quality of providers including those in areas with inadequate health systems, especially rural areas and inner-city areas. Support expands for: service-linked regional education networks, e.g., AHECs, geriatric education centers."

As may be seen from the foregoing segment of the Clinton proposal, AHECs and other health professional development programs are at least included in the overall concept. What appears to be missing is the same attention to detail for this part of the plan that has been afforded to coordinated benefit programs, managed competition and a host of fiscal and other related issues.

One aspect of Health Care Reform, at least as is being proposed by the current administration, is now quite clear. This is, that because of the controlled nature of the economy under discussion, Health Care Reform will have government checks and balances built widely into the system. For example, a national health board will meet to establish "global budgeting" targets for the country. As this is translated into funding allocations, resource constraints are likely to become more real. It is possible that such a board should establish health professional production and distribution targets, as well. Limited federal funds could then be channeled to those programs – such as AHEC – which promote these goals.

In the past, President Clinton has periodically referenced rural health care as a matter of concern. He also has been known to cite school-based clinics as a model for health care, while extolling the work of community health centers and similar organizations in providing health care delivery to medically underserved peoples. As the former governor of a small southern state, he clearly comes from an environment which is depended upon health professional development programs in order to continue to supply the needs of that state's population. AHEC is one such program which has been developed to a high degree in the state of Arkansas.

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Dr. Nichols was a Professor at the University of Arizona, Director of the Arizona AHEC Program and of the University of Arizona Rural Health Office. He also was Chairperson of the National AHEC Bulletin Editorial Board. He died April 19, 2001.

National Health Care Reform *(Continued from Page 17)*

The director of that program, Dr. Charles Cranford, provides seven tests by which Health Care Reform proposals might be assessed for their ability to improve access to health care in rural and other medically underserved areas. He suggests that these be used as a test to indicate if a National Health Care Reform proposal is likely to fill access gaps. (*The proposed "screen" is outlined in the box below.)*

In his article on the subject, which appears in the same issues of The National AHEC Bulletin as Dr. Mayer's article, Dr. Cranford goes on to mention that there are three major federal programs which were designed to fill underserved area gaps in health care delivery. These are and have been the Community Health Centers/Migrant Health Centers program, the National Health Service Corps program and the Area Health Education Centers (AHEC) program. Each one has a slightly different, but complementary focus and mission. It the aggregate they help deal with the problems of medical underservice.

Dr. Cranford concludes his article on this subject by stating that: "AHEC programs are ideally positioned to address the maldistribution of the health care workforce. It is what we do." Indeed, this is what AHECs do. They do not pretend or expect to solve the problem alone. Rather, they expect to be partners in an ongoing process of reformation which will systematically attack the problems of an inadequate health care delivery in our society. Just as Community/Migrant Health Centers and the National Health Service Corps each have a vital role to play in the process of filling these gaps, so does AHEC. The seven-part screen suggested by Dr. Cranford is not "loaded" as a sole way of promoting the AHEC program. Some items are relevant to AHECs and others are not.

What, then, is the role of AHEC in National Health Care Reform? We have already asserted that health professional development plays a very small part in the National Health Care Reform debate. We also have indicated that comprehensive reform is virtually impossible without a strong recruitment and retention component which is educationally based. Third, we have seen that such a program (AHEC) can only provide a portion of the answer to health care delivery needs, with other programs and activities having to supply the rest of these needs. In the aggregate, a solution could and should be found.

Accordingly, it is suggested that the AHEC program refocus national attention on healthy professional recruitment and retention as an essential part of any health care system designed to operate in the 21st century. It is inconceivable that access can be guaranteed without the kind of education and training that promotes recruitment and retention to medically underserved areas. It is equally unlikely that quality can be assured without any intermediatory such as AHEC to facilitate information dissemination. Further, it is improbable that cost containment can successfully occur without a program which facilitates bringing targeted health professionals voluntarily into the service of medically underserved areas, with an emphasis on primary care as the means to achieve that goal.

As noted in the beginning of this paper, AHEC has the potential to improve access, help decrease cost and promote higher quality health care delivery. That is what Health Care Reform is – or should be – all about. It is clearly what AHEC is about. The role of AHEC in national Health Care Reform, then, is first and foremost to be a part of that reform. To do any less would be to miss an historic opportunity to improve health care delivery in the United States.

Seven Tests to Assess Health Care Reform Proposals

Dr. Charles Cranford provides the following seven tests by which Health Care Reform proposals might be assessed for their ability to improve access to health care in rural and other medically underserved areas.

1. Proposal emphasizes the increased production and improved distribution of the primary health care workforce.
2. Proposal emphasizes removal of systemic access barriers that exist in rural and other underserved areas.
3. Proposal emphasizes the role of voluntarism and public service in health care reform.
4. Proposal emphasizes the role of community public health in health care reform.
5. Proposal includes incentives for development of integrated health care networks with innovative linkages involving both urban and rural communities.
6. Proposal contains a program for the development of needed health care facilities in underserved areas.
7. Proposal emphasizes local state and federal collaborative roles in health care reform.

Section II:

Nursing Shortage?

What the AHECs are Doing About It

By David Bott, PhD; Rosemary Orgren, PhD, and Robert Best

Registered nurses constitute the largest group of health care professionals in the United States. About one out of every 50 American women (in all age groups) is a registered nurse. Fully one percent (>2.5 million) of the entire population have chosen to dedicate their professional lives to the care of the sick and infirm through registered nursing.

Nonetheless, the nation is facing a severe nursing shortage. In some areas of the country, 10 percent or more of the registered nursing positions remain vacant.

Furthermore, unlike most previous shortages, this one is not a simple fluctuation in the labor market. It appears to be a potentially sustained shortage based on the increased demands of an aging population, an aging nursing workforce, a decreased supply of new nurses and workplace demands that cause nurses to explore other career options.

In years past, the major employers of nurses — hospitals and nursing homes — have developed a number of organizational strategies to manage staffing levels and shortages, often including salary increases as one component. These strategies met with varying degrees of success. With the dramatic changes in the health care system in the recent past, however, it is unclear whether any of the previously used strategies will be effective in managing the current shortage, especially for vulnerable populations.

The impact of this shortage on the quality of care is potentially enormous. Research on the relationships between specific nurse workforce changes and quality of care or improved patient health has been established by the American Nurses Association in several studies and the evidence points to a direct relationship between staffing, skill mix and quality. Because this issue has a direct impact on the health care system and the health of all Americans, the issue has captured the attention of employers, academic institutions, professional societies and both state and federal legislators.

AHECs are uniquely situated, and specifically chartered, to address issues pertaining to a national broad-based shortage or localized limited supply in the health workforce. The following pages document examples of what AHECs are doing to investigate and improve the nursing workforce shortage.

Dr. Orgren is Director of the New Hampshire AHEC Program and Assistant Professor at Dartmouth Medical School in Hanover. Dr. Bott is Research Associate with the NH AHEC and the Center for the Evaluative Clinical Sciences, DMS. Mr. Best is Executive Director of the New Hampshire Nurses' Association.

New Hampshire: Developing Partnerships

The New Hampshire AHEC, under the direction of Rosemary Orgren, PhD, is addressing the nursing workforce shortage by developing partnerships with the New Hampshire Department of Health and Human Services, the New Hampshire Institute for Health Policy and Practice, Dartmouth College, the University of New Hampshire, the New Hampshire Nurses' Association and other related professional societies to promote research and recommend policy and action regarding the nursing workforce.

Specific components of the New Hampshire AHEC plan include:

- **Develop** an information system that uses the Dartmouth Primary Care Service Area (PCSA) geographic information system as a model to accumulate and share nursing and direct health care workforce data that can be linked geographically to employers and populations.
- **Develop** and sustain a program of research to investigate the impact of the current nursing shortage on health and health care delivery at the regional, state and, potentially, national level.
- **Collaborate** with the New Hampshire Nurses' Association to develop a master plan to address the workforce shortage in New Hampshire.
- **Participate** in state-wide forums such as the *New Hampshire Nursing Summit* that develop strategic initiatives to offer solutions and relief to the current shortage.

Members of one discussion group from New Hampshire Nursing Summit V.

Nursing Shortage?
East Texas AHECs: Grassroots Solutions

In response to regional nursing shortages, the East Texas AHEC Program centers partnered with communities to develop several initiatives. While national and state activities are being planned and beginning to be implemented, these efforts have been organized on a regional basis as grassroots community approaches. These efforts reinforce a basic AHEC belief that local involvement in workforce development is essential for effective long-range solutions addressing shortage and distribution issues.

Brazos AHEC, Waco

♦ **CNA and LVN School Project Gatesville:** Coryell Memorial Hospital in Gatesville is suffering from the nursing shortage. Nurses are working overtime to cover all shifts. Also, nurses are leaving the area because of the large bonuses and salaries available in larger cities but not affordable for a small rural hospital.

The hospital's new nursing home will need about 28 Certified Nurse Assistants (CNAs) and eight LVNs. Brazos AHEC helped to bring about an evening CNA program at Central Texas College in Killeen, in which 12 students are now enrolled. Applications for a full-time, Gatesville based, LVN program are being accepted.

The Coryell Memorial Hospital Foundation will sponsor CNA students and is contemplating sponsorship of LVNs. Brazos AHEC has sponsored three events to promote these new programs; more than 100 participated.

♦ **Nurse Recruiters Group:** School and hospital nurse recruiters from McLennan and Bell counties, under the facilitation of the Brazos AHEC, are working to increase enrollment in nursing school programs in the two counties. This is the first time this group has collaborated to address the nursing shortage. Plans include an AHEC training session on ways to promote nursing in junior high and high school through interactive and educational presentations. Brazos AHEC also is coordinating school career days. In the Fall, the group will host information sessions and luncheons for junior high and high school career counselors in each county.

♦ **Nursing Retention Project:** Project is under consideration by two facilities in the service region. *(See Lake Country for project description.)*

♦ **Recruitment in Schools:** Nursing as a career has been presented to more than 6000 students of all grade levels, including some undergraduate.

Coastal AHEC, La Marque

♦ **Recruitment in Public Schools:** Nursing as a career has been presented to more than 2800 public school students. Staff are integrating discussion of the nursing shortage and opportunities in nursing into the health careers promotion activities.

♦ **Partnership Task Forces:** AHEC staff serve on task forces in Matagorda, Chambers and Liberty counties where health professionals shortages are discussed and ideas formulated.

♦ **Speakers Bureau:** Nursing professionals and educators are available by appointment to speak to school classes and church or community groups about nursing topics.

Dallas-Fort Worth AHEC, Irving

♦ **Increase Nursing Class Sizes:** DFW AHEC entered into an agreement with the DFW Hospital Council to administer a $700,000 program designed to increase the class size of area nursing schools. As a result of this effort: an additional 120 nursing students are in school; task forces have been formed to discuss curriculum, training sites and the retention of students; 85 nursing students are enrolled in a mentor program designed to keep them in nursing school; and a program has been formed to find financial assistance for nursing students.

♦ **Recruitment in Public Schools:** "Nursing as a Career" has been presented to more than 5000 public school students

♦ **Middle School Mentoring Program**: More than 80 middle school students are involved in an AHEC mentoring program designed to insure that these students are prepared academically to enter the nursing profession.

♦ **Team Mentoring Program for Nursing Students**: The Student Support and Retention Task Force has developed a team mentoring program in which 85 nursing students from six nursing programs in DFW have been matched with mentors according to geographic area, interest/need, background, etc.

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Nursing Shortage?

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East Texas AHECs: Grassroots Solutions

♦ **Nursing Retention Project** *(See Lake Country for project description.)* Under consideration by facilities in the region.

♦ **First Choice: Nursing** — This two-day seminar, based on the Piney Woods AHEC program, is for high school juniors and seniors interested in nursing. Thirty students attended the first seminar; another is planned for Fall. The first day is an informational workshop with skills labs and the second day is job shadowing at a hospital.

♦ **Nurses Stepping Out for Nursing** is partnership with a nurse from the area who organized a group of volunteer nurses in the metroplex to help get young people interested in nursing. Class presentations will be scheduled and a web site will be developed to link to the hospital council web site.

♦ **Nurses for Nursing Video** is also a joint project with a metroplex nurse. AHEC is working with Primedia, a video production company, which has agreed to cover all the production costs for a video by nurses for nursing. AHEC will coordinate production of a video with three segments — for elementary, middle school and high school. Primedia will own and sell the video.

Greater Houston AHEC, Houston

♦ **Greater Houston Partnership Task Force**: Members include the San Jacinto College System, Houston Community College System and North Harris Montgomery College System and the Greater Houston AHEC. Dr. Adena Loston, President of San Jacinto South, serves as chair, and deans and nursing department directors represent the various campuses.

The group is currently compiling information and conducting an assessment of members' strengths, weaknesses and needs. This will be submitted to the San Jacinto Chancellor and the Greater Houston Partnership. This is the beginning of dialog between hospital CEOs and the community colleges that is intended to result in the training of more qualified nurses.

Lake Country AHEC, Tyler

♦ **Nursing Retention Project** – Under consideration by several hospitals and hospital systems. Topics include *Improving Nursing Image,* with modules for nurses, for organizational change, for nurse preceptors and for nurse mentors. The section on *Improving the Working Environment* includes: Hospital administrative teams; review of the role of nursing in hospital strategic planning; identifying role stressors directly related to the internal hospital environment which thus can be changed; identifying findings from research that can be adapted and implemented by hospitals, utilizing cost and manpower information.

The *Review Nursing Involvement/Non-involvement in Hospital Governance* section will help identify factors that influence this, and propose changes that administrative teams can initiate to increase nursing involvement and commitment in the governance and survival of the hospital.

Improving the Working Environment teams will: initiate an ergonomic review of routine nursing activity and identify how adaptations can be made to make the work less of a strain (a vital component as the nursing workforce becomes smaller and the bedside nursing workforce becomes older); plan, implement and evaluate a pilot project of this study in at least two hospitals, one metropolitan (nonacademic health center) and one community (rural); and refine and market the product to offer to other parts of Texas and other interested areas.

♦ **"Celebrating Nurses"** – a nursing awareness program open to fifth, eighth and tenth graders in Tyler and Longview area schools. Students will be able to explore, through poster, essay or video contests, nursing themes such as "A Nurse I Know," "Jobs Nurses Do," "What a Nurse Looks Like," "Why I Want to Be a Nurse" and "What Would Life Be Without Nurses."

♦ **"I Always Wanted to Be a Nurse"** evening programs for adult career changers. These open meetings, which will be announced as they are scheduled, will offer a panel discussion by practicing nursing professionals, representatives from area nursing schools and information on financial aid.

♦ **A speakers bureau of nursing professionals** and educators available by appointment to speak to school classes and church or community groups about nursing topics.

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Nursing Shortage?

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East Texas AHECs: Grassroots Solutions

♦ Established the **North East Texas Leaders in Nursing Coalition (NETLINC),** a coalition of upper level nursing administration leaders from across East Texas. The group plans several area-wide projects to draw the attention of students and career-changing adults to the nursing field. Staff are developing programming that is specific to middle school and high school students, since beginning at student level is a key to improving the long-term supply of capable nurses. NETLINC also will target adults who may want to enter the nursing field.

Pecan Valley AHEC, Victoria

♦ **Growing Regional Interest in Nursing (GRIN):** Pecan Valley AHEC invited local nursing leaders to join a committee to help address the nursing shortage. The committee name was chosen to portray a positive image. Nursing students, faculty and individuals interested in nursing attended the *First Annual Nurses Make A Difference Event* at Victoria College. The committee will follow attendees and provide support during nursing school. The overall goal is to retain the current enrollment by providing students with support, mentors and shadowing experiences. Also, Pecan Valley AHEC collaborated with Tech Prep and local hospitals to coordinate shadowing experiences in which students could request a special area of interest and shadow a nurse for a day.

♦ **Health Industry Steering Committee Nursing Task Group** is a greater Austin area initiative in which Pecan Valley AHEC is a participant. AHEC developed and coordinates a very active speakers bureau.

♦ **Education High School Counselors About Nursing Options:** Pecan Valley AHEC coordinated nursing career workshops for high school counselors at a conference sponsored by the Texas Education Agency.

♦ **Expanding Your Horizons** project provides two one-day workshops each year to encourage middle school age girls in Central Texas in the fields of math and science. AHEC partners with the *Tomorrow's Women in Science and Technology (TWIST)* organization to help prepare young women for opportunities in nursing and other health careers.

Piney Woods AHEC, Lufkin

♦ **Nursing Shortage Task Force**: At the recommendation of a local hospital, Piney Woods AHEC convened a group of interested individuals to look at the regional nursing shortage. The response was so great, a grassroots effort began under the direction of the AHEC and three committees were formed: recruitment, retention and statewide issues.

♦ ***Recruitment*** — This committee offers a seminar *First Choice: Nursing*, for those who might enter a professional nursing program within two calendar years – underemployed adults, college students and juniors and seniors in high school. The day-long training and information session is followed by two half-days of shadowing a working nurse in a participating hospital. The seminar also covers academic requirements, career pathways, career options and financial aid, including nursing scholarships, and other assistance. The first program, held in Lufkin at Angelina College, had 24 participants who ranged from high school students to adults.

In addition, the committee planned and delivered two training sessions for nurses to create "Nurse Ambassadors," equipping them with current academic information on nursing training programs and nursing shortage information. *Nurse Ambassadors* make classroom presentations in rural schools and attend college and career fairs to discuss nursing opportunities and dispel myths about nursing programs, including difficulty, admission waiting lists and costs. A list of the nursing programs in Texas, Louisiana and Arkansas was provided to participating hospitals to aid in recruiting visits. A speakers bureau was also created for general nursing or specialized topics.

A final project of this committee is to develop a regional video touting the area's attractiveness that hospitals and other institutions can use to recruit people to the area. AHEC staff are collaborating with Chambers of Commerce, the hospitals and higher education institutions on the project. Target date is Fall 2001.

♦ ***Retention*** – The Retention work group is concerned with working nurse satis-

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Nursing Shortage?

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East Texas AHECs: Grassroots Solutions

faction. The members of the group have developed a survey to evaluate job satisfaction and related issues for practicing nurses in East Texas. The survey has been distributed to 400 nurses with the aim of identifying what factors are important in keeping a nurse working, and identifying changes facilities could make to increase nurse satisfaction. Incentives also will be examined. Results will be shared with participating agencies and other interested parties.

Another concern for this work group is inactive nurses with valid licenses. The group is considering how to assess these nurses and any factors that might draw them back into the workforce. This plan is under development and will be addressed following the survey completion.

♦ ***Statewide Issues*** – Since this group includes the most diverse participants, it will serve as watchdog for the overall project. Members have polled local, state and federal agencies to determine their efforts to solve the shortage. The group also has met with local, state and national legislators to keep them informed of local efforts and get updates on any state or federal issues. They provide information to the steering committee and the other work groups. During the legislative session, the members will be watching for any legislation on health care, specifically nursing.

Piney Woods AHEC facilitates the committee meetings, sending notices, setting agenda items and preparing and distributing minutes. The individual groups continue to meet on a regular basis. AHEC has convened two joint meetings of the committees. More than 125 people have worked on the individual projects and committees. The members come from multiple hospitals and long-term care facilities, Stephen F. Austin State University, Angelina College and include state and federal legislators and their staffs and one retired physician.

Prairie AHEC, Denton

♦ **High school and college student career development.** The AHEC has developed a Microsoft PowerPoint presentation that highlights job outlook information, pay scale, responsibilities, education and curriculum, and scholarship opportunities. A Speakers Bureau of RNs is forming to assist with the presentation. Staff are also trying to procure an IV-Demonstration arm for the presentation, since IV insertion has been identified as one of the skills that deter some potential nurses. Response to the first presentation in Clay County was excellent; guidance counselors and college department chairs will be contacted to further implement the program.

♦ **Medical Spanish Initiative**. The community-based program will ask for Spanish-speaking volunteers from high schools to help with the immersion process for Medical Spanish students This will give the high school students exposure to nursing professionals, and Midwestern State University will offer eligibility for a Health Professions scholarship to these high-schoolers.

Colorado AHEC: Nursing Alliance 'CANDO'

The Colorado AHEC, under the direction of Marie E. Miller, RN, PhD, has developed the Colorado Alliance of Nursing Workforce Development Opportunities (CANDO). The Colorado CANDO Consortium has committed to four major goals:

1. Develop regional and statewide employer/educator and educator/educator relationships that identify and address current and future workforce and educational needs and expectations.

2. Develop pre/post educational strategies that provide mastery in setting specific skills/competencies in Acute Care, Home Health, Long Term Care and Public Health.

3. Establish systems to gather and quantify dependable data on current workforce capacities and to anticipate and forecast future capacities.

4. Ensure that the Consortium represents primary stakeholders and has long-term viability.

For additional information on the Colorado CANDO Consortium,

visit the web site http://www.uchsc.edu/ahec/cando/

California AHECs: Early Players in Nursing Workforce Initiatives

By Ellen M. Lewis, MSN, RN

The California AHECs have a long history of supporting workforce initiatives and were in the ball game well before workforce planning became a national, state and local issue.

Grant funds were awarded to the Orange County AHEC in the early 1990s to help establish the California Strategic Planning Committee for Nursing (CSPCN/CIC). This important initiative helped establish the project that later was funded in part by the Robert Wood Johnson Foundation's *Colleagues in Caring: Regional Collaboratives for Nursing Workforce Development.* The CSPCN/CIC project has resulted in the creation of a data base which provides valuable information regarding the supply and demand for professional nurses in California.

Ms. Lewis is Director of the Student Training Center and Associate Clinical Professor at the University of California — Irvine College of Medicine.

The California AHEC continues to fund initiatives to recruit and retain underrepresented minorities in nursing education programs, as well as expanding program capacity. This support is critical because the diversity of the California workforce in nursing does not reflect the population it serves nor does California have adequate program capacity to educate professional nurses.

CSPCN/CIC's Phase II report, *Planning for California's Nursing Workforce*, reported in its 1998 Employer Intention Study that acute care hospital employers had a mean vacancy rate for RN staff nurses of 10.6 percent. Further, an *increase* in demand for RN FTEs of three percent among all employment sectors was present between 1997 and 1999.

The federal Bureau of Labor and the California Employment Development Department list RNs and LVNs among occupations with the largest expected growth by 2006. The California Employment Development Department projects an absolute growth of 39,470 RN and 19,970 LVN jobs for the period 1996 through 2006. These numbers may be conservative, since California's population is expected to increase by more than 17 million individuals by 2025; half of the increase is expected to come from foreign migration.

California has no parameter that allows an opportunity for quick adjustment in RN supply. The proportion of RNs per 100,000 population is already among the lowest in the nation. The RN nursing workforce continues to age, with less than 10 percent of it under 30 years of age and nearly 30 percent of the workforce over 50 years of age. Eighty-five percent of nurses with active California RN licenses who are living in California work full or part time; this is higher than the national average. California already relies on other states and countries for 50 percent of its nursing workforce at a time when enrollments nationally are declining.

California's associate degree and baccalaureate RN pre-licensure programs were universally fully subscribed in 1997-98. Further, there are no opportunities, at present, for the public colleges and universities to increase enrollments. Private colleges may be able to increase enrollments but tuition cannot be met by many students without scholarship assistance. Additionally, students who attend the University of California have no opportunities for undergraduate education in nursing. Difficulty in recruiting faculty contributes to the problem.

Beyond the demand for RNs in general, there is a specific demand for RNs prepared at baccalaureate and higher degree levels. Among employers responding to the Em-

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'The proportion of RNs per 100,000 population is already among the lowest in the nation. The RN nursing workforce continues to age, with less than 10 percent of it under 30 years of age and nearly 30 percent of the workforce over 50 years of age.'

California: Nursing Workforce Initiatives

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ployer Intention Survey, the intention is to *decrease* employment of RNs educated at the associate degree level by –5.8 percent, *increase* employment of RNs with baccalaureate preparation by 8.8 percent and *increase* employment of RNs with master's degrees by 9.7 percent.

Approximately 70 percent of RNs educated in California graduate from associate degree programs. On average, only 20 percent of associate degree nurses continue their education for a baccalaureate or higher degree in nursing (16 percent in 1997) or another field.

California's ethnic/racial diversity is not reflected in the current RN nursing workforce *(See accompanying side-bar on next page)*.

California faces significant challenges to provide an adequately prepared nursing workforce for the future. Balancing nurse supply with demand remains a challenge for health care provider organizations, nurse leaders and state government. Given the projected requirements for RNs and LVNs, a concerted effort by all needs to be directed at providing an adequate supply of appropriately prepared nurses to meet the needs of California's people.

Current and future AHEC funds would be well utilized to assist in actualizing strategies to help ensure diversity amongst that adequate number of Professional Nurses in California and the rest of the nation.

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Enhancing Cultural Diversity in Nursing Workforce

By Ellen M. Lewis, MSN, RN

California's ethnic/racial diversity is not reflected in the current RN nursing workforce. However, the ethnic/racial background of students currently enrolled in pre-licensure programs is more closely aligned with the ethnic/racial background of the population. There is one notable exception: the proportion of Hispanic/Latino students lags behind the proportion of Hispanics/Latinos in the population.

The CSPCN/CIC Phase II Report contained three major recommendations to assist in assuring an adequate nursing workforce for California. One recommendation addressed the need to enhance the cultural diversity of the California RN workforce.

The specific strategies are as follows:

- Recruitment and retention of a culturally diverse RN student population in all programs must occur to provide care to an increasingly diverse population. In particular, strategies to increase the proportion of Hispanic/Latino students need to be supported since the proportion of Hispanic/Latino RNs lags behind the proportion in the population. Strategies need to include nursing career information beginning in junior high and high school. Other strategies may include mentorship programs, science education tutoring and involvement of culturally relevant groups, such as the church, in support of nursing education.
- In addition to recruitment of culturally diverse students, requirements to assure cultural competence/ sensitivity need to be implemented in all nursing programs.

Western Maryland

Constructing a Long Term Relationship: AHEC and School of Nursing as Designers

By Gail Mazzocco EdD, RN

During the past 20 years the Western Maryland Area Health Education System (WMAHEC) and the University of Maryland School of Nursing (UMSON) have forged a cooperative relationship that is rare among such partners.

The relationship is informal, operating without a general written agreement, though some specific written contracts exist. The relationship reflects local community values and takes into account the disparate environments of which each partner is a part. One might ask how such an association developed and has continued to flourish.

Dr. Mazzocco is Assistant Professor at the Department of Administration, Administrative Health Policy and Infomatics, at the University of Maryland School of Nursing and is Outreach Site Coordinator for Western Maryland.

In the mid-1970s, the University of Maryland School of Nursing began the process of developing a baccalaureate degree completion program aimed at registered nurses in Appalachian Maryland. Because the region is far from the state's urban centers and has no nursing educational programs beyond the associate degree level, few nurses had higher degrees in nursing.

At the same time, the local community was working with area legislators and the University of Maryland School of Medicine in an attempt to increase the number of health professionals trained in, and then practicing in, the region. That group set the groundwork for what would later become the Western Maryland AHEC.

The two endeavors, supported by different schools located on the same campus, were separate entities. While faculty members at both schools were aware of the others' activities, their respective schools did not see the two programs as prospective cooperative ventures. However, that was not the case in Western Maryland. The single local nursing school faculty member was invited to become a member of the developing AHEC, and was regularly involved with AHEC's activities. At that point, the local AHEC was a small organization and the School of Nursing Outreach site was even smaller.

When the local AHEC hired its first executive director, the process of developing a cooperative venture accelerated. Since the School of Nursing faculty member was an active AHEC participant, the executive director and she had a number of opportunities to discuss ways in which the developing health education programs could assist and support one another.

Those initial discussions were expanded to include a new partner, the University of Maryland School of Social Work, which also was interested in participating in a mutual endeavor. Those early efforts were quite limited. The local AHEC provided shared office space and phone services to the two local off-campus programs. In return, the AHEC counted students in, and graduates of, the programs when the organization tallied the number of health professional students and graduates who practiced in rural areas.

From this small beginning, an enduring cooperative relationship has developed between the Western Maryland AHEC and the University of Maryland School of Nursing. That growth has been the result of small but steady steps on the part of each of the partners. Because the population of the region is limited, it has been difficult to ensure that the student enrollment is sufficient to support the outreach nursing effort in Western Maryland.

The Western Maryland AHEC has tried from the beginning to ensure that the School of Nursing RN-to-BSN curriculum had an op-

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'Both by using political action and by recognizing the School of Nursing's commitment to the region, the Western Maryland AHEC was central to the school's continued presence in the area. This effort resulted in a significant increase in the number of bachelor's degree prepared nurses in the region and thus contributed to a central AHEC goal.'

Long Term Relationship

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portunity to remain and grow in Western Maryland. Both by using political action and by recognizing the School of Nursing's commitment to the region, the Western Maryland AHEC was central to the school's continued presence in the area. This effort resulted in a significant increase in the number of bachelor's degree prepared nurses in the region and thus contributed to a central AHEC goal. Moreover, because the bulk of these students are local residents, large numbers of them remain in the rural locale.

Over time, step by step, the cooperative relationship has grown and flourished. In addition to faculty office space, the Western Maryland AHEC provides outreach nursing students with access to a classroom with interactive video services, on-site health information assistance, a small computer lab and an organization committed to supporting and encouraging their educational progress.

At the same time, nursing faculty members have served on the Western Maryland AHEC Board of Directors, and have encouraged nursing students to participate in the organization's interdisciplinary service-learning projects. The latter activity is not limited to off-campus students. Increasingly students from the main campus have come to Western Maryland to take part in interdisciplinary projects.

'Nursing faculty members have served on the Western Maryland AHEC Board of Directors, and have encouraged nursing students to participate in the organization's interdisciplinary service-learning projects.'

Despite the expansion of the relationship, the connection between the associates remains informal. Significant differences in style, values and patterns of interaction make it difficult to negotiate a contractual relationship in which each partner feels fairly treated. This is likely to be the case where one partner is a large urban university and the other a nonprofit organization intent on retaining its community ties and independence. In view of those realities, an informal relationship seems to be the most reasonable approach.

What might one conclude about the success of this relationship? Starting small and taking incremental steps allowed each partner to learn to know and trust the other and to identify the degree to which its needs are apt to be met. Moreover, it was relatively easy to develop and to make changes in a program that has only a few components.

Next, it is essential to base the partnership on local needs and characteristics. While it is essential that a school "buy into" the relationship, it is the community that has the greatest interest in supporting local programs that improve the educational qualifications and access to local health professionals. Without community commitment it is unlikely that the Western Maryland partnership would have been successful. It is possible to foster the local cooperation necessary to a working partnership, especially at the regional level. Face-to-face interaction and negotiation born of need does work, especially in a small community.

It may appear to the casual reader that this process is a bit too easy. That is certainly not true. There will always be differences in the vested interests and styles of the two partners. Such differences are one of the reasons that it may be difficult for locally based AHECs to prosper. It is also the reason that developing a general contract is so difficult. It is relatively easy to develop an agreement around a specific grant or activity, since the specificity of the project helps make expectations clear. However, defining the outlines of a broad contractual relationship raises issues of competition and self-interest and may make concurrence difficult to achieve. For that reason, the Western Maryland AHEC found it wiser to forgo that step.

Despite the AHEC's success over the past 20 years, there are no guarantees that this success will continue in its current format. For that reason, it is essential that both the School of Nursing and the Western Maryland AHEC be alert to signs that the informal relationship is not working well and needs to be adjusted.

Times do change, as do the needs and relationships of the partners. Despite that possibility, using an informal pathway to cooperation may serve well those AHECs that resemble Western Maryland's as they attempt to work cooperatively with area schools of nursing.

Colleagues in Caring

Overcoming Obstacles, Targeting Solutions for Nursing Education and Practice

Colleagues in Caring: Regional Collaboratives for Nursing Work Force Development *is a national nursing workforce program funded by The Robert Wood Johnson Foundation. Through collaboration and consensus,* Colleagues *establishes tools to overcome obstacles and target solutions for nursing education and practice. This article describes the* Colleagues *Program and the work of the project nationally. The article on Pages 30-32 features an interview with Dr. Rebecca B. Rice, Deputy Director of the Robert Wood Johnson* Colleagues in Caring Project*, conducted by Dr. Marie Miller, Program Director of the Colorado AHEC System.*

By Rebecca B. Rice, EdD, RN

Dr. Rice is Deputy Director of the Robert Wood Johnson Colleagues in Caring Project.

Through collaboration and consensus, *Colleagues in Caring* establishes tools to overcome obstacles and target solutions for nursing education and practice.

Twenty sites have been partially funded to assess the capacity of the nursing workforce in their regions, to develop systems for educational mobility and to foster stable and satisfying practice environments that promote career advancement and lifelong learning, regardless of practice settings. The coalitions consist of the major stakeholders in nursing care; i.e., representatives from the major settings in which nurses practice, from all levels of nursing education, from the various trade associations and professional organizations, and from regulators and accreditors. The collaborative approach helps to assure that multiple and diverse perspectives are incorporated in the work of the coalitions.

Goal 1: Workforce Assessment

The program is in its sixth year of funding. Much of the early work of the coalitions was devoted to assessing the capacity of the nursing workforce to meet the health care needs of the population of the regions. In order to accomplish this, the sites determined the availability of data about the supply of nurses, the demand for their services and the health care needs of the population.

Supply data are most often obtained from state boards of nursing, but not all state boards collect data. Therefore, in some *Colleagues* sites, coalition members could not adequately report on how many nurses were employed in nursing, where they were working, whether they were working full-time or part-time, and what was their basic and subsequent education in nursing. In order to meet the goal of assessing the capacity of the nursing workforce, lack of data became a hindrance and had an adverse effect on the site's ability to develop evidence-based policies.

Likewise, in the early years of the *Colleagues* program, data on the demand for nurses was difficult to obtain. Very few states had in place means for analyzing the demand. In some states, the hospital associations gathered this information on their members, but since about 40 percent of the nursing workforce works outside of hospitals, data on this large group of nurses were not available.

Gathering data on the population needs was easier. In all states, there is adequate information of population demographics, mortality and morbidity statistics, and other health parameters that assisted *Colleagues* coalitions in their deliberations about the types of nurses that are needed now and into the future, given population trends.

Therefore, combining information on supply, demand and need was a formidable task for many *Colleagues* sites, and most have done really remarkable work in gleaning this information — with few fiscal resources. Nevertheless, having this information was essential to accomplishing the other goals that The RWJ Foundation asked *Colleagues* sites to do.

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Colleagues in Caring

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Goal 2: Educational Mobility

A second *Colleagues* goal related to educational mobility. That is, the sites were asked to evaluate the current system of educational articulation in their sites — how easy or difficult was it for nurses to move from one level of education to the next without having unnecessarily to repeat or duplicate prior learning? Was distance education readily available? If educational mobility plans were in effect, what did the data tell about the numbers of nurses who pursue additional formal education? What were the needs of nurses for continuing education to maintain competencies in their workplaces? What incentives were in place within their places of employment to promote educational mobility among nursing employees?

To answer these questions, many sites examined statistics on mobility where available, surveyed current and prospective students about their perceptions of access to formal advanced education and surveyed employers about their promotion of educational mobility within the workplace. The data were used to modify or develop educational articulation models and test new distance education methods.

Goal 3: Practice Environment

A third *Colleagues* goal related to fostering stable and satisfying practice environments that promote career advancement and lifelong learning. In order to achieve this goal, some sites have developed competency models for graduates of each level of education from LPN through the master's degree.

As a result of this work, some sites have used their models to assess the graduating competencies of their students, develop educational programs, modify job descriptions in the work environment and develop and test differentiated practice models. Many sites have developed and tested school-to-work transition programs and other educational methods that aim to prepare graduates better for the work environment.

Goal 4: Recruitment

Because of the staffing crisis and emerging severe shortage of nurses, another goal has emerged that was not in our original work, and that is recruitment into the profession. A task force of CIC participants has been formed to gather information on best practices in recruitment to share widely. In addition, many CIC participants are willing to share their recruitment themes and products at cost with others. CIC believes that this cross-pollination will reduce costs and increase benefits to all.

Goal 5: Sustainability

Finally, the last *Colleagues* goal relates to sustaining the work over the long haul. This has two components — one related to some sort of sustaining structure, and the other to the process. Both are important.

A structure must be found to "house" this work. The model for "structure," we believe, is the North Carolina Center for Nursing. The Center was created in the late 1980s at the time of the last nursing shortage. Through its work, the Center analyzes trends about the supply, demand and need for nursing; develops and implements recruitment campaigns; and increases nurses' commitment to the profession through leadership development.

However the structure looks, it must be seen by all stakeholders as neutral, objective and data-driven. Which gets us to the process. Any sustaining process has to include all the major stakeholders in nursing care. Having everyone at the table may make the work more complex, but, in the end, the decisions will be more readily embraced because of the inclusive membership.

Finally, the process must include a systematic analysis of the data about the nursing workforce and recommendations based on that analysis. Of course, an evaluative plan must be in place to determine whether the recommendations are operationalized and to measure the extent of their effectiveness. *(See related interview, next page.)*

'When we started this work, we believed that each regional labor market was unique, with its own challenges, opportunities and solutions. However, we have found that our challenges, opportunities and solutions are more shared than they are different. Hence, we are better off consolidating our resources, sharing our successes and learning from one another, than we are to go this alone — region by region.'

Colleagues in Caring: Lessons for the Future

Following are excerpts of an interview with Rebecca B. Rice, Deputy Director of the Robert Wood Johnson Colleagues in Caring Project *(RR), conducted by Marie Miller, RN, PhD, Program Director of the Colorado AHEC System (MM).*

MM: In your opinion, what have been the *Colleagues in Caring* Project's most successful strategies for addressing nursing workforce issues?

RR: I would like to address successful strategies by program goals, but first start with the formation of the collaborative. It is through the coalition that the work is delineated and accomplished. The sites that have done phenomenal work combine a well-running and inclusive coalition *and* an active, committed leadership. Where either or both don't exist, the work output has been poor. I think the site suffers, because who will pick up the ball and run for nursing in those regions?

'The sites that have done phenomenal work combine a well-running and inclusive coalition *and* an active, committed leadership. Where either or both don't exist, the work output has been poor.'

Strategy 1: Workforce Assessment

RR: The first goal was to assess the capacity of the nursing workforce in meeting the health care needs of the citizens. Assessment points to the need and use of data. Sites that had good sources of data held an advantage over sites with no or limited data. That seems like an obvious statement, but when we first started the project we weren't doing a great deal with data. Even state boards of nursing with good supply data were issuing annual reports and, as far as I could see, stakeholders were not doing a whole lot with those reports.

We have definitely raised the bar on data collection and analysis. Our data task force has developed a minimum supply data set that we are hoping our sites will use to influence data collection in their states. Our minimum demand data set may be useful for influencing agencies to collect demand information — the jury is still out on that one.

Having and using data are two different items. However, in the past year or so, we have seen more and more of our sites being called upon to testify at the state and national levels about the supply and the demand for nurses in their states. Just recently, the General Accounting Office asked our sites to share the status of supply and demand as their data indicate, in a report the Office was preparing for Congress. Within two weeks, those data were delivered. That could not have been done without the presence of *Colleagues.*

Strategy 2: Educational Mobility

With regard to our educational mobility goal, I think we have definitely moved forward through our *Colleagues* work. **Colorado** has updated its outstanding educational articulation plan. **California** worked on a model. **Missouri** has been engaged in revising its plan. Other states have stripped barriers to educational mobility. We have been fortunate that several of our sites have been awarded Helene Fuld Trust grants for educational mobility.

There is more work to do. I do not think we are using data to analyze the effectiveness of our plans. For example, **Maryland** had the first statewide articulation model in the country. Yet, the statistics in Maryland indicate that the percentage of nurses with associate degrees pursuing the baccalaureate is at the national average.

That would suggest to me that other factors may be in place that adversely influence nurses' decisions to pursue the baccalaureate. Personal factors such as family concerns may play a role. So might employers.

What are the incentives for nurses to pursue advanced education if it is not valued in the workplace? Here is where our partnerships with service come into play. Those CIC sites working on educational mobility must do this collaboratively with service. One would hope that we can influence a change in the value and support of advanced education.

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. . . Lessons for the Future

(Continued from Page 30)

Strategy 3: Practice Environment

In terms of successful strategies with regards to fostering stable and satisfying practice environments**,** we have achieved pockets of success, but this is an area that we are just beginning to tap. **Kansas City** developed a common student orientation plan that is used now across all agencies in the Kansas City regional area. Consequently, students don't have to go from one hospital to another and get reoriented in each facility. **South Carolin**a developed a residency program to promote the transition from the student to graduate role that has had pretty good outcomes.

I'm not sure we have done as good a job in disseminating our best practices in this area. I'd like to see us do more of that in the future so that when somebody has a successful strategy that is working, we don't reinvent a wheel, but we give that information to someone else and let them run with it. Then we collect better data on how effective they are.

MM: Would this show the strategies that can be replicated across states?

RR: I definitely think so. When we started this work, we believed that each regional labor market was unique, with its own challenges, opportunities and solutions. However, we have found that our challenges, opportunities and solutions are more shared than they are different. Hence, we are better off consolidating our resources, sharing our successes and learning from one another than we are to go this alone — region by region.

MM: Have you added additional states to the project?

RR: Yes. One other thing we should say is that although The Robert Wood Johnson Foundation is partially funding the work of 20 states, CIC has added close to 20 more states to its network. We are delighted that this has happened, because much of what we do is shared with others, and having more states in the network only creates more opportunities for learning.

We believe there are several reasons for this expansion. First, many of our site leaders have ties with national nursing and health-related organizations. Naturally, they spread the word about what they are doing. Second, once the nurse staffing crisis emerged, people were looking for solutions, and they learned about *Colleagues.*

Finally, we have fun — despite the hard work with little money. What else is new for nurses? That word also gets around, and people want to join a group whose members enjoy what they are doing.

MM: How do states get invited into the network?

RR: Most of them get in touch with us at the national program office first. Usually their first question is whether there is additional funding available from The Robert Wood Johnson Foundation.

Although no additional funds exist right now, we can provide technical support, and we share everything we have with any site interested in doing this work. We hook them up with our network, ask them to participate on our task forces, come to our meetings and, in any way we can, offer assistance. They can become partners to the extent they wish to be. That has created extra work for us, but I think in the long run we're all enriched by having expanded our network.

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'The nursing shortage has reached a crisis in many states. Some experts believe that when shortages reach 10 percent to 12 percent, agencies begin to express their concern. They want data to assess the problem.'

. . . Lessons for the Future

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Goal 4: Recruitment

MM: Will you talk about the successful processes that have been developed by states for recruitment?

RR: What I think we are seeing is a willingness among our sites to look at what is working in some states and a willingness to accept findings from one state to another.

I'll give you an example. The **North Carolina Center for Nursing** has done some really nice work using focus groups to determine what interests young people searching for health careers. From their research, the North Carolina Center developed a recruitment theme and related materials, including public-service announcements and a recruitment video. Their materials are available for other sites at cost.

Some sites are adopting North Carolina's work, while others are conducting their own focus groups with an eye toward developing their own recruitment materials. Maybe this duplication isn't necessary.

MM: The nursing shortage has reached a crisis in many states. Some experts believe that when shortages reach 10 percent to 12 percent, agencies begin to express their concern. They want data to assess the problem. We have certainly reached that point in the **State of Colorado.**

Where do you think the *Colleagues* project will go in the future in terms of the continuing shortage of nurses?

RR: I would like to see the *Colleagues* program continue to be the vehicle through which, by which, from which, successful grassroots strategies can be tested and shared. I'd like to see the CIC sites become "think-and-action tanks" for trying old and new workforce strategies. This would include increasing the numbers of people coming into nursing and working on effective ways of using nurses so that nurses can nurse. This would include using data about supply and demand to make meaningful recommendations and then holding themselves accountable for carrying out the recommendations.

Strategy 5: Sustainability

RR: You know, this shortage is not going to get any better tomorrow or in a few years. This is not as simple a fix as we have been able to accomplish in the past, and I see the *Colleagues* sites as being there to do this work into the future.

MM: The National AHEC Network has a 30-year history of building and sustaining the pipeline for health careers. Therefore, I wonder if there is a way to merge our efforts — *Colleagues in Caring* and the AHECs — in terms of some collaborative strategies?

RR: I don't see why not. Our recruitment task force is very active, and we could include AHEC folks as participants. There is much we could learn from the AHECs and probably vice versa.

We need to recognize that the focus of AHECs is on all health professions, not just nursing. We need more pharmacists and other allied health professionals, but nursing is critical to the public's health. People go to hospitals for nursing care. If they could have their treatments outside of the hospitals, they would. But when they go into the hospital, it is because they need the care that only nurses can provide.

I worry that we could lose the focus on nursing if nursing workforce were left solely to the AHECs. We need a vehicle for focusing on the nursing workforce in and of itself. I would like to see *Colleagues in Caring* work jointly with AHECs in areas of mutual concern, such as multi-disciplinary health professions work and recruitment.

These are a few examples of ways in which AHECs are addressing the current nursing shortage in the United States. We are confident there are sufficient numbers of other programs addressing this topic that we hope to develop a thematic issue of the Bulletin devoted to the current and future responses of AHECs nationwide to the problems and opportunities the nursing shortage creates.

Increasing Awareness Enhances Natural AHEC Partnerships

AHEC and HETC programs have had close working relationships with Community and Migrant Health Centers (C/MHCs) and other Bureau of Primary Health Care-funded activities for many years, yet the awareness of such collaborative efforts is low. The following articles describe examples provided by components of our national network. Increased awareness is important because of the significance of the outcomes of these partnerships, as well as the renewed emphasis on safety net providers and the role AHEC and HETC can play in providing workforce development support.

The on-going collaboration among these HRSA programs has incorporated many different types of efforts, including education for administrative and professional staff; technical assistance in operational and education subjects; learning resource materials support; undergraduate and graduate health professions training support; clinical practice guidelines; quality assurance; case management; community outreach, and a variety of other areas.

Increased awareness of existing collaborative efforts among our colleagues and potential collaborators may increase opportunities for replication and stimulate new funding possibilities to support new endeavors.

Oregon Pacific AHEC Teams with CHC

Oregon Pacific AHEC, on contract with Samaritan North Lincoln Hospital, facilitated planning meetings and wrote the actual application for a proposed CHC in rural Lincoln County, Oregon. Submitted for the 2001 funding cycle, the application was one of only 13 new starts awarded.

Currently, Oregon Pacific AHEC is supporting initial health center start-up activities by recruiting and training staff and developing a Promotore Latino outreach program.

Arizona: Nesting an AHEC within a CHC

By Ann M. Roggenbuck, MPH, MBA, PhD

Approximately six years ago, I took on the challenge of blending a fledgling free clinic with a newly defunded AHEC with the intent of constructing a "viable and progressive teaching community health center."

July 1, 2001, Northern Arizona AHEC entered its sixth year as both a federal and state funded Community Health Center and AHEC (due to the recent passage of Arizona Proposition 204, thanks in large part to our recently departed friend and colleague, Dr. Andy Nichols). We enter the new year with a budget of approximately $4 million, a positive bottom line, three months of cash reserves and no debt – yet. I think that meets the viability criteria.

The criteria for judging our success at becoming a "progressive teaching community health center" is another matter. What is clear is that, in our first five years of organizational development as a community health center, we maintained a similar yet different level of AHEC programming as part of a community health center with only a modest federal AHEC budget.

We were able to do this because community health center work parallels that of an AHEC. It just does it in specific communities and at specific sites instead of in entire regions of a state.

Whether this is good, from an economies of scale perspective, or bad, is, to me, unclear. What I do know is that we have accomplished the same level of programming (including student placements, continuing education and youth health career education) as part of a CHC that we did as a stand alone organization when we tried to be everything to everyone in a very large service area.

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Dr. Roggenbuck is Executive Director of North Country Community Health Center/Northern Arizona AHEC in Flagstaff, Arizona. She also is past president of the National AHEC Center Directors Constituency Group.

Arizona: Nesting an AHEC

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In fact, many soft money funders were, and continue to be, more responsive in awarding training and outreach program grants to North Country than they were when we were a stand alone AHEC. There are probably many reasons for this, but I personally think funders better understand what a primary care center is than what an AHEC is and that there is the perception that CHCs control a greater resource base, thus better ensuring program success.

Lupe Woodson, FNP, left, works with a student during an examination of a diabetic patient at North Country Community Health Center.

North Country CHC Northern Arizona AHEC outreach programs present students excellent training experiences and project opportunities: perinatal outreach program; women's cancer prevention/early treatment program; diabetes education program; and various smoking cessation programs. The recent launch of our internal pharmacy presents yet another venue for medical student training projects.

I think Andy Nichols was proud of the North Country Community Health Center/ Northern Arizona AHEC partnership and viewed it as a successful AHEC operational model. However, he would still have a list of things to enhance the partnership and, after 20 years of his mentorship, I think I have a similar list.

The new state AHEC funding will allow Northern Arizona AHEC to rebuild programs in outlying rural/frontier areas of the region and to develop program goals with quantifiable outcomes. We believe this will give us a better return on investment with program outcomes financial economies and political positioning.

The North Country team will include approximately 80 employees by the end of the current fiscal year. Current priorities include rebuilding the AHEC in rural communities, building more primary care access points in northern Arizona, thus creating more community-based AHEC student training sites, along with completing a capital building campaign over the next three-to-five years. We continue to build the ship as we sail.

I know of only a handful of AHECs across the country who are part of Community Health Centers. I believe the factors of history (timing) and politics have prevented this model from developing, which, ironically, are the same factors that often encourage evolution of the model. One interesting observation I have made is that I now see and talk with health professional students every day, whereas I rarely saw or spoke with a student in the old, stand-alone AHEC days, when we served more as a broker in matching health professional students with remote teaching sites.

I also know much more about the complexities involved with the delivery of primary care services. My advice to the "faint of heart" is to stay put in your AHEC — the primary care business can be brutal.

'I think Andy Nichols was proud of the North Country Community Health Center/Northern Arizona AHEC partnership and viewed it as a successful AHEC operational model. However, he would still have a list of things to enhance the partnership and, after 20 years of his mentorship, I think I have a similar list.'

California: AHEC Revitalization Includes CHCs, NHSC

By H. John Blossom, MD

The California AHEC Program began a revitalization process last year, with the centerpiece of a group of carefully planned activities being the construction of a long-range plan (LRP) for the central office and ten AHECs.

Drawing upon the wisdom of community leaders and academic partners, the LRP focuses attention upon three interlinked domains: increasing community-based health professions training, increasing health workforce diversity and increasing AHEC ties to organizations with similar missions and values.

Participating in development of the LRP were representatives from the California Primary Care Association, Region IX HRSA (now known as the HRSA Pacific West Cluster), Center directors and academics from the state's health sciences campuses. Distribution of future AHEC resources will be informed by the values which were expressed in the LRP; review committees for grant applications will include members from these groups.

Since inception of this revitalization, AHEC leadership has carefully developed and nurtured strong ties, and regular meetings, with the California Primary Care Association which represents most of the community health centers in the state.

National Health Service Corps sites are an obvious target of interest to faculty wanting to increase the community-based educational experiences of health learners. To aid in this effort, the California AHEC has been holding meetings with the HRSA Pacific West Cluster to discuss common interests; these center around attracting potential NHSC providers to underserved communities through offerings of community educational activities during training years. Doug Pendelton, NHSC leader in the HRSA Pacific West Cluster, has been especially valuable to this process.

California is very proud of its accomplishments in distance education of nurses. One effective program is the web-based training of advanced practice nurses broadcast out of Chico, California, in conjunction with the Superior California AHEC. This academic program allows nurses to participate in rigorous educational activities while remaining in their otherwise underserved northern California communities.

Many California AHEC programs are putting special energies into health workforce education pipelines. Outstanding programs in Los Angeles, East San Jose, Fresno and elsewhere are informing young, and frequently disadvantaged, minority students about nursing, pharmacy and medical professional opportunities. The students are also enrolled in a variety of academic and experiential programs to insure that opportunity is leavened with strengthening of candidacies. *(See related article below.)*

Dr. Blossom is Project Director of the California AHEC Program.

Northern California: New Site, New Name, New Affiliation

By C. Dean Germano, MHSc, FACHE

The Northern California AHEC recently moved to a new location and acquired a new name and new affiliation. The former Superior California AHEC based in Sacramento moved to the Shasta Community Health Center and is now known as Shasta Community AHEC (SCAHEC). It is located in Redding, a city of approximately 75,000 at the base of Mount Shasta, one hour south of the Oregon border.

Shasta Community Health Center (SCHC), a Federally Qualified Health Center, was formed in 1988 after the traumatic closure of the county hospital. The only community health center in the area, SCHC has satellite clinics in other smaller rural communities in Northern California. The practice has grown over the years and now serves 40,000 patients — about one in four residents of Shasta County. Of that, 96 percent of patients served fall below the Federal Poverty Level.

Because distances are so great in California, where counties are as large as some whole states, it was a challenge for SCAHEC to reach out to the local, and mostly rural, communities that represent most of far Northern California. The only other grantee in SCAHEC region was based at the Chico State School of Nursing in Chico, California.

From its modest beginnings, SCHC had been challenged in finding and keeping primary care physicians in its practice. Throughout this period, a Family Practice Residency training program was based at Mercy Medical Center-Redding and affiliated with UC Davis. This training track was a critical element in find-

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Mr. Germano is Executive Director of Shasta Community Health Center and Director of Shasta Community AHEC in Redding, California. He also is a Fellow of the American College of Health Care Executives.

New Site, New Name

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ing and keeping primary care physicians at the CHC. SCHC was one of only a handful of CHCs with a comprehensive Family Practice training program. Through many meetings with, and the support of, the Residency Program Director and the support of the hospital, 25 percent of the program residents (two residents per year, six in total) would be matched and trained by SCHC faculty.

Through a University AHEC grant process, SCHC was able to enhance the training and support needs of the residency-training program as well as reach out to the local high school-aged populations, encouraging them to seek careers in family medicine.

The AHEC has added library resources and training resources to the health center. Staff are currently branching out to do many consultations via tele-linking and will be hooking up with the local Regional Centers in the area to provide continuity of care to the handicapped population.

Dr. Ann Murphy, Medical Director of SCAHEC, shows a young patient the workings of a stethoscope.

Physician Assistant Susan Rhyne, a faculty member for the Shasta Family Practice Residency Training Program, has a tender touch for a young patient.

To become the AHEC for this northern region the first step was to approach SCHC's Board. With the help of the Statewide AHEC, a process of educating the Board and staff of SCHC was started; it became apparent to the Board and staff that becoming an AHEC meant going beyond FP training and included taking responsibility for the innovative distance-learning program for Nursing at Chico State.

More than that, as a CHC serving the medically underserved, shortages in health manpower were felt first. Becoming an AHEC would provide an opportunity for regional health manpower planning with a focus on the health staffing needs of the patients served by CHCs — which are not necessarily the needs of the hospitals or the private sector.

By becoming an AHEC, this CHC has been working with the local community colleges, private health care academies and the universities in identifying impending shortages and finding ways to creatively meet demand.

One such example is a partnership with the local dental society, community college and SCHC. Because of an extreme shortage of dental hygienists, all parties, private and public, have been stretched. By coming together and sharing resources, a new dental hygiene training program was established, with part of that training and service happening at the CHC dental program.

There is little doubt that CHCs mirror much of the purpose of AHECs in the development of health resources, and often of human resources, to serve otherwise underserved communities. There also is little doubt that, at least in California, regional AHECs are under-capitalized and have very modest dollars to fill a very important role. The AHEC structure allows CHCs to think beyond their four walls and think strategically about the health manpower needs of the communities that, by definition, CHCs serve. This structure also promotes cooperation with other CHCs in the region and helps to develop creative mechanisms for joint ventures and partnerships. For Shasta Community Health Center the benefit of being an AHEC is still evolving before us. This could not be done without the financial and technical support of various funders including federal, state and university-based sources. SCHC looks forward to being both a CHC and a regional AHEC.

'There is little doubt that CHCs mirror much of the purpose of AHECs in the development of health resources, and often of human resources, to serve otherwise underserved communities.'

Connecticut AHECs and CHCs: Expanding Capacity

By Charles Huntington, PA, MPH; Anne Nelson, MA; Meredith Ferraro; and Patricia Harrity, MS

Evelyn Barnum, Executive Director of the Connecticut Primary Care Association (CPCA), describes the relationship between her organization and the Connecticut AHEC Program as one of "expansion." She is both passionate and articulate about what AHECs can bring to Community Health Centers (CHCs).

She characterized the Connecticut CHCs as "pretty focused on CHC business" yet, in collaborating with the AHECs, she said, the capacity of CPCA and its members to reach its client population is greatly expanded, because the AHECs bring with them a broad range of community partners.

'In collaborating with the AHECs, the capacity of the Connecticut Primary Care Association and its members to reach its client population is greatly expanded, because the AHECs bring with them a broad range of community partners.'

For example, CPCA and the Connecticut AHEC Program collaborated to develop a training curriculum for outreach workers. By making the curriculum available to a much broader audience of community-based organizations, the ability to reach the CHCs' clientele was multiplied many times over. It wasn't just the CHCs' outreach workers who are now doing a better job of enrolling people into the Children's Health Insurance Program (CHIP).

AHEC staff members provide direct support to the staff of the Hill Health Center in New Haven, one of the nation's oldest and largest CHCs, for the continuous quality improvement (CQI) projects each department is carrying out this year.

CQI is a requirement for Joint Commission on Accreditation of Healthcare Organizations accreditation, which the Hill Health Center will be renewing this Fall. AHEC meets with departmental managers one-on-one to review their progress and discuss the next steps as they seek to improve particular procedures. AHEC staff will meet with them several times over the course of the year and remain available by phone for interval consultations.

Eastern Connecticut AHEC

In collaboration with the Connecticut Primary Care Association, Eastern Connecticut AHEC has developed a statewide outreach network and provided training and networking opportunities for outreach workers. These workshops are conducted in each AHEC region, making it easier and more accessible for outreach workers to attend. The cost has been minimal because CPCA received funding for the network.

Since 1999, Eastern Connecticut AHEC has developed and provided training statewide (regionally) to approximately 400 outreach workers in Connecticut. The first workshop was a "celebration" for outreach workers; AHEC provided a speaker on stress management followed by afternoon stress relieving activities such as tai chi, aromatherapy and chair massage.

The second workshop, on cultural sensitivity for outreach workers, was a day-long intensive session with a national trainer. In the third workshop, on diabetes, workers learned about cultural issues, disease management, those at risk and issues of compliance.

Eastern Connecticut AHEC is developing its fourth workshop, providing core competency training/asthma case management core training.

AHEC staff work regularly with the CHCs to provide medical/community service rotations for medical students, physician assistants (PAs) and nurse practitioners. AHEC also assists in recruitment of physicians, PAs, etc., for the CHCs. The CHCs are represented on the AHEC Community Health Advisory Board.

The Community Health Advisor training curriculum is a direct result of AHEC's "partnership" with *Community Health Works* (a partnership consisting of CHW, San Francisco State University and City College of San Francisco). Nine years of research and development went into the program and Eastern Connecticut AHEC staff attended the conference two years ago on "The Implementation of the CHW Certificate Program." Community Health Works provided AHEC staff with an implementation manual, curriculum for the 17-credit certificate course and support via the network of CHW programs that exist in the United States. Staff attended a train-the-trainer seminar at San Francisco City College.

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Mr. Huntington is Associate Director of the Connecticut AHEC Program.

Ms. Nelson is Health Careers Coordinator and Interim Director of Eastern AHEC in Norwich, Connecticut.

Ms. Harrity is Executive Director, Northwestern AHEC in Torrington, Connecticut.

Ms. Ferraro is Executive Director of Southwestern AHEC in Bridgeport, Connecticut.

Andy was a tireless advocate who used his medical knowledge as well as his administrative and political skills to help raise public awareness of the very real needs of very real people - and to help assure that funds were directed to address those needs.

Lance Diskan and John Sciacca, Arizona Health Careers Opportunities Program

Andy Nichols: A Life of Service

Andy Nichols was a man who unceasingly lived his convictions, who made sure he made a difference. It was when important goals were threatened that he became the most quietly forceful. Challenges seems to stimulate his ingenuity. His convictions were so deep it was unthinkable to give up, and he wouldn't let others quit either. He was truly relentless — and effective.

Sally Henry, Oregon Pacific AHEC

Andy's dedication, enthusiasm , encouragement and faithful support were the greatest assets for our global project "Universities and health of the disadvantaged ". Without Andy, there would have been no such project.

Charles Boelen, World Health Organization

Andy Nichols' influence reached far beyond the borders of Arizona. He was a respected colleague and voice of wisdom within the National AHEC and HETC network.

Carol Wolff, NAO President

Andy touched the lives o
physician, politician,
family

Andy "
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It was Andy who coined the name The National Rural Recruitment and Retention Network. I believe the Arizona Rural Health Office is the oldest in the country. I served with Andy on the board of directors of the National Rural Primary Care Association, the precursor to NRHA. Andy was always dedicated to rural health in every venue that I saw him in. He was a great thinker, a man who understood how to get things done in Washington as well as Arizona.

Fred Moskol, Executive Director
National Rural Recruitment and Retention Network, Inc.

In our struggle to mainstream s
taged communities in the work
needed the involvement of disti
cians of the stature of Dr. Nicho
death has again robbed us a se
health of the disadvantaged.

Dr
of Com

Few policy makers — at the state or national level — embody the quality of character found in Andy Nichols. Still fewer physicians choose to dedicate their life to improving health access, services and protections. He was an innovator and leader who took good ideas and advanced them. He had a knack for cutting through the confusion, obfuscation and jargon that pervades many conversations about health and or politics. From genetics, to child health, to insurance, to the health workforce — there seemed no end to his energy to make the world a better place. *Kay Johnson, Milbank Memorial Fund*

Andy was a role model for the rest of us in so many respects: his passion for rural health, his high level of commitment and integrity, his caring and compassion, his leadership abilities, his masterful ability and command of the Kind's English and oratory. He was a close and dear friend in the rural health loop.

Dave Young, National Organization of State Offices of Rural Health

Such an outstanding person of total honesty and commitment! The best of Arizona...never sparing his energies. Christine Von Furstenberg, UNESCO

Andy's death is a loss for all of us who care about the plight of the underserved and the disadvantaged. While many viewed with alarm, Andy got out front and made a difference.

Dan Blumenthal, Georgia AHEC Program Director

He was a true friend of environmental protection . . . he acted as a strong advocate for environmental protection while serving on the House Environment Committee and tried to help defeat the worst of the environmental legislation . . .

Sandy Bahr, Conservation Outreach Director, Sierra Club

f many people — as a administrator and man.

walked the talk" of working to address the needs of the erved and disadvantaged. Now that his final accounting is nade, there is no doubt in my mind that he sets a very high rd for all of us to strive for, when it comes to desire, ion, commitment, dignity, charity, humility, focus and vision.

Steve Shelton, East Texas AHEC Program Director

olidarity with the disadvan- of universities, we desperately nguished statesman, academi- ls. In his sudden departure, asoned champion for the

: Dan Kaseje, Tropical Institute mmunity Health, Nairobi, Kenya

Andy challenged us to think beyond the present, to what we would want our work, our community, our lives to be. His work in Arizona was often a model of what "could be." He was always thinking ahead and asking, "What about this...?

Richard Perry, Oklahoma AHEC Program Director

Although we will miss Andy very much I believe he would not want us to mourn his leaving. Rather, I believe he would, as would I, ask that you mourn for those who through disease or accident spend their final days wasting away. Fortunately, Andy spent all of his days doing the things he enjoyed and did so well. He would, no doubt, agree that life has no kinder gift than to allow a person to be happily engaged to the very end.

May we all learn from what his life has taught.

Charles Cranford, Arkansas AHEC Program Director

Connecticut AHECs and CHCs: Expanding Capacity

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Community Health Works also gave the AHEC permission to use its model survey which has been implemented statewide.

AHEC now is working with an advisory board, CPCA, Three Rivers Community College and AHEC as partners in the Community Health Advisor Training Program that is a pilot at Three Rivers. AHEC has modified the curriculum as needed and added a second course, *Core Competencies in Community Health Work*.

Both Housatonic Community College and Northwestern Community College have expressed interest in offering the CHA program at their schools.

Southwestern Connecticut AHEC

Southwestern Connecticut AHEC has worked with its Community Health Centers in the following ways:

- **Stamford CHC —** Has trained staff in CPR and OSHA by locating trainers, making arrangements and paying the trainers' fees.
- **Bridgeport CHC** — Childhood Obesity: Worked to link the CHC to Yale-New Haven Hospital Pediatric Obesity Clinic by setting up a meeting with the pediatric staff of BCHC and the medical staff of the Yale Obesity Clinic. The clinic was awarded a grant from the Charles Smith Foundation, which has an after-school program for youth. The foundation is linked with the Rafaela Center in Bridgeport, where BCHC has a satellite clinic. They are now working together on this emerging epidemic — Childhood Obesity. SW AHEC served as the locator of resources and the broker in bringing the partners together.
- **Hill Health Center** — Diabetes Collaborative — SW AHEC provided educational programs for Hill Health Center staff on various aspects of diabetes, and also recruited public health students who were trained to be chart abstractors for the CQI process. AHEC staff also participated in the CQI process.
- **Hill Health Center** — For the Center's Cardiovascular Disease project, SW AHEC provided the needs assessment services for the first phase of the State of Connecticut Department of Public Health funded project. This consisted of being part of the steering committee, developing a survey for residents that asked about the four risk factors of CVD (tobacco, nutrition, lack of physical fitness and diabetes), evaluating survey results and convening focus groups for community input. A plan was developed for the successful second round of funding for implementation of the project.
- Have offered support for the **UCONN Dental General Practice Residency** program which began at the Hill Health Center this year.
- **Fair Haven Community Health Center** — Two nurse practitioners from FHCHC were the guest speakers for SW AHEC's program at the Yale School of Medicine, Department of Epidemiology and Public Health, during National Primary Care Week 2000. They presented the "Chronic Disease Model in Primary Care as it Applies to Diabetes," providing students with information as to how this model will apply to all chronic diseases.
- **Southwest Community Health Center** — co-sponsored with the Michelle Project a conference on the "Psychosocial Aspects of Breast Cancer" for patients, families and the community. This was a successful collaboration, which has lead to a productive ongoing working relationship.
- Have worked to link **Southwest CHC** and **Bridgeport CHC** with St. Vincent's Medical Center Prostate Institute which will provide free prostate screenings to the uninsured.
- Applied for a National Library of Medicine grant for the CHCs to provide Internet access and training.
- Other examples are the CPCA/AHEC collaborative with the outreach network. Diabetes, Cultural Competency, Stress Relief and Asthma trainings for outreach workers are offered by SW AHEC as a part of the partnership.

Northwestern Connecticut AHEC

Northwestern Connecticut AHEC is working to place dental hygiene students at the Community Health Center in Danbury. The AHEC has successfully placed two nurse practitioner students, one at the CHC in Danbury and another in Torrington.

The CHC in Torrington, operated by Charlotte Hungerford Hospital, closed its doors recently as a result of budget cuts due to heavy financial losses the hospital has been experiencing in recent years. NWAHEC has chaired meetings of community leaders including hospital representatives to develop a plan to con-

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Connecticut AHECs and CHCs: Expanding Capacity

(Continued from Page 40)

tinue primary health care services to patients at the now-defunct CHC. State Senator Andrew Rorback is leading the charge. Commissioner Raymond Gorman from the Office of Health Care Access also has been involved in the conversations.

NWAHEC is facilitating group discussions in Waterbury, including Staywell Health Center, about implementing a Brief Screening and Intervention tool at Chase Clinic at Waterbury Hospital and Staywell Health Center, focusing on homeless and near-homeless patients.

Waterbury Hospital received a planning grant from the Substance Abuse and Mental Health Service Administration to build community agency/hospital/and consumer support for implementation of an exemplary practice (EP) that has proven successful in other communities.

AHEC is under contract to facilitate the group's consensus-building around acceptance of, and modifications to, the EP, based on the community's unique needs.

The EP chosen in Waterbury is the Alcohol Brief Screening and Intervention (ABSI). During a primary care medical visit, the patient is screened for "at risk" alcohol use (more than an average of one drink per day for women and two drinks per day for men). Patients identified as "at risk" are further screened to get a clearer picture of their alcohol use. The primary care physician then educates the patient about recommended alcohol consumption levels and setting goals to reduce "at risk" drinking.

This method has proven successful in middle class populations with medical insurance. The AHEC group is attempting to apply the ABSI to homeless and near-homeless populations, who typically do not have medical insurance and are reluctant to share drinking information with providers because they fear who the information will be given to. Also, alternate coping mechanisms to use in place of alcohol are harder to find for someone who is homeless or near-homeless. After the planning process is concluded, the group will apply for money to implement the Alcohol Brief Screening and Intervention.

North Carolina AHEC/CHC Clinic/Education Ties

The Duke University AHEC Program has a long-standing clinical and educational relationship with Lincoln Health Center, a federally qualified health clinic with a distinguished record of service to a predominantly minority community in Durham County, North Carolina.

Primary care providers at Lincoln with faculty appointments at the Duke University School of Medicine serve as primary care preceptors for students, residents and fellows in all primary care disciplines. In addition, one of the distinctive features of Lincoln is its fully integrated mental health clinic, making it a fertile training ground for personnel interested in the interface of physical and mental health programs.

'North Carolina AHEC has supported a number of specially designed rotations for residents and fellows interested in working with Latino patients.'

Student clerkships in community-based primary care at Lincoln are among the most sought after rotations for Duke medical students. In addition, psychiatry student, resident and child psychiatry fellow rotations have become a cornerstone for teaching rotations in primary care and psychiatry.

The rapid influx of Latino patients in North Carolina has had a dramatic impact on clinics like Lincoln Health Center. NC AHEC has supported a number of specially designed rotations for residents and fellows interested in working with Latino patients.

With a dearth of Latino mental health providers, bilingual Duke learners also have filled critical clinical roles, especially in child psychiatry — an area of particular need. Several learners have worked with Lincoln Health Center to develop Spanish language patient education materials and resources.

Through a grant from the Duke Endowment, the Duke School of Nursing and the NC AHEC have provided intensive training in medical Spanish for health providers. Lincoln staff and providers have enrolled in several trainings, including a specialized training in medical Spanish for mental health and substance abuse providers.

South and Central Florida

Nova Southeastern University AHEC Creates Links with Community, Migrant Health Centers

By Steven B. Zucker, DMD, MEd

Working closely with the community and migrant health centers and the National Health Service Corps (NHSC) throughout Central and South Florida has been a major priority of the Nova Southeastern University (NSU) AHEC Program and its affiliated Everglades and Central Florida AHEC Centers since its inception. This is in large part due to the demographics of its South and Central Florida service area.

Within AHEC's many isolated rural communities and inner-city urban areas, the migrant and community health centers, staffed in large part by NHSC personnel, frequently have been the only major providers of primary care in these highly indigent areas. Ten community and migrant health center organizations and clinics now are integrally involved with the NSU AHEC Program and its affiliated AHEC Centers.

In addition, through an agreement with the University of South Florida AHEC Program, the Central Florida AHEC also provides for rural osteopathic medical student training at the Ruskin Community Health Center in Hillsborough County and at Manatee Community Health Centers in Manatee County.

To increase contact of community and migrant health centers with the health sciences educational centers, several strategies have been developed and utilized by the AHECs. These community and migrant health centers are now part of a substantial component of AHEC community-based training of osteopathic medical residents and medical students, physician assistants, nurse practitioners, pharmacy students and students from other health professions fields.

In the past year, well over 400 students have selected AHEC service/learning rotations (many of which were three months each) in these community and migrant health centers. The primary care providers at these community health centers also have been offered full use of the NSU AHEC "Library Without Walls" resource services, which include literature searches, health science literature distribution, audiovisual collections, interlibrary loans and Internet access to medical data bases.

More than 1500 library informational requests from community health center providers in the region were received and serviced by the NSU AHEC affiliated centers in the past year. Physicians, nurses, dentists and other providers at these community health centers also are major participants at AHEC continuing education programming targeted to the needs of these providers on an on-site, local basis and on a regional level through statewide distance learning teleconferences, in collaboration with the Florida AHEC Network.

For the community providers at these community and migrant health centers, serving as adjunct faculty has helped them stay up-to-date in their respective health care fields, and helped to reduce their professional isolation in these remote areas.

For the faculty and administrators at participating schools, such training sites have offered excellent training laboratories in which students can learn to treat various underserved cultural and ethnic populations whose life-style practices, health care problems and attitudes towards health care differ from those traditionally seen during medical training.

The NSU AHEC Program also has worked closely with community and migrant health centers and state primary care associations, such as the Florida Association of Community Health Centers, in a variety of important workforce recruitment initiatives. As

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Dr. Zucker is Associate Dean for Community Affairs at Nova Southeastern University and NSU AHEC Program Director.

Many Welcome Opportunities

Providers at these community health centers often are overburdened with extremely heavy case loads, limited resources and long working hours, so the opportunity to develop formal linkages and collaborative programs with the academic health science centers has offered many welcome opportunities. These include:

- Gain additional workforce resources during periods of peak demand;
- Keep practitioners current and up-to-date in the ever changing health care field;
- Sensitize future practitioners to the important role of community health centers in the provision of health care in underserved areas; and
- Continually recruit future graduating students as potential practitioners in these clinics and underserved areas. Isolation from educational centers also is a prevalent complaint of newly assigned NHSC practitioners in community and migrant health centers.

Nova Southeast University AHEC *(Cont. from Page 42)*

a result, more than 40 osteopathic physicians and physician assistants from NSU AHEC affiliated outreach programs have been recruited to practice in well over 20 isolated, rural communities and inner-city urban areas throughout Florida. These sites include all of the 12 community health center organizations affiliated with the NSU AHEC Program and several community health center sites at which more than one graduate has gone into practice.

'These community and migrant health centers are now part of a substantial component of AHEC community-based training of osteopathic medical residents and medical students, physician assistants, nurse practitioners, pharmacy students and students from other health profession fields.'

The NSU AHEC Program has developed active and effective linkages with numerous community and migrant health centers in its vast and highly underserved service area.

These linkages and partnerships have led to a broad-based array of workforce recruitment, training and retention programs with these centers which have been extremely successful to date and have continued to evolve and expand in both comprehensiveness and scope. *(See related article below.)*

A Florida Role Model of AHEC Recruitment Success

By Steven B. Zucker, DMD, MEd

One example of the NSU AHEC Program recruitment success is Dr. Robert Trenschel. During his time as an osteopathic medical student at the NSU College of Osteopathic Medicine, Dr. Trenschel, a 1989 graduate, was involved in several AHEC educational programs which further strengthened his commitment to practicing in rural communities and his interest in providing care to underserved and indigent patients.

Among these AHEC educational experiences was an AHEC clinical rotation at the Opa Locka Health Center, a primary care center serving the needs of an indigent and underserved South Florida population.

During his medical student years, Dr. Trenschel also worked to establish the *AHEC Practice Opportunities Program,* through which teams of students travel each Summer to rural, small-town communities throughout the state to conduct demographic profiles of the communities and health assessment site surveys.

"Participating in these AHEC activities helped me to appreciate fully the potential benefits of both practicing primary care with underserved populations and of working in a small-town rural Florida community," Dr. Trenschel said.

After completing his training, Dr. Trenschel accepted a position at the C.L. Brumback Health Center in Belle Glade, a federally funded community and migrant health center located in a rural, migrant community. The area borders Lake Okeechobee and is, uniquely, also part of the Palm Beach County Health Department System.

Dr. Trenschel, who received his residency training in preventive medicine, continues to practice primary care and public health in Belle Glade. He also continues to serve as a preceptor for osteopathic medical residents and medical students as well as physician assistant students on their AHEC-sponsored rural clinical rotations. In addition, he lectures as a role model for AHEC in various rural medicine and public health recruitment initiatives both on campus and in the community, and serves as a representative of the Belle Glade community on the Everglades AHEC Center Advisory Board.

Numerous other examples of graduates like Dr. Trenschel now exist throughout the NSU AHEC service area.

Dr. Robert Trenschel with Sonya Jackson-Simmons, Nursing Director at the Carl Brumback Health Center, and Lisa Gorn, fourth year osteopathic medical student on her three-month rural rotation.

Illinois AHECs: SEARCH Yields Partnerships

By Rajesh Parikh, MD, MPH

The Illinois SEARCH Program is an excellent example of AHEC partnership with Community Health Centers (CHCs), the National Health Service Corps (NHSC) scholarship program and health professions education, including nursing education.

Specifically, through this program, the Illinois AHECs collaborate with 12 CHCs in Illinois to enhance their clinical education capacities by providing financial and technical support. AHEC has conducted several faculty development programs for community preceptors from CHCs in Illinois. Students from many programs, including advance nurse practitioner programs, participate in clinical education in the CHCs through the SEARCH Program.

In addition, for the past several years, Illinois AHECs have collaborated with the NHSC programs in several ways. The AHEC office was used for conducting interviewers training. Several staff from the Illinois AHEC are trained and regularly devote four or five days every year to conducting interviews for the NHSC applicants. Recently three AHEC staff members interviewed about 40 applicants in Chicago; one later traveled to Minneapolis to help with this process.

Dr. Parikh is Director of Clinical Education for the Illinois AHEC Program.

National Health Service Corps and Illinois Department of Public Health schools attend a SEARCH orientation session .

Illinois AHEC Program has collaborated also with the college of Nursing at the University of Illinois in several ways. Richard Wansley, PhD, Illinois AHEC Program Director, is co-director of the Chicago Health Corps (an Americorps project) based at the UIC College of Nursing. A Spanish immersion program in collaboration with that project is being developed for primary care providers in Chicago. AHEC also collaborates with several other nursing programs for clinical education through the SEARCH program.

Strengthening Linkages

Since January 2000, the Illinois Health Education Consortium/Illinois Area Health Education Centers Program (Illinois AHEC) has collaborated with the Illinois Primary Health Care Association (IPHCA), the grantee agency for the federally funded Student/Resident Experiences and Rotations in Community Health (SEARCH) Program, to create a student educational program. The goals of the collaboration are to facilitate and strengthen community-academic linkages and to increase the recruitment and retention of health care professionals in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). The primary method to accomplish these goals is by expanding the number of high-quality service-linked training opportunities available in these communities.

The Illinois SEARCH Program targets National Health Service Corps and Illinois Department of Public Health scholars in medical, dental, advance practice nursing and physician assistant programs and is also open to other health professions students and residents.

SEARCH offers innovative programs, curriculum and learning resources for students, residents and community-based preceptors, as well as preceptor education programs, student/resident placement and on-site support to academic programs, residencies and community health centers.

In the coming years, SEARCH plans to continue its current activities and expand to

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Illinois SEARCH

(Continued from Page 44)

include oral health and behavioral science students in its program. The program will continue to seek federal support while developing strategies for self-sufficiency through local, state and private support.

Innovative Program Components

Needs Assessment: The Illinois AHEC and the IPHCA, drawing on extensive experience in community-based health professions education, surveyed the literature on successful programs and held focus groups with community health center preceptors, academic faculty and residency faculty to develop a program that meets federal guidelines and the specific needs in Illinois.

Program Development: Using assessment data and program parameters set by the National Health Service Corps, the SEARCH Program established an administrative structure, appointed an Advisory Committee and invited all Illinois Community Health Centers to apply to become models sites**.** Staff from the Illinois AHEC and IPHCA formed a Management Team to direct all aspects of the Program. Twelve model sites in medically underserved areas were selected with special attention to achieving a balance of urban, rural and suburban locations. These sites offer a range of services to consumers of many ethnic, racial and cultural groups and provide the potential for diverse educational experiences for students and residents.

Program Content: The Illinois AHEC worked with training programs for medical, dental, advanced practice nursing and physician assistants and with family practice residencies to orient students/residents and faculty to the advantages of participation.

SEARCH program activities represent outreach to health professions programs and residencies; recruitment of students, especially NHSC and IDPH scholars, for pre-clinical and clinical experiences; student placement; student orientation; preceptor education; and SEARCH liaison to students, residents, preceptors, academic programs and Community Health Centers.

Curriculum Content: The Illinois SEARCH Program developed specific new curricula for all participating students and residents that includes a structured, half-day orientation educational programs focusing on the background of community health centers, a presentation by a seasoned clinician in practice in a medically underserved area and a workshop on culture and health.

Pre-clinical modules for students interested in short experiences combine patient care with a preceptor and learning activities in either community assessment, culture and health, health promotion, health education or nutrition. Clinical students and primary care residents complete all clinical work required by their academic programs as well as SEARCH mini-projects, generally in regards to community assessment and cultural competency.

Participation: In 2000-2001, more than 150 Illinois students and primary care residents will have completed SEARCH educational experiences in the 12 Community Health Center sites. The trainees are a diverse group from medical, dental, advanced practice nursing and physician assistant programs who come from many racial and ethnic groups with significant participation from NHSC scholars. In 2000-2001, more than 30 community preceptors, belonging to disciplines from 12 model sites, will undergo preceptor development program**.**

Community Partners: The SEARCH Advisory Committee was appointed *with* representatives from public agencies, professional organizations, academic programs and Community Health Centers who provide expertise, feedback on initiatives and networking opportunities. These community partners have worked closely with Illinois AHEC and the IPHCA and are committed to the continuation of the program.

Outcome/Evaluation: Evaluation from the first year of operation has shown that SEARCH has met its goals to develop and implement its program and to recruit and place targeted students and residents in Illinois. Evaluation of student/resident satisfaction has shown a high level of satisfaction for students of all disciplines.

Illinois SEARCH, an effort of Illinois AHEC and the Illinois Primary Health Care Association, offers innovative, community-based learning opportunities to medical, dental, advance practice nursing, physician assistant students and primary care residents with the goal to increase recruitment and retention of health professionals for careers in communities in need of health care services and to improve the health status of Illinois consumers.

Lost Ground:

Trends in Underrepresented Minorities' Participation in Medical Education in California

The release of findings from the 2000 Census has called attention to the growing racial/ethnic diversity of the United States population. Most notably, the number of Hispanics grew by 58 percent during the 1990s, to 35 million persons. Hispanics now comprise nearly as large a percentage of the U.S. population as do African Americans. These trends are especially pronounced in California, the most racially/ethnically diverse state in the union.

By Janet Coffman, MPP

Ms. Coffman is a doctoral student at the University of California, Berkeley. She formerly served as Associate Director of the Center for California Health Workforce Studies at the University of California, San Francisco.

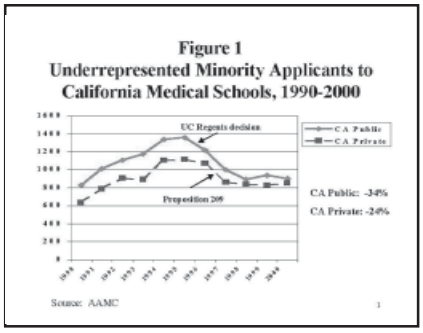
The increase in California's racial/ethnic diversity has heightened concern about the racial/ethnic composition of the state's physician workforce. Hispanics account for one third of California's population, but only 4 percent of its physicians. African Americans and Native Americans also are underrepresented among California's physicians.

These concerns prompted the UCSF Center for California Health Workforce Studies to monitor trends in the participation of underrepresented minorities in undergraduate medical education in California.

The UCSF Center is one of four health workforce studies centers in the United States funded by the U.S. Bureau of Health Professions; the other centers are at the University at Albany (New York), the University of Illinois and the University of Washington.

Further information about the UCSF Center is available on the web site: http://futurehealth.ucsf.edu/cchws.html.

The UCSF Center released a report summarizing its initial findings in March 1999. This report can be downloaded from the UCSF Center's web site at: http://futurehealth.ucsf.edu/cchws/pubs.html. The Center has updated its analyses annually as new data are released by the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine. Highlights from the analyses follow.



Findings: California has 11 medical schools, five of which are public institutions operated by the University of California. There are four private allopathic medical schools (Charles Drew, Loma Linda, Stanford and the University of Southern California) and two private osteopathic medical schools (Tuoro and Western). In 1999, approximately 5300 students were enrolled in California's medical schools.

Applicants: The number of underrepresented minorities applying to California medical schools has declined significantly since 1995. *(See Figure 1.)* At public (i.e., University of California) allopathic medical schools, the number of underrepresented minority applicants fell by 34 percent between 1995 and 2000, from 1358 to 903 applicants.

Applicants to private allopathic medical schools (Loma Linda, Stanford and University of Southern California) also dropped significantly, falling by 24 percent between 1996 and 2000. Comparable data were not available for California's two osteopathic medical schools.

The decline in underrepresented minority applicants reflects two developments. First, interest in careers in medicine has decreased among all racial/ethnic groups. The total number of applicants to medical schools declined by 18 percent between 1996-97 and 1999-2000. Second, anti-affirmative action policies appear to have deterred some underrepresented minorities from applying to California medical

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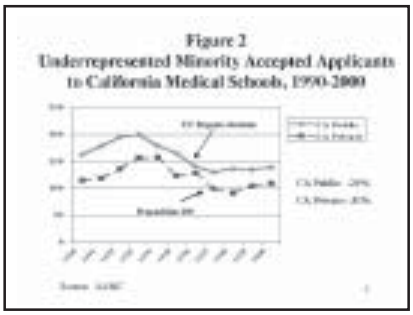
Lost Ground

(Continued from Page 46)

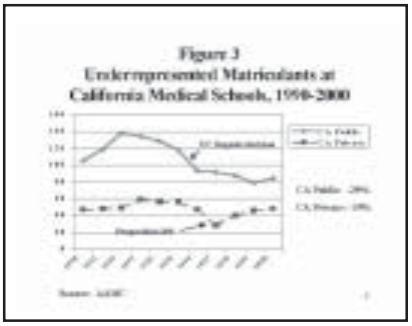
schools. In 1995, the Regents of the University of California prohibited the consideration of race in admissions decisions. California voters subsequently approved Proposition 209, a ballot initiative banning affirmative action in 1996. The sharp decrease in underrepresented minority applicants to California schools immediately following the ban suggests that these policies influenced underrepresented minority applicants' perception of the climate at California schools and their prospects for admission.



Accepted Applicants: The number of underrepresented minority applicants who received offers of admission from California medical schools also declined dramatically. As *Figure 2* indicates, the number of applicants accepted by public medical schools fell by 31 percent between 1993 and 2000, from 200 to 138 persons. The number of applicants accepted by private allopathic schools also fell by 31 percent during this period. These trends reflect both the drop in the number of underrepresented minority applicants and a decrease in the proportion of underrepresented minority applicants admitted to California schools. For public schools, the number of accepted applicants declined most dramatically prior to implementation of the UC Regents' decision. This pattern may reflect the trajectory of the debate over affirmative action within the UC system. Admissions to UC medical schools were carefully scrutinized prior to the UC Regents' decision, which may have led to preemptory changes in admissions committees' procedures. Comparable data were not available for California's osteopathic medical schools.

Matriculants: California's public and private medical schools experienced different trends in the number of underrepresented minority matriculants (i.e., first year students). Among public medical schools, the number of underrepresented minority matriculants fell by 39 percent, from a high of 138 in 1992 to 84 in 2000. *(See Figure 3.)* This trend reflects the decrease in the number of underrepresented minority applicants accepted by public schools, as well as a decrease in the percentage of accepted applicants choosing to enroll in California's public medical schools.

At private allopathic schools, the number of underrepresented minority matriculants fell dramatically immediately following the enactment of Proposition 209, but subsequently rebounded. The number of underrepresented minority matriculants at private allopathic schools peaked at 59 in 1993 and stands at 48 in 2000, yielding a net decrease of 19 percent.



A different pattern occurred at the two private osteopathic medical schools. The total number of underrepresented minority matriculants at these schools more than tripled between 1989 and 1999, rising from nine to 31 students. This difference reflects broader differences in enrollment trends in California's allopathic and osteopathic medical schools. As in the U.S. overall, total enrollment in California's allopathic medical schools

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'In the short term, California will have to rely on medical schools in other states to augment its meager supply of underrepresented minority physicians. One viable option would be for California's medical residency programs to recruit greater numbers of underrepresented minority students from medical schools in other states.'

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was flat during the 1990s. In contrast, total enrollment in osteopathic schools increased by more than 100 percent, due to an increase in class size at one school (Western) and the opening of a new school (Tuoro) in 1997.

While the gains achieved by osteopathic schools are important, the total number of underrepresented minority matriculants at California medical schools remains lower than in the mid-1990s. The total number of underrepresented minority matriculants peaked at 430 in 1995 and fell by 26 percent to 320 students in 1999.

Conclusion: The results of the analyses suggest that anti-affirmative action policies are associated with a significant decrease in the number of underrepresented minorities enrolling in California's medical schools. However, other factors, such as overall trends in the number of applicants to medical school and the preferences of accepted applicants, also contribute to these trends.

Regardless of the significance of any particular factor, these trends are disturbing. In the short term, California will have to rely on medical schools in other states to augment its meager supply of underrepresented minority physicians. One viable option would be for California's medical residency programs to recruit greater numbers of underrepresented minority students from medical schools in other states. Approximately 55 percent of California's active patient care physicians completed residency in California, a finding which suggests that a large percentage of underrepresented minority physicians trained in California residency programs would remain in the state to practice. Residency programs supported by the California Area Health Education Center can make important contributions to such efforts.

The current legal and political climate render restoration of affirmative action unlikely. Other strategies are required to increase the number of underrepresented minorities who can compete successfully for admission to medical schools and other health professions schools. The UCSF Center is currently conducting a study for the U.S. Bureau of Health Professions and the California Endowment that will characterize the range of diversity strategies used by health professions schools and assess the evidence of their effectiveness. This study will be completed in late 2001.

Acknowledgments

Lois Colburn and Kehua Zhang of the Association of American Medical Colleges and Lorrie Van Akkeren of the American Association of Colleges of Osteopathic Medicine provided data for this article and other projects of the UCSF Center for California Health Workforce Studies.

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California AHECs Achieve High Success Rates

In the November 2000 *"Special Report on Medical Student Diversity"* prepared by the Medical Students Diversity Task force for Richard C. Atkinson, President of the University of California, the California AHEC Program was listed as a program with "documented effectiveness at attracting/retaining underrepresented minority and educationally disadvantaged students into health professions."

In the year 2000 the California AHEC trained 399 underrepresented minority students throughout the state. Many programs such as the Wilmington/Los Angeles Port AHEC and the Multicultural AHEC have success rates as high as 80 percent of their underrepresented minority program graduates going on to select primary care as a discipline and returning to the community where they trained.

First Comprehensive Study in Three Decades

Who is the Public Health Workforce?

By Kristine M. Gebbie, DrPH, RN

Information about the size and composition of the public health workforce is of importance to a wide range of policymakers and educators who are considering such questions as curriculum design, continuing education, staff development, program development and community development. Unfortunately, there has been no commitment to a regular enumeration of the workforce, and there has been no data base that could be consulted when information was needed.

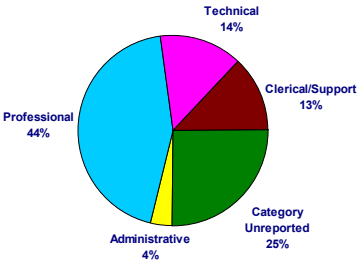
The Center for Health Policy at Columbia University School of Nursing was funded to complete the first comprehensive attempt to estimate this workforce since the 1970s. The result is that 448,254 workers in salaried positions were identified; their efforts are augmented by 2,864,825 volunteers in non-governmental organizations.

For historic comparison, in 1923, there were 27 workers per 100,000 population. The height of the health workforce appears to have been in 1979, when there were an estimated 219 workers per 100,000. A slight drop in the number of public health workers, and a large growth in population, means that in the year 2000, there were only 158 workers per 100,000, despite the continued increase in threats to the health of the public.

The data reported in this study are all secondary data, and were gathered through state health departments, federal web sites and requests to individual professional associations. The reported public health workers come from almost all of commonly identified health professions, but also may be persons with technical training or, in some cases, those who have been trained on the job.

Because of the breadth of tasks to be done, they range from professionals with extensive advanced education to those with a high school diploma and a willingness to learn. Data about workers were classified using four major categories: administrative, professional, technical and support, and then by the public health job categories developed by HRSA for use by the Department of Labor Bureau of Labor Statistics. Within these, the largest number of subcategories were in professionals, and the total number of job categories came to 55.

The accompanying charts summarize some of the key findings.



Occupational Categories of Public Health Workers

In order to make sense of the differences in numbers across regions, or across states within regions, it is important to understand each state's public health systems. The workforce is very different in those states that have elected to provide a large proportion of primary or home health care using public health employees. South Carolina, with the highest ratio of public health worker to population, clearly illustrates this point. In contrast, Pennsylvania has by far the lowest ratio (37 per 100,000); it is a state with only a limited number of local health departments serving only a portion of the state's population.

A substantial challenge in enumerating the public health workforce is the distribution of workers across multiple agencies at all levels of government. For example, in order to identify the federal public health workforce, data were included from the entire Department of Health and Human Services and portions of the Departments of Labor, Agriculture, Trans-

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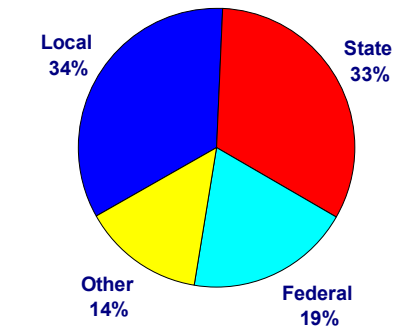


Location of Public Health Workers

Dr. Gebbie is Director of the Center for Health Policy at Columbia University School of Nursing and Elizabeth Standish Gill Associate Professor of Nursing at Columbia University.

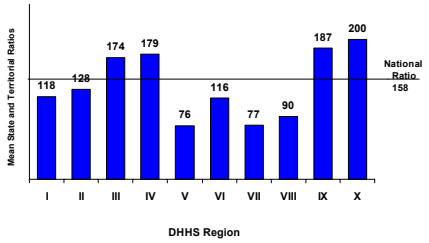
First Comprehensive Study

(Continued from Page 49)

portation and Veterans Affairs, the Environmental Protection Agency and the military.

Few state health departments could easily provide information about the full range of involved agencies; Wisconsin proved an exception because of a recent state-funded effort to identify all laws bearing on the public's health and the workforce associated with implementing those laws.

Public health workforce data available today are descriptive, and their use demands not only understanding of the differences across states, but the differences from other health workforce data bases. Due to the extended interval between enumeration efforts and a lack of policy agreement on a data base, the numbers reported are from different time periods (though most are less than five years old) and varied in such elements as whether or not the report was on number of employees or number of full time equivalents.



Range of mean ratio of workers, by USPHS Region

Most health worker data bases have existed for a number of years and are suitable for use in trend analysis. Many include information such as the age, education or job content of the described workers, detail that is as yet unavailable for the public health workforce. And while some of these data bases include individuals reported as being in the public health setting, it is difficult to reconcile the numbers. They appear to vary because of such things as the difference between self-report of 'specialty' and definition of public health by specific agencies.

Among those who have an interest in the enumeration data developed thus far are those in leadership positions in public health agencies, evaluators of public health programs, faculty of schools of public health, policy analysts in legislatures and executive branch policy offices and workforce researchers of all kinds. The information generated to date can be used as the basis for developing policy regarding future enumeration and for at least some comparative analysis in specific areas such as nutrition and public health education, for which the numbers are most complete.

Moving forward to a regular cycle of enumeration requires that several questions be answered by public health policymakers. *(See box at left.)*

A forthcoming report from the Public Health Leadership Society, prepared with the support of the Health Resources and Services Administration, which also supported this study, will give an initial answer to these questions. The mutual commitment to workforce development by HRSA and the Centers for Disease Control and Prevention, in collaboration with most of the existing public health-related organizations, should be the beginning of a better understanding of the public health workforce in the 21st century than we have had during the last quarter of the 20th century.

For more information on this enumeration, go to http://cpmcnet.columbia.edu/dept/nursing/chphsr/projects.html

Questions for Public Health Policymakers

Moving forward to a regular cycle of enumeration requires that the following questions be answered by public health policymakers:

- What range of governmental public health should be included?
- What is the range of workers outside governmental public health to include?
- What level of specificity (age, ethnicity, education, job title, job duties) is needed?
- Should any public health professions be reported in detail while others are not?
- What agency or organization should provide data to the data base?
- What time period should be used to limit information?

North Carolina AHEC Completes Mental Health Programs Needs Assessment

By Karen Stallings, RN, MEd, and Jessica Barr, MPH, MHA

The North Carolina AHEC Program has been involved in mental health education for the past 15 years. As a result of recommendations of a 1985 legislative study commission on mental health, the NC AHEC Program was funded to support expanded community training for psychiatry residents, to provide continuing education to health professionals employed in the mental health system and to expand access to information resources in the mental health field.

Today, AHEC supports rotations of psychiatry residents from all four medical schools in the state to community mental health centers. In 1999-2000, more than 600 continuing education programs on mental health topics were attended by 18,782 professionals, and AHEC libraries have dramatically expanded their holdings on mental health topics.

Despite all the efforts to strengthen the capacity of the system to serve the needs of the state, the mental health system in North Carolina, as in many other states, is under considerable stress. Turnover of staff in many centers is high; de-institutionalization efforts severely stress community programs that serve patients with complex and multiple problems; and funding for mental health services has been reduced. The NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the area mental health programs face severe resource pressures and are in the process of reorganization.

In an effort to better focus AHEC efforts to address the training needs of the system, NC AHEC mental health education directors designed and conducted a needs assessment survey of the state's 40 area mental health programs. The survey was used to identify the workforce and training needs key to providing quality mental health care services. It specifically looked for needed personnel, areas of specialization, training topics, training formats and additional ways that AHEC could assist in responding to education and training needs. The information gathered through the needs assessment survey was instrumental in developing a strategic plan for NC AHEC Mental Health Initiatives, included as part of the 2001-2005 Program Plan for NC AHEC.

Survey Reveals Needs

Survey responses revealed North Carolina's mental health centers have wide-ranging workforce and educational needs. One statewide trend is the need for additional psychiatrists, especially child psychiatrists. Not only do mental health centers need additional psychiatrists, they need staff psychiatrists with expertise in certain clinical specializations. Those specializations most needed are child psychiatry, substance abuse and geriatrics.

North Carolina psychiatrists generally devote at least 90 percent of their time to clinical work, with other time divided between administration and program development. Increased demands in documentation and organizational changes may be leading to the increased use of mid-level practitioners, especially master's level psychologists. In addition to the needs for psychiatrists and mid-level practitioners, the greatest staffing needs appear to be in social work and case management.

Educational Needs Identified

Educational needs reflect three areas: clinical skills, skills related to clinical practice and workplace skills. Skills in each of these areas appear to be learned "on the job" in many NC area mental health programs. Skills needed include:

- short-term treatment modalities
- group-work training
- treatment of dual diagnoses
- clinical supervision
- ethics and confidentiality
- cultural diversity
- new psychotherapies, medications
- new regulations
- general workplace skills

(Continued on next page)

Ms. Stallings is Associate Director of the North Carolina AHEC Program.

Ms. Barr is a Project Analyst for the North Carolina AHEC Program.

North Carolina Needs Assessment

(Continued from Page 51)

Learning Formats Explored

The current methods North Carolina mental health practitioners use to gain needed skills include workshops, conferences, literature and worksite training. Few formal methods for training practitioners about standard-of-care issues and treatment guidelines appear to be in place.

The state's mental health centers are willing to support a variety of learning formats, including customized on-site training, seminars and case consultations. Web-based training may be used increasingly as a learning format, as 87 percent of the centers that responded reported having Internet access.

Response Developed

With the information gained from this needs assessment, North Carolina AHEC will be better able to meet the education and training needs of the state's area mental health programs, fulfilling its goal to enhance the workforce development of the public mental health system. For the NC AHEC 2001-2005 Program Plan, a working document that guides NC AHEC to meet identified areas of need in all health disciplines and areas of educational programming, the NC AHEC Mental Health Directors used information from the needs assessment survey to identify key priorities for the next four years. Those priorities include:

1. Provide educational leadership to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services and its area programs during current reorganization and transition;

2. Embrace technology wherever possible to assist in the delivery of educational programming that meets the needs of mental health care providers;

3. Develop Best Practice Models and other programs to update the clinical skills of practicing mental health professionals.

4. Continue efforts toward workforce development, including: mapping demographics of working professionals, mental health careers recruitment, cultural competency training, support for distance degree programs for working professionals and resident and student training; and,

5. Create and foster collaborative partnerships for interdisciplinary education and a leverage of limited resources.

Information Shared

In addition to helping formulate a four-year plan, the information gleaned from the survey has been shared with colleagues in the training section of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, with departments of psychiatry of the state's four medical schools, with the state's schools of social work and with other North Carolina university and community partners engaged with the NC AHEC Program in responding to mental health education needs.

Needs for Psychiatrists with Certain Clinical Specializations

Child	**20 (51%)**
Substance Abuse	**18 (46%)**
Adult	**9 (23%)**
Geriatric	**8 (21%)**
Other	**6 (15%)**
Forensics	**5 (13%)**
Generalist	**4 (10%)**
Adolescent	**1 (3%)**

Thirty-nine Area Mental Health Programs responded to the workforce section.

The NC AHEC 1999 Mental Health Needs Assessment Survey is available on the NC AHEC web site: www.med.unc.edu/ahec/

AHEC Teams with County Health District

By Stephanie Dean Ehlers, MBA

The Coastal AHEC in LaMarque, Texas, has been hosted by the Galveston County Health District (GCHD) since its inception in 1993. This unique working relationship has served well both Coastal AHEC and GCHD on several levels.

First, the most obvious, is as a student training site. The Coastal AHEC has scheduled and placed more than 300 medical students, physician assistant (PA) students, nursing students and residents within the GCHD. Many of these students had never stepped inside a local health department, let alone considered it as a career option or a place they would eventually practice medicine. However, through their AHEC contact and GCHD experience, many are practicing in LaMarque. This served well as a recruitment tool for the GCHD, especially in the areas of nursing and physician assistants.

Coastal AHEC also coordinates educational for the GCHD. In years past, the Coastal staff would advertise a particular subject, arrange for CE credit and monitor the sessions. Now, the system has evolved so that the GCHD staff feels empowered to request specific downlinks to the AHEC staff, whose members arrange for and monitor the session.

Next, the Coastal AHEC has been able to establish several learning resource centers (LRCs). AHEC staff maintain three libraries and a computer lab which house books and software purchased by AHEC to provide easy access to information for GCHD staff and students.

In addition, the AHEC office houses a library with not only medical and career information, but also educational information ranging from stress management to dealing with difficult people to financial freedom. AHEC receives visitors on a weekly basis, usually GCHD staff, who are interested in receiving information about advancing their careers within health care.

Other resources Coastal AHEC brings are computer expertise and equipment access. Several staff members are "fluent" in software programs such as MS Publisher, FrontPage, Access, etc. Frequently, GCHD staff receive informal training in these programs in the AHEC office. Additionally, for several years the AHEC housed the only color printer and copier in the entire building and provided the use of this equipment to the GCHD. The AHEC's LCD projector and display boards are available and used monthly by GCHD staff when making presentations.

In the area of health education, the Coastal AHEC primarily assists the GCHD with CPR certification. Several times a year, a health educator on the AHEC staff trains and certifies GCHD employees in CPR.

AHEC receives referrals from GCHD staff for families who need information and follow-up with SCHIP. Training for GCHD clients on breast feeding, diabetic self-management and oral hygiene is planned for the upcoming year.

Finally, the AHEC is available to the GCHD to assist with special projects. Several years ago, AHEC staff assisted the GCHD with the Texas Public Health Association annual conference coordination. Coastal AHEC staff members have expertise in coordination, logistics and developing marketing materials. Staff assisted the district with conference planning, logistics, production of signage and registration.

Ms. Ehlers is Executive Director of Coastal AHEC in LaMarque, Texas.

Section V: Local/Regional Workforce Efforts

Oregon AHEC: Career Pathways for Hispanic/Latinos

By Hector Hernandez, MA, MFA; Kathleen Savicki, MSW, LCSW; and Sally A. Henry, MA, RN, FHCE

Mr. Hernandez is Director of Hispanic Programs at Oregon Pacific AHEC in Corvallis.

Ms. Savicki is Quality Improvement Coordinator at Mid-Valley Behavioral Care Network, Salem, Oregon.

Ms. Henry is Executive Director of Oregon Pacific AHEC in Corvallis.

The rapid increase in the Hispanic/Latino population in the United States during the past ten years has posed challenges to health service providers around the country. Mental health and chemical dependency agencies are experiencing particular pressure to meet the growing demands of services for Hispanic/Latino populations.

One approach to this challenge was the development of the Mental Health/Chemical Dependency *Career Pathways* project by Oregon Pacific AHEC (OP AHEC) and the Mid Valley Behavioral Care Network (MVBCN).

The growth rate of the Hispanic/Latino population in the state of Oregon from 1990 to 2000 was 144 percent. The increases in the eight counties of northwest Oregon served by OP AHEC ranged from 60 percent to 254 percent. In response, the OPAHEC Board identified improving access to health care for this population as a high priority.

The MVBCN manages Oregon Health Plan/Medicaid behavioral health services in four of the OP AHEC counties plus the more urban Marion County which contains the state capitol. The Network's 19 public and private member agencies which provide mental health and chemical dependency treatment services have struggled to recruit and retain staff who can be most effective dealing with Latino clients. Clearly, in a field in which precise language is so critical, there is a tremendous need to increase the numbers of bilingual, bicultural providers.

Many non-curricular barriers must be overcome by people interested in earning credentials in the mental health and chemical dependency fields, particularly those who have emigrated to the United States as adults. Financial, cultural and academic problems are among the more significant.

The financial hurdle is perhaps the highest due to heavy family responsibilities carried by Hispanic/Latino individuals. Another important barrier is language. In order to become a bilingual professional, it is necessary for an individual to be proficient not only in Spanish but also in English. Mastering writing skills in English represents a major challenge to those who have not grown up in the United States. The academic culture is also an important challenge. The rhythm of study can be difficult for people who are years out of school. In some cases, students drop their courses under family and academic pressure solely due to the lack of a realistic plan of study.

In this context, OP AHEC and MVBCN jointly funded a needs assessment in 1999 which led to development of the Mental Health/Chemical Dependency *Career Pathways* project. Additional funding was granted by the Northwest Health Foundation for the year 2000.

To establish the initiative, six partner educational institutions who conducted courses or programs in behavioral health were identified: two community colleges, two universities and two graduate schools. The initial estimate of a 150-person pool of candidates was expanded in part due to the large number of Hispanics/Latinos in the medical field interested in changing careers.

These professionals have earned their credentials in Latin American countries but faced problems of credentialing in the United States. Consequently, skilled doctors, nurses and dentists are working in low paying jobs, wasting much needed expertise.

Other program participants were recruited from bicultural staff working within behavioral health care agencies who indicated an interest in further education leading to higher levels of professional credentialing. More candidates were identified after regional high school and college classroom presentations targeted Latinos/Hispanics. An increasing number of students have attended the health career presentations each term during the past year.

Those individuals identified as interested in pursuing careers in the mental health and chemical dependency fields received bilingual information (in Spanish and English) and orientation on the programs offered by the six educational institutions by the bicultural *Career Pathways* project coordinator.

After the first year, there have been 17 designated program participants. Eight currently are enrolled in behavioral health programs. The remainder are "in the pipeline," strengthening their English skills or obtaining

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Career Pathways for Hispanic/Latinos *(Continued from Page 54)*

their GEDs. Once participants are identified, they are invited to join the MVBCN's established regional Latino Team, which assembles staff from member agencies to address issues relating to the behavioral health needs of the Hispanic community. The provider team members support and mentor the students, leading them to internships and job placements within the Network.

The project coordinator also responded to an invitation from the local chapter of the National Alliance of the Mentally Ill for assistance in implementing the Family to Family educational program. Latino Team members have helped develop a culturally appropriate method for outreach to the Hispanic/Latino community to provide training in mental health issues for families with mentally ill members.

Additionally, bi-lingual, bi-cultural staff have been assigned to the Early Assessment and Support Team to promote early intervention strategies for individuals experiencing their first episode of psychosis.

The most recent initiative was to develop a proposal to work with Marion County Health Department and to offer mental health services for Hispanic/Latino people suffering HIV/AIDS. These efforts will lead to training activities, and may also provide an entry-level experience for future Hispanic/Latino practitioners.

Hector Hernandez guides a student along the Mental Health/Medical Dependency Career Pathway.

By involving volunteers, students and practitioners in a variety of ways, it will be possible to increase the pool of Hispanic/Latino professionals in the field of mental health and chemical dependency. The *Career Pathways* program continues to search for additional avenues to respond to the increasing demands of the Hispanic/Latino population. One consideration is the possibility of hosting forums to explore alternative credentialing mechanisms for immigrants with skills developed in other systems.

National AHEC Evaluation Underway

During the 105th Congress, the Committee on Labor and Human Resources passed a mandate directing HRSA to conduct an evaluative study of AHECs to identify key factors, characteristics and methodologies employed by successful AHECs as well as factors, barriers and impediments in areas where AHECs have not been able to cover their defined service areas, to involve other health professions, and to maintain an interdisciplinary focus."

Results are to be used to define further the selection criteria program requirements essential for successful AHEC operations and to assure effectiveness in providing primary care to underserved areas.

An external evaluation committee of program and center directors provided input to the federal office on the design and conduct of the study.

Through a Request for Proposals (RFP), Health Systems Research (HSR), Inc., was selected as the prime contractor, with Research Triangle, Inc., and the Sheps Center at the University of North Carolina, forming a consortia. The kick-off meeting was held on July 13, 2001.

Experienced AHEC project staff and consultants are represented among the contractor's group. Methodologies will be: focus groups, site visits and utilization of the AHEC CPMS/UPR data for FY 1999 and 2000.

Focus groups will be conducted in September among participants of the NAO meeting in Little Rock and during nine site visits which will begin in November and continue through early Spring 2002.

HSR will develop the site visit tools; the team will consist of the contractor staff along with at least one member of the external evaluation committee and a representative of the Federal AHEC staff for each site visit. A determination of the sites to be visited was to be made this summer. The AHEC CPMS/UPR data analysis will be performed utilizing the FY 1999 and 2000 data.

The study is to be completed in 12 months, with a report to Congress as the final step. As the study progresses, more information will be made available from the Federal AHEC Office. Captain Audrey M. Koertvelyessy serves as the Government Project Officer for this study.

South Texas AHEC

Increasing Opportunities for Dental Care, Education Along the Texas-Mexico Border

By Julie Collins

Prosthodontics residents, indigent patients and dentists along the Texas-Mexico border are all benefiting from a cooperative agreement between the Department of Prosthodontics at the University of Texas Health Science Center at San Antonio (UTHSCSA) and Gateway Community Health Center in Laredo, Texas.

State funding from the South Texas/Border Region Health Professional Education Initiative (STBI) first was awarded to the Laredo Prosthodontics Program in December 1995 at the recommendation of the Mid Rio Grande Border AHEC, a center of the South Texas AHEC. With this funding, the Department of Prosthodontics has developed programs in Laredo that increase educational opportunities for UTHSCSA prosthodontics residents, provide continuing education for Laredo dentists and create access to prosthodontics services for low-income and uninsured members of the Laredo community.

Ms. Collins is an Informational Writer for South Texas AHEC.

Now, as state funding for education programs in Laredo has increased through the creation of UTHSCSA's Laredo Campus Extension, the prosthodontics program has been able to grow even further, delivering maxillofacial services that were previously inaccessible to people in the region.

Prosthodontics services such as crowns and bridges are provided for patients at Gateway Community Health Center by UTHSCSA faculty and residents.

In 1996, the Department of Prosthodontics began an affiliation with Gateway Community Health Center whereby UTHSCSA sends a team of prosthodontics residents, faculty and staff members to the center for three-day visits twice a month to provide prosthodontics services to Gateway dental patients.

Prosthodontics is the branch of dentistry that deals with the replacement of missing teeth and related oral structures, including crowns, bridges and dentures. "Gateway could not afford to offer these services because the associated laboratory fees were too great," said Dr. William Kuebker, retired chair of the Prosthodontics Department, who still serves as co-director of the Laredo program. "So Gateway's patients, who don't have the financial means or insurance to go to Laredo's private dentists, either had to cross over into Mexico for treatment or go without treatment altogether."

The clinic's affiliation with UTHSCSA solved this problem because the visiting teams from the university bring the patients' lab work back with them to San Antonio for completion. Then they deliver the prostheses to the patients on return visits to Laredo.

In addition to bringing a much-needed service to indigent patients, this arrangement also benefits the prosthodontics residents. "Often the residents' training in San Antonio involves them in extensive types of treatments that go on for months and years," said Dr. Kuebker. "In Laredo, they do more common types of prosthodontics that they will see frequently in private practice. So the trips to Laredo give them a good experience with a different type of patient than they see in San Antonio."

Dr. Robert Cronin, co-director of the Laredo program, added, "The residents enjoy going to Laredo because of the people we have the opportunity to help. The program allows residents to provide care for an indigent-based population and to treat patients in a different facility. They genuinely enjoy working with the patients in Laredo, who are so appreciative of the service we provide."

Recently, the Prosthodontics Department has added maxillofacial prosthetics services to its Laredo program at Gateway. Services include the replacement of facial structures, such as artificial eyes, ears or noses. This type of treatment is often needed by pa-

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Dental Care, Education

(Continued from Page 56)

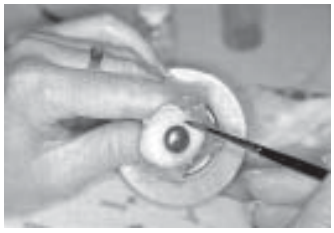
tients who have had developmental defects, accidents or cancer.

"There is really nobody in the Laredo area who provides this type of treatment," said Dr. Kuebker. "We were made aware of the great need the community had for this service by an ocularist here at the Health Science Center who is from Laredo. When funding became available in 1999, we put together a proposal to add the maxillofacial component to our program."

More than 2100 Laredo patients have received the benefit of some type of prosthodontics service by Health Science Center residents and faculty since the program's inception in 1996. But the patients are not the only ones to benefit from the UTHSCSA presence in Laredo.

Faculty make themselves available to provide numerous continuing education opportunities for Laredo area dentists. Of course, staff members at Gateway always are invited to observe the techniques being used by residents and faculty during their visits to the clinic.

In addition, the Prosthodontics Department sponsors study club meetings and other continuing education programs several times a year, making them available both to the dentists and dental staff at Gateway and throughout the community. Upon invitation, the department also provides guest speakers for meetings of the Laredo District Dental Society.



Maxillofacial services provided in Laredo by the UTHSCSA Department of Prosthodontics include orbital and ocular prostheses such as those being constructed at left by Nancy Hansen, CDT, BS, a medical sculptor and anaplastologist. An orbital prosthesis, above, includes a section of the face, whereas the ocular prosthesis involves just the eye.

"Some of the topics we cover are related to general dentistry, and our OSHA Update always draws a big crowd. Other topics relate to the latest updates and advances in prosthodontics," said Dr. Kuebker. *(See related article below.)*

Dental Services Reach Student Athletes

The Laredo Prosthodontics Program also has combined with local dentists in a major community service activity, the Free Mouthguard Program.

On a designated Saturday in August, a team of 20 to 25 UTHSCSA faculty members, residents and staff join a similar-sized group of Laredo dentists and dental staff to provide free mouthguards for athletes at the six Laredo high schools. More than 1300 athletes have participated since the program's inception.

"It's preventive dentistry, really," said Dr. William Kuebker, co-director of the Lardeo program. "Mouthguards are required in football, but not in basketball, soccer and other sports in which there is still a lot of contact. Oral injury does occur. This program provides protection for the athletes, and it allows the Health Science Center and local dentists to work closely with the community on a service project. It also gives us the opportunity to talk with the athletes about the importance of wearing mouthguards."

It is a busy day for the dental team, who fit 200 to 300 athletes with custom mouthguards. At 7:30 a.m., they begin making impressions of the athletes' teeth at Gateway Community Health Center and at the City of Laredo Health Department Children's Dental Health Clinic. Then the dental team goes to work in the laboratory at the city clinic preparing the mouthguards, which are given to the athletes by late afternoon.

Even the preparation requires a team approach. "We bring the supplies with us (from the Health Science Center), and the Laredo dentists work with the local high schools to coordinate the project," Dr. Kuebker said.

An indirect benefit of the continuing education and free mouthguard programs is that they have energized the Laredo dental community. "The Health Science Center's programs have rekindled the professional interests of the members of the Laredo District Dental Society," said the society's president, Dr. Sonia Rodriguez. She said that before these educational programs were initiated, the society had few attendees at its mostly social activities.

Last year, a total of 65 dental staff members and 26 local dentists, including 24 of the 26 members of the dental society, participated in some aspect of the Laredo Prosthodontics Program.

Eastern Virginia AHECs

'Students and Communities Both Benefit'

Following are two selected examples of networking, partnering or cooperative ventures between Eastern Virginia AHECs and their local Community Health Centers, Primary Care Organizations and Primary Care Associations.

By Robert J. Alpino

Mr. Alpino is Administrative Director of the Eastern Virginia AHEC at Eastern Virginia Medical School in Norfolk.

Service-learning educational efforts have been a high priority of the Eastern Virginia Area Health Education Center (EVAHEC), a program of Eastern Virginia Medical School in Norfolk and one of eight community-based AHEC centers in the Virginia Statewide AHEC System. By combining health professions education with health care delivery, students and communities both benefit.

One example involved a collaboration involving EVAHEC, the City of Portsmouth Mayor's Health Services Advisory Committee (MHSC) and the Virginia Primary Care Association. The MHSC consisted of individuals representing public and private health care entities and concerned private citizens who worked together to improve access to health services for Portsmouth residents and to obtain necessary funding to support those services.

'The Mayor's Health Services Advisory Committee and Eastern Virginia AHEC, with the support of the Virginia Primary Care Association, responded by applying for a federal Community Health Center planning grant to provide primary care services for medically underserved citizens.'

A needs assessment conducted by the City of Portsmouth Health Department in 1991 indicated that additional primary care health resources were necessary for low-income Portsmouth residents.

The MHSC and EVAHEC, with the support of the Virginia Primary Care Association, responded by applying for a federal Community Health Center planning grant to provide primary care services for medically underserved citizens. The grant was approved in 1992, with full operational grant funding approved by the Bureau of Primary Health Care of the Health Resources and Services Administration in 1993.

During the planning phase of the Portsmouth Community Health Center (PCHC) project, EVAHEC facilitated the drafting of organizational by-laws and articles of incorporation, budget preparation, development of goals and objectives, board development, grant writing training and conducting community focus groups, as part of a systematic approach for developing the finalized grant proposals and determining the range of services to be offered.

Since it opened in May 1995, the PCHC has provided comprehensive primary care services on a sliding-scale fee basis for more than 10,000 patients. It subsequently served as an EVAHEC clinical training site for medical, physician assistant, nursing, nurse practitioner and medical assistant students, as well as medical and podiatry residents.

The development of the PCHC is but one example of the synergy that can be created when community-based AHECs work with state primary care associations and localities to develop win-win solutions that benefit all parties.

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Eastern Virginia AHECs

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Norfolk Developing Expansion Site

Recently, EVAHEC has worked closely with the PCHC, Eastern Virginia Medical School, the Virginia Primary Care Association and local hospitals and health care systems to develop a Norfolk Community Health Center as an expansion site of the PCHC to serve several thousand more of the region's medically underserved population.

EVAHEC's Program Director served on the steering committee for the CHC expansion project, while EVAHEC's Administrative Director chaired the finance committee for the project as well as serving on the PCHC Board of Directors. The expansion grant application was submitted to HRSA in May 2001; a decision is expected in September 2001, with the Norfolk Community Health Center set to open in December 2001, if funding is provided.

Telemedicine Network Has Positive Impact

Primary health care providers on the rural and isolated Eastern Shore of Virginia for many years sought access to Eastern Virginia Medical School (EVMS) continuing medical education (CME) offerings, such as Grand Rounds lectures, via a televised linkage so they could obtain CME credits.

The Eastern Virginia AHEC (EVAHEC) is partnered with the Eastern Shore Rural Health System, Inc. (ESRH), a Community Health Center network of four sites located on the Eastern Shore of Virginia, and four other Eastern Shore partners (health department, hospital, private practice multispecialty group and the local community college) to propose such a system to the Virginia Health Care Foundation (VHCF).

In December 1996, EVAHEC and ESRH were notified by the VHCF that their joint grant application was approved for partial funding of the development of such a televised linkage. Matching funds to complete the project were provided by EVAHEC, EVMS, ESRH and the remaining community partners.

All of 1997 and the Spring and Summer of 1998 were utilized to develop the project, which was technical in nature, involving licensing issues with the Federal Communications Commission and requiring extensive renovations of the EVMS Hofheimer Hall Auditorium for use as a broadcast studio.

The inaugural broadcast of what came to be known as the Eastern Virginia Telemedicine Network (EVTN) on October 7, 1998, was viewed by one nurse and three physicians at three sites, all on the Eastern Shore.

From the initial eight EVTN viewing sites on the Eastern Shore, the EVTN has expanded to a total of 19 sites throughout eastern Virginia. Sites consist of a mix of hospitals, community health centers, health departments and private practice physician offices, with three additional sites to be added in August 2001.

Currently EVMS Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, Psychiatry and Behavioral Sciences and Geriatrics and Gerontology Grand Rounds are regularly broadcast over the EVTN in addition to non-EVMS produced programming downlinked from other sources, such as the Centers for Disease Control and Prevention and the Alabama Department of Public Health.

The EVTN is unique in design and approach because EVAHEC utilizes revenues from paid EVTN subscriptions from subscriber health facilities in medically well-served areas to help underwrite the free EVTN subscriptions that are provided to Community Health Centers and other health care facilities located in designated Health Professional Shortage Areas (HPSAs) in eastern Virginia.

For the federal fiscal year from October 1999 to September 2000, 970 hours of 'face-to-face' category 1 CME credit were earned by 204 eastern Virginia health care professionals through the viewing of EVTN broadcasts.

The availability of the EVTN has positively impacted the recruitment and retention of primary care providers on the Eastern Shore and has improved the educational process for health professions students and medical residents who are training on the Eastern Shore. In addition, the health care provider education provided via the EVTN has had a positive influence on the quality of care provided on the Eastern Shore.

Pennsylvania

AHEC Partners with Temple Health Connection

By Leona Joseph

Temple Health Connection (THC), a neighborhood nursing center administered by the Department of Nursing at Temple University's College of Allied Health Professions, provides primary care and family planning to those living in two Philadelphia Housing Authority developments (Norris Homes and Apartments and Fairhill Apartments) and the surrounding community.

For the past four years, the SouthEast Pennsylvania AHEC has collaborated with THC to address the needs of African American men and youth, aged five-to-eight years. Projects include:

- **Screening and education** of males for diabetes and hypertension. Men were recruited from neighborhood basketball courts and provided with incentives to participate in screening, follow-up and education at THC.
- **Development of a summer camp** for community youth aged five-to-eight years. The purpose of the camp is to provide skill development to decrease the children's risk in activities of violence, substance abuse and teen pregnancy. The risks for these children are greater than in the city of Philadelphia as a whole. Through a partnership with the Temple University Leonard Gordon Institute of Human Development Through Play, children participated in creative play designed to foster inclusion, self-esteem, conflict avoidance and cooperative play.
- **Lead poisoning prevention** education to children participating in Head Start programs in North Philadelphia, an area where children are at risk due to their environmental exposure to lead. An intervention featuring puppets and craft projects was utilized to educate the children and their caregivers.
- **Enhancement of the after-school program** through the development of a Positive Self-Identity program focused on connecting youth with Black History and Black Heroes.

Learning about Black history and Black heroes helps children develop a positive self-identity in an after-school program.

Ms. Joseph is Program Manager of the SouthEast Pennsylvania AHEC in Philadelphia.

Sharing the day's activities with a counselor brings a big smile to the face of a young girl in the after-school program.

Bright yellow T-shirts with the message: "Prevent Lead Poisoning" help to educate at-risk children participating in the AHEC-Temple Health Center awareness program.

Approximately 150 children and 20 adult males have participated in these programs. Preliminary evaluation of the various programs designed to increase young people's self-esteem have shown a positive increase in the development of conflict resolution, problem solving and self-awareness skills.

'Spirit of AHEC'

AHEC Rotations Lay Career Foundation

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

There are times when all the stars are in alignment and everything is good. Such was the case when three different HRSA grantees, representing four different HRSA programs and two different HRSA bureaus, worked in a seamless fashion to impact the career of Michelle Touw, MS, PA-C.

Ms. Touw received her physician assistant training at Midwestern University in Downers Grove, Illinois, and graduated in August 1997 with a Master of Science degree in Physician Assistant Studies.

While at Midwestern, she had many excellent clinical rotations both in Chicago and throughout Illinois that were coordinated through the Illinois AHEC Program, which is based at Midwestern University .

Upon graduation from Midwestern University, Ms. Touw took a position as a PA in a Chicago internal medicine practice specializing in endocrinology. Her husband, a U.S. Navy physician, soon received orders to report to the Naval Medical Center in Portsmouth, Virginia, to begin a medical residency in July 1998.

'AHEC personnel have a great deal of knowledge about the primary care landscape and what is going on in community health. It seemed logical to contact the AHEC serving southeastern Virginia because I knew they would be able to help me in my search for a PA position in community health.'

Ms. Touw contacted Robert J. Alpino, Administrative Director of the Eastern Virginia AHEC, for information on primary care positions in community health in Virginia. Her message included information on her Master's degree project on maternal/child health in a community clinic in Chicago, that she spoke Spanish and that she had been in contact with the National Health Service Corps (NHSC) about loan repayment through the Corps.

Ms. Touw said that, based on her experience in Illinois, "AHEC personnel have a great deal of knowledge about the primary care landscape and what is going on in community health. It seemed logical to contact the AHEC serving southeastern Virginia because I knew they would be able to help me in my search for a PA position in community health."

Mr. Alpino also serves on the Board of Directors of the Portsmouth Community Health Center, Inc. (PCHC) a private, non-profit health care organization that receives a federal subsidy from the Community Health Center Program of HRSA's Bureau of Primary Health Care.

The PCHC and the Eastern Virginia AHEC have always had a strong working relationship, since the Eastern Virginia AHEC played a major role in the founding and development of the PCHC. John Schalk, Executive Director of the PCHC, formerly served as the administrative director of the Eastern Virginia AHEC.

Coincidentally, the PCHC at just that time was seeking to develop an obstetrics and gynecology practice. A phone call from Mr. Alpino prompted Mr. Schalk to arrange an interview. Ms. Touw's qualifications and experience in maternal/child health were a perfect fit for the PCHC's needs and she was hired and given responsibility for the PCHC Performance Improvement program as well as working alongside the PCHC Ob-Gyn physicians.

"The patients loved Michelle right from the start," said Angela Fitzgerald, PCHC Center Manager.

As a primary care provider, and with the PCHC being located in a federally designated Health Professional Shortage Area (HPSA), Ms. Touw was eligible for participation in opportunities available under the National Health Service Corps Program. She was accepted as an Obligated Loan Repayer in the NHSC Loan Repayment Program and served in this capacity at the PCHC until March 2001.

Ms. Touw recently relocated to Florida, where her husband has been newly stationed by the U.S. Navy.

Michelle Touw's experience shows what can be achieved when HRSA's grantees in varied programs and Bureaus work together for the benefit of the medically underserved. While her story may be somewhat unusual, our goal should be to make stories like hers the routine rather than the exception, with the hope that the stars can be aligned more often.

Ms. Hanes is Program Director of the Virginia Statewide AHEC Program.

National Primary Care Week 2001

'Mobilizing Interdisciplinary Teams'

By Janet B. Clear, MPH, RN, C, and Yvonne K. Fulbright, MSEd

In its annual fashion, National Primary Care Week (NPCW), a HRSA sponsored interdisciplinary, student-led initiative, coordinated by the American Medical Student Association (AMSA) in conjunction with the AHEC network, is gearing up for 2001.

This year's theme, "Healthy People (HP) 2010: Mobilizing Interdisciplinary Teams," underscores the contributions that primary health care professionals make towards improving the health of individuals and communities through collaboration. Collaboration is key to developing and enhancing improved access to community-based primary health care services, particularly health promotion disease prevention services.

NPCW 2001: October 14 -20

Collaboration is also the hallmark of AHECs. NPCW is a ready-made vehicle, with national recognition, to drive — and highlight — AHEC contributions to community-based health professions education and services. Select several of your AHEC activities and align them to coordinate with the national recognition of NPCW.

Past AHEC participation in NPCWs has included identifying local student coordinators from health professions schools in AHEC areas, and assistance to student coordinators in planning, organizing and implementing NPCW events. AHEC visibility in NPCW activities not only markets AHEC capabilities , it also informs students and communities about primary care services, workforce issues, and career opportunities. It is a powerful motivator and catalyst for students exploring career goals and a fantastic mechanism to disseminate health information to communities.

NPCW 2000 with the theme, "Caring for Communities," was celebrated at 115 health professions schools nationwide. It highlighted primary care issues, challenges and opportunities, as well as the needs for primary care among underserved and high risk populations. *(For an example of NPCW 2000 activities at one university, see related story on next page.)*

With more student leaders aware of the AHECs and their services in 2000 than in 1999, 38 percent of leaders completing an evaluation reported collaborating with their AHECs in the form of speaker referrals, planning, financial assistance, promotions, materials, photocopying, facilities and/or other personnel contacts.

Among the needs identified for school-AHEC collaboration are increased support and leadership from the AHECs, particularly those that have been unable to get involved in past efforts. AHECs can play an essential role in NPCW, helping students to plan activities. Other suggestions from student leaders for AHEC support included more financial support, more help in identifying speakers, and more communication as to what kind of assistance an AHEC can provide.

All AHECs involved in NPCW 2000 indicated that they plan to be involved in the 2001 efforts. Among future events suggested were: faculty development workshops, health fairs, health careers promotion, research

(Continued on next page)

NPCW goals:

- To improve health professions students' understanding of primary care
- To highlight the many career options and opportunities in primary care, including, but not limited to, public health, health policy, interdisciplinary health care delivery, academia and primary care research
- To demonstrate the importance of collaboration between primary care professionals and the communities they serve
- To encourage students to participate in community service events
- To introduce students to policy issues surrounding primary care and the political process

Ohio Students Plan, Carry Out NPCW Events

Ohio University College of Osteopathic Medicine's celebration of National Primary Care Week 2000 consisted of a series of lunchtime presentations and a service-learning activity to promote health careers. Kristin Johnson and Adan Fuentes, both second year osteopathic medical students, with the support and assistance of AHEC staff member Teresa Dunfee, RN, Early Clinical Contact Coordinator, planned and implemented the following activities on the OU-COM campus.

- Osteopathic Medical Students at Ohio University attended a presentation by Ladoira Dils, RN, CPTC, manager of hospital relations/professional education for Lifeline of Ohio, on *Organ and Tissue Donation and Procurement As Related to the Primary Care Physician.* This session gave the osteopathic medical students the opportunity to improve their understanding of primary care in the final hours of an imminent death of a patient, as well as to view the importance of collaboration between primary care practitioners and the community agencies that secure organs and tissues for transplant,

This session was co-sponsored by OU-COM's chapters of AMSA and SNMA as well as the AHEC at OU-COM.

- Patrick Harsch, PhD, SEARCH Program Coordinator for the Ohio Department of Health made a presentation on the SEARCH Program and the availability of summer preceptorship opportunities in the medically underserved areas of Ohio and another on *Health Literacy* with a video from the American Medical Association and its study of the problem of Health Literacy.
- Christopher Simpson, DO, Assistant Professor Family Medicine at OU-COM, spoke on *the Role of the Primary Care Physician in a Rural Area.* Dr. Simpson has spent the majority of his career practicing in rural areas, from New England to Southeastern Ohio.
- Medical students led a tour of the OU-COM campus for Washington County Career Center's nurse aide students who are in 11th and 12th grades of high school. Four second year osteopathic medical students shared their reasons for choosing osteopathic medicine and the positive choices of other health care professions.
- An interdisciplinary panel discussion including Ruth Waibel, PhD, Associate Professor of Health Sciences at Ohio University; Beth Margolies, fourth year physical therapy student; and Teresa Dunfee, RN, Early Clinical Contact Coordinator, Ohio University College of Osteopathic Medicine, provided insight to the related health care careers of the primary physician.
- The final event was a survey of the first and second year medical students about their expectations and desires upon completion of medical school and what would it take to have them choose to practice in a rural community.

'Mobilizing Interdisciplinary Teams'

(Continued from Page

projects, and education programs. AHECs also indicated that community outreach events should be incorporated into future NPCW, better fulfilling the project goals – an effort for which AHECs are best suited.

Given the success of NPCW activities, the majority (73 percent) of leaders felt that NPCW would encourage the development of year round, primary care focused activities for students, an increase of 52 percent from 1999.

NPCW is supported by the Division of Interdisciplinary, Community-Based Programs, Division of Medicine and Dentistry, and Division of Nursing, all located in the Bureau of Health Professions, HRSA.

For more information on National Primary Care Week 2001, visit: www.amsa.org/programs/npcw/npcw.html, or contact Yvonne Fulbright at AMSA: 703-620-6600 x204 or Janet Clear at the AHEC Branch, DICP, BHPR, HRSA: 301-443-6194.

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

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The AHEC Mission

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

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