A Collaborative Role for AHEC In Creating A Blended Learning Experience in Behavioral Health
Creating a Sound Mind and Body: 
The Role of AHEC in Creating a Diverse Behavioral Health Workforce

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NAO State of the Union

Jacqueline R. Wynn, MPH, NAO President; and Robert M. Trachtenberg, MS, NAO Chief Executive Officer

As in past years, we are speaking with one voice, your NAO Board President and Chief Executive Officer, to share our thoughts about the present and the future state of our national organization. The National AHEC Organization is stronger than ever and has had multiple successes this past year and key signs indicate that the future is shaping up to be even more successful.

Everything starts with an appropriately ambitious strategic plan, and the NAO board chair and the board of directors and I have been working diligently over the past year to identify those key strategic priorities which act as guideposts for organization growth in the coming years. The accomplishment of this single success over the past year will pay, I am certain, substantial dividends to NAO and our vast and varied AHEC network.

With a clear, sharp focus on enhanced organizational and governance effectiveness, the development of an increasingly sophisticated and coordinated national-scale advocacy system, the increase in capacity of our AHEC network to address local health care issues on a national scale via our new National Training Center, the expansion of an entrepreneurial spirit and a clearly articulated plan for expanding NAO staffing, we are positioned as never before to make transformative progress towards our crucially important mission of help our AHEC members achieve their vital mission through advocacy, education, and research.

Much of the recent past’s discussion has focused on articulating NAO’s ‘value proposition’, which can be defined as “a promise of value to be delivered and acknowledged and a belief from the customer that value will be delivered and experienced. A value proposition can apply to an entire organization, or parts thereof, or customer accounts, or products or services”. As we’re beginning to see with greater frequency, as articulately pointed out by NAO partner organization The George Washington University Cancer Institute, “a key strength of the AHEC network is its ability to creatively adapt national initiatives to help address local and regional healthcare issues”. Indeed, as NAO past-president Dr. John Blossom stated last year “we (AHECs) are arguably the nation’s best coordinated and distributed tool to reach rural, frontier, and inner city health providers”. There is no doubt that the NAO and the AHEC network’s value in this realm is just beginning to be revealed.

As we move steadily into such national-scale issues as population health and the social determinants of health while continuing to focus on our traditional health workforce activities, the use of our AHEC network to facilitate provider education and community health education will certainly increase, and therefore, will increase our aggregate value in the eyes of federal agencies, partner organizations and associations, and the United States Congress.

We expect the ‘new normal’ in the coming months and years will be that the full AHEC network will continue to do its historically excellent work in preparing a diverse health care workforce for the future while equally and simultaneously engaging in continuing provider education and community health education on a wide variety of salient health issues facing our population. AHECs have an unparalleled reach into underserved communities, indeed touching nearly 90% of US counties or county equivalents (such as parishes, etc.). Any national association is only as strong as its organizational membership, and clearly our AHECs are invested, engaged and active members; we wouldn’t have it any other way! Indeed, one of our greatest assets within NAO and the AHEC network that supports that investment is the strong and enduring culture and spirit of engagement among our AHECs in every part of the country. It’s just one of the attributes that makes us shine!

Please read through this edition of the Journal of the National AHEC Organization carefully. We’re sure you’ll find something to make your day.
A Collaborative Role for AHEC In Creating A Blended Learning Experience in Behavioral Health for Advanced Practice Professionals

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Abstract

Primary care providers, including advanced practice professionals, see large numbers of patients with behavioral health needs in their offices. Blended learning behavioral health curricula in shorter and longer formats offer flexible training to meet the educational needs of advanced practice professionals not gained in academic training programs. AHEC played a central role as both collaborator and educator in this project.

Introduction – Scope of the Problem

Nurse practitioners (NPs) and physician assistants (PAs) play a critical role in delivering health care to patients in the United States. Because one in five American adults suffer from a mental disorder in any given year, providers in primary care see large numbers of patients with behavioral health needs (Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council for Behavioral Health, 2013; Hamrin, Antenucci, & Magorno, 2012). One of the greatest needs in primary care practices is for medication management of psychotropic drugs and the associated laboratory follow up (Brown & Wissow, 2012; Olfson, Kroenke, Wang, & Blanco, 2014). Physician assistants and nurse practitioners can prescribe medications, order and analyze the necessary laboratory testing associated with medication management, and bill for these services. But in most cases, these PAs and NPs have had no regular forum for learning about behavioral health care evaluation and management. They often practice in communities with limited or no available psychiatric resources due to the shortage of practicing psychiatrists in underserved regions (Dewan, Meszaros, & Manring, 2014). Even greater is the shortage of behavioral health care professionals for pediatric and adolescent populations (Tolan & Dodge, 2005).

AHEC’s Problem-Based Solution

In early 2011, Southern Regional AHEC, based in Fayetteville, NC partnered with Duke University’s Department of Psychiatry to develop and implement a three year project funded by The Duke Endowment that would address the lack of behavioral health training for advanced practice professionals in primary care. The project’s aim was to deliver two levels of continuing education: an intensive program and a shorter academy, for both adult and child providers. The goals of the program were focused and targeted: 1) to enhance patient-centered psychiatric interview skills; 2) to improve skills in the diagnosis and treatment of specific psychiatric disorders and clinical presentations in adults; 3) to increase knowledge and application of appropriate treatment modalities in the care of patients with mental illness; and 4) to develop knowledge and skills regarding the legal, ethical, and policy aspects of mental health care in North Carolina.

The one-year, intensive program was offered for a pilot group of 14 PAs and NPs working in sites with large numbers of behavioral health patients. Participants initially attended an intensive three-day didactic training held on Duke’s campus. The focus of this initial training was on care of the adult with behavioral health/mental health conditions. Content was delivered by a cadre of expert psychiatric faculty and ranged from the psychiatric assessment and forming the differential diagnosis to medication prescribing and management. There was also content on motivational interviewing and forming the differential diagnosis to medication prescribing and management. There was also content on motivational interviewing and developing the treatment plan to include education for the patient and family. Participants returned to work and participated...
in monthly webinars and monthly case supervision calls with a psychiatrist to allow for deeper discussion of topic areas and discussion of difficult-to-manage patients. After six months, the participants returned to campus to engage in similar topics focused on the care of children and adolescents with behavioral health conditions. The use of webinars and case supervision calls were employed again and a supervising expert child psychiatrist provided close guidance. The entire program was accredited by Southern Regional AHEC and participants were awarded continuing education credits for their participation.

To supplement learning and engagement over the year, a website (http://www.sraheclearningcenter.org/elearning/) was created using a learning management system (Moodle platform). The website began as a warehouse of resources, including links to references, behavioral health assessment tools, posting of work assignments, and group discussions. The use of the site quickly expanded to include the posting of recorded monthly webinars for those who could not attend the live sessions. Participants were offered the opportunity to receive continuing education credit for these enduring material courses. The evaluation and post-assessment pieces were also added to the site so that outcomes data could be tracked and housed in a central location. Adjunct content, such as a webinar on billing psychiatric codes for mental health care, was added to the site.

In addition to the year-long program a shorter, one-day academy was offered. This continuing education program was intended for NPs and PAs with a need to gain similar skills and knowledge in managing behavioral health but who did not have the time to invest required by the intensive option. The academy was organized in six month blocks of participation. Each six month block began with a face-to-face, one-day continuing education forum followed by participation in the monthly webinars. There were two blocks of content offered over the year – one for adult and one for child content.

Project Outcomes or Lessons Learned?

Southern Regional AHEC provided a key role in the development of the learning structure, engagement of the participants over the course of the programs, and maintenance and management of the e-learning site, to include participant support and outcomes evaluation. Duke University provided the much-needed content expertise. The collaboration provided a solid training opportunity for professionals providing care across North Carolina. As stated above, the project had four goals focused on improving mid-level provider practice in the area of behavioral health. Four methods were used to assess outcomes: Level 1 – reaction or satisfaction post-activity survey; Level 2 – classroom competency via a pre-/post-test; Level 3 – application in the workplace measured via pre- and 30-day post comfort skill level self-reported assessment; and Level 4 – pre- and post-patient level data. For the shorter academies, a standard reaction survey included a question about application of content in the workplace.

Results of the project were extremely positive. One hundred and ten providers were trained across North Carolina (See Graph 1). Analysis of the data showed 96% of participants reported meeting project goals 1 and 2, while 92% reported meeting goal 3 and 89% reported meeting goal 4. Pre/post-tests (across cohorts) showed an average improvement or gain in knowledge of 30%. Overall, comfort level of skill increased by 15% (comfort level of skill across 14 indicators, such as “conducting a thorough mental status exam” on a Likert scale of 1 – 5 with 5 being “very comfortable”). Of those participants completing the courses, most reported improved communication with patients and families, and that they would modify their treatment plans based on course content.

Patient-level data was also measured before and after the educational intervention. The process for collecting data was chart abstraction as used in quality improvement work. Data was de-identified and aggregated at the practice level. A number of metrics were used including frequency of laboratory testing and weight assessment for patients on antipsychotic drugs, percentage of patients with labs within normal limits, and other quality metrics.

One of the greatest needs in primary care practices is for medication management of psychotropic drugs and the associated laboratory follow up. Even greater is the shortage of behavioral health care professionals for pediatric and adolescent populations.
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limits, and percentage of patients seen in a follow-up visit within 30 days of being newly prescribed an antipsychotic drug. These data proved difficult to measure, collect, and subsequently interpret. There were various reported difficulties in collecting data, including: some participants did not prescribe antipsychotics but only followed patients who were prescribed these medications; some participants changed employers over the year while enrolled in the project; some participants never prescribed medications as part their role; and life circumstances. While the data were difficult to interpret, some general conclusions can be drawn: most (near 90%) patients seen were not started on new antipsychotics by the advanced practice provider but rather by their supervising physician; most (near 99%) patients seen had weights obtained before and after the project (no change); most (near 90%) of patients were scheduled for three month follow-up visits before and after the project (no change); many (near 50%) of patients’ fasting glucose was followed before and after the project; fewer (near 50%) patients were ordered fasting lipid panels before and after the project (no change); and there were a significant number of missed follow-up appointments in this patient population. We were unable to assess whether there was a significant increase in ordered labs because of limited post project data as listed above. Although it was difficult to interpret changes in patient outcomes for this project, we can say there was enough other evidence to support that changes in provider practice resulted from this educational intervention.

Unexpected Results Lead to Changes in Processes

There were also four sustainable process outcomes as a result of the project. The use of the blended learning model provided a dynamic format for the behavioral health content. The model was originally developed and implemented to warehouse a large volume of behavioral health resources and for the providers to have access to these resources between face-to-face sessions. But the use of the site expanded during the project to also be a means for posting recorded webinars that the providers missed due to clinic schedules. Providers could view the webinars and take a post-test and earn CME credit in place of attending the live webinar. This blended learning model is now being used to teach cognitive behavioral therapy in a statewide initiative.

The use of the e-learning site allowed us to test the use of enduring materials. For instance, would providers take the time to access the missed material and earn CME credit? Many providers found this offering very useful with their clinic schedules and did take advantage of the format. This type of learning was effective and we have now expanded the original site to include additional courses (on a variety of topics) recorded and posted in this way to provide on-demand access for providers who need content and CME.

Recruitment of participants using the ordinary marketing strategy of direct e-mailing brochures did not work for this program. There are many reasons why the basic strategy might not have been an effective approach: the program was complex and needed some explanation; it was important to hear feedback from those interested; many people needed to talk through a decision to commit and invest in a year long program to determine their return on investment. Marketing approaches had to change early during the project in order to be able to recruit the proposed participation goal. Non-traditional marketing approaches evolved each year as recruitment geared up for another group. Word of mouth from former participants was a useful tool. Reaching out through phone calls to organizations in need of this training proved useful. Targeting the rural health centers through statewide networks helped us reach rural counties by year three. Because of the changes in marketing strategies for this project, we now have regular meetings with our marketing department to identify programs that will need specialized marketing strategies and to develop a marketing plan geared specifically toward each the goals of the program.
Creative financial options were needed to help facilitate enrollment into the courses. Brainstorming various options that would attract providers with decreased financial resources was necessary. Options such as payment plans and scholarships were used to attract participants who otherwise would not have been able to attend the courses. These creative financial options continue to be used for other programs for which cost is a barrier.

Conclusions
Real collaboration takes effort and a lot of communication. The success of the behavioral health initiative is no exception. Working with our academic partner required the investment of time and additional resources beyond the grant in order to keep the implementation team focused and single-minded over the three years. Equally important was keeping participants enrolled in the one year course motivated and engaged. Southern Regional AHEC played a central role as both collaborator and educator in this project. Once again, AHEC helped to bring the resources of academic medicine to the community and address very real needs in behavioral health. Southern Regional AHEC was able to respond in flexible and creative ways to address the issues and remained flexible throughout the life of the grant by responding to ongoing participant feedback and implementation challenges. While maintaining the integrity of the grant, the changes implemented throughout the grant cycle only helped to enhance the original vision and produce some sustainable resources for future providers. The work of training primary care advanced practice professionals in behavioral health is still ongoing, and Southern Regional AHEC has established a role in this training due to the groundwork this grant helped to lay in the state.

REFERENCES


Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council for Behavioral Health (2013) Mental Health First Aid, Revised First Edition.


Partnership Benefits Rural Veterans: Trainings Help to Build Understanding of Issues Facing Veterans in Pacific Northwest Rural Communities

Amy Dunkak, Interim Deputy Director of the Oregon Area Health Education Center, and Nico Patel, Senior Project Associate of the Area Health Education Center of Eastern Washington

Over five million veterans live in rural communities nationwide. These veterans have higher rates of suicide and mental illness, and sometimes struggle to access the basic care they need. The Veterans Health Administration Office of Rural Health (VHA ORH) is tasked with improving care for rural veterans in remote areas. In an effort to address the needs of these veterans, the VHA ORH-Western Region partnered with select Area Health Education Centers (AHECs) in Alaska, Oregon, and Washington in 2014 to produce a series of educational events. The goal was to provide healthcare professionals and community advocates the tools and knowledge needed to better serve their local rural veterans. The VHA ORH and AHECs worked together to develop the “Healing Our Heroes: Competencies for Healthcare Providers and Community Advocates” brand as well as standardized training formats, supplies and tools. Experts on military culture, posttraumatic stress disorder (PTSD), suicide prevention, and the VA Healthcare System were brought together to train civilian providers and advocates to more adequately meet the needs of veterans. As a result, seven successful trainings on Veterans Mental Health took place throughout the Northwest region, showing that when organizations such as the VHA ORH and AHECs work together they can have a meaningful impact on creating an effective system of care in rural communities by training civilian health professionals to recognize and respond to veteran specific needs.

Over 300 people attended the Healing Our Heroes trainings in three states. The events brought together community volunteers, nurses, public health officials, higher education staff and students, primary care and behavioral health providers, long-term care professionals, and others who provide care and services to veterans. Most had little knowledge of the health and life challenges that veterans face, but have seen an increase in the number of veterans they work with in recent years. The events helped to stress the importance of identifying veterans in order to effectively treat veteran related health concerns. As one attendee stated, “I now know why asking, ‘Are you a veteran?’ is so very important.” The VHA estimates that over one million veterans in Alaska, Oregon, and Washington with a significant portion of these in rural communities are without easy access to health services. In addition, rural veterans also have higher rates of physical comorbidities than their urban counterparts. The Healing Our Heroes trainings provided tools for community members to use to care for veterans long after they have traded in their uniforms.

Healing Our Heroes’ Military Culture and Navigating the VA Healthcare System sessions highlighted the complex health problems and reintegration struggles of returning veterans in finding employment, readjusting to home and family, and returning to school. The trainings outlined how the needs of veterans differ from those of the general population. With limited access to VHA services or resistance within the veteran community to treatment in the VHA, many veterans seek care in the civilian healthcare system. Partnerships between organizations like the VA ORH and the Area Health Education Centers are vital in connecting more veterans to civilian providers with the appropriate knowledge to better serve the veteran population and their families. Healing Our Heroes is a model for connecting civilian service providers and...
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advocates to the resources and programs available to better serve veterans.

The Veteran’s Mental Health segments on PTSD and suicidal behavior provided attendees with valuable information and connections to help identify and aid veterans with these conditions. One attendee stated, “I will be able to give vets more referral resources and better understand my spouse’s behaviors with PTSD.” In fact, those who attended a Healing Our Heroes event overwhelmingly stated they had met the objectives of the training including the ability to define military issues and their effects, understanding military culture, navigating the VA system, understanding the signs of PTSD and treatments for it, gaining knowledge of community resources for veterans, and understanding suicide risk in the veteran population. During round table workgroups attendees identified other salient topics that require additional training including: 1) Women’s Veterans Health, 2) Military Sexual Trauma and 3) Aging Vietnam Veteran Populations Entering Geriatric and Long-term Care Organizations. Attendees stressed the value they found in these trainings and asked for more events that address veterans’ health issues in the private healthcare sector.

The 2014 Healing Our Heroes pilot project laid an important foundation that the VA ORH can build on to save time, improve care, and reduce expenses associated with serving the rural veteran population. Area Health Education Centers are uniquely positioned to help fulfill the VHA ORH’s goals because of their long standing relationships with health care advocates in rural communities and their experience providing quality continuing education and training. As evidenced by the words of one event attendee, “Great presentations! This meeting has increased my knowledge relative to communicating and interacting with people who have served in the military.” Because of the Area Health Education Centers’ historical role in advocating for rural health and the strong level of coordination between AHECs in the Pacific Northwest, the partnership between the VA ORH and AHECs of Alaska, Oregon, and Washington was a great success. In the past, AHECs across America had worked to highlight veterans’ mental health needs as part of the A-TrACC Veteran Mental Health Project, but had limited support and collaboration with the VHA. The AHECs strong commitment to rural health and previous experience with Veterans Mental Health make them an ideal partner to continue working with the VHA ORH if provided the opportunity. As the AHECs move forward into a new year, they continue to search for and seize upon opportunities to support underserved and at-risk populations throughout the communities they serve. The Healing Our Heroes events serve as exceptional example of how working together with those who have a similar mission can strengthen outcomes and have a greater impact on community health.

Special thanks to Amy Dunkak, Interim Deputy Director of the Oregon Area Health Education Center, and Nico Patel, Senior Project Associate of the Area Health Education Center of Eastern Washington, for their contributions to the writing of this article.
Behavioral Health Symposium Positively Impacts Northeastern Kentucky

Nicole Winkleman

Nearly a quarter of a million adults and children in Kentucky live with a serious mental illness, and those with mental illness are at increased risk for heart disease, diabetes, and other chronic illness. An estimated 8.9 million U.S. adults have co-occurring mental illness and substance abuse disorders, and suicide is almost always the result of untreated or undertreated mental illness. These are just some of the reasons integrated health care is so important, and in 2014 Kentucky took steps to promote and improve integrated behavioral health services by adding primary care to the list of services to be provided by community mental health centers, as well as making these services Medicaid-reimbursable at the same rate set for primary care centers.

The inaugural Kentucky Rural Behavioral Health Symposium (KRBHS), presented in October 2014 by the Northeast Kentucky Area Health Education Center (NE KY AHEC), was designed to help train a variety of providers and prepare them for an integrated health care model – and may have long-lasting effects on behavioral health for the state. One example of this is a grant developed by Dr. William Elder, professor of family and community medicine at the University of Kentucky, and Carlton Craig, faculty in the UK College of Social Work. The funding application to the Health Resources and Services Administration aims to improve access to behavioral health services for children, adolescents, and transitional-age populations by increasing the number of well-prepared behavioral health social workers.

“[I] collected much information we are applying as we develop our HRSA grant to train social work students in integrated behavioral health care,” said Dr. Elder, an attendee of the symposium. The information he gleaned from the symposium included trends in behavioral health needs, as well as making connections with people interested in, and informed on, the needs for rural behavioral health care.

The KRBHS was a full-day symposium organized into five different workshops. Participants could choose between two or three different topics for each workshop, and each activity lasted approximately one hour. Topics included self-injurious behaviors, adolescent substance abuse, recognizing addiction, post-partum depression, critical issues with today’s veterans, trauma-informed care, and changes within the behavioral health services of Kentucky. During lunch, the symposium featured keynote speaker Dr. Kay Matlock, program development officer for Stone Mountain Health Services in rural southwest Virginia, who presented, “Integrated Behavioral Health in Rural Areas.” Her session highlighted the integrated behavioral health care model and its positive impact on patient outcomes.

Dr. Sondos Al Sad, then a family medicine resident at St. Claire Regional Medical Center in Morehead, Ky., said she appreciated the session on depression and navigating anti-depressants with multiple comorbidities. “I am [now] more inclined to look up side effects of anti-depressants before prescribing any,” she said. Dr. Giogios Bidales, who also was a family medicine resident at St. Claire Regional Medical Center, said the symposium helped improve his comprehension of the local patient population and better understand the issues affecting that population.

The NE KY AHEC serves a 17-county area in northeastern Kentucky. The region is largely rural and suffers from of lack of medical providers, especially in the area of behavioral health. Fifteen of the NE KY AHEC’s counties have been identified as health professional shortage areas in mental health by the U.S. Department of Health and Human Services. Due to this shortage, the NE KY AHEC partnered with other regional health care organizations to educate providers on rural behavioral health issues. Co-sponsors of the symposium included the Kentucky Office of Rural Health; Our Lady of Bellefonte Hospital, located in Ashland, Ky.; Pathways, Inc.; the Rowan County UNITE (Unlawful Narcotics Investigations, Treatment, and Education) Coalition; and St. Claire Regional Medical Center’s Behavioral Health Services.

The symposium attracted nearly 60 attendees and received positive reviews from most participants. Many liked the variety of topics the symposium offered and its focus on dealing with special populations such as veterans and adolescents. “I really liked this day. I learned more than I expected,” said Sister Judine Lambert, assistant director of mission integration and chaplain at St. Claire Regional Medical Center. “There
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was so much the chaplains and I learned that we can use to improve our practice of pastoral care. This ranged from broadening our understanding of trauma and how it may impact one’s spiritual grounding, to helping us think about the role of chaplaincy service in the medical home.” Other attendees expressed an interest in learning about behavioral health issues in dealing with young children and geriatric patients. This information will help guide future behavioral health offerings from the NE KY AHEC.

The NE KY AHEC followed up with participants three months after the symposium to see if their practice had been affected by their participation in the symposium. Attendees said the symposium made them more aware of issues and trends in behavioral health and helped them focus on areas that needed improvement in services offered. It also helped better evaluate their care practices.

Initial feedback suggests the Kentucky Rural Behavioral Health Symposium has had a positive impact on the behavioral health services and providers in the northeast Kentucky region. Providers are better educated, with a greater understanding of current issues, challenges, and trends and many have changed or plan to change their practice as a direct result of information they gained at the symposium.

“In the ever-changing world of health care, the Northeast Kentucky Area Health Education Center is dedicated to keeping our region’s providers up-to-date and informed,” said KaSandra Hensley, education coordinator for the NE KY AHEC, which is now planning the 2nd Kentucky Rural Behavioral Health Symposium, set for Oct. 21, 2015.

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REFERENCES


AHECs and VA Medical Centers Partner to Improve the Mental Health of Veterans and their Families

Cynthia Selleck, PhD, RN, FAAN, Art Clawson, EdS, Regina Knox, MPH, CHES, Martha Davis Vignes, MA, Nathan Crowell, LCSW, ACSW, PIP & Joy Germanos, LCSV, PIP

Meeting the mental health needs of Veterans and their families has become increasingly important in recent years as more is known about the distinct challenges they face. In a 2012 report released by the National Council for Behavioral Health, it was estimated that of the 2.4 million active duty and reservists deployed to Iraq and Afghanistan since 2001, almost 30 percent will have a mental health condition. More than 18 percent will suffer from post-traumatic stress disorder (PTSD), major depression, or a combination of both. Yet less than half of returning Veterans needing mental health services receive any treatment and even fewer receive evidence-based care (National Council for Behavioral Health, 2012). Once deployments end, adjustment to non-combat life present a significant challenge to many and while the Veterans Health Administration (VHA) offers a variety of health and mental health services, most Veterans are seen by community providers who are not knowledgeable about military culture and the challenges faced by returning service members.

Since 2009, the National AHEC Organization, AHEC program offices, and regional centers have been active educating community health professionals on the importance of identifying Veterans, service members, and their families and providing care for their unique needs. The Health Resources and Services Administration-supported AHEC Training and Consultation Center (A-TrACC) developed trainings that are used by AHECs to impact delivery of health care services in the civilian sector for Veterans, service members, and their families coping with post-deployment mental and behavioral health and substance abuse issues. AHEC staff members across the nation have educated more than 13,000 health care professionals on military culture; signs and symptoms of PTSD and traumatic brain injury, among other conditions; and resources available to Veterans, service members, and their families (A-TrACC, 2012).

Recognizing that the majority of Veterans seek health care outside of Veterans Affairs (VA) facilities, in 2013 the VHA charged each VA medical center with hosting a community mental health summit to help build and sustain collaborative efforts with community partners and enhance mental health and well-being for Veterans and their families (Department of Veterans Affairs, 2014; Veterans Health Administration, 2014). A total of 152 VA facilities conducted summits during 2013 with more than 12,000 participants, 60 percent of whom were community-based, non-VA personnel. In March 2014, the VHA again required each VA medical center to conduct a community mental health summit before Sept. 15, 2014, and every year thereafter (Department of Veterans Affairs, 2014). A Community Mental Health Summits Facility Implementation Toolkit was developed and provided to VA facilities with lessons learned from the 2013 summits. Each VA facility was tasked to develop the specific purpose and objectives of their 2014 summit, based on community needs and resources (Veterans Health Administration, 2014).

Alabama has large numbers of Veterans, as well as current active duty service members and reservists. The state ranks as the third-highest in the nation in the number of persons deployed to Iraq and Afghanistan, including active duty and reservists from every county of the state (Alabama Executive Order, 2013; Citizen...
AHECs and VA Medical Centers Partner to Improve the Mental Health of Veterans and their Families

Soldier Support Program, 2012). With three VA medical centers in the state and 13 community-based outpatient clinics, community health care providers need training about military culture and Veterans’ health.

The Alabama Statewide AHEC Program, a new infrastructure development program, has focused on Veterans’ health since hosting a statewide conference titled “Painting a Moving Train: Working with Veterans of Iraq and Afghanistan and their Families” in February 2013. This was followed by a number of local and regional trainings. Alabama AHEC was tapped for participation in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2013 Service Members, Veterans and their Families Policy Academy and for membership in the Alabama Executive Veterans Network (AlaVetNet). Alabama Governor, Robert Bentley signed an Executive Order in December 2013 establishing AlaVetNet for the purpose of developing a unified, seamless, and systematic method of accessing services for Alabama’s Veterans in education, employment, health, homelessness, legal assistance, and family services (Alabama Executive Order, 2013; Alabama Executive Veterans Network, 2013; Alabama Executive Veterans Network (AlaVetNet).)

The Alabama AHEC was positioned to collaborate with the state’s VA medical centers on their 2014 community mental health summits and became an active partner and co-sponsor of all three summits held in different regions of the state. Planning for each summit began in April 2013 with AHEC program office and regional center staff members helping convene summits in Birmingham, Opelika, and Tuscaloosa. Each summit was required to have sessions on family issues, military culture, and use of the National Resource Directory (www.ebenefits.va.gov/ebenefits/nrd). The role of AHEC differed slightly from summit to summit; however, in all areas it consisted of an active role on the planning committee; identifying and supporting speakers; identifying sponsors; promoting the summit to community providers and students; provision of continuing education credit; providing supplies; and duplicating materials. AHEC registered participants for two of the summits and provided the speaker for the required session on military cultural competence for all three summits. The University of Alabama at Birmingham School of Nursing also partnered with the Birmingham VA Medical Center and, together with AHEC, supported Linda Schwartz, DrPH, MSN, RN, USAF (Ret.) as the keynote speaker for the Birmingham summit. Formerly the commissioner for the Connecticut Department of Veterans Affairs, Schwartz was confirmed as the assistant secretary of Veterans Affairs for Policy and Planning in September 2014; her presentation was titled Identifying and Supporting Veterans through the Campaign: “Have You Ever Served?” The American Academy of Nursing launched the “Have You Ever Served?” campaign in 2013 and Schwartz served in a key role in development and deployment of this initiative, endorsed by the National Association of State Directors of Veteran Affairs (American Academy of Nursing, 2014).

The Alabama AHEC produced and disseminated a Veteran’s Health Toolkit for Community Providers, contents of which were compiled by former North Carolina AHEC staff member, Sheryl Pacelli. Each participant received a copy of the toolkit, which included a number of printed resources helpful to primary care and mental & behavioral health providers who work in non-VA facilities—who are likely to see Veterans and their families. Information on military culture; tips for serving Veterans, service members, and their families; assessment instruments; and the Military Health History Pocket Guide for Clinicians produced by the VA Office of Academic Affiliations were included. A CD-ROM with additional resources was also enclosed.

Approximately 400 individuals participated in the three Alabama community mental health summits during August 2014, including physicians, nurses, and mental and behavioral health specialists, as well as students and faculty from a variety of health professions programs. Veteran-serving organizations were well represented and a number of Veterans and their family members also attended. VA medical center staff, representing different program initiatives, also participated in each summit.

The Veteran population in the United States has grown to more than 21.3 million (National Center for Veteran Analysis and Statistics, 2014). Meeting the mental health needs of these Veterans and their families is a high priority for the Department of Veterans Affairs. As partners in the VA's annual community mental health summits, AHECs bring their interest in Veterans’ mental health and their strengths in community collaboration and program planning to the expertise of the VA in managing the mental health needs of Veterans. Based on the results of the 2014 community mental health summits in Alabama, the partnership of VA and AHEC served to improve the mental health needs of Veterans and their families.
AHECs and VA Medical Centers Partner to Improve the Mental Health of Veterans and their Families

REFERENCES

Alabama Executive Order Number 42, signed by Robert Bentley, Governor, December 10, 2013.


Department of Veterans Affairs, Memorandum from Assistant Deputy Under Secretary for Health for Clinical Operations, to Network Directors, Subj: Community Mental Health Summits (March 24, 2014).


Integrated Care and the AHEC Mission

Matt Martin, Deborah Teasley, and Deepu George

A nurse paged Deepu George, a behavioral health consultant and an author of this paper, for a consultation. The patient waiting in exam room 6 was “extremely worked up, freaking out about the camera in the room, and experiencing hot flashes.” Dr. Lase (all names, besides George’s, have been changed), a second-year family medicine resident, wanted a behavioral health consultant (BHC) to see the patient first.

After taking care of the camera in the room, George introduced himself as a member of the medical team to Cassidy and Isabel. Cassidy, the patient, was a young woman who appeared sweaty, nervous, defensive, and not very happy to be there. She sat on the exam table while Isabel, her partner’s mother, sat in a chair. Cassidy provided quick, one-word answers to all of George’s questions. She had experienced anxiety for several days but struggled to explain what was happening. Isabel said Cassidy needed to learn how to calm down. Cassidy stated firmly that, “I don’t like coming to the doctors. I am sweating real bad and having hot flashes. And I don’t like male doctors.”

After the initial encounter, George shared his assessment with Dr. Lase. Although the patient had both an individual and family history of psychiatric illness, George felt Cassidy was engaged and cooperative in her medical care. While Dr. Lase was still concerned, he and George went back into the room together for the medical visit. Dr. Lase listened to Cassidy’s physical complaints and responded appropriately to each one. He asked her if she had thoughts of hurting herself or others. She responded by saying, “Well, if someone pisses me off, I want to chop them up.” Dr. Lase was very concerned with this response. He asked if she felt safe or wanted to go to the hospital. Cassidy did not seem to understand the question. He informed her that he would step outside to talk with George about a plan.

Outside the exam room, Dr. Lase raised his concerns about the immediate danger of the patient and suggested involuntary commitment to a psychiatric facility. George was surprised by this recommendation and was afraid that an involuntary hospital admission would destroy the trust between Cassidy and the medical team. Dr. Lase shared his belief that the patient was not in a condition to return home and that her behavior could put his medical license in jeopardy. George assured him that Cassidy was safe and that Isabel planned to take her home. Since they could not agree on a plan, they decided to involve the residency program director, Dr. Rossman. Dr. Lase and George explained the situation to him and Dr. Rossman decided to meet Cassidy. After the meeting, Cassidy seemed less anxious. Dr. Rossman recommended that Cassidy be medicated for her condition and scheduled to return in two or three days. George offered to provide case management until she returned. The team agreed that Cassidy did not need hospitalization and that she would be closely monitored by the entire team.

This clinical example is not meant to be a case study in patient risk assessment and intervention, but rather an example of the collaboration and learning that can occur in a medical residency program that practices integrated care. Interdisciplinary collaboration is a sometimes challenging and stressful endeavor but it can enhance medical education and patient care. In this paper we will describe the effort to integrate multiple disciplines into our family medicine residency program and clinic, the match between integrated care and the area health education center (AHEC) mission, the creation of a block rotation that trains residents to work with other disciplines, and the lessons we have learned along the way.

History of integrated care at Southern Regional AHEC

Southern Regional AHEC’s (Fayetteville, NC) first attempt to integrate mental health services into primary care was in 2002. There was a large gap in availability of mental health providers throughout the region. Primary care providers reported large numbers of patients in their practices that needed treatment for depression. However, there were few resources for treatment referral and those that were available had long wait times.

Southern Regional AHEC received a two-year grant from the Kate B. Reynolds Charitable Trust to support hiring a full-time licensed clinical social worker (LCSW). Her role was to work at Southern Regional AHEC’s Family Medicine Center and four other primary care sites throughout our nine-county region. She was at each primary care practice one day a week. Each participating primary care practice agreed to screen patients for depression and schedule patients needing further follow up with the LCSW on the day she was at that practice site. The LCSW provided a combination of individual and group appointments and used cognitive-behavioral therapy as the treatment approach.
Integrated Care and the AHEC Mission

We learned from this project those things that did work and those that did not.

Restricting patients receiving mental health services to a single diagnosis. Although there initially was a great need for depression treatment, once the patients in a practice received treatment and were stable there were not enough new patients joining the practice to sustain a therapist one full day a week. Initially, the decision was made to limit the services to depression treatment since it was the most prevalent need in the practices and the LCSW would only be available one day a week at each site.

Financing the care.

There were difficulties billing the depression treatment. In some instances, mental health services were not eligible for payment if provided under a primary care physician rather than a psychiatrist. Many private insurance companies had a closed provider panel and would not authorize care outside that panel. If the care was authorized, the co-pay for “specialist” care was higher than for primary care and was beyond what many patients could afford to pay. Many of these same restrictions continue to exist today.

What did not work

What did work

Screening all patients for depression. Staff in the practices initially expressed concern about adding patient screening to an already busy workload. The approach used was each patient at check-in received three written questions to check “yes” or “no”. If they responded yes to at least two questions they were given a Zung depression screening tool to complete. This took less than five minutes for most patients to complete. After the initial three months of using this screening, all participating sites agreed that it was not time prohibitive and that “it worked.” Depressed patients were identified by staff without patients stating they were depressed.

Having a mental health provider on site. All of the practices agreed that having a mental health provider on site in their practice benefitted them and their patients, even if it was only for one day a week.

When the depression care grant ended, Southern Regional AHEC was one of the initial participants in the statewide North Carolina ICARE project. This project’s goal was to create a health care system that is Integrated, Collaborative, Accessible, Respectful and Evidence-based. The project created a resource for assessment, training, and technical assistance to health care professionals and organizations, ultimately becoming The NC Center of Excellence for Integrated Care.

In 2010, the decision was made to recruit a full-time PhD therapist trained in medical family therapy to join the family medicine residency faculty. This faculty member was charged with revising the family medicine residency curriculum to reflect integrated care practice.

Integrated care and the AHEC mission

Integrating behavioral health providers into primary care practices fits perfectly with 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.” Mental health problems affect all age groups and millions of people in the U.S. each year (Collins, Hewson, Munger, & Wade, 2010; Reeves et al., 2011). Many of these conditions are manifested in nonspecific physical symptoms and it is often difficult for physicians to properly diagnose mental health issues because symptoms appear to be only somatic and not psychosocial (Ruddy & McDaniel, 2005). The first place persons with these symptoms are usually seen is the primary care practice (Gunn & Blount, 2009; Institute of Medicine, 1996; Katon, 1995). The ability to access care in a familiar, supportive environment is the ultimate goal for primary care. This eliminates the need for patients to travel to access specialized mental health services that are in short supply in virtually all but the most metropolitan areas.

Mental illness still carries stigma in our society. Receiving care for all aspects of health in a site where patients can be supported, educated, and treated will go a long way to helping people be more receptive to receiving mental health care and will ultimately reduce the stigma of mental illness in general. Moreover, this model of enhanced patient care also creates a unique learning experience for medical residents and students.

Integrated care at multiple levels

Our integrated care model is inherently a systemic enhancement of educational and patient care responsibilities. Medical and pharmacy residents and students who work in the clinic collaborate with behavioral health consultants and consequently develop an understanding of the values, roles, and responsibilities held by behavioral health personnel. Behavioral health services are available to all of our patients and their families and represent a concerted effort to address the biopsychosocial needs of patients and their families.
Integrated Care and the AHEC Mission

Enhancing medical education

There is a growing interest to educate professionals from various disciplines to work together for the benefit of patients and their families (IECEP, 2011). Moreover, there are multiple ways to provide this training including workshops, seminars, training modules, webinars, books, and articles. We chose to create a three-year, progressive block rotation for the purpose of preparing family medicine residents to work in integrated care settings and to practice interdisciplinary collaboration.

There are two main goals for this rotation. First, residents will gain knowledge and skills in integrated care. Second, residents will recognize and appreciate the role of other disciplines in the community. During orientation, all first-year residents spend half a day with the behavioral health team learning about the integrated care model. This provides residents with a basic understanding of how to initiate behavioral health consultations. Throughout the rotation, residents complete a required number of consultations with both behavioral health and pharmacy providers. Residents learn about the value of introducing patients to behavioral health consultants as part of the referral process for psychotherapy and of asking pharmacy consultants to review and explain medications to patients. They also learn about which patients will benefit most from a consultation and which strategies are most effective in communicating patient needs (e.g., face-to-face conversation, electronic medical record message system, pager, or phone call).

Residents also spend time observing behavioral health consultants doing psychotherapy and consultations. By inviting them into the therapy room, residents learn about the treatment process and can thus effectively explain psychotherapy to patients. An end goal for this rotation is that residents will have the confidence and competence to work in a multidisciplinary system that requires constant, effective communication across professionals and patients of various backgrounds. We also expect that residents will have the skills to address behavioral health needs when they do not have access to integrated behavioral health services.

Enhancing patient care

In addition to enhancing our medical residency education, our integrated care model also helps us address a wide variety of patient behavioral health needs. Integrated behavioral health services have been shown to be more effective than traditional care in treating anxiety and depression and in increasing patient satisfaction (Archer et al., 2012). Behavioral health consultants can help patients with medical treatment adherence, chronic disease management, substance use disorders, relationship conflict, patient-physician relationship issues, and health behavior change. These are issues that many physicians do not have the time or skill to address but that are important for increasing the success of medical treatment and improving patient quality of life. We work to increase the self-efficacy, engagement, and relationships of our patients, including the relationship between patient and physician.

Integrated behavioral health services have been available in our current model for the last three years. Our clinical data reports show that there is a steady demand for the service and that all providers are referring patients for treatment. A fully integrated system requires a shared vision of patient care, meaning that the medical and behavioral health staff members share a biopsychosocial view of patients and a commitment to working together. To reach this shared vision, behavioral health consultants are placed in offices that are close to the patient examination rooms and also spend time in the precepting office where residents present patient cases to faculty supervisors. The idiom “out of sight, out of mind” is an accurate description of what happens when behavioral health consultants do not make themselves available to patients and physicians. The success of our model is based on the trust that continues to grow between the behavioral health staff members and the nurses and physicians. This trust exists because the behavioral health consultants respect and appreciate the opportunity that has been given to them to work alongside the nurses and physicians.

Lessons learned

Practice what you preach

Integrated care is not a single policy, protocol, or procedure. It is a cultural and paradigm shift in expectations toward education and patient care. Such a change requires trust, time, and careful attention to the needs of the organization as a whole and individually. We have learned that an integrated care practice is best developed with all stakeholders at the table. In other words, our success has been dependent on the collective effort of operational, financial, and clinical personnel within the organization. For example, the electronic health record manager has helped develop digital behavioral health forms that have been critical for documenting and communicating behavioral health assessment and treatment plans. The billing and coding staff have been instrumental in creating a list of billing codes for behavioral health services. The administrative assistants have helped with the arduous process of insurance paneling and credentialing. The
Integrated Care and the AHEC Mission

nursing personnel have been influential in making sure that all new patients receive a screening for depression. Collaboration is the key to developing an interdisciplinary integrated care service. Just as the physicians rely on behavioral health consultants for their expertise on patient care, the behavioral health consultants rely on the operational, financial, and clinical experts within the organization.

Proof is in the pudding

Program evaluation is important for measuring the success of any organizational change. We are currently collecting quantitative and qualitative data on the impact of the integrated care block rotation on the beliefs and attitudes of medical residents. Preliminary quantitative data suggest the integrated care rotation has a positive impact on residents’ beliefs about psychosocial health and the physician’s role in integrated care; however, there seems to be no change in beliefs regarding collaboration and behavioral health consultants as a result of the rotation.

One second-year resident, in response to a question about how he defines behavioral health, said, “You could potentially apply it to anything and everything. It’s not just the psychological stuff. If you would have asked me [about behavioral health] back in medical school, I would have said it was just the psychological stuff. But now after working with you all, I’ve found how helpful it is when dealing with smoking cessation, obesity, and other stuff. You guys do a lot more than just the depression and anxiety stuff.”

Our clinical data reports show that behavioral health personnel (2.5 FTE), on average, generate nearly 150 patient encounters per month, which includes consultations and psychotherapy. More than 70% of referrals come from residents and more than 100 referrals for behavioral health services are generated each month. Based on the data thus far, we feel confident that our integrated care model is a success.

Pipers need payment

One of the biggest challenges to maintaining an integrated care service is reimbursement. Many insurance panels are closed to new mental health providers and the credentialing process for open panels is long and grueling. Our integrated care service was started by a modest two-year grant; however, long delays in licensing and credentialing seriously hampered our ability to provide behavioral health services. Most of the patients who receive behavioral health services have government insurance because those networks have been the easiest to join. We recommend that other practices looking to establish integrated care make sure that they are financially and emotionally ready for the long process of credentialing and that they work closely with billing and coding staff members.

Conclusion

The purpose of integrating behavioral health services into a primary care setting is to enhance the quality of primary and preventive care available to the general population. This is a perfect match with the AHEC mission. Concordantly, another purpose of our integrated care model is to prepare resident physicians to provide a high level of care to patients and to effectively work with professionals from other disciplines. Implementing and sustaining such a model takes a valiant effort from many people. We believe the outcome of such an endeavor is worth every bit of effort.

REFERENCES


Call for Articles
“Promoting Population Health: AHECs leadership in developing community-responsive primary care providers”

For more than four decades, AHECs have established strong partnerships that address systemic issues from healthcare access to diversity in the health care workforce. AHECs have also educated and trained communities in health & wellness and fostered and promoted trainings that facilitate the use of proven, evidence-based interventions. However, for past several years, our focus has been enriched by relevant research and directed by the transformation of national health care landscape through the passing of the Affordable Care Act (ACA). As a result, the next edition will address issues related to Training Health Professions Students to address population health.

The Editorial Board is looking for articles that address five important topics:

1. AHECs response in creating Interprofessional Education & Practice opportunities to cultivate community-responsive primary care providers

2. AHECs role in training community-responsive primary care providers that link clinical and community-based preventive services to address social determinates of health

3. AHECs unique and innovative models in the development of community based primary care and residency education in Rural and Urban Underserved communities

4. AHECs development of IPE education models, including continuing education, short and long-term training models and other unique and innovative approaches to IPE

5. Barriers facing AHECs and solutions AHECs have developed to address community based training programs. Including recruitment of and incentivizing of preceptors, new medical school development, health care system reform and other challenges

Please submit drafts, photos and accompanying materials to editor@NationalAHEC.org.


Submission Cover Sheet must be included with the article www.NationalAHEC.org/documents/SUBMISSION%20COVER%20SHEET%202010.pdf

We welcome you submission for the next edition. Please have articles submitted to: Paul Rossmann at editor@nationalahec.org by February 29, 2016.
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### National Training Center

**CDC HPV Immunization Project:**  
- Gretchen Forsell  
- Trisha Schulz

**National Library of Medicine-Center for Public Service Communications Teen Health Information Literacy Project:**  
- Rachel Chase

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The National AHEC Organization Mission

The National AHEC Organization represents a network of more than 300 AHEC program offices and centers that serve over 85% of United States counties. The NAO mission is to help its members achieve the AHEC mission through advocacy, education, and research.

The AHEC Mission

The AHEC mission is to enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of healthcare professionals via strategic partnerships with academic programs, communities, and professional organizations.

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