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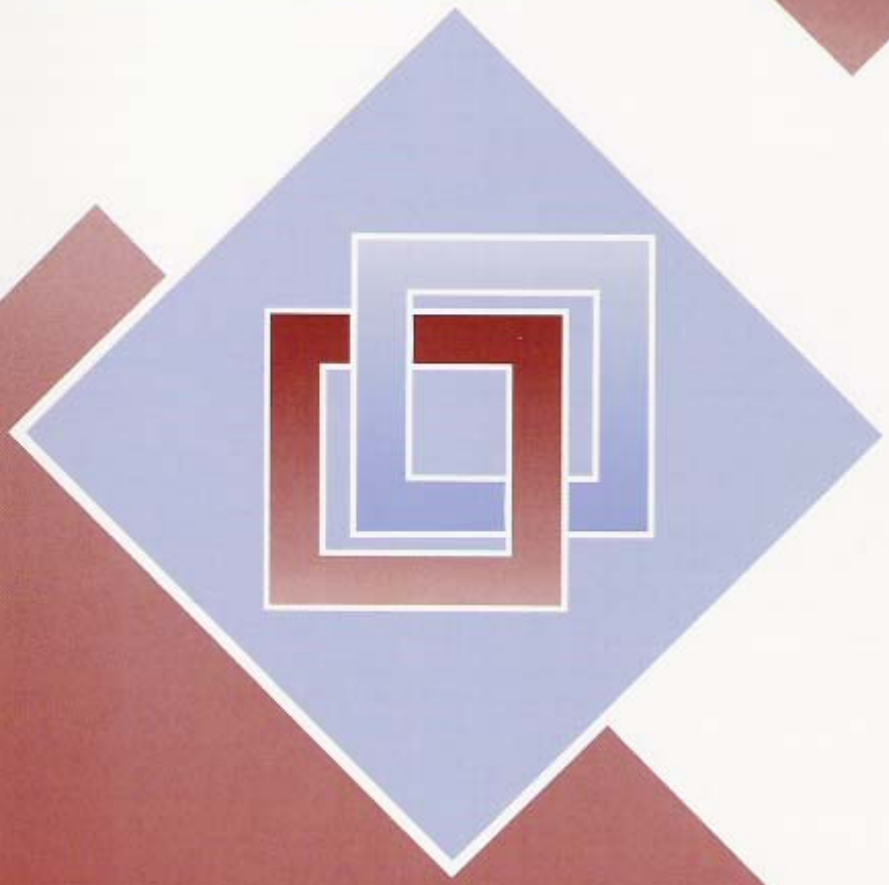

Sustaining the AHEC Mission

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The National Area Health Education Centers Bulletin

The Future of AHECs in the Bureau of Health Professions

By Vincent C. Rogers, DDS, MPH
Associate Administrator, Bureau of Health Professions

Sustainability is defined as "to keep in existence." It has the connotation of a continuation of effort or activity, without interruption, diminution or elimination. As such, sustainability is one of the most important aspects of federal programs, especially those performing important services concerning the health care of the citizens of the nation. As we at HRSA look to the future, it is paramount to think about this issue of sustainability and how it can be attained. Federal programs providing important services like the AHECs must have inherent sustainability.

Vincent C. Rogers
DDS, MPH

As head of the Bureau of Health Professions, I believe that AHECs are the vital and viable link to communities and their needs and, as such, they have an important present and future role in the Bureau. AHECs clearly articulate the Bureau goals and mission in working to assure an appropriately trained health professions workforce that meets the communities' health needs. The interdisciplinary focus that typifies AHECs is one of the major strengths of this program. Through the provision of primary care training of health professions students in an interdisciplinary manner and by offering continuing education for practicing health professionals in the community, as well as through other measures, this mission is

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Changes in Health Care Financing Create Opportunities for AHEC

By Senator Bill Frist, MD
Republican - Tennessee

The AHECs are truly a success story. This is especially true for my home state of Tennessee, which suffers serious shortages of primary care workers in both rural and inner-city communities. Despite the presence of major academic medical centers, large, medically underserved populations remain. That is why I have been pleased to support the AHEC programs. They are accomplishing great things, both for my home state and for the rest of the country.

Senator Bill Frist, MD

Meharry Medical College, in Nashville, Tennessee, is one of the Centers of Excellence for the Health Resources and Services Administration and has long excelled at training members of the primary care health workforce. Their expertise is sought after throughout the Tennessee region. To its credit, the program has used this recognition to collaborate with local organizations in creative ways.

- It has developed education and training programs which are multidisciplinary and community-based.
- It is recruiting and retaining health professionals within its communities. Furthermore, the Meharry AHEC has developed an academic/community network which is strengthening those efforts.
- It has forged new territory by developing a partnership with a managed care organization. Together, these two part-

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In This Issue

AHEC Spans Two Centuries to Meet New Challenges

This issue of the Bulletin straddles two centuries. These pages record past AHEC accomplishments in local, state, national and global endeavors. They also issue a challenge for the future: AHECs sustaining themselves in a world of shrinking public funding and elusive private money.

AHECs were reauthorized for three years with the passage of the Health Professions Education Partnerships Act of 1998. Tennessee's Senator Bill Frist was a prime sponsor of the legislation, which had bipartisan support. In an article that begins above, Sen. Frist urges AHECs to create new alliances, to try new ways of thinking and to confront their beliefs about traditional methods of funding.

One alternative, the conversion of an AHEC to a "social entrepreneur corporation," drew a great deal of attention during the 1999 National AHEC Workshop in Louisville, Kentucky. At that time, South Texas AHEC Program Director Richard Garcia suggested changing the mindset of an AHEC Board to change the focus of its activities. His presentation, expanded in an article beginning on Page 6, opens the door for consideration of AHECs as competitive businesses, investigating market niches and selling services.

Another attention-getting session at the Louisville workshop was a presentation describing the opportunities made

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ners have trained 163 certified nursing assistants statewide. Most of these workers were on public assistance and now are employed as outreach workers within their communities. This project is having a direct impact on the health care of those populations. Emergency room visits are declining, because more preventive care is being provided. The Meharry AHEC is meeting needs in all areas of the health care marketplace.

Other programs in Tennessee have been successful as well. Despite the closure of the East Tennessee State University's Northeast AHEC, its programs continue to exist and have become part of the school's infrastructure. Primary care outreach to local communities still is taking place.

• More than one thousand health care professionals have been served by continuing education programs which reach physicians, nurses and other health care professionals.

• A network of rural preceptor sites provides interdisciplinary clinical training for health professions students and medical residents. This network also provides programs which address the needs of local health care professionals in practice.

AHECs have a strong national track record as well. Thirty-six states currently are part of the national AHEC network of more than 140 community-based centers. Eighty medical schools and 500 other health professions training institutions have participated. These programs have coordinated and supported the training of nearly 1.5 million students and residents in medicine, allied health, dentistry, nursing, pharmacy and other disciplines in underserved areas. Hundreds of thousands of continuing education hours have been provided to health professionals. Information dissemination systems are responding to the needs of practitioners. Four dollars in state and local matching funds have been generated for every dollar invested by the federal government.

Clearly, AHECs are meeting their goals, both locally and nationally. But what about the future? Recent changes in regulations and statutes are changing the playing field. Funding priorities seem to change on a daily basis.

To some observers, it may seem that biomedical research efforts, such as those at NIH, are more of a federal priority than efforts to reach medically underserved populations. My answer is this: While it is important that we fund research efforts which lead to new treatments for disease, we also must fund the organizations that put those outcomes into practice by educating our health care practitioners. The AHECs excel at this task, and must be supported.

To others, it may seem that the challenge to become self-supporting is too great. State and local agencies are not always able to provide funding to replace federal monies. The East Tennessee State University AHEC was closed for this reason.

Given these funding uncertainties, many want to position their programs for survival. An understanding of the history of AHEC legislation will guide strategic planners.

'AHECs have a strong national track record. . . Clearly, AHECs are meeting their goals, both locally and nationally.'

Since coming to Congress in 1994, Sen. Frist has put his medical expertise to work on a variety of health care issues. He received his medical degree from Harvard Medical School and is board certified in both general and heart surgery. He serves on four key Senate committees: Budget; Commerce, Science and Transportation; Health, Education, Labor and Pensions; and Foreign Relations. He also chairs the Subcommittees on Public Health; Science, Technology and Space; and African Affairs.

The Health Professions Education Partnership Act

I was pleased to sponsor the Health Professions Education Partnerships Act of 1998 (P.L. 105-392), which reauthorized the Health Professions programs at HRSA. It represents an opportunity to improve the quality of, and access to, health care for millions of Americans.

The Act's programs are intended to:

• Improve the distribution of health professions workers to underserved areas;

• Strengthen the infrastructures of organizations which facilitate their training and performance;

• Improve accountability for federal dollars used in these processes; and

• Improve the representation of minorities and disadvantaged in the health professions, better reflecting the communities which they serve.

Patients in underserved areas depend on programs funded by these monies in order to receive their health care. Training providers in these areas greatly increases the likelihood they will work in these areas when they complete their educations.

Opportunities for Change

The Act is an example of our government's ability to act as a catalyst. Too often we, as legislators, are forced to step in and micromanage such health care issues as hospital lengths of

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stay in order to preserve quality of care. I believe we are far better served to develop programs that stimulate the types of efforts which create innovative solutions for these problems, and give practitioners/clinicians the tools necessary to make needed changes.

The Act fosters collaboration. Although foundations are still being laid, the many interest groups involved in this bill are learning to work together. They have discovered that they do have areas of common interest and they are learning to build on those incentives. Within many institutions, new interdisciplinary programs are being developed and this legislation stimulates those activities. Over time, it will streamline care and improve cost-effectiveness.

Over the years, AHECs and other successful programs have been funded through this legislation. However, these grantees do not always function similarly. Thus, clarification of the goals and objectives of these programs is a priority. We have to find ways to function within our budgetary constraints as well.

In 1995, Senators Kassenbaum, Kennedy and I attempted to take the 44 programs involved and consolidate them into six groups or clusters. Performance outcomes were added. This approach was used to streamline the granting process, and to allow HHS to use budgetary factors, to leverage areas of development and to align with community workforce needs. It also provided flexibility for strategic planning of the workforce supply, and ensured a greater percentage of program dollars would go directly to grantees rather than federal administration.

After the Act passed in the Senate in 1996 but failed to pass in the House, I re-examined the bill to identify areas of disagreement. I made a concerted effort to overcome those obstacles. Another hearing was held because I wanted to be sure that I listened to all parties and that all possibilities for compromise were addressed. My staff worked very hard to maintain that level of input. We sought to involve many constituency groups in the preparation of this legislation.

Implications for AHECs

AHECs are meeting these goals and more. Furthermore, they are uniquely positioned to help other programs as well. They have learned how to be cost-effective and outcome-oriented. They have developed networks and infrastructures which can assist other grantees as they mature. This ability to reach out and support other groups will ensure that all survive and flourish.

Yet, the issues for the Tennessee AHECs mirror the challenges which face other AHECs. Collaborations across institutional and even disciplinary lines must be supported. New types of funding must be sought, especially within the managed care sector. Practical, relevant outcomes which are measurable and reproducible must be developed and used. Partnerships with HRSA programs outside of the assigned clusters must be supported.

These types of alliances may require new types of thinking. The paradigms of health care education may be challenged. New funding techniques may confront traditional methods. Interdisciplinary collaboration will require new types of coordination — from design of schedules to design of curricula. Partnering organizations may insist that control of funding and philosophies be shared.

Our system of health care financing is changing, but the basic needs are still present. Our medically underserved populations still require care. It is our task to use these changes as opportunities — opportunities to develop new tools for patient care. I believe the AHECs are rising to meet these challenges to better serve patients across the United States.

Structure of the Act

The 1998 Health Professions Education Partnerships Act accomplishes its goals in several ways:

- It uses only seven clusters, but has 15 lines of authority as well. This approach, while more complex, also is more reflective of both existing and potential alliances. It gives security of funding to groups within these clusters and, in turn, allows them to plan longer range.
- Flexibility is built into the bill over time. As funding lines change, the Secretary's authority to move funds across program lines increases. Thus, programs can grow into the cluster concept. This revision will better reflect the constantly changing health care needs of communities and the rapidly changing health care delivery system.
- Since so much of the Act's flexibility is based on the discretion of the Secretary, we have added advisory councils to ensure that the viewpoints of those on the front lines are heard. This will restore confidence among the grantees and encourage positive collaboration between agency officers and the programs they manage. In addition, these councils will report back to Congress to assure oversight of these programs.
- To encourage independence from federal funding, matching requirements for non-federal funds are required where appropriate. Federal dollars provide the seed money necessary for many health clinics to get on their feet and, in turn, secure other financing mechanisms.
- Programs which attempt to resolve cultural barriers, especially those related to language, are restored.
- Community-based organizations are empowered so that the patient's voice can be heard.
- Geriatric initiatives have been strengthened and expanded to train health care personnel as we promote and integrate geriatrics into American medicine.

The Future of AHECs

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accomplished. As AHECs continue to demonstrate the value of partnerships between the academic and community environments, education and training becomes their means of sustainability into the new millennium.

As of October 1, 1999, the National AHEC Program Office moved from its location within the Division of Medicine in the Bureau of Health Professions into a new Division of Interdisciplinary and Community Based Programs. This Division, created during a recent reorganization of the Bureau, follows new legislation that enhances and aligns programs with a similar focus.

Dr. Rogers is Associate Administrator for Health Professions in the Health Resources and Services Administration's Bureau of Health Professions.

The reorganization reinforces function rather than administrative tradition. Previously, programs with similar functions were spread discretely throughout the Bureau. With this reorganization, they all will be brought together under the umbrella of one division. This increases collaboration and coordination of programs and reduces the duplication of efforts. The new Division includes the Geriatric Education Centers Program, the Rural Interdisciplinary Programs and the AHEC Program. Several other initiatives that are deemed secretarial level programs, i.e., the Primary Care Fellowship Program, also will be housed within the new Division.

'AHECs have moved beyond serving only medical schools and are venturing into the realm of interdisciplinary training. This shift raises an issue that needs to be addressed, and that is the difference between multidisciplinary and interdisciplinary.'

As we evaluate how AHECs meet community needs, we find several examples of AHEC programs fulfilling the Bureau's goals. The Illinois AHEC has a fellowship program that uses community leaders as mentors for minority dental, medical, nursing, psychology and public health students. Their students participate in the program for one year, attending leadership development seminars and working on projects that encourage other minority students to enter health careers.

Another example is the SPARX (Student Providers Aspiring to Rural and Underserved Experiences) program of the Washington AHEC. In SPARX, medical, nursing, physician assistant and health administration students are exposed to experiences in both rural and urban underserved settings. They are taught Spanish for health professionals and work with both community and migrant health centers.

A third example is seen in the response of the North Carolina AHECs to Hurricane Floyd which this past summer produced record-high floodwaters that covered 19,000 square miles and forced 48,000 people out of their homes and into shelters. The AHECs in eastern North Carolina provided training for more than 700 health care providers and other caregivers helping families, and particularly children, deal with the emotional and psychological impact of the disaster. They also trained University of North Carolina-Chapel Hill medical students to provide assistance to flood victims they encountered on AHEC-sponsored trips into communities in distress. In addition, they printed and distributed more than 75,000 copies of an English/Spanish coloring book designed to help children work through their feelings.

These are just three of the many ways that AHECs across the country are listening to the needs of the community and, by doing so, furthering the mission of the Bureau of Health Professions.

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The Future of AHECs

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The vital role of AHECs also is seen in their cohesive function that brings the four Bureaus of HRSA together and helps them to maintain this collaboration. For example, through their training activities with CHCs, AHECs shape linkages with the Bureau of Primary Health Care. The same is true through participation in the State Systems Development Initiative for the Maternal and Child Health Bureau and with the AIDS Education Training Centers within the HIV/Aids Bureau.

Both of these AHEC roles are enhanced by the move to the new Division where it becomes even more clear that AHECs have moved beyond serving only medical schools and are venturing into the realm of interdisciplinary training. This shift raises an issue that needs to be addressed, and that is the difference between *multidisciplinary* and *interdisciplinary*. To me, multidisciplinary means that there are multiple programs available at the same location. Interdisciplinary, on the other hand, means that the different programs actually work in concert with one another, thereby increasing the effectiveness of all program components.

It is into this type of activity that AHECs lead the way. The integration of programs that occurs in interdisciplinary endeavors helps to minimize the phenomenon of academic silos. It occurs by fostering knowledge sharing between the faculty and students among the various disciplines. This sharing encourages a team approach to patient and family needs, as well as community needs. Working examples of this are seen in the Southeast Pennsylvania AHEC where medical, dental, nursing and podiatry students work together to manage clinical problems. This AHEC was one of those highlighted in the *What the Heck is an AHEC?* video.

In the Western Maryland AHEC, the Geriatric Assessment Interdisciplinary Team brings together students from medicine, nursing and occupational therapy to learn assessment skills. This AHEC also manages an Interdisciplinary Rural Training Program, which brings together respiratory therapy, occupational therapy, nursing, social work, physical therapy and public health students.

The Western Maryland AHEC demonstrates what I alluded to earlier: that the other programs of the new Division (Geriatric Education Centers and Interdisciplinary Training Programs) work in conjunction with AHECs. Combining the three into one Division furthers communication and coordination efforts.

AHECs also are leading the way for the Bureau in other ways. They have collaborated with other offices outside of the Bureau, such as the Office for the Advancement of Telehealth and the Office of Rural Health Policy. In addition, AHECs will have a key role in assuring the success of two new initiatives within HRSA, the Oral Health Initiative and the Kids Into Health Careers program. The Oral Health Initiative will address access to critical oral health services for children and vulnerable populations. The Kids Into Health Careers Program will expand HRSA-BHPR efforts to increase the number of academically prepared underrepresented minorities and students from disadvantaged backgrounds to enter one of the many careers in the health professions. The results of these efforts will be reaped by all of the Bureaus in HRSA, once again establishing AHEC's role as a unifying element.

AHECs have many roles and serve many functions throughout the Bureau. My vision is that this redesign will serve to accentuate these traits and help AHECs to become even more effective. The interdisciplinary focus of the AHECs represents a major strength now and for the future for all health professions programs within the Bureau. This may be the major sustainability element that can be emulated by others. Through all of this, we maintain our focus on the goal of equal access to quality health care for all people, with a particular emphasis on the underserved people of this nation.

'AHECs have many roles and serve many functions throughout the Bureau. My vision is that this redesign will serve to accentuate these traits and help AHECs to become even more effective. The interdisciplinary focus of the AHECs represents a major strength now and for the future for all health professions programs within the Bureau. This may be the major sustainability element that can be emulated by others.'

AHEC
The National Area Health Education Centers Bulletin

Converting an AHEC
to a Social Entrepreneur Corporation

By Richard A. Garcia, MPA

Area Health Education Centers receive federal core funding only for a limited period (six years) and the necessary level of required state funding to continue AHEC operations does not always materialize. So how can a federally funded 501(c)(3) center continue to operate as a functional progressive organization beyond its six-year federally funded life?

The process of transitioning from a traditional not-for-profit corporation to a social entrepreneur corporation requires the acceptance of certain philosophical attitudes. First, it is important to realize and accept the fact that not-for-profit corporations are businesses, not charities. Second, it is vital for not-for-profit corporations to achieve operational profits in the production of their services or products. In order to achieve a profitable operation, not-for-profit corporations must adopt business tactics typically utilized by for-profit organizations. These include competition, creativity, risk analysis, cost accounting, financial reporting, marketing and profit making.

'There are numerous examples of competitive business opportunities which can support the basic mission statement of an AHEC Center.'

Competition is an acceptable strategy whenever a marketing or needed product niche is found. Operational risk must be recognized, understood, evaluated and accepted as a by-product of doing business. The social entrepreneur corporation should focus on its organizational mission and embrace the fact that the corporation exists to provide a defined service or product. It is the responsibility of the corporation's executive director and its board of directors to do whatever it takes to deliver that service or product. If this means that the corporation must invest in or should start an unrelated business enterprise in order to use those profits to increase the defined mission, then that is what the corporation should accomplish. If it means entering a competitive business domain with other providers, the corporation which can provide the better service or product at equal or less cost should win out over its competitors.

There are numerous examples of competitive business opportunities which can support the basic mission statement of an AHEC Center. Some of these opportunities are found in real estate acquisitions (student housing), office building rental/lease agreements, professional recruitment and placement services, professional billing and collection services, medical transcription services, office and clinic equipment leasing services, office management contracts, community-based needs assessments, health delivery program assessments, continuing education programs and program outcome measures and evaluations. This listing is not intended to be all inclusive but is presented simply as a stimulant for creativity.

In the process of moving from a traditional not-for-profit corporation to a social entrepreneur corporation, several important administrative functions must be conducted. Formally establishing, or reestablishing, a mission statement becomes pivotal. The mission statement of a corporation defines the legal reason for its existence. It is the basis of the not-for-profit tax exemption granted to the corporation by the U.S. Internal Revenue Service. If the corporation does not perform its mission as stated in its formal mission statement, the IRS has the authority to remove the corporation's tax exempt status. If the corporation finds it has generated significant income from activities that do not significantly contribute to the formal mission statement, the corporation risks not only the loss of its tax-exempt status, but may also incur a tax liability due to unrelated business income.

It is interesting that many not-for-profit corporations are technically in violation of their formal mission statements and may actually be

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Mr. Garcia is Program Director of the South Texas AHEC Program, headquartered in San Antonio. He also is a member of the National AHEC Bulletin Editorial Board.

Social Entrepreneur Corporation *(Continued)*

generating unrelated business income. In most cases, this occurrence is unintentional and usually is the result of an outdated mission statement which has not been periodically reviewed and amended by the board of directors. For example, if an AHEC's defined mission statement identifies certain geographic regions, services or products but due to growth and time the AHEC now serves a wider geographic region or provides a wider range of services or products, income generated from the new geographic region(s) and by any new service(s) or product(s) may be considered by the IRS to be unrelated business income. The not-for-profit corporation may be in technical violation of its tax-exempt status.

It is important therefore to review the existing mission statement, note any substantial changes which have occurred, have the new mission statement approved by the board of directors and forward the new mission statement along with the minutes of the board of directors' rectifying action to either your state attorney general or the secretary of state and to the U.S. Internal Revenue Service. The IRS always will judge the corporation's tax-exempt status and unrelated business income provisions against the corporation's mission statement which it has on file. Remember though, it may be acceptable to have unrelated business income; you simply have to pay taxes on the profits it generates.

In line with the reestablishment of a corporation's mission statement, the acceptable risk level of the corporation needs to be defined. Not-for-profit corporations are businesses, and business by its very nature involves risk. A real concern is the identification of the level of risk which the corporation is willing to accept on behalf of its mission. Each corporation's risk acceptance is as different as each situation. Understanding, evaluating and accepting risk is part of management. Very few opportunities exist in business which do not carry an element of risk. It is the appropriate balancing of opportunities and risk which results in successful business enterprises; this activity is the responsibility of the corporation's executive director and board of directors.

Another step in the corporation's social entrepreneur process is defining how profits generated by the new activities will be utilized. It is extremely important to be specific about what will be done with the projected profits. This process identifies a recognizable goal for both staff and board of directors, which explains the extra work and risk involved in the proposed process. Nowhere is it mandated that a not-for-profit corporation must lose money or even break even. The U.S. Internal Revenue Code merely states that "profits of the corporation shall not inure to the benefit of various people." It is expected that a well-directed not-for-profit corporation will generate corporate profits which will then be used to further the mission objectives of that corporation.

Now is the time to develop a feasibility study. This study will produce an informal written document of four to five pages describing the proposed product or service, defining and detailing the competitive market to be served, describing the reason for a demand for the proposed product or service, stating how the proposed product or service will be delivered, identifying potential barriers to success and how they will be overcome or minimized, and providing preliminary financial projections.

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". . . Opportunities are found in real estate acquisitions (student housing), office building rental/lease agreements, professional recruitment and placement services, professional billing and collection services, medical transcription services, office and clinic equipment leasing services, office management contracts, community-based needs assessments, health delivery program assessments, continuing education program, and program outcome measures and evaluations."

Social Entrepreneur Corporation *(Continued)*

With the preliminary information completed and an executive decision made that the proposed activity is feasible, a formal business plan is developed. This written plan must account for all the variables involved in starting the new business venture. It must be based in reality, must be critical and must be persuasive, but totally objective. The business plan is the basic operating tool used to manage the beginning of the proposed business venture and it identifies the steps required to ensure success. This plan will be the instrument for communicating the proposed business concepts to others and will provide the basis for the financial projections. It is important to realize that the majority of business failures are due to a lack of proper planning. For not-for-profit administrators familiar with grant applications, a business plan is not a new concept. *(See box below.)*

Viewing the Grant Application as a Business Plan

Whether realized or not, a typical grant application is a business plan whose characteristic contents are described below:

- **A cover letter** identifying the corporation which developed the business plan. This should include the name, title, address, phone/fax number of the submitting officer; the month and year the plan was written; and the limitations on the business plan's distribution;
- **A table of contents telling what is included in the plan;**
- **A summary of the business plan** describing the proposed product or service, a short description of the target market, and an explanation of the financial requirements;
- **A description of the corporation,** the proposed product or service, the targeted consumer, a verification of the consumer's desire for the product or service, and the sales strategy to be employed;
- **A marketing plan** including information on potential consumers, potential competitors, regional demographics, geographic economy, available technology, governmental or legal issues, cultural factors; how these aspects affect the marketing, distribution, and sale of the proposed product or service, and an evaluation of potential pitfalls;
- **Time line charts** identifying major events — e.g., start times, deadlines, completion dates, etc.;
- **A financial plan** with sources and applications of cash and capital. This plan should include a list of equipment to be acquired, a balance sheet, a break-even analysis of operations, monthly cash flow estimates for the first year of operations followed by quarterly estimates for years two and three, projected revenue and expenses for the first three years and notes of explanation for each of the estimates; and,
- **An appendix** with management resumes, organizational brochures, newsletters, annual reports, letters of endorsements, copies of signed contracts or agreements, etc.

In establishing financial projections, it is extremely important to ensure that all costs are taken into account. This is the time to be brutal about projections. Starting a business venture with insufficient cash reserves, underestimating the number of days for accounts receivable, pricing the proposed service or product too high or too low, not understanding break-even analysis and not allowing for "Murphy's Law" will each have significant adverse effects on the implementation of a new business venture.

It is important to realize that as not-for-profit corporations move into the private business sector, financial reimbursement practices commonly found in governmental grants and contracts are found not to be appropriate. The private venture administrator should avoid "use it or lose it" contracts or cost reimbursement agreements. Negotiate into any contract the business concept of providing a specified number of defined services or products for *X* dollars at an established level of quality. As long as the terms of the contract are met, any excess funds at the end of the contract become the corporation's "profit" to keep (the opportunity). This means, however, that you must keep your budget under control because if you spend more than the specified *X* dollars to deliver the number of defined services or products, you eat the loss (the risk).

If the not-for-profit corporation begins to acquire large net revenues (profits) it may be beneficial to determine if these profits should be placed in a new secondary corporation established under the parent not-for-profit corporation. It is common for large not-for-profit corporations to harbor property, such as buildings, vehicles, equipment, etc., in a secondary corporation and lease it back to the parent corporation at a fair market value. Commercial lenders such as banks or foundations will typically reimburse rental or lease costs, but not depreciation or interest on loans or mortgages. It would be appropriate to check any potential funding source's policies regarding related corporate transactions before establishing a secondary corporation to shelter assets.

A not-for-profit corporation also should consider establishing and utilizing restricted accounts for specific expenditures such as capital funds and depreciation. When deciding whether to provide financial support, commercial lenders and foundations are much more interested in how general revenue funds are used by a corporation than its restricted funds. If restricted accounts are to be established, it is important that

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the corporation's board approve these accounts and that the corporation's annual financial reports identify these restricted funds.

At some point, any business corporation will need to borrow money either to cover cash flow or to cover the advance costs associated with a new venture. Nearly all business corporations need some form of debt at some point, and the corporation's credit rating will be influenced by how well commercial lenders know the corporation and its repayment history if any. Despite its name, commercial banking is a personal business. Your personal relationship with a single person in a single bank will go a long way toward improving your corporation's "creditworthiness." While nothing replaces a solid balance sheet and profitable operations, very few commercial lenders will take a risk on your corporation unless they know you personally and understand your business. Your main advocate, besides corporate financial reports, will be your commercial lender. If you have not kept this individual up-to-date on your corporation's business ventures, activities and future plans, chances are that a commercial lender will not accept the perceived financial risk on your loan request, the requested loan may be reduced, the interest rate on the loan may be increased or the loan request denied outright.

Remember that most commercial bankers don't fully understand the operations of a not-for-profit corporation. Consider the perception of a typical not-for-profit corporation through the eyes of a commercial banker who is accustomed to dealing with the private sector: *(See box at right.)*

So how can a not-for-profit corporation improve its relationship with commercial lenders? First of all, the corporation must be businesslike in its fiscal activities. Regular accurate financial statements, annual audits with management recommendations which are implemented, tight cash controls and good billing and collection activities are essential records to be presented to a commercial lender. In addition, knowing which programmatic activities make money and which ones lose money, producing and tracking productivity reports and being aware of trends, opportunities and competition will go a long way to convincing commercial lenders of the corporation's business abilities.

Second, establish a business relationship with a commercial lender. As stated before, commercial banking is a personal business. Lenders will want to know as much as possible about the corporation and its history, about your abilities as a business manager and the operating philosophy of your board of directors. It is important to establish periodic meetings with this individual to review the fiscal status of the corporation and to update the commercial lender on corporate plans and operations. One good time to meet with this individual is shortly after the corporation's annual audits are completed when a detailed review of the past year's activities and plans for the current year may be discussed.

Commercial lenders fear the unknown or what they don't understand. It is up to executive management and members of the board of directors to ensure that sufficient information is provided to alleviate concerns. When corporate strategic plans are developed, inviting a commercial lender to participate on the financial parts of the discussions or asking for a review of the financial projections will go a long way in establishing a business relationship with a commercial lender.

When this process is followed, commercial lenders and other institutions will learn what you have known all along. Termination of federal core funding does not mean the end of an AHEC. Rather, termination of federal core funds should serve as a managerial catalyst, compelling AHEC leadership to seek opportunities for growth and change and to establish a viable business plan which ensures the corporation's success for years to follow.

AHEC Through a Commercial Banker's Eyes

Consider the perception of a typical not-for-profit corporation through the eyes of a commercial banker who is accustomed to dealing with the private sector:

- Most of the not-for-profit AHECs' funds come from a single source, usually a governmental entity, from donations, from multiple small grants, etc., which at best are very unreliable, unpredictable and whose funds are only guaranteed for short periods, typically a one-year period.
- The corporation's executive director usually is not a trained, proven business administrator.
- The not-for-profit corporation takes pride in providing a service or a product at a lower cost compared to the private sector, usually at a loss made up by deficit funding requests.
- Revenue collection efforts (if any) for the corporation's services or products are inefficient, even from those who have an ability to pay.
- The corporation is controlled by a board of directors of do-gooders who do not have personal financial interests in the success of the corporation.
- The corporation's staff members are program fanatics.

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Reinventing the Maine AHEC Health Literacy Center:

Entrepreneurship for the Public Good

By Susan Stableford, MPH, MSB

Succeed as a business or go the way of the dinosaurs — by the mid-1990s those were the choices facing the Maine AHEC Health Literacy Center. After five years of sustained endeavor, the Center was facing the end of federal funding in a state that also lacked economic capacity to support the Center. Nor could the AHEC's private, tuition-driven College of Osteopathic Medicine finance what had become largely a public health enterprise.

The Chinese character for crisis well embodies the double-edged situation the Maine AHEC faced: "danger" and "opportunity." Rather than succumb to the danger, staff mobilized the energy it generated to sharpen their focus and create the opportunity. As with any successful business venture, a combination of hard work, good timing and luck favored them.

In the early 1990s, the Literacy Center was established with the financial support of an AHEC Special Initiative grant as well as a local Bingham Program grant. Those grants enabled staff to respond to a request from AHEC physician preceptors as well as public health professionals statewide for easy-to-read health information. The AHEC responded by building capacity as well as producing materials. The dozens of professionals trained created 80-plus easy-to-read pamphlets available to the public about a wide range of health issues.

Ms. Stableford is Director of the Maine AHEC Health Literacy Center at the University of New England College of Osteopathic Medicine in Biddeford, Maine.

The success of this initial effort emboldened the AHEC to offer a National Summer Institute on its university campus. Supported the first summer by a private grant from the Maine Community Foundation, the Institute attracted health professionals from all over the country, including Alaska. Learning how to reach low literacy audiences was a hot topic. Professionals were eager for the knowledge and skills offered.

The timing couldn't have been more opportune. The 1992 National Adult Literacy Survey (NALS) proved what smaller studies in Maine and elsewhere had pointed to — that almost half of American adults had very limited reading abilities, around eighth grade level or below. In contrast, as numerous journal articles documented, most health information was written at a tenth grade reading level or above. This mismatch between adult reading abilities and the reading demands of most materials meant that 90 million adults were unable to read and use most health information. And this at a time when patients were expected to play a more active role in coping with new care systems as well as their health conditions.

The NALS highlighted the limited literacy skills of most minority populations. At the same

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Ingredients of Most Successful Businesses

- **Providing a superior product.** The staff of the Maine AHEC Health Literacy Center focused on three core competencies — consulting, training and materials development.
- **Outstanding customer service.** They customized products and services to each organization — sometimes meeting tight deadlines, working within fiscal constraints and tailoring training materials to the customer environment and needs.
- **Effective marketing and networking.** The Center continually revised its Summer Institute curriculum and brochure, updated its Center brochure and mailing lists regularly, authored professional articles, attended appropriate forums and networked conscientiously with others in the field.
- **Realistic pricing.** The Center charged market prices for its products and services, believing that social good could and would have to be supported adequately to ensure its long-range survival.

time, federal health programs were starting to focus on the serious health disparities of minority communities. The need for establishing clear, simple communication strategies thus garnered additional support. And finally, critical research studies documented the serious effects of low literacy on health behaviors and outcomes.

These events helped to shape as well as reflect an environment capable of supporting an expanded vision for the Health Literacy Center. Even as the Center's financial situation grew more precarious, the need and appreciation for its work grew. The Center received inquiries about offering training programs off-site, about producing easy-to-read materials to meet the needs of other health organizations and about helping to design communication strategies that worked.

Out of necessity, staff began to reinvent themselves, imagining themselves as a business and starting to behave like one. They developed a marketing brochure, let others know about the work in professional articles and forums, put a price tag on participation in the Summer Institute and offered the products and services that customers requested.

They continued to seek grants and in 1996 obtained a training grant through the Robert Wood Johnson Medicaid Managed Care Initiative. This provided a financial cushion during the transition to more contract work, a more business-driven model. While the Center staff's notion of social justice and of empowering consumers with information they could understand provided the sustaining vision, practical strategies and budgetary realities guided their weekly and monthly activities.

They focused on the ingredients of most successful businesses. *(See box on preceding page.)*

The late 1990s have been kind to the fledgling field of health literacy. In June 1998, President Bill Clinton issued a Plain Language Memorandum, requiring that all federal agencies communicate with the public in plain language. In 1999, the American Medical Association published a policy paper, supporting the importance of health literacy knowledge and skills for health care providers. The importance of these policy statements has been underscored by additional research which, in turn, has fueled an action agenda. For the first time, the health objectives for the nation (for 2010) include health communication objectives and reference health literacy. Multiple federal agencies are training their workforce in plain language *(See the website, www.plainlanguage.gov)*.

These initiatives expand awareness of the need for what the Maine AHEC Health Literacy Center has to offer. Staff have had the opportunity and pleasure of working with large federal agencies — HCFA, EPA, CDC — as well as the Maine State government and a variety of private health organizations.

Small businesses are never certain of the future, and this one is no exception. There is no "guarantee" of the Literacy Center's long-term success. Yet, so far, it has demonstrated the ability to compete and work within both the public and private sectors, doing work that enhances the public good in a way that financially sustains itself. It is hoped that the Health Literacy Center will continue to become an entrepreneurial legacy of which the AHEC family can be proud.

In Memoriam

Jane Root, PhD
1920 - 1999

Jane Root, PhD, a renowned national literacy expert, co-founded the Maine AHEC Health Literacy Center (with Sue Stableford) and remained as a principal until her death from cancer in June 1999. Dr. Root, the co-author of the definitive book on the subject, *Teaching Patients With Low Literacy Skills,* retired to Maine in the late 1980s with her husband, Gus. Her retirement was short-lived. Ms. Stableford "discovered" her shortly after her arrival in the state. As Dr. Root later would say, she was plunged into her fifth and most rewarding career —teaching others what she cared about so passionately.

Dr. Root leaves a phenomenal legacy of thousands of grateful pupils all over the country, many of whom came to know her through her work with the Maine AHEC. She unstintingly shared who she was and what she knew. Indeed, the question workshop participants most frequently asked her was: "How we can we grow old like you?"

Now there's a tribute!

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Tobacco Tax Revenues: A Ready Resource for AHECs

By Donald E. Proulx, MEd

Mr. Proulx is Associate Director of the Arizona AHEC Program.

Arizona's efforts to improve the health of its residents by preventing and/or reducing the use of tobacco have provided the statewide AHEC Program with a new source of revenue and new avenues for community action.

The state's four rural AHEC Centers have expanded their role in promoting the health of Arizona's rural population through tobacco tax supported initiatives. In 1999, close to $415,000 was awarded to the AHEC Program from state tobacco tax revenues.

Tobacco tax settlements in most states will run into the millions of dollars. This is a ready resource for AHECs not only to gain additional funding, but also to expand their role in the prevention, education and cessation services that states likely will be providing.

Arizona voters in 1994 approved a Tobacco Tax and Health Care Act which increased the sales tax on tobacco products by 40 cents per pack. Revenues generated by this tax increase were designated to fund health care for medically needy, medically indigent and low-income children. Also to be funded were tobacco education and prevention and tobacco-related research.

The Arizona Department of Health Services (ADHS) established the Arizona Tobacco Education and Prevention Program (TEPP) and put out Requests For Proposals (RFPs) to form local projects in every county statewide and fund statewide initiatives.

Three statewide prevention education and cessation projects were implemented and now are operated through a partnership between the Arizona AHEC and the state's three universities. This partnership system has become TEPP's statewide infrastructure of support for the activities of 23 local tobacco projects organized within Arizona's 15 counties.

This complex network of collaborators/project partners relies on the AHECs as outreach centers for delivering these initiatives. In addition to having a direct relationship with the basic AHEC mission, these state-funded projects help the AHEC generate its non-federal matching support.

Arizona's four rural AHECs serve as critical outreach agencies for these three statewide initiatives in all counties except Maricopa:

I. The Arizona Tobacco Information Network (ATIN)

ATIN is a statewide clearinghouse of information, curriculum, training and technical assistance services. Now in its fourth year, the ATIN utilizes Arizona's AHECs, located in four rural regional service areas, to provide access to bulk literature items, technical assistance and training in tobacco prevention approaches for schools, communities, health care entities, public libraries and work sites. The statewide clearinghouse utilizes available technologies to increase access to services, including toll free telephone numbers, a helpline and the Internet.

ATIN's Fit with the AHEC Mission

- The ATIN has become a natural extension of the AHEC's work in providing library and learning resource services to support providers and students working and training in Arizona's rural, medically underserved and otherwise resource-poor communities.
- In addition to providing CE and CME programs, these AHECs, as outreach ATIN centers, are providing training programs for providers, students and the public on tobacco use prevention and cessation services.

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Advantages to AHECs

Engaging in tobacco prevention, education, cessation programs can:

- Generate and/or expand statewide recognition for the AHEC's mission/role in providing community-based health professions educational services.
- Expand the base of state funding support for the AHECs . . . When state tobacco settlement funds kick in, the potential for the AHEC's inclusion in that funding is excellent.
- Have a proper fit with national AHEC goals relating to provision of:
  - Youth health career education and school-based programs;
  - Remote-site community-based health professions education and clinical training;
  - CE and CME for remote-site providers;
  - Remote-site library and learning resource services, including video teleconferenced symposia, workshops, etc.; and,
  - Community health/public health education/promotion.

Tobacco Tax Revenues

(Continued)

- The public health training component of the AHEC (with MPH students, as well as students in medicine, nursing, etc.) has been extended through the ATIN.
- The AHEC's role in community health education and health promotion programs has also grown through the ATIN project.

II. The Arizona CHAMPS Peer Project for Tobacco Use Prevention

This initiative engages students in grades five through seven in a Peer Leadership Project, known as CHAMPS (Champs Have And Model Positive Peer Skills), to reduce tobacco use by youth. The project is funded by the ADHS Tobacco Education and Prevention Program, based on the results of planning grants carried out by the AHEC Program Office (at the University of Arizona) and the Arizona Prevention Resource Center at Arizona State University.

The CHAMPS Program believes youth peer pressure can be a good thing if directed in the right way. Research indicates that peer leadership programs are the most effective way to change attitudes and social norms among youth. This project was developed to provide schools and local projects with a highly effective peer-driven program to help students resist the pressure to use tobacco in all forms. By making youth a part of the solution the rural Arizona AHECs offer the opportunity to build and maintain a statewide program whose aim is to reduce tobacco use significantly among young people.

CHAMPS Program Fit with the AHEC Mission

- Tying CHAMPS demonstration schools and control schools in with AHEC's health careers education and recruitment programs (this is a natural extension of the youth interest in CHAMPS):
  - Including health careers information at school health fairs and
  - Forming school health clubs with health career information/education
- Engaging local schools and youth in community health promotion activities.
- Providing MPH and other clinical rotation students an opportunity to see a youth prevention education program in action.
- Learning resource dissemination and support mission of the AHEC is personified.

III. The Arizona Cessation Training and Evaluation (ACTEV) Project

ACTEV uses a training-of-trainers methodology to provide cessation services in schools, work sites, health care sites and community service sites. The purpose of the Arizona Cessation Training and Evaluation Project is to support *Arizona 2000,* the Arizona Department of Health Services' Tobacco Use Prevention Plan, to develop a community-based delivery system for tobacco use prevention, education and cessation. Specifically, *Arizona 2000* states: "All Arizonans who wish to quit using tobacco should have access to affordable, state-of-the-art cessation services."

Arizona's four rural AHECs are participating in the: 1) design, dissemination, evaluation, standardization and development of performance standards for three levels of tobacco cessation skills certification training, health care systems training, school and worksite trainings; 2) Spanish language translation of educational materials; and 3) delivery of cessation training statewide.

The AHEC staff co-facilitate training and the presentation of education modules and provide technical assistance to Local Projects. The AHEC staff have been certified as Tobacco Cessation Specialists to carry-out the ACTEV Project functions in Arizona's rural communities.

ACTEV Program Fit with the AHEC Mission

- Preparation of providers (certified cessation providers) in and for rural and medically underserved communities;
- Continuing education for health care systems providers;
- Community health education services and health promotion;
- Local/remote-site training and ongoing technical assistance;
- Regular assessment of local/remote-site community needs; and,
- Ongoing quality improvement monitoring.

It is anticipated that $500,000 will be generated each year in support of the Model AHEC Program to participate in as the outreach arm for Arizona's rural and medically underserved communities in the provision of tobacco prevention, education and cessation services for many years to come.

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Innovative Stewardship:

Finding Creative Ways to Finance Non-profit Activities

By Judith O'Connor

Non-profits are continuously adapting to changing circumstances. Powerful environmental shifts, advances in technology and increased competition affect the way nonprofits operate and how they plan for the future. To adapt and thrive in a time characterized by conflicting societal forces, non-profit boards must serve as strong and innovative stewards. Whether it comes in the form of re-evaluating board structure and operations in order best to respond to pressing issues or rethinking the way the organization secures funding for its programs and services, innovative leadership by the board is indispensable.

Ms. O'Connor is President and Chief Executive Officer of the National Center for Nonprofit Boards.

Among non-profit organizations, the drive to innovate, to find new and better ways to provide services while maintaining financial stability is based in part on changes in the public's expectations. Non-profits increasingly are expected to deliver top-quality services or products efficiently, at competitive prices, while always being mindful of their mission. With expectations echoing those placed on the private sector, many nonprofits are adjusting the way they work to capitalize on the strengths exhibited by for-profits.

Non-profit board responsibilities include such varied roles as hiring and assessing the organization's chief executive, determining the mission and purposes, planning for the future and serving as a public spokesperson or advocate. Chief among the board's responsibilities is the duty of ensuring financial stability. Achieving financial stability may require a comprehensive investment strategy, a proactive fundraising program that involves the board, as well as other income-generating activities. Changing expectations combined with funding uncertainties have prompted many organizations and their boards to forego the proverbial bake sale in favor of more entrepreneurial methods of funding their charitable endeavors. From basic fee-for-service arrangements to cause-related marketing partnerships, nonprofits are becoming increasingly financially self-reliant.

'For some organizations, developing alternative revenue sources may require an internal culture shift. Nonprofit board and staff members may need to overcome their discomfort with words like *customers*, *marketing* and *profit*.'

For some organizations, developing alternative revenue sources may require an internal culture shift. Nonprofit board and staff members may need to overcome their discomfort with words like *customers*, *marketing* and *profit*. As they employ market mechanisms to their social causes, nonprofit entrepreneurs face the challenge of balancing the dual goals of fulfilling mission and attracting financial resources. For some, these goals seem in conflict, however they don't need to be.

Methods of producing earned income vary — from the basic level of providing goods or services that customers are willing to pay for, such as conferences, educational materials or health care services, to more advanced earned income ventures, such as logo licensing agreements or sales of products unrelated to the organization's mission. These more complex endeavors may require partnerships with local businesses or the establishment of a for-profit subsidiary.

The most basic method for producing earned income is to develop products or ser-

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Innovative Stewardship

(Continued)

vices related to your mission that people want to buy. The National Center for Nonprofit Boards has built several core business activities — including publishing books and other resources, convening conferences and offering one-on-one consulting services — that not only support NCNB's mission, but also produce earned income that help to fund the organization's ongoing activities. NCNB's revenue-producing activities are linked inextricably to its mission of improving the performance of nonprofit organizations by strengthening their boards of directors.

Many organizations have distinguished themselves by finding creative ways to fund social purpose ventures. The Public Broadcasting System has reduced its reliance on government funding by capitalizing on the commercial success of its children's programming, including video sales and logo licensing of Barney and the Teletubbies. Pioneer Human Services has profited by employing its clients — former convicts and drug addicts — in the for-profit businesses it owns and operates. *Share Our Strength*, a DC-based hunger relief organization, has contributed more than $45 million to hunger relief organizations worldwide while shunning nearly all traditional fund-raising methods. Instead, *Share Our Strength* has developed mutually beneficial cause-related marketing partnerships with corporations including American Express.

New income-generating ventures inevitably have some critics. It's human nature to be wary of things unfamiliar — that's why innovation isn't easy. Some people fundamentally oppose nonprofit involvement in traditionally for-profit endeavors, asserting that it somehow taints mission achievement. Others harbor the misconception that nonprofits aren't allowed to make a profit, even though the most successful and responsible organizations find ways to generate annual surpluses to insulate the organization from unforeseen circumstances. Critics fear that increased financial self-sufficiency may hinder the organization's chances to garner continued foundation or governmental support.

Despite some criticism, the success that many nonprofit organizations have realized provides hope. Organizations that are willing to challenge the status quo help the public realize that to be "nonprofit" is not necessarily synonymous with being resource-poor, while challenging the nonprofit community to increase its standards and broaden its vision.

Getting Started

Jeff Boschee, president and CEO of the National Center for Social Entrepreneurs, offers the following tips when evaluating whether an earned income or other financial venture is appropriate for your organization.

- Evaluate how the income-producing venture supports the organization's mission.
- Bring people to the organization who have experience and can offer valuable advice—for instance, a successful business person or the executive director of a local nonprofit that has found new ways to finance its operations.
- Make sure the effort has a champion. Unless someone is passionately committed to its success, no new venture has much of a chance.
- Determine the factors critical to success in generating earned income. Some examples include price, quality, ability to permeate the market, ability to attract necessary personnel.
- Determine the environmental forces that will influence your business. Environmental forces may include demographic shifts, changes in the stock market, advances in technology.
- Identify primary competitors.
- Determine the size and direction of the market. Remember that markets are cyclical.
- Determine the potential profitability. When evaluating profitability make sure to account for the full impact of both direct and indirect costs. Some nonprofits make the mistake of ignoring overhead or employee expenses because they are covered by a particular grant or other funding source.

Resources:

Boschee, Jerr. *Merging Mission and Money: A Board Member's Guide to Social Entrepreneurship*. National Center for Nonprofit Boards: Washington, DC, 1998, 22 pages. 800-883-6262.

Shore, Bill. *Revolution of the Heart: A New Strategy for Creating Wealth and Meaningful Change*. New York: Riverhead Books, a division of G.P. Putman's Sons, 1995.

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Northern Wisconsin AHEC

Self Sufficiency and Service in an Age of Shrinking Government Funds

By Betsy Seglem

Federal AHEC funding has come and it has gone for many AHEC centers. Does the average state budget provide enough revenue to sustain the same quality programs for which the AHECs have been known? Are good projects being cut out because of apparent lack of funding? While budgets have decreased over the last several years, Northern Wisconsin AHEC (NAHEC) has stepped up its efforts to be less dependent on shrinking state dollars and rely on more entrepreneurial methods of maintaining projects.

Ms. Seglem is Program Coordinator of the Northern Wisconsin AHEC, Inc. in Wausau, Wisconsin.

In 1997 NAHEC created *Training Connection,* a membership program devoted to continuing education for health professionals. *Training Connection* made education more accessible and efficient by brokering and leveraging members' combined resources. For a minimal fee, members could, for example, request information from NAHEC staff, get reduced costs for selected workshops or ask for assistance with identifying funding sources. By providing one-on-one services to specific members, this program brought NAHEC out of the office and directly into health care organizations.

'By providing one-to-one services to specific members, this program brought NAHEC out of the office and directly into health care organizations.'

The next logical step to ease the burden of shrinking state funds was to expand the Training Connection concept into a general Northern Wisconsin AHEC membership. Organizational and individual partners across NAHEC's 38-county region were invited to join the NAHEC team.

Membership services span several categories such as health sciences library services, health information, health professions student support, community health improvement, continuing education and general services. Needs assessments, program evaluation, reduced cost local workshops, library consulting, meeting facilitation, collaborative program planning and brochure consultation are just a few of the services from which members can choose. Members are responsible for determining their specific needs and NAHEC works with them to address these needs. In creating this membership process, review and work mechanisms have been put into place. Projects are proposed, brought to the NAHEC staff to be evaluated, prioritized and then delegated to appropriate work groups which are comprised of staff members, consultants and/or partners while steady communication with the members who proposed the projects is maintained. The efficient use of time and resources is vital to the success of the membership concept.

The fees, based on an organization's number of full-time employees, are minimal, and at first will serve only to ease the budget for further programming. But the benefits are many.

Publicity is necessary to insure that organizations know what NAHEC can offer them. With publicity come new members/partners and the opportunity to broaden NAHEC assistance throughout the region. A quarterly newsletter sent to members, potential members and academic partners not only spreads the word about what NAHEC is doing, but also gives members ideas for what NAHEC can do for them. NAHEC also sponsors a listserve which provides members with a mechanism to share ideas and resources. The NAHEC web page details the services and also provides many useful links to health information.

Partners can use NAHEC services up to a maximum number of hours allowed per year. Health care needs are brought forward and solutions are worked out together. The membership concept takes NAHEC one step closer to self sufficiency and a greater sphere of influence in which to continue the mission of the health education center.

Garden AHEC, New Jersey

From Networking to Partnership

By Sally A. Henry, MA, RN, FHCE

Just as individuals, initially dependent on parents, develop and change over time to become adults who can support themselves, so must AHECs, which start out on public funds, become mature and self-sustaining.

In the beginning stages, AHECs are funded to develop initiatives that benefit both the communities they target and their affiliated health professions schools. However, federal funding is time-limited and subsequent state funds often are insufficient to maintain the same level of service. As they come of age, AHEC staff and boards need to abandon the entitlement mindset and transition to a business approach. Recently, Garden AHEC in rural southwestern New Jersey had an opportunity to expand a local networking success into a new statewide business partnership which generates its own income.

Southern New Jersey has a high prevalence of lead poisoning, due to the age of many homes, the residue of longtime agriculture and wooden boat building industries and the acidic nature of the major aquifer. In 1993 the New Jersey AHEC Centers collaborated with the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine's Lead Poisoning Prevention and Education Program to establish the South Jersey Lead Consortium. Local health departments, the regional perinatal cooperative and human service agencies, including those administering WIC and Head Start programs, joined in a loosely affiliated network to share concerns and take action to reduce lead poisoning.

The Consortium has thrived. It has conducted major interstate conferences, supported the formation of a parents' support group and initiated a number of creative public information initiatives. Concurrently, AHEC gained a reputation as an effective project manager committed to community development.

Based on the Consortium's work, the Interagency Task Force on the Prevention of Lead Poisoning (an arm of the Governor's Council on Mental Retardation) approached Garden AHEC to conduct a series of forums that would result in a White Paper for policy makers. Holding public policy forums and developing white papers were a stretch for the AHEC. There were numerous reasons not to move into this new field. But it was time to change from being a deliverer of pro-bono services to becoming a self-supporting business.

Criteria were established to determine the project's feasibility. *(See box below.)*

The benefits clearly outweighed the costs. The project fit our mission and we could use familiar methods to deliver a product that would not only pay for itself, but included some extra funds to support the organization. We didn't need to learn a whole new set of techniques; we merely had to acquire a business mentality.

We have been successful on several fronts:

- we conducted three forums for a White Paper which has been delivered to every member of the New Jersey legislature and is being used as a reference for new health legislation;
- we used skills already in place to expand into a new arena;
- we obtained funding from outside the usual stream; and, most importantly,
- we grasped an opportunity arising from community networking and turned it into a business partnership.

We took adult AHEC steps.

Ms. Henry is Center Director of the Garden AHEC in Bridgeton, New Jersey. She also is a member of the National AHEC Bulletin Editorial Board.

Determining the Project's Feasibility

1. Did the project fit our mission? Certainly helping to shape state policy on what both the US Public Health Service and the World Bank have called the "Number One Children's Environmental Health Issue" was consistent with our mission of *"strengthening the health of the community through ... partnerships that ... promote optimal health, especially in underserved populations."* That was clearly a reason to go for it.

2. Did we have the skills to plan and implement these forums? As we reflected on basic AHEC initiatives, we realized our skills at meeting planning and extensive networks were directly applicable to this project. It was "AHEC 101," learned conducting countless continuing education programs! Another encouraging answer.

3. Did we have the economic resources, including staff time? This project wasn't in our current budget; we would need to be paid for our efforts. We knew what process to use to identify costs and we had learned how to bargain over the years. So we could negotiate a contract in which the Task Force would purchase our services and we would provide a product — the forums. This was simply a variant of a familiar grant proposal.

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Coastal AHEC, East Texas

Natural Partners: AHEC and CHC

By Kelli Glenn, MBA, RD

Coastal AHEC in La Marque, Texas, is hosted by a federally funded Community Health Center. The AHEC utilizes its 501(c) 3 non-profit corporation as a vehicle for acquiring funds. During the center's startup in 1992, the center director submitted Articles of Incorporation to the State Comptroller's Office. The newly formed corporation remained dormant until 1996 when the 501(c)3 was activated as a way to enhance the organization's flexibility in obtaining and utilizing funds to support AHEC activities.

Coastal AHEC has utilized its non-profit corporation to secure funds from state agencies, private foundations, and individual donors. In 1999, the 501(c)3 applied for and received a large contract with the Texas Department of Health to provide abstinence education training for primary care practitioners in our service region. With this contract, food is not a reimbursable expense, but the center incurs these costs in the process of providing training workshops. Staff utilize individual and corporate donations, both cash and inkind, to offset a portion of these expenses.

Also in 1999, the center experienced a need to secure a cash or service donation to support an AHEC health careers summer camp. One of the students attending the camp required the services of a sign language interpreter. Staff were unable to locate a volunteer interpreter or a company who would donate the service, and the cost of the interpreter exceeded the budget for the entire camp. The center applied to the Trull Foundation, a foundation in the student's home town for support; the funds were granted, and the student was able to participate in the camp.

A non-profit corporation can be established relatively inexpensively. Coastal AHEC utilized a Health Care Administration student to conduct the initial research and to draft necessary documents. A local attorney reviewed the documents and provided legal counsel.

To reduce research and legal expenses, check out the numerous texts and Internet sites devoted to establishing non-profit corporations, including *How to Form A Non-Profit Corporation* by attorney Anthony Mancuso. This book includes the hows and whys of non-profit corporation law, as well as state-specific information, and a disk with forms and sample bylaws. The costs of maintaining the corporation include board related expenses and tax/financial services. In the experience of Coastal AHEC, the benefits of establishing and maintaining 501(c)3 status exceed the costs.

Ms. Glenn is Executive Director of the Coastal AHEC Center in LaMarque, Texas.

Southwest Georgia AHEC

Creating a Survival Kit to Carry on the AHEC Mission

By Pamela M. Reynolds, MN, MEd

The Southwest Georgia AHEC has created a multitude of educational tools that can be used in a variety of settings to educate students who either want or need health career information, or to enlighten adults who wish to make career changes. Sale of these tools has provided not only a way of marketing knowledge but also a "survival kit" or source of revenue for the AHEC.

Use of the teaching tools allows far more students to be reached and influenced than one AHEC recruiter normally would have the ability to accomplish. The tools also can enhance other AHEC's efforts in improving recruitment of health care professionals.

All of the products were designed with cultural sensitivity to reflect the ethnic and gender makeup of the U.S. population. Specific tools are meant for middle and high school students, and individuals in technical schools and community colleges. Kits for each age group include a curriculum, video and classroom posters. SOWEGA AHEC's products have been sold in 45 states and are in more than 600 schools throughout the nation. Feedback has been excellent.

In Southwest Georgia, teachers were brought to train-the-trainer sessions in how to use the tools in the classroom. Each teacher re-

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Ms. Reynolds is Center Director of the Southwest Georgia AHEC in Albany.

A Survival Kit

(Continued)

ceived a copy of the curriculum, video and posters; the AHEC tracked the usage and received ongoing comments from the subsequent two years. Many high school teachers use the high school curriculum over the course of half a year because there is so much content contained within the resource.

Tools available for middle school students include a 10-day curriculum on *Health Career Discovery,* a video exploring the *Faces of Opportunity* in the health care professions and a bulletin board idea book. For high schools and technical schools/colleges, the curriculum on *Exploring the Faces of Opportunities* is expanded to 25 days and includes a four video set called *Fast Forward to Your Future* and the bulletin board ideas.

Planning, creating and developing these tools was neither easy nor inexpensive.

Faces of Opportunity, a video teaching tool for middle schools, was produced by part-time staff and an independent contractor over a nine-month period. After two years of sales and a production cost of approximately $20,000, the AHEC now is realizing a gross profit.

Developing the high school curriculum was done internally over an 18-month period by two part-time staff members with educational/teaching backgrounds. An additional six weeks were spent by one full-time staff person to review and edit the curriculum. Excluding these internal costs, the gross profit margin, after allocating ongoing personnel costs, is approximately 30 percent.

Creating the video set *Fast Forward to Your Future* was contracted out over 12 months with a video production company. Three months were given by two part-time staff members to assist in pre-production (reviewing scripts, casting of health care professionals and actors and organizing props and filming locations). An additional two months was given by two part-time staff to assist in production and post-production. The cost was close to $90,000 and it will be at least one to two years before costs will be recouped.

One tool, an interactive CD-ROM, *Anatomy of Health Careers,* is an appropriate resource for all age groups as well as for any adult learner, media center or library.

The CD highlights 64 of the most in-demand health careers and is divided into 15 "user friendly" sections, each containing an interview with a professional in each occupation, typical places of employment, salary information, requirements to enter the career, financial aid information, professional organizations to contact and "hot" links to web sites.

The CD, which took a year to produce, was very labor intensive because the technology and understanding of production was fairly foreign to most of the AHEC staff. The content (materials, video clips, scholarship information, photographs) had to be developed and supplied by the AHEC, while the interactive content was developed by another company. Legal help was sought to ensure that the end product was owned by the AHEC. Four staff members worked a total of four months on the project.

Since this is SOWEGA AHEC's newest product, profits are unknown, but it is hoped that within six months SOWEGA will cover costs. The cost of the video clips will be borne by sales of the videos.

The curriculum developed by SOWEGA-AHEC is an innovative way of marketing greater knowledge of the variety of health careers available to students. It allows educators to discuss career choices for at least 25 consecutive days and sometimes influence career choices.

For more information on products, phone: Peggy Cole or Janel McGinley, 912-439-7185; write: Southwest Georgia Area Health Education Center (SOWEGA-AHEC), PO Box 528, Albany, GA 31702; or E-mail: cole.p@gain.mercer.edu

The Need for Educational Tools

The development of these tools came about because:

- Teachers lack background knowledge about various health careers.
- Students are highly visual and hands-on learners.
- No comprehensive curricula was available to teachers in middle and high schools that would cover many health careers, provide current information, stimulate learning, increase depth of knowledge and provide teaching tools (pre- and post-tests, worksheets, videos, color transparencies, games, lesson plans, lecture materials and bulletin board ideas).
- Many students and adults utilize computers and like to learn while using today's technology.
- The AHEC does not have enough personnel to *intensely* educate students or *intensely* "grow our own."
- The development and marketing of the tools would allow the AHEC to continue to accomplish its mission while helping to defray costs.

AHEC
The National Area Health Education Centers Bulletin

Business Planning Skills for Health Care Organizations

By Cynthia C. Scalzi, RN, PhD, FAAN

Heath care is a business and adopting the tools and techniques of "business" makes sense. The business plan is a standard tool for presenting changes in programs or developing new services. In fact, most health care systems require that business plans be presented when preparing annual budgets as well as for programmatic changes.

AHECs have a long and distinguished history of accomplishments which center on improving the supply and distribution of health care professionals, thus improving the quality and access to health care. But what will it take to sustain this mission in an era of constrained resources and increased competition for limited federal and state funding? The development of business planning skills can facilitate the successful pursuit of AHEC's strategic goals.

Why business planning? Business plans are expected of health care professionals who wish to raise venture capital or other equity for a new program or service or to expand an existing one. Business plans serve as an operating blueprint to guide program development and growth.

Who should write the business plan? The management team responsible for implementation should prepare the actual plan. It is not necessary and may not even be advantageous to hire outside consultants. This process enables the team to examine the consequences of different strategies and tactics and the human and financial requirements needed for implementation. Outside funding sources attach great importance to the quality of the team and their understanding of the business plan. For some health care professionals this may require a new set of skills. They include:

· ***Conducting a market analysis*** – one that convinces the reader that the proposed program or service will achieve its stated goals despite the competition. Both the internal (organizational) and external markets must be analyzed. Success of the plan depends on the realistic assessment of the strengths and limitations of both the organization and the targeted market. This also may be referred to as a SWOT Analysis — that is, identification of the program's Strengths, Weaknesses, Opportunities and Threats.

· ***Setting marketing goals*** — and objectives that are specific and achievable. Plans have to be made for marketing management, training, staffing and ongoing market evaluation to assist in expansion or modification as the program progresses.

· ***Operational planning*** — describes how the program or service will be designed, developed and provided. An operational plan with specific time frames must be established. Gantt or Pert Charts are techniques frequently used in this part of the business plan.

· ***Conducting a financial analysis*** — to determine if the program is viable. This analysis integrates and compiles all the data from the goals and objectives of the business plan. Summary of tables of projected income and expense, balance sheets and cash flow projections on a quarterly basis should be included. Working capital requirements and spreadsheets of accounts receivable and payable will be expected. A break even analysis in graph form, as well as "worst and best case" scenarios with financial implications also may be expected.

· ***Developing the monitoring and evaluation plan*** — with a month-to-month timetable that shows the interrelationships among the major events will be expected in the business plan.

Planning Pitfalls

There are a number of commonly cited problems or barriers to effective planning. They include: having no real goals, or ones that are vague, not measurable or time phased. Admirable missions, such as "improving performance" or "increasing educational opportunities," are not concrete goals and plans centered around them are not likely to be achieved. Excessive optimism can seriously impede the ability to anticipate obstacles and to develop alternative strategies. Loss of key personnel, new market competition and an overly ambitious timetable are just a few of the obstacles that can arise. Having a short-term orientation with few milestones and progress reviews will lead to problems. Often plans that fail have no concrete milestones, such as revenue, cost and cash flow targets, and no progress review dates (they may exist but are not adhered to). Finally, failure to revise goals, having a plan that never changes or is unresponsive to a changing situation is programmed for failure. Progress reviews are wasted if a new situation is not met with a change in strategy or emphasis.

Dr. Scalzi is Program Director of Nursing and Health Care Administration School of Nursing and The Wharton School of the University of Pennsylvania.

AHECs and Philanthropy:

Demystifying the Rubik's Cube of Foundation Funding

By Michael Beachler

Foundation funding can be an important source of venture capital to help AHECs and HETCs fulfill their mission. Seeking foundation funding also can be perplexing, time consuming and frustrating. As my colleague and office neighbor, Linda Kanzleiter (Associate Director of the Pennsylvania AHEC), noted, perhaps this article can help demystify the Rubik's Cube of philanthropic funding.

Many books and manuals have been written about successful grant writing. Grant writing workshops have become a small industry that readily attracts thousands of health, human services and education profession grant seekers each year.

'AHECs have several characteristics that can make them particularly attractive candidates to secure foundation funding. These strengths are a result of the history and structure of AHECs as well as the individual backgrounds and skills of key AHEC staff.'

Like solving Rubik's Cube, no easy step-by-step method exists that will guarantee successful grant seeking. However, 14 years experience as a grantee, foundation officer and director of a complex multisite grant program has taught me that following some key principles can enhance your ability to secure foundation funding. I will summarize some of the most important principles hoping to will bring it alive by providing a few successful examples involving AHECs.

Know Your Target Audience

The importance of knowing your target foundation's priorities can't be underestimated. This is no easy task, as thousands of philanthropies exist to fund health and education programs. Individual foundations have unique goals and program priorities that differ in ways that are important for the effective grant seeker to understand. The vast majority of proposals that I have reviewed for the Robert Wood Johnson Foundation (RWJF) that did not receive funding were linked to an applicant's lack of understanding of RWJF's mission, major objectives and current funding priorities. Knowing what program areas a foundation wants to invest in is important. It also is important to know whether a philanthropy is looking for projects of regional or national significance or is more likely to fund efforts that help solve local community problems.

Most foundations are generally interested in promoting innovation and often use their funds to demonstrate a new approach. Foundations also may be interested in elevating the visibility of a specific health care issue on the local, state or national agenda. As the new President of the Carnegie Corporation of New York, Vartan Gregorian, PhD, recently put it, "We're not an oxygen tank to keep not-for-profit institutions alive. We're an incubator for ideas." Even when foundations are interested in replicating a specific effort, they are more apt to support an effort that adapts a specific program model to the unique "real world" needs of the target community.

So how do you get to know this mysterious and elusive foundation community? Publications like the Foundation Directory and Chronicle of Philanthropy are a start. If these are too expensive to purchase, ask your statewide AHEC office to obtain a summary of the foundations that fund in your state. Local and regional philanthropies are key and increasingly important audiences, particularly given the rapid growth of new health-oriented foundations as a result of the conversion of not-for-profit insurance companies and health care facilities in many states. Most philanthropies are posting the most important information about their ac-

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Mr. Beachler is Director of the Rural Health Policy Center of the Penn State Geisinger Health System. He also is National Program Director for the Robert Wood Johnson Foundation's Southern Rural Access Program.

tivities on the Internet. Annual reports, quarterly newsletters, and calls for proposal are other sources, and it generally only takes a phone call to get placed on a foundation's mailing list.

Establishing professional relationships with foundation staff can be an important way to increase your odds of obtaining funding. Invite foundation staff to address your annual state AHEC or other related state association meetings. You also may want to try to get invited to participate in a state association of health and human services grantmakers forum. These forums are convened by grantmakers in a growing number of states to educate each other on topics of mutual interest. Sponsors of these forums are often looking for experts in specific content areas to make presentations.

Use your judgment regarding how assertively to "pitch" an idea to foundation staff. Foundation staff are used to being asked for support because giving money away is a major part of their job. However, on certain occasions, it may be more appropriate to take a more subtle approach that focuses on making the human connection and showing that AHECs are strong, capable organizations. Funding opportunities may result as a natural outcome of such connections.

To illustrate, in 1995, I was invited to make a presentation at a national AHEC meeting in Seattle. The networking at the meeting helped influence me to highlight AHECs as possible lead agencies in the Robert Wood Johnson Foundation's Partnership for Training Program. Today, AHECs provide leadership for three of the eight projects in this initiative to promote regional interdisciplinary partnerships to train nurse practitioners, physician assistants and certified nurse midwives in underserved areas. The credit for leadership of these projects belongs to the Colorado AHEC Program Director Marie Miller, PhD, Wisconsin AHEC's Barbara Nicolls, and San Joaquin Valley Health Consortium representative Katherine Pomaville, but the invitation to the Seattle meeting helped open the door.

Market Your Strengths

AHECs have several characteristics that can make them particularly attractive candidates to secure foundation funding. These strengths are a result of the history and structure of AHECs as well as the individual backgrounds and skills of key AHEC staff. AHECs are generally very *flexible* organizations. AHECs are perhaps the only organizations that have the capacity to understand the dynamics and complexities of both academic health centers and underserved communities. Understanding the importance of community development and knowing what makes a healthy community can complement the in-depth knowledge of the organizational, fiscal and academic forces that hinder and/or promote the ability of academic health centers to serve those same communities. This can be a tremendous asset to enable AHECs to serve as very effective facilitators of partnerships between these very different worlds.

AHECs in different states have used this flexibility to take on new and very interesting foundation-funded roles. Western Arizona Health Education Center (WAHEC), under the leadership of Amanda Aguirre, has used foundation funding to expand use of community health advisors/*promotores* in the community to conduct outreach and provide assistance to children who are eligible for children's health insurance. Two AHECs that participate as major subcontractors in Louisiana's RWJF's Southern Rural Access Program effort are playing far different roles. As a result of the banking industry background and expertise of Executive Director Brian Jakes, the Southeast Louisiana AHEC is providing leadership for a Rural Health Development Fund designed to assist rural health care providers in underserved areas better access capital financing. The strong community development orientation of Southwest Louisiana AHEC Center Director Jeanne Solis-Daigle was an important factor in its selection to lead a network develop-

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'AHECs have several characteristics that can make them particularly attractive candidates to secure foundation funding . . . AHECs are perhaps the only organizations that have the capacity to understand the dynamics and complexities of both academic health centers and underserved communities.'

ment effort. The network project is working in an eight parish (county) region to improve access to primary care services for the medically indigent by creating new partnerships and changes in reimbursement arrangements between public and private providers.

AHEC's ability to serve as effective brokers and facilitators is another important asset. This is especially true in an increasingly competitive health care and educational environment. Many foundations are interested in funding community-wide or regional efforts and are less likely to fund efforts that will benefit just one institution. Institutions that can work effectively with a wide range of agencies are apt to serve as leads or key partners in these broad community or regional efforts. This ability to serve as a trusted, effective and inclusive facilitator was an important factor that led a broad range of agencies to select the East Texas AHEC Program, under the leadership of Executive Director Steve Shelton, to serve as the lead agency for their Southern Rural Access Program grant. Similarly, these skills assisted the Colorado, Wisconsin and San Joaquin Valley AHECs to be selected to lead the RWJF Partnerships for Training effort.

'The funding structure of the AHEC program has helped agencies to become very knowledgeable about the complexity and dynamics of state government policy making.'

Many AHECs also have demonstrated an ability to be politically savvy and nimble.

The funding structure of the AHEC program has helped agencies become very knowledgeable about the complexity and dynamics of state government policy making. This can be an advantage as many foundations like to eventually see their funded efforts positively influence state policy. Some foundations also see state funding as one possible source to continue their efforts after foundation funding ends.

Make sure your knowledge of both state and local policy shines through when you craft a proposal. The Massachusetts AHEC, under the leadership of Program Director Mick Huppert, has consistently used these skills to attract both foundation and state government funding in areas as diverse as recruitment and retention of primary care practitioners in underserved areas, as well as child health insurance outreach and enrollment.

Perfecting the Pitch: Short, Sweet and Persistent

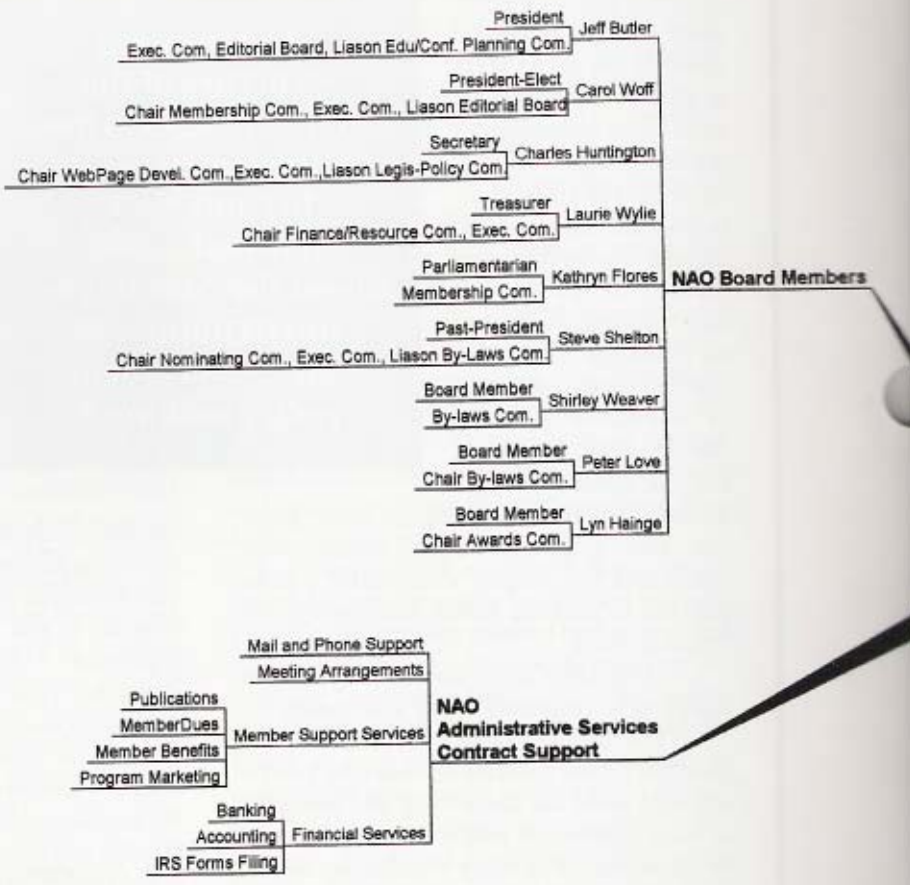
When it comes to proposal development, it is important to communicate the essence of your project concisely. The cover letter and/or executive summary are critically important communication devices, yet they are often the weakest parts of the proposal. I recall one foundation officer at RWJF who noted, " If you can't say it in three pages, then it isn't worth funding" and then generally acted accordingly. Even if the proposal guidelines call for a 25-page proposal, be prepared to communicate the heart of the proposal through the cover letter and the executive summary. Similarly, for those foundations that require site visits, make sure that your verbal presentations are concise. The site visit team's major objective is to get answers to their questions, so it is wise to leave plenty of time on the agenda to answer them.

Finally, it is important to be persistent in your efforts to secure foundation funding. Most foundation officers review many more proposals than they fund, so expect review delays. Occasional phone calls to inquire about the status of the proposal or to see if you can answer any questions are appropriate. I generally saw these short, occasional and polite phone calls as an indication that the applicant was very interested in implementing the project. On more than one occasion, this persistence was an important factor in the decision to move the project forward through the staff and board review process. If a proposal is not funded, call the assigned staff officer to ask the reasons for the turndown and to see whether he/she has any ideas for other places to seek funding. This conversation also may stimulate discussion about other ideas that may be a better match for the foundation's priorities.

Solving Rubik's Cube and securing foundation funding both require effort, ingenuity, persistence and adherence to a few basic principles. The journey you take to secure Foundation venture capital can be well worth the effort, particularly if you approach it with the same sense of adventure and commitment that influenced you to become involved with AHECs in the first place.

Organizing fo

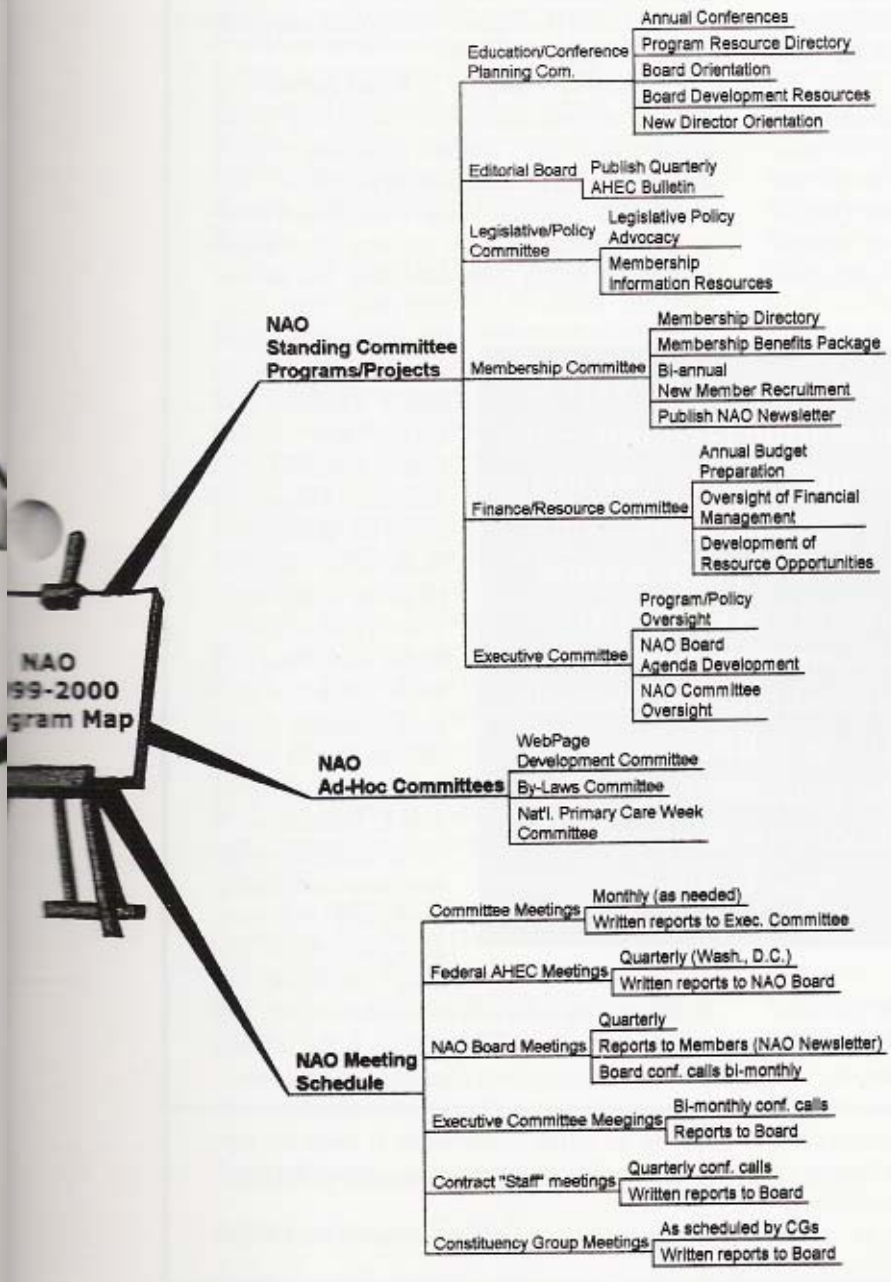
The National AHE



The interlocking squares symbolize the role of AHECs as a link between communities and their academic educational partners.

Sustainability

Organization (NAO)



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Oregon: Building a Case for an AHEC Foundation

By Barbara Grigsby, MPA

When we think of foundations, we often think of organizations that raise money for causes such as hospitals and universities. Of course, there are those foundations to which we submit grant requests that give funds to non-profit organizations like AHECs. But have you thought about establishing a foundation that builds friends and financial support for your AHEC?

AHEC of Southwest Oregon decided that establishing its own foundation was one piece of a strategy to achieve its goal of long-term sustainability. The AHEC of Southwest Oregon is a 501(c)3 non-profit organization, eligible to receive donations and provide verification to donors that their gift is tax deductible. So what is the advantage of forming a second 501(c)3 to receive tax-deductible donations? Doug White, EdD, charter founder of AHEC in Southwest Oregon and current AHEC Foundation member, said, "A separate organization focusing only on raising friends and funds for the AHEC is a tremendous resource. It's always a benefit to increase your circle of friends and supporters."

Ms. Grigsby is Executive Director of the AHEC of Southwest Oregon in Roseburg.

'The board of the AHEC Foundation is comprised of people who have fund-raising, marketing and business experience and have networks of friends and partners who have similar skills. Two boards with very different skills is the primary reason for having two separate organizations.'

Yes, it is true. There are two non-profit organizations in southwest Oregon that focus on the AHEC mission. The first, formed in 1994, is the Area Health Education Center of Southwest Oregon. Its mission is "to enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships." The second non-profit, the AHEC Foundation, "supports the mission of the Area Health Education Center of Southwest Oregon in strengthening public relations and conducting fundraising activities." Each organization has its own board of directors, and staff is assigned to help each organization accomplish its goals.

There is a total of 28 board members in the two organizations, each committed to the mission of AHEC. But the important point is that each board is comprised of people with different skills, expertise and networks. Board members of AHECs typically are very knowledgeable about health care, education and service delivery. However, they generally have little experience in public relations, marketing and raising funds. The AHEC of Southwest Oregon decided to maintain a board with valuable program experience. That knowledge is highly valued and very much needed in program creation, implementation and monitoring. The board of the AHEC Foundation is comprised of people who have fund raising, marketing and business experience, and have networks of friends and partners who have similar skills. Two boards with very different skills is the primary reason for having two separate organizations.

But there are other valid reasons for establishing an AHEC foundation. It frees the program board from planning and organizing fund-

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AHEC Foundation

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ing strategies. While the complete AHEC team needs to help with fund raising, assisting is very different from full responsibility. Additionally, a foundation provides grant makers and donors with proof that the organization is serious about long-term sustainability. Should the AHEC become involved with nationwide sales, the bylaws of the foundation can specifically address the receipt of revenues from outside your region for the purpose of fulfilling the AHEC mission. This will enable your organization to avoid unrelated business revenue taxation. And finally, it is a vehicle through which funds can be invested for a higher rate of return. Program boards are understandably more cautious about aggressive investment policies due to their fiduciary responsibility of meeting operating expenses.

AHECs have big missions that affect many lives throughout their service areas. To fully achieve their goals, it will take more money than any federal, state or private foundation can or will grant. To complete the mission, it takes many strategies: grant writing, fund-raising, entrepreneurial activities, fees for services, planned giving, personal solicitation and direct mail. The Southwest Oregon AHEC foundation is working in each of these areas and is developing strategies to make each one productive. Deborah Ameen, incoming Foundation president, said, "There are so many needs in rural health care, and the economic strength of the region depends very much on every resident and visitor having access to health care. Is it possible for health care to be accessible to everyone? We believe it is, and the AHEC Foundation is committed to finding resources to make it happen."

You may ask, "If forming a foundation is the answer, why doesn't every AHEC form one?" Every AHEC is different. Southwest Oregon is populated by very supportive solution-driven people. It is a region made up of people who truly believe they live in the greatest place on earth. Consequently, they want to make their social structures the best and find resources to meet needs. It is a region with abundant resources, yet many people who previously had good jobs in the timber industry now struggle to find services for their families. Collaboration and consensus are common ways of working together. Thus, an AHEC Foundation is viewed as a solution-driven organization that is helping all people access health care. Would people in your region have similar beliefs? Would people in your region view your mission as a very important one for which to raise funds?

You may also ask, "What amount of staffing does a foundation require?" This is an important consideration. Most organizations do not function very well for long periods of time without paid staff, and certainly a foundation needs staffing. In the first two years, the AHEC Foundation was directed by a consultant who brought in-depth experience in working with foundations. Now, in the fourth year, the Executive Director of the AHEC Program is designating 50 percent of her time to the foundation. By the year 2001, capacity building funds will have been secured from an Oregon foundation which focuses on building strong organizations. By the year 2004, it is anticipated that the foundation will be able to hire its own staff.

Building a foundation is a long-term process. If you need money tomorrow, a foundation is not the answer. Plan for four to five years of building to make the organization return the results your region needs to meet its mission.

Building friends, building friends and building friends is the number One activity of a foundation. AHECs tend to do this very well, but may not think of friends as potential donors. People are looking for ways for their money to help others. If you provide for them a trusted, well-managed, reliable and effective place to put their money to work, they will help you!

'AHECs have big missions that affect many lives throughout their service areas. To fully achieve their goals, it will take more money than any federal, state or private foundation can or will grant. To complete the mission, it takes many strategies: grant writing, fund-raising, entrepreneurial activities, fees for services, planned giving, personal solicitation and direct mail.'

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Louisiana AHEC Center Serves as a Financial Resource Center

The Southern Rural Access Program, funded by The Robert Wood Johnson Foundation, is designed to help improve access to basic health care in eight of the most rural, medically underserved states in the country: Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, East Texas and West Virginia. The program supports work to increase the supply of primary care providers in underserved areas, strengthen the health care infrastructure and build capacity at the state and community levels to address health care problems.

Many AHEC partners play key roles in the Southern Rural Access Program, including James M. Herman, MD, Director of the Pennsylvania AHEC Program, who serves as senior medical consultant for the Program. The following article describes the innovative leadership the Southeastern Louisiana AHEC Center has provided by creating a loan program to help build health care capacity within the state. While every AHEC Center may not have a former banking industry executive on staff, the article invites consideration of unexplored tools and resources that can provide new opportunities for the 21st century.

By Susan C. Dollar, PhD, and Brian P. Jakes

If someone were to analyze the health care infrastructure in many rural Louisiana communities, it would be clear that the lack of primary health care services is due in part to the scarcity of community resources to support and sustain these services. AHEC staff and others concerned about rural communities are now approaching this long-standing problem through a financing model called the "Louisiana Rural Health Loan Fund" program.

The purpose of the loan program is to build capacity through capital investment and technical assistance. It is a unique approach to the AHEC mission of improving primary health care in medically underserved areas. The fund builds rural infrastructure in two ways: first, by mobilizing financial and technical assistance resources to underserved rural communities, and second, by infusing rural leadership with the direct technical assistance they need to develop business plans and long-term growth strategies for improving access to primary care for their communities.

The fund is being implemented through the Southeastern Louisiana Area Health Education Center (SEL-AHEC). The loan program was created in early 1999 in response to a grant award from the Robert Wood Johnson Foundation. Louisiana is one of eight southern states to develop initiatives to address primary and preventive health care access under the Southern Rural Access Program. Administered by the Louisiana State University Health Sciences Center in New Orleans and the Louisiana Department of Health and Hospitals, the project will be long-term in nature and involve efforts to improve rural primary care infrastructure in underserved regions of the South. Other states which are involved in the Southern Rural Health Access Project are West Virginia, South Carolina, Alabama, Mississippi, Arkansas, Georgia and Texas.

The Louisiana Rural Health Loan Fund targets activities that will contribute to improvements in primary care access and service delivery. Examples to include on an ideal loan application would be establishment of an emergency 911 system, purchase of an ambulance or other equipment, upgrade of MIS or business applications or financing the establishment of a new

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Dr. Dollar is a Southeast Louisiana AHEC staff member and Senior Rural Health Development Specialist on the AHEC portion of the LSU-led Robert Wood Johnson Southern Rural Access Grant.

Mr. Jakes is CEO of the Southeast Louisiana AHEC in Hammond and serves as the CEO of the Rural Loan Development Fund on a pro bono basis.

'While most community development loan funds manage their own financial operations, the SEL-AHEC serves as the financial resource center, leaving the loan processing and the capital management of the venture capital fund to well-established finance professionals.'

Financial Resource Center

(Continued)

medical practice. The impact of the Rural Health Loan Fund should be long-term improvements in the rural health system.

The Louisiana initiative is unique in several respects. First, statewide AHEC involvement is central to the fund's success. AHECs are viewed as neutral agents in the community and can therefore extend the loan program to communities without being viewed as having "a hidden agenda." Most communities know that the AHEC mission is to work toward overall improvements in access and quality of rural health care, and this goal keeps the entities collaborative in nature and open to new growth opportunities for fund resources.

In keeping with its collaborative nature, SEL-AHEC has assembled a cross section of the state's business and civic leadership to govern the Rural Health Loan Fund. The advisory committee's leadership represents community agencies, educational institutions, governmental agencies, private foundations, corporations and others interested in long-term growth and development for the state's health system.

Another unique aspect of the Louisiana Rural Health Loan Fund is its structure. While most community development loan funds manage their own financial operations, the SEL-AHEC serves as the financial resource center, leaving the loan processing and the capital management of the venture capital fund to well-established finance professionals. We "leave the banking to the bankers" and concentrate on providing technical assistance and follow-up which will equip clients with business and marketing plans that will serve their needs in securing financing. A case-by-case basis typically is used in determining how a business plan in the total loan application is prepared. The finance plan is purposefully flexible and based upon the client's purpose, risk and time requirements. If staff find that the client's plan does not meet the Rural Health Loan Fund's criteria for primary and preventive services, they are prepared to make referrals to other governmental and private funding sources.

Finally, there is a "venture capital" component which most loan programs do not offer. This fund will be used to aid applicants who do not meet credit criteria for conforming loans. Access to the "venture capital" pool will be founded upon broad-based selection criteria, which is established by a statewide loan committee. This committee will have significant authority to assist in salvaging credit requests to meet conforming criteria.

The Rural Health Loan Fund Program is one of four key components of the Southern Rural Health Initiative. The other three components involve: 1) development of rural health networks throughout the state to improve linkages and referral systems among providers; 2) development of statewide "Chambers of Health," a coalition of health, business, civic, religious, education leaders and consumers who help to ensure community involvement in planning and implementation of health programs and 3) recruitment and retention initiatives to ease the shortage of health professionals in rural areas. This last initiative includes the expansion of telemedicine and distance education networks throughout the state.

"AHECs are viewed as neutral agents in the community and can therefore extend the loan program to communities without being viewed as having 'a hidden agenda.' Most communities know that the AHEC mission is to work toward overall improvements in access and quality of rural health care, and this goal keeps the entities collaborative in nature and open to new growth opportunities for fund resources."

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AHECs: Critical Catalysts in Interdisciplinarity

By Denise E. Holmes, JD, MPH

Dr. Holmes is Director of the Association of Academic Health Centers/HRSA Center for Interdisciplinary, Community-Based Learning and Liaison to AIHA.

As we look to the 21st century, we see not only a burgeoning of opportunities for interdisciplinary health professions education, but also a heightened emphasis on interdisciplinarity on the part of our nation's academic health centers. In 1997, the Association of Academic Health Centers (AHC) and the Health Resources and Services Administration (HRSA) jointly established the AHC/HRSA Center for Interdisciplinary, Community-Based Learning (CICL).

Housed at AHC, CICL Has Three Primary Objectives:

1. strengthening academic health centers' commitment to interdisciplinary, community-based learning;
2. providing expertise with respect to model curricula and training sites for interdisciplinary, community-based learning; and
3. supporting an interdisciplinary network of health care professionals.

While cross-professional collaboration has long occurred at the programmatic level, particularly in community-based settings, we are now witnessing plentiful examples of academic institutions embracing this approach at the institutional level. In light of this growing trend, the Association of Academic Health Centers has produced a new monograph, *Catalysts in Interdisciplinary Education: Innovation by Academic Health Centers*. Of the seven institutional case studies included in this volume, several amply illustrate the vital role of AHECs in encouraging and fostering cross-professional synergies. Brief examples from three of these remarkable institutional narratives follow.

University of Arkansas for Medical Sciences: *Developing the Interdisciplinary Education Network*

The University of Arkansas for Medical Sciences (UAMS) has long recognized and tapped the inherent merit of AHECs. The six Arkansas AHECs operate in some respects as freestanding satellites of the main campus, or "mini academic health centers." However, the lines of communication and the flow of information also run from the field back to the UAMS campus, sometimes by way of interactive video consultations. The UAMS Vice Chancellor for Regional Programs, Charles O. Cranford, DDS, MPA, who serves on the CICL advisory committee, directs the Arkansas statewide AHEC program.

In its current strategic plan, UAMS emphasizes the expansion of opportunities for interdisciplinary education and specifically cites AHECs as key partners in this endeavor. The decentralized network also includes community health centers, affiliated teaching hospitals, private medical practices, family practice residency programs and preceptors. Each year, the "typical" Arkansas AHEC provides an educational experience for family medicine residents, as well as undergraduate medical, nursing, pharmacy and allied health students. At one site, family practice residents expand their knowledge of geriatrics by working closely with colleagues and students from nursing, pharmacy and social work.

East Carolina University: *Retooling to Meet the Needs of a Changing Health Care System*

East Carolina University (ECU) is located in eastern North Carolina, a largely rural region. Given the surrounding medically underserved community, ECU's health professions students experience community-based learning in rural settings where interprofessional collaboration is required. One important mechanism for this education is the Interdisciplinary Rural Health Training Program (IRHTP), which was launched in 1994. ECU students participate in the IRHTP in conjunction with the Eastern, Southern Regional and Coastal AHECs, as well as seven other universities. Ten disciplines are represented in the IRHTP: health education, medicine, nurse practitioner, nursing, nutrition, occupational therapy, pharmacy, physical therapy, physician assistant and social work.

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Critical Catalysts

(Continued)

In collaboration with the Fayetteville and Eastern AHECs and Duke University, ECU is a demonstration site for Partnerships for Training (PFT). This Robert Wood Johnson Foundation-funded program, designed to alleviate health workforce shortages in underserved areas across the country, supports consortia of nurse practitioner, midwifery and physician assistant programs. PFT's unique feature is its emphasis on training students in their own communities. While interdisciplinarity per se is not a goal of PFT but merely a means, the program has demonstrated the value of learning about the roles of other health professionals early in one's professional training. Following several years of project planning, the first class of 41 students in North Carolina matriculated in 1998, and the second class of 51 matriculated in 1999.

Medical University of South Carolina: *Building an Interdisciplinary Culture*

In the past decade, the Medical University of South Carolina (MUSC) has made tremendous strides toward integrating its components into a cohesive institution. Indicators of this progress include the development of a common academic calendar across six colleges; establishment of an interdisciplinary Office of Educational Planning; and adoption of the AHC Health Professions Covenant, which has been incorporated into the university catalog and commencement program.

In 1994, MUSC, together with the South Carolina AHEC, was selected as one of four institutions to participate in a national interdisciplinary collaborative sponsored by the Institute for Healthcare Improvement (IHI). The IHI project's goal is "to improve health, health care and health professions education – especially interdisciplinary education – through the use of continuous improvement methods."

To this end, MUSC faculty and the South Carolina AHEC have developed and implemented several interdisciplinary learning experiences, including an annual rural interdisciplinary practicum for students from the Colleges of Health Professions, Medicine, Nursing and Pharmacy. As student demand for these opportunities has risen dramatically, MUSC and the Low Country AHEC successfully have obtained additional funding.

Academic Health Centers and AHECs: *Strategic Allies*

AHECs provide patient care services – particularly primary and preventive care services – that in underserved communities are all-too-often otherwise unavailable. The typical AHEC is not only a long-standing resource, but also a vital ally in the academic-community partnership. In the course of examining the activities of our nation's AHECs, one would be remiss in failing to note the significant ways in which AHECs foster cross-professional collaboration in general and interdisciplinary health professions education in particular. From the vantage point of an academic health center, the AHEC is often pivotal to such opportunities. Academic health centers and AHECs alike are responding to the health care system's shifting emphasis from the provider to the consumer of care. As the UAMS, ECU and MUSC stories plainly show, AHECs continue to serve as critical catalysts for advancing interdisciplinarity among those providers with an eye toward enhancing care for health care consumers.

Additional information about interdisciplinary efforts at UAMS, ECU and MUSC is included in the monograph *Catalysts in Interdisciplinary Education: Innovation by Academic Health Centers*. Copies are available from the Association of Academic Health Centers, Suite 720, 1400 Sixteenth Street, NW, Suite 720, Washington, DC 20036; Phone: (202) 265-9600.

AHEC
The National Area Health Education Centers Bulletin

AHECs Help Reinvigorate Primary Care Week Activities

By Bruce E. Gould, MD

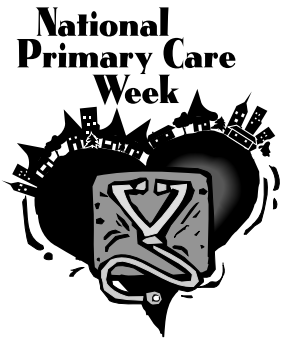
Students at 125 allopathic and osteopathic medical schools across the country celebrated the first National Primary Care Week (NPCW) from September 27 to October 2, 1999 with a variety of informative and exciting events.

The national initiative, sponsored by the Health Resources and Services Administration (HRSA) Division of Medicine, was organized in partnership with the American Medical Student Association (AMSA) and AHECs across the United States. The purpose of this new initiative was to highlight the importance of primary care providers in meeting the health care needs of our communities, especially those that are underserved.

Donald L. Weaver, MD, Director of the National Health Service Corps and a pediatrician by training, works a puzzle with children in a Head Start program/day care center during Primary Care Week activities at the University of Connecticut. Other photos are from the same week's activities at UConn.

Dr. Gould is Program Director of the Connecticut AHEC.

NPCW evolved from National Primary Care Day, a project sponsored by the Association of American Medical Colleges (AAMC) starting in 1994 to encourage medical students to consider careers in primary care. The AAMC dropped its sponsorship in 1998 when numbers of medical students recruited to the primary care disciplines seemed to be increasing, making it appear the "primary care crisis" was over. Subsequent match results showed a decrease in recruitment to family medicine and demonstrated a need to assure that Primary Care retained visibility as a viable career option for health professions students.



Re-establishment of the effort, with its expansion to other primary care disciplines and its focus on community needs, began with members of AHEC approaching Claude Earl Fox, MD, MPH, director of HRSA, at the National AHEC meeting in August 1998. A needs assessment was conducted by staff at HRSA and an advisory committee established, which included representatives from many of the National Primary Care Organizations.

AMSA was asked to be the lead organization. Staff developed a NPCW manual that included a play-by-play description of how to get a local "celebration" underway. They recruited from their membership at each allopathic and osteopathic medical school student coordinators who secured support from school administrators, raised needed funds, and planned and promoted events to local audiences.

AHECs across the country worked with student committees at their schools to make the "pieces fall into place." AHECs helped with mailings, fundraising, banquet planning, obtaining speakers, making connections to community groups . . . just about anything that the students needed. Perhaps the most important role of the AHEC was in connecting medical students to their counterparts in other health pro-

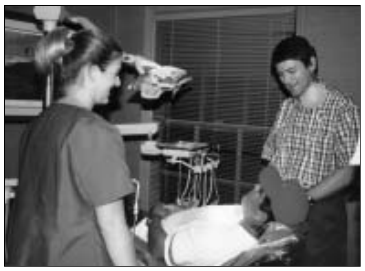
(Continued on next page)

Primary Care Week

(Continued)

fessions that participate in the "primary care team" (dentists, nurse practitioners, physician assistants, nurses, social workers, nutritionists, etc.). At some schools, events included a variety of team members. At others, medical students planned and celebrated the week without their counterparts in other disciplines. AMSA staff members noted that "no two communities celebrated National Primary Care Week in exactly the same way."

Local organizers created events that reflected the needs and interests of the communities they served. AHECs were of great help in connecting student groups to community groups and assisted in organizing community service projects targeting local community issues. Activities included smoking cessation programs; cholesterol, blood pressure, glucose, and dental cavity screenings; nutrition education for parents of Head Start children and public school health education programs.



Educational programs also were held on campus to highlight primary care as a career. These events included brown-bag lunches featuring distinguished faculty members speaking; practitioner shadowing programs; primary care

career fairs for students. Some AHEC centers not near a health professions school hosted interdisciplinary events for health professions students placed in communities within their region.

An assessment of the 1999 NPCW activities funded by the Robert Wood Johnson Foundation is underway at AMSA. Preliminary results show that 88 percent of allopathic and osteopathic medical schools (of a possible 142) participated in some way. So far, 40 of the 192 AHECs (21 percent) have responded that they assisted their local health professions schools in celebrating community focused primary care. The National AHEC Organization, in conjunction with AMSA and HRSA, is starting to plan for the year 2000 celebration with the hope that all AHECs will "put their shoulders to the wheel" and get involved.

NPCW is an opportunity for AHEC to partner with students in a very direct way that assures that all health professions students gain knowledge of AHEC and an understanding of what AHEC can do for them and their communities. The committee's hope is that as students graduate and go out into their communities to practice they will recognize the unmet needs of those communities and realize that AHEC is there to assist them in meeting those needs.

The dates for the year 2000 celebration will be announced soon and will be forwarded through the NAO. Anyone interested in working on planning for AHEC's participation in the 2000 National Primary Care Week effort may contact Bruce Gould, MD, Director of the Connecticut AHEC Program: 860-679-4322; Fax: 860-679-1282; E-Mail: Gould@adp.uchc.edu.

The contact at AMSA is Yvonne Fulbright, MSEd, NPCW Project Coordinator, AMSA Foundation: Phone: 703-620-6600, ext. 204; E-Mail: YKF@www.amsa.org.

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Louisiana and Arizona AHECs

Learning Medicine and More at Fort Yuma Indian Hospital

By Gerald Falchook

In the desert. A small medically underserved community. Rural medicine. Native Americans. Primary care. A dearth of medical professionals in a community that badly needs them.

These are the visions that led me to Fort Yuma Indian Hospital. And AHEC enabled me to fulfill those dreams.

With the support and coordination of both the Southeast Louisiana AHEC Center and the Western Arizona AHEC Center, I was able to participate in an AHEC preceptorship at Fort Yuma Indian Hospital following my first year of medical school.

Meaningful clinical experiences are sometimes few and far between for many first-year medical students. Exposure to primary care in rural underserved areas early on in the medical education encourages students like myself to consider serving in medically underserved communities in the future.

Gerald Falchook, right, with members of the Fort Yuma Indian Hospital staff, from left: Dr. Jose Piscoya, Dr. J. Lorch and Dr. Raouf Hanna.

Certainly, a rotation at a place like Fort Yuma is likely to entail career-shaping experiences.

Fort Yuma Indian Hospital is located on the Fort Yuma Indian Reservation which straddles Arizona and California. This facility, an institution of the Indian Health Services, serves the health care needs of two local Native American tribes: the Quechan and the Cocopah.

The hospital sits atop historic Indian Hill, which overlooks the Colorado River and offers a wonderful view of all the lands owned by the Quechan Indian Nation. One can see acres of corn, wheat, cotton and melons. To the west and north, beyond the multicolored fields of agriculture, there is a wide span of desert, which also belongs to the Quechan. Beyond the desert, the lofty peaks of the Chocolate Mountains and the Gila Mountains stand proudly, roughly drawing the boundaries of the reservation.

Four primary care physicians staff the hospital. And they work hard. They are the primary source of medical care for this community of 3,300 people. For such a small community, however, the patients seem to have very serious and often quite varied medical conditions. Despite the sometimes limited resources of the hospital, these physicians are committed to providing the best possible care to their patients.

Learning about Native American culture was an important aspect of this AHEC experience. The Quechan and Cocopah are kind, friendly people. I enjoyed working with them and for them. I met many, many Native Americans during my stay at Fort Yuma, from many different tribes from all over the United States: Quechan, Cocopah, Mojave, Navajo, Hopi, Zuni, Tohono O'Odham, the Colorado River tribe, Cherokee, many of the Oklahoma tribes and even tribes in Alaska. I learned much about Native Americans, about their culture, their customs, their traditions and the issues they face in the modern world.

I learned a lot of medicine, as well. With the consent of the patients, I was permitted to perform histories, physicals and to ask all the questions that only a novice medical student like myself would ask. And the physicians and nurses at Fort Yuma welcomed me with open

(Continued on next page)

Medicine and More

(Continued)

arms. For every question I asked, they had an answer, an explanation and often a demonstration.

They taught me some medicine, but more importantly, they introduced me to the human aspects of medicine. They taught me about bedside manner. They taught me to be comfortable with a patient, how to touch and treat a patient and how to listen to the patient.

The physicians at Fort Yuma are proud to be able to spend 30 or even 40 minutes with a patient, talking, spending time educating the patients who, optimally, would get only seven or eight hurried minutes from a doctor in a big city or in a larger hospital. The physicians, nurses and staff at Fort Yuma are proud to be the primary health care providers to this small Native American community, a community with lots of medical problems.

By the end of the preceptorship, I did not want to leave Fort Yuma. The people there have set an example for me, an example of respect and decency, that I can only hope to achieve in the future. They have introduced me to the noble and pleasant aspects of working for a small community, in this case a seriously medically underserved community. They have asked me to keep in touch, to send letters and to return to Fort Yuma. They tell me I should come back for a fourth year rotation, and I can think of no reason to refuse.

They say they still will be there, waiting, should I ever wish to return for a visit, for a rotation or forever.

Inside This Issue

(Continued from Page 1)

possible for many states through receipt of tobacco tax revenue. Arizona AHEC Associate Director Donald Proulx sketches out the fit between tobacco-tax supported programs and the AHEC mission, as well as the way Arizona's AHEC has used tobacco tax revenue to provide public health education and community health promotion. Tobacco dollars represent an opportunity for many states, and the program is described in an article beginning on Page 12.

Just as Mr. Garcia created an atmosphere of new directions in Louisville, the goal of this issue is to create an atmosphere of thinking . . . to change mindsets . . . to tear down barriers to creativity.

To help AHECs accomplish these goals, an article by Dr. Cynthia Scalzi of the Wharton School of the University of Pennsylvania presents the nuts and bolts of business planning skills for health care organizations.

Another avenue for funding is pursued in an article by Michael Beachler, National Program Director of the Robert Wood Johnson Foundation's Southern Rural Access Program. He lauds AHECs' strengths and, because the "job" of a foundation is to give away money, he urges AHECs not to be afraid of using those strengths to obtain foundation support.

What tools would an AHEC need to take advantage of those opportunities? One answer is illustrated in an article describing the way a Louisiana AHEC Center turned the banking industry experience of its director to its advantage as the Center became a financial resource center. Other examples follow.

It is the hope of the Bulletin Editorial Board that you will use this edition as a springboard for thought and discussion. What is the role of the AHEC in your community? How does the AHEC leverage its resources, its partnerships and collaborative relationships to best advantage? Are AHEC's strategic alliances a means to program stability and sustainability ?

As we straddle the chasm between centuries, between public and private funding for AHECs, let us hear from you.

AHEC
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Cherry Y. Tsutsumida

Memorial Takes Shape Under Former AHEC-er's Guidance

By Barbara Clarihew

With the same enthusiasm she always gave to AHEC, Cherry Yuriko Tsutsumida proclaims that her new project is doing "spectacularly well." As Executive Director of the National Japanese American Memorial Foundation, Ms. Tsustumida helped to raise $8.6 million for the construction of the memorial. After reaching that goal, characteristically, she raised the goal another $2 million – to fund an educational outreach campaign.

The memorial will commemorate the sacrifice of Japanese Americans who fought and died in defense of their country, as well as those who spent up to four years in internment camps during World War II. Groundbreaking ceremonies were held in October and completion is targeted for November 2000.

Ms. Tsutsumida welcomes Secretary of the Department of Interior Bruce Babbitt to the recent groundbreaking ceremonies for the National Japanese American Memorial Foundation. Secretary Babbitt is a former Governor of the State of Arizona, where the Tsutsumida family was interned.

In early spring of 1942, all persons of Japanese ancestry in California and Alaska and portions of Arizona, Washington, Oregon and Hawaii, some 120,000 in all, were sent to internment camps. Although she was not yet eight years old, young Ms. Tsutsumida remembered clearly the terror of being rounded up, with her family, by federal agents and trucked off to a camp in Arizona.

Turning the first shovels of dirt was a task for many hands at the groundbreaking ceremonies.

The desolation of the camp was broken by a visit from First Lady Eleanor Roosevelt, who pleaded with the prisoners not to lose faith in the democratic process. "It was terribly hot that day – probably 117 degrees – when Mrs. Roosevelt came to see us. She was wearing a silk blouse and hat," Ms. Tsutsumida recalls. "She was so proper, yet she was truly reaching out to us. It made me feel very happy that a woman in her position had the courage to come to visit us.

"You can imagine that the members of her husband's Cabinet would have tried to prevent her from doing this," she said. "Mrs. Roosevelt's message was a counterpoint to all the terrible things that were happening."

Those memories, and her lifelong devotion to causes of the underdog, were factors in Ms. Tsutsumida's decision to leave her position in the Health Resources and Services Administration to head up the memorial foundation.

She feels the most important message of the new memorial conveys is that, despite the abridgement of their civil rights, Japanese American men, women and children maintained their loyalty on the home front.

"In the long term, this rededication to fairness is a new commitment to America's democratic principles and a demonstration of faith to freedom-loving people everywhere," she said.

The most rewarding feeling for both the Japanese American soldiers and the older Japanese American generation, according to Ms. Tsutsumida, is that, after all their sacrifices, the United States has acknowledged officially that what they did to the Japanese American people was wrong. "It is a very important catharsis for them and that makes me feel good," she said.

The foundation's educational outreach campaign will convey the message that any kind of abridgement of civil rights is dangerous because it sets a precedent for others. "It's an opportunity for us to say, 'We went through this. We want to prevent anyone else from going through it,' " Ms. Tsutsumida said.

The memorial will be built on a triangular plot of federal land bordered by Louisiana and New Jersey Avenues and D Street, equidistant from the Capitol and Union Station.

'Covered Minds'

North Carolina Partnerships for Continuing Education

By Sheryl Pacelli

With the advent of managed care comes a financial crunch: insufficient funds to provide quality training for health care professionals, and the expectation of doing more with less. As resources dwindle, collaboration becomes an important way to enhance resources and strengthen communities. The Coastal AHEC in Wilmington, North Carolina, has partnered with a mental health center, a community college and another AHEC to offer quality mental health continuing education at little cost.

Coastal AHEC serves five counties, three rural and two with pockets of rural areas. Within the AHEC's continuing education department is a mental health division that provides continuing education to health care providers in the fields of mental health, substance abuse and developmental disabilities.

In the past few years, the mental health director started offering more programs through contract to meet the unique needs of the individual mental health centers in a more cost-effective manner. One model that grew out of this history involves a contract with Duplin-Sampson Mental Health Center (DSMHC) in Kenansville. (Duplin and Sampson are the counties served by the center. Sampson County also is served by Southern Regional AHEC, which collaborated to offer one program.)

'The Coastal AHEC has partnered with a mental health center, a community college and another AHEC to offer quality mental health continuing education at little cost.'

The contract was written to enable DSMHC to send unlimited staff members for a flat fee per program instead of a per person fee. The agency allowed the programs to be opened to other mental health providers at a per person fee. For each dollar Coastal AHEC received in registration fees and other cosponsorships, the contract to the mental health center was reduced by one dollar, up to the contracted cost of the program. This arrangement permitted the education of as many other mental health professionals as possible, encouraged cross agency training and reduced DSMHC's training costs.

Coastal AHEC had cosponsored a program the previous year with the Small Business Center at James Sprunt Community College (JSCC). Collaborating with Coastal AHEC fit into the mission of the Small Business Center to improve productivity of businesses in the area through community-based educational programs. The college provided classroom space, staff support and a portion of the instructional expenses. Participants registered as students at the college, with the AHEC providing professional continuing education credit. The mental health center distributed training information and helped coordinate registration.

Programs in the contract consisted of seven topics for a total of 63 hours of education. Half of the speakers were from health science schools accessed through AHEC contracts, the others were private consultants/trainers.

A total of 189 people attended. Participants from outside the mental health center were from three local school systems, two county social service agencies, the local inpatient psychiatric unit, all city and county law enforcement departments and other mental health providers in the area. As a way to enhance working relationships, the mental health center included some of these participants (particularly law enforcement and school personnel) under their contract cost instead of charging a registration fee.

The provisions of the contract saved the mental health center 48 percent of the money guaranteed. The center trained 74 people in 56 hours of instruction at a cost of $.08 per contact hour per person, which means a one-day, six-hour program cost the mental health center less than $.50 per person. Two programs attracted enough participants from outside the agency that the training was actually free to the mental heath center. Without the cosponsorship of the community college, the savings would have been 37 percent of the guaranteed amount.

This model works well for three reasons. The first is the excellent relationship the North Carolina AHEC System has with the School of Social Work and Department of Psychiatry at the University of North Carolina at Chapel Hill, and the Department of Psychiatry at Duke University, which provided speakers for three of the programs. Second, dedicated mental health center contact people promoted the program and coordinated registration. Third, the belief of DSMHC and JSCC Small Business Center that collaboration toward one goal is essential allowed everyone in the project to benefit.

Ms. Pacelli is Director of Mental Health Education at the Coastal AHEC in Wilmington, North Carolina.

AHEC
The National Area Health Education Centers Bulletin

AHEC Praised as Global Model

The National AHEC Network was praised and presented as a model for community-based action around the world during a global conference on *"Universities and the Health of the Disadvantaged."*

AHEC Program Directors, Center Directors and staff were among the more than 170 participants from 30 countries and 18 states who assembled in Tucson in July for the conference.

As the featured presenter during a conference plenary session, Steven R. Shelton, MBA, PA-C, Executive Director of the East Texas AHEC and President of the National AHEC Organization, described the National AHEC Network as a model for community-based action and proposed it as a model which can be replicated in other areas of the world.

Dr. Carol Gleich, former AHEC Branch Chief, accepts a Global Conference commemorative tile from Dr. Andrew Nichols. Looking on are Dr. George Dines, left, HRSA Senior Advisor for International Health Affairs, and Dr. Daniel Baden, AHEC Medical Director.

Among AHEC's strengths, Mr. Shelton listed AHEC's knowledge of the communities it serves, the high respect AHEC holds as a change agent, its identity as a community partner and the fact that it is established as a supportive grassroots network.

Conference Co-Convenor and United Nations Educational, Scientific and Cultural Organization (UNESCO) Representative Mrs. Christine Von Furstenberg praised the AHEC network and the "incredible commitment of the AHEC people." From her perspective as an agronomist and specialist in sustainable development, she urged AHECs to reach beyond the "medical model" to interact with other university departments (sociology, social work, political science, etc.) to become more visible in the communities they serve.

The University of Arizona Rural Health Office, which houses the Arizona AHEC and HETC Program offices and also is a World Health Organization (WHO) Collaborating Center for Border and Rural Health Research and Development, hosted the five days of events. Co-convenors were WHO and UNESCO. Key collaborators included the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC). A pre-conference symposium was co-sponsored by the University of Arizona Rural Health Office and HRSA and a bi-national border meeting was co-sponsored by the Pan American Health Organization (PAHO), the WHO Collaborating Center and the Rural Health Office.

Mr. Shelton addresses the Global Conference.

Participants represented universities, academic health centers, governmental entities, community health projects, grassroots groups and indigenous peoples. They examined ways the potential and experience of universities can be utilized to reinvigorate a sense of solidarity in all forces of society in favor of the most needy.

At the end, a Charter representing the core ideas of the conference was adopted, calling for universities to undertake eight steps to fulfill their "moral imperative" to engage in service to the disadvantaged. The Charter has been approved by the National AHEC Program Directors and approval is pending from AHEC Center Directors and HETC directors.

Also birthed during the Conference was an ongoing project ***UNI-SOL: Universities in Solidarity for the Health of the Disadvantaged.*** This global network will provide a mechanism for the development of "model" projects which will illustrate the conference objectives. It also will enable the continuing exchange of ideas and experiences aimed to improve the health of the disadvantaged around the globe.

Mrs. Francine Fournier, Assistant UNESCO Director-General for Social and Human Sciences, said: "It is obvious we need to root such endeavors in the solid grounds of universities. Medical education goes far beyond educating and training doctors. As physical and mental health are at the very core of what is meant by quality of life, the training of physicians requires . . . ethical standards, political impartiality and, at the same time, a better articulation with the problems of society, the world of work and the existing institutions."

Global Conference Co-convenors Mrs. Von Furstenberg and Dr. Charles Boelen of WHO, right, with Marco Antonio Dias of Brazil.

Federal AHEC Office Update

Summary of Significant Program Accomplishments in FY 99

By Louis D. Coccodrilli, MPH
AHEC Branch Chief

Model and Core Programs

- Completed the FY 99 competitive cycles for the Basic AHEC, Model AHEC, and HETC Programs.
- Added Basic AHEC Programs in underserved regions of Alabama, Maryland and the District of Columbia, bringing the total to 40 in FY99.
- Added a chief medical officer, a statistician and classified staff at the federal office.
- Initiated and completed a purchase order to support the FY2000 National AHEC Conference in Fort Worth, Texas.
- Collaborated with NAO and the University of Louisville AHEC Program to carry out a most successful 1999 National AHEC Workshop.
- Developed an AHEC Program Directors Listserve; initiated a project to stimulate use of WEB pages by programs and centers.

Collaboration

- Created a Managed Care Advisory Group to work with the AHEC Program and HRSA's Center for Managed Care to identify training needs for FY2000.
- Established a national Evaluation Study Workgroup to provide guidance to the Congressionally requested evaluation of the AHEC Program.
- Participated in the development of the newly established Advisory Council on Interdisciplinary and Community Based Programs.
- Successfully established the FY 2000 AHEC Workgroup to review and implement the new legislation in the FY 2000 competing AHEC application kit.

Total number of Student Trainees in AHEC Programs in 1999:

12,552	Medical Students
3,066	Medical Residents
2,998	Nursing Students
1,923	Physician Assistant Students
2,122	Nurse Practitioner Students
1,044	Dentistry Students
650	Pharmacy Students
2,751	Allied Health Students
271	Mental Health Students
392	Public Health Students
27,769	TOTAL

News & Views

From the National AHEC Program Office

Continuing Education

- Developed, produced and disseminated the video "What the Heck is an AHEC."
- Revitalized national Primary Care Day activities at medical school campuses throughout the nation with assistance of ongoing AHEC programs and centers.
- Sponsored/coordinated continuing education (CE) programs for more than 100,000 health professionals in local communities.
- Developed and carried out a second national satellite broadcast, focused on Primary Care Week and CHIP outreach efforts in Texas and Massachusetts.

Special Initiatives

- Global Conference in Tucson, Arizona, on "Universities and the Health of the Disadvantaged."
- CFIDS (Chronic Fatigue Syndrome) continuing education modules through Illinois AHEC and the CFIDS Association.
- Continuing education series on domestic violence at Meharry Medical School.
- Primary Care Partnerships in Washington State to address persistent shortages of primary care personnel in rural areas.
- Assisted the Bureau of Health Professions in preparing for a new initiative: Kids Into Health Careers; cited ongoing model health careers programs in Kentucky, North Carolina, Texas and Virginia AHEC programs.
- Bureau of Health Professions's new Oral Health Initiative.
- Recruitment of American Indian students into health careers involving two tribal colleges and the Montana AHEC.
- Outreach to train *Promotores* in the Texas HETC for the CHIP Program, including residents from Arizona, California and Texas.
- Supported the Border Vision Fronteriza project administered by the Arizona HETC in the four US-Mexico border states.
- Developed CE curricula to provide primary care practitioners with knowledge to assess children exposed to a toxic environment.
- Collaborated with the Office for the Advancement in Telehealth (OAT) to supplement existing AHEC awards in Utah, New Hampshire and Texas for the support of telehealth projects.

Native dress, cooperation and camaraderie were in evidence everywhere as participants from 30 countries assembled for a souvenir photograph during the Global Conference on "Universities and the Health of the Disadvantaged." AHEC was showcased as a model for community-based action around the world for the more than 170 participants (see story and related photos on Page 38).

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AHEC

The National Area Health Education Centers Bulletin

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.

From:

To:

A Publication of the National Area Health Education Centers Program