Addressing the Needs of the Underserved: Refocusing on AHEC Roots

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Safety Net Services Changed the Face of America’s Health Care

AHEC: One of Three Essential Strategies
By Charles Cranford, DDS, MPA

The year was 1971. Such notable figures as Warren Magnuson, Ted Kennedy, Paul Rogers, Ralph Yarborough, “Scoop” Jackson and Harley Staggers, all outstanding health care advocates, were in the U.S. Congress.

In Washington, health care was on everyone’s mind. Medicaid and Medicare were in their infancy. Community Health Centers (Neighborhood Health Centers) had been authorized by the Congress in 1964 through the Economic Opportunity Act, then transferred to the U.S. Public Health Service in 1969.

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AHEC: Speaking for the Public Good
By Wayne Myers, MD

In the historical development of the three key public programs to improve access to health care, the development of Medicare and Medicaid in 1965 not only reflected a powerful sense of Americans’ responsibility for their fellows, but made clear that there was no health care system to achieve that goal. Policy makers set about developing the three components of what would come to be called the health care “safety net,” particularly in more rural and remote parts of our country.

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Refocusing On Our AHEC Roots
By Sally A. Henry, MA, RN, FCHE

Consider the health care term “safety net.” It has a comforting sound implying strong, comprehensive holistic services for all. A “safety net” will catch those without ability to pay, without employer-funded health plans. It sounds as if the United States, the country with the most advanced science, the most evolved technology, has also found a way to provide for its most vulnerable, marginalized residents.

Yet the reality is much different. Despite 30 years of well-intended, hard work by thousands of committed professionals and policy-makers, the U. S. health care safety net early in the 21st century is incomplete, torn in places and certainly too small.

This edition of the National AHEC Bulletin examines the history and partnerships of three interrelated federal programs that address the health care needs of underserved populations — the Area Health Education Centers (AHECs), the Community Health Centers (CHCs), and the National Health Services Corps (NHSC).

The lead articles discuss the safety net story since its inception in President Lyndon Johnson’s Great Society. Charles Cranford and Wayne Myers tell strikingly similar tales. Cranford, long the highly regarded Arkansas AHEC director, gives the Area Health Education Center perspective; Myers speaks as a veteran rural health advocate. Both talk of the necessity of collaboration to make the safety net system work. It needs facilities in which to operate (CHCs) as well as supply of interested clinicians (NHSC) trained to meet the distinctive needs of these clients (AHECs).

(Continued on Page 8)
One of Three Essential Strategies

Washington was abuzz with talk that a national health insurance program was expected by 1975. President Nixon was in his first term and preparing for a re-election campaign. On the last day of 1970, President Nixon had signed the enactment of Public Law 91-623 authorizing the National Health Service Corps.¹

While there was great excitement about health care for all Americans — health care that was to be a safety net for many — there was grave concern about the shortage and maldistribution of the health care workforce. Noting that the training site serves as a powerful predictor for ultimate practice location, the Carnegie Commission in 1970 proposed establishing a series of Area Health Education Centers (AHECs) which would serve to decentralize undergraduate, graduate and continuing education for physicians, dentists and other health practitioners.

The Commission noted that AHECs would offer opportunity to enrich both the quality and type of the educational experience, while also providing resources to expand universities’ capacity to train health science students.

The 1971 President’s Message on Health stated that a “series of new Area Health Education Centers should also be established in places which are medically underserved…I am requesting that up to $40 million be made available for this program in fiscal year 1972” (a level of federal funding not yet provided 30 years later).²

Into this environment the AHEC program, called a vital component of the delivery and access to health care for all Americans, was born in 1971. The program was conceived out of recognition by the Congress that a safety net is only as good as the strong arms that hold it. A promise of health care is valid only when there are providers to deliver it. No one program does the entire job; no one program can bear the entire responsibility. It takes a set of programs that together engage many hands and minds to create a seamless system that can deliver health care with none left behind.

Three programs — the AHEC Program, Community Health Centers (CHCs), and the National Health Service Corps (NHSC) — were inextricably linked to address access to health care for special populations who are often underserved. They were to be three essential parts of the strategies for accomplishing the access goal. The strategies include: 1) to distribute the health care workforce in such a way as to not omit any geographic area of need; 2) to provide a culturally competent health care workforce; 3) to establish health care systems in locations and to population groups where no health care providers practice. The access goal would be accomplished by a continuum of assistance that begins with health career counseling of prospective health professionals, continues with scholarship support for culturally diverse health professions students, progresses during their education to encourage and reinforce their commitment to underserved populations and finally, upon completion of training, providing a place to deliver health care to the underserved.

Area Health Education Centers, the National Health Service Corps and Community Health Centers have distinctly different but complementary roles. Although created by the Congress in different acts and at different times, they were all brought together within the Public Health Service within a three-year period. It was a time of concern about the weakness of the health care infrastructure in the United States.
One of Three Essential Strategies

(Continued)

cern about the decline of the U.S. Public Health Service and hope for providing health care to many elderly and poor people who were not receiving the health care benefits promised by Medicare and Medicaid.

All three are required to create the chain that leads to improved access to health care. Working effectively together, they produce an extraordinary combination of synergistic benefits.³

The purpose of the AHEC Program was stated succinctly in its legislative authorizing language in 1971: “For the purpose of improving the distribution, supply, quality, utilization and efficiency of health personnel and the health services delivery system.”

AHEC programs have a major role in recruiting for the National Health Service Corps. AHEC programs are an integral part of academic health centers where the majority of health professionals are educated. AHEC programs conduct health careers programs for thousands of prospective students each year, counsel others about health careers and maintain an advisory role with large numbers of health professions students who complete educational rotations in the many sites sponsored through AHEC programs. These experiences are ideal opportunities to inform pre-professional students and enrolled health professions students about the need for their services in the U.S. Public Health Service.

Congress recognized the need for linkages between health training and health services at the local level. The discussions within the Public Health Service following congressional action made it very clear that an AHEC Program must have alliances with health care delivery for education and training. In the list of providers of health care delivery, neighborhood health centers (Community Health Centers) were specifically mentioned.

Some 30 years later, partnership among these three safety net health access programs is more vitally important than ever. The very first goal of AHEC Programs listed on the HRSA website is to “form linkages between health care delivery systems and educational resources in underserved communities.”

As an example, the National Health Service Corps and the AHEC Program are collaborating on an initiative called ‘NHSC Campus-Based Ambassador Program’ (see related article on Page 49). The purpose of the program is to develop the next generation of primary health care clinicians committed to serving underserved populations. NHSC data indicated that 50 million Americans are without access to primary medical care, and 108 million are lacking dental care. Thousands more primary care clinicians are needed. AHEC staff are working as NHSC Ambassadors throughout the country on their respective campuses.

Ambassadors provide career guidance to students who wish to pursue a career in primary care serving underserved populations across the country. As stated by the NHSC program, Ambassadors are in a unique position to identify and recommend students committed to service for the NHSC scholarship program. The Ambassador program is an integral part of NHSC strategy to identify the next generation of primary care clinicians committed to serving the underserved in areas of greatest need.

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‘National Health Service Corps data indicated that 50 million Americans are without access to primary medical care, and 108 million are lacking dental care. Thousands more primary care clinicians are needed.’
One of Three Essential Strategies (Continued)

Community Health Centers contribute to a health workforce and are significant partners within a community. AHEC Programs combine with the NHSC to be the strongest influences that encourage health professionals to choose underserved communities.

Collaborations in many states enhance the ability of Community Health Centers to deliver health care services to the underserved. AHECs and Community Health Centers work side by side to improve health care. Students and medical residents are able to take a portion of their clinical training at Community Health Centers, an arrangement that ends up benefiting everyone. Students and residents receive an exposure to health care delivery in a community setting. CHCs are able to augment their services with highly qualified health personnel, and the people of the community benefit by having increased access to health care.4

It is generally agreed that the placement of medical residency education in locations near or in underserved areas is the most effective way to address shortages of primary care physicians. AHECs provide an excellent vehicle for creating primary care residency programs in such locations. The regionalization of medical residency education works when it is a part of the educational continuum. Community Health Centers in rural and underserved areas are often a part of that educational continuum as partners with academic health centers. Each benefits from such partnerships; each needs the other. Each contributes its respective resources to enable academic health centers to achieve their educational and service missions and to enable community health centers to develop and maintain viable health care delivery systems.5 It is essential that the three major community-oriented health programs, the AHEC Program, Community Health Centers and the National Health Service Corps, work together addressing access gaps in underserved areas, each in different and important ways, developing the primary care infrastructure.

It has often been said that AHECs provide a bridge between the community and the academic health center. It is a bridge without which health care reform is unlikely to succeed. Claude Earl Fox, former Administrator of HRSA, said it so well: “AHEC Programs are a catalyst in both the communities they bridge — spurring the academic enterprise to attend to the needs of underserved people — and sparking the community of people served to involve themselves in the training of health professionals.”6

The AHEC Program has evolved into an effective partnership involving the federal government, state governments, local governments, health science schools, community hospitals and health care practitioners. The outcomes of AHEC Programs are long term, not as easily palatable as those of Community Health Centers and the National Health Service Corps. There is a long pipeline from health careers counseling and matriculation in a health professions program to providing health care for the underserved. However, the value of such infrastructure building is no less, even if evaluation of outcomes is more difficult. Few federal programs ever move uninterrupted toward their goals. These three programs, the AHEC Program, Community Health Centers and the National Health Service Corps, are no

Successful Partnerships in Arkansas

The Arkansas AHEC Program has had effective partnerships with community and migrant health centers for many years, as partners in the education of medical students and residents. Community and Migrant Health Centers (CHCs/MHCs) help provide rural experiences in culturally diverse environments. The AHEC Program provides continuing education for CHC staff, and provides assistance in recruiting physicians to fill staff vacancies. Many of the graduates of Arkansas family practice residency programs are employed by CHCs/MHCs. In one site, the facility is shared by a CHC and the AHEC Program, the Community Health Center providing the clinical services, the AHEC providing the educational component.

In a recent report to Arkansas citizens, University of Arkansas Medical School Chancellor I. Dodd Wilson described the benefits of the AHEC Program to the state: “Overcoming the boundaries of distance and access, AHEC faculty, physicians, residents and staff provide and continually improve its services in health care fields to the people of Arkansas, including those living and working in rural and medically underserved areas. Community partnerships emphasize the preparation of health care providers and encourage young physicians to locate and practice in rural areas.”

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exception. Buffeted by budget shortfalls, changes in executive and congressional leadership and political advocacy of special interest groups, these programs have suffered their ups and downs. Through it all, after 30 years, the need for these programs has not diminished. As this article is being written, top health officials in the Bush administration have announced a major reorganization to revitalize the Commissioned Corps of the U.S. Public Health Service (PHS), the uniformed force of health professionals. The announcement states that “the Corps’ duties include tackling disease outbreaks, such as severe acute respiratory syndrome, promoting healthy lifestyles, offering medical support in wars and sending health care workers to areas with poor access to services.” The latter duty is precisely why the National Health Service Corps was founded in 1970 and the AHEC Program in 1971. Both programs will welcome the reinforcements.

As the PHS is being expanded it would be a good time for some trial assignments in AHEC Program offices to assist recruitment of graduating health professionals, to identify new opportunities for NHSC scholars and to develop ways to add experiences during the family practice residency programs to help medical residents consider assignments in the Public Health Service and in Community Health Centers from a more informed position. Through such trial assignments, a major set of synergistic benefits could occur to improve access to health care in underserved areas.

Bioterrorism and Homeland Security have shown yet another need for partnerships between AHEC Programs, Community Health Centers and the National Health Service Corps. AHECs are strategically positioned to provide scientifically sound education programs in bioterrorism for health care providers throughout their service areas. Gaps in the delivery of the needed education can easily occur without the AHEC Program giving special attention to rural hospital employees, to Community Health Centers and to the National Health Service Corps personnel who work in these underserved areas.

Can you imagine how powerful it would be for academic health centers, AHECs, Community Health Centers and the National Health Service Corps to develop a coordinated legislative agenda at both the federal and state levels? It can be done because of their common vision to build infrastructure in areas where it does not exist, and to continue to undergird and enhance health care systems. These programs can forge a dynamic force to improve access to health care for the underserved, and they have a heavy responsibility to do it now.6

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1 For a good insight into the authorization of the NHSC, see The Dance of Legislation by Eric Redman (New York: Simon and Schuster, 1973).

2 In 1971, the author was an intern with the Senate Health Subcommittee (chaired by Senator Ted Kennedy), an insignificant witness to a most significant moment in American health care history.


4 Testimony before the Senate Appropriations Committee, May 3, 1993, by Charles Cranford as Chairman of the National Organization of AHEC Program Directors.


Speaking for the Public Good

Workforce was a major problem. Health care was seen as the only sector of the economy with a shortage of skilled workers. There weren’t enough doctors and the general health care workforce was poorly distributed in terms of geography and specialty. Medical school was for men (Only about four percent of medical students were female) and nursing school was for women. General practitioners were a vanishing species and their loss was most acutely felt in our rural communities. Family medicine was a brand new concept, familiar to few medical educators and accepted by fewer. Several of the allied health professions were in very short supply. Few students from minority, rural or inner city communities were entering the health professions. The Carnegie Commission in 1970 recommended a national system of Area Health Education Centers (AHECs) to address these recruitment and training workforce issues.

Despite the physician shortages in communities, the federal agencies had ready access to doctors and other health care professionals. The “doctor draft” for the Viet Nam war made alternative federal service in the Commissioned Corps of the U.S. Public Health Service very attractive to newly trained physicians. Typical assignments included the Indian Health Service, the National Institutes of Health, the Centers for Disease Control, as well several smaller agencies. But most people realized this public service incentive wouldn’t last. The National Health Service Corps (NHSC), authorized by the Congress in 1970, was seen as the federal government’s answer to the most serious health workforce distribution problems.

Still, there was no answer to the perennial question: “where can a poor person without health insurance see a doctor?”

It should be noted that the concepts of training nurses for advanced clinical practice and retraining independent duty military medical corpsmen as physician assistants were gaining acceptance, but graduates were rare. Many hospitals and city health departments had free clinics staffed by hired physicians, volunteers and trainees. But the model that gained ascendancy, the Community Health Center (CHC), was much more comprehensive and self-contained.

The best known CHC was a facility built upon a service base in Mound Bayou, Mississippi, originally developed by Meharry University. Boston University, under the direction of Dr. Jack Geiger, developed an institutional prototype in Mound Bayou that included consumer ownership and governance and a wide range of clinical and support services such as transportation. This model came to be reflected in federal authorization as the Community Health Center.

It is impressive that the decade 1960-70 gave rise to so much innovation in American health care: Medicare (including federally financed graduate medical education), Medicaid, the National Health Service Corps, Area Health Education Centers and Community Health Centers. Over the succeeding generations these models have evolved and been elaborated, and other strategies have been added, but none so powerful as this assemblage.

We might think of these three programs — NHSC, AHEC and CHC — as a “system” for assuring America’s health resources safety net.

In spite of their successes, each of these three programs has had its problems. Each was largely affiliated with an interest group and has had to work its way into a position of greater flexibility. Each seems to
be emerging from these difficulties stronger than before and more able to address challenges. AHECs, for better or worse, are quite different from the vision of the Carnegie Commission. The Commission described AHEC as moving health professions training to outlying communities and bringing the clinical services of the teaching hospital to communities lacking them. As the agents through which academic medical centers would guide the development of high quality services across their regions, the AHECs would assure that services would be under the direction of local governing bodies. However, the medical schools had little interest in regional health services except as a referral source, and in many instances came to control AHEC missions at the expense of local decision making.

Currently, AHECs primarily support training and are gaining more control of their resources and programming as state and local funding supplants federal support. Moreover, they have shown the capacity to meet new as well as old community needs through local innovation and problem solving.

The Community Health Centers were captured by their own grantees. They became frozen in place geographically and programmatically. The early grantees aspired to provide a very broad range of services to a very needy population. Arguably, the needs of these local populations grew faster than the appropriation, therefore any additional appropriation went to existing grantees. In Washington it was widely but erroneously believed that most communities had access to the services of a CHC.

In fact, in most of rural America, CHCs were few and far between. Early on, Community Health Centers faced systemic resistance from the medical establishment, and even great hostility in many communities.

A tradition of self-sufficiency and avoidance of collaboration has outlived the environmental hostility which created it. In the past few years the federal government has greatly increased the appropriation for health centers. Congress also has brought heavy pressure on the Bureau of Primary Health Care to put funding into new starts including some in lower population density areas.

The National Health Service Corps (NHSC) was captured by the Community Health Centers to the extent that the Private Practice Option atrophied. States without Community Health Centers got practically no Corps assignees. The “Conrad State Twenty Program” permits states to access international medical graduates for practice in underserved areas through waivers of the requirements of their J-1 Visas. This practice is arguably attributable to the capture of the Corps by the CHCs. Administration of the Corps has now been transferred to the Bureau of Health Professions from the Bureau of Primary Health Care, which funds CHCs. It is reasonable to hope that this will lead to a broader approach to national needs.

Thirty years into the AHEC/ NHSC/ CHC saga, America still has no health care system, no broad access to care and no comprehensive safety net. Instead, there is a multitude of individual agencies and organizations each doing its very best to help as many people as it can, but meeting only a little of the need. There are 44 million people who are uninsured, but even those with basic medical coverage often lack access to mental health or oral health services.

If you are uninsured and have cancer you are more likely to die of your disease than if you’re insured. If you are uninsured and seriously injured you are more likely to die of your injury than if you are insured.'
Speaking for the Public Good

increase. The federal government has responded by proposing a 32 percent budget increase to develop new and expand existing federally subsidized Community Health Centers, and by reorganizing the National Health Service Corps placement system.

As the situation deteriorates, the nation needs its resource safety programs to collaborate if we are to achieve the full potential of their social benefits. They will be stronger in the aggregate than the sum of their individual strengths. Who but AHECs speak for the public good in health professions education?

The professions and the schools have interests of their own unrelated to public needs. AHECs should speak up regarding who is taught where, what and by whom rather than simply regarding themselves as field placement offices. AHECs should be advocating for the National Health Service Corps and should know which health professions students are NHSC scholars and identify others who would like to be. These socially motivated young people are of value out of proportion to their numbers and should be nurtured. And NHSC clinicians should be exchanging support and assistance with their AHECs to nurture the next crop of responsible clinicians. Likewise the Community Health Centers should be looking to the AHECs for their next generation of clinicians and pitching in on interest building among their students and summer placements as they move through school.

In recent years values such as public responsibility have lost ground to avarice as a basis for health policy. Greed is not working out very well as an organizing principal for caring. The publicly governed AHECs, Community Health Centers and their colleagues in the National Health Service Corps have a message for the country. “Caring is rewarding. We ARE our brothers’ and sisters’ keepers, and we are proud to be. Now pitch in and help.”

Refocusing on Our AHEC Roots

The 2003 study by the National Association of Community Health Centers, cited in the article by Hawkins, revealed that 57 percent of the responding CHCs partnered with their local AHECs. Here, certainly, is an opportunity for closer alliances not only in student and resident training, but for continuing education and other support. Articles in this issue by Cleghorn, Swanson, Withy, Wolpin and Zaucha all describe successful models of such collaboration.

In his Call for Action, Mick Huppert advocates for a national “Centers of Excellence in Workforce Development” strategy that would provide intensive training for CHC clinicians in strategic locations throughout the U.S. This regional approach can further strengthen other national planning efforts, including those of the National AHEC Organization and the National Advisory Committee on Interdisciplinary, Community-Based Linkages.

The edition is organized in three sections that follow personal reflections by John Blossom and Carl Toney, two distinguished clinicians whose careers weave through many safety net system components. Each section contains articles from the perspectives of specific safety net system agencies. Examples are included from successful programs that provide creative, energetic, even fun services to communities with unmet needs.

As Peter Kohler, President of Oregon Health and Sciences University, said at a recent Oregon AHEC Statewide Advisory Committee meeting, “While progress is being made, we continue to lose ground.” The Washington DC-based Center for Studying Health System Change’s report, Economic Downturns and State Budget Woes Overshadow Seattle Health Care Market, details a crisis that “threatens to unravel much of the progress made in expanding health insurance coverage ... (B)udget deficits...cut safety net funding significantly in 2003.” Across the country AHEC and CHC directors can detail similar situations and many have mobilized for action.

I urge readers to not simply acknowledge the value of articles as written, but consider how these ideas, and others, can be employed in one’s own locality or, even better, throughout a larger region to keep the U.S. Safety Net system from unraveling.
The Synergy of AHEC and the ‘Safety Net’

By Laurie Wylie, MA, ARNP

The creation of the national AHEC program in 1971 provided the third program to complete a social contract of the federal government with underserved populations in the nation. Designed to assure access to quality health care for all, it included the Community Health Center (CHC) program, the National Health Service Corps (NHSC) and the Area Health Education Centers (AHEC) program. Each program was intended to be part of a system that would create a “safety net” for those at high risk of not having health care services.

The CHC program was designed to provide health care services to the most underserved populations in urban and rural areas by placing point-of-service facilities in those areas. The NHSC was to deliver providers to the areas which had the most difficult time recruiting and retaining them. The AHECs were to train a workforce with a passion to work in underserved environments by creating service-learning opportunities while bringing the resources of academia to communities.

Recent federal budgets have seen an influx of funds into the CHC and NHSC programs. Moving the social contract forward on just two fronts leaves a huge hole in the safety net, and hobbles the success of all three programs.

In June 2003 NHSC’s Director Donald Weaver said that it would take 27,000 additional providers to fill all of the openings in Health Professional Shortage Areas (HPSAs). The current field strength of the NHSC is 2,765. This tenfold increase in the number of providers cannot be achieved by NHSC alone.

Community Health Centers have a chronic need to recruit and retain providers, even without expanding the program. The current and expanded needs of both of these programs cannot be met without AHEC. The personnel shortages will not be solved by the theory: “if we build it, they will come.” Health professionals must be trained, groomed and socialized to work in underserved communities.

Currently, the Administration proposes no funding for AHEC/HETC. The traditional restoration of funds through Congress becomes increasingly tenuous as national economic conditions continue to decline. It is time, if not past time, for these three programs to purposefully link to gain the financial bases that will allow true access to health services for all underserved populations. These programs were designed to work in concert. All three must grow to be able to address and meet the needs of our constituents.

Collaboration is essential. At the national level, the National AHEC Organization (NAO) has established many collaborations on behalf of the AHEC/HETC system. Liaison activities have been established with the NHSC and CHC.

The National Advisory Committee for Interdisciplinary, Community-Based Linkages, which has AHEC/HETC representatives, has made recommendations to HRSA which will support the interworkings of these safety net programs. NAO’s Washington representative keeps our needs, successes and interests visible.

‘At the local level, each of us needs to be active in policy development . . . to link with NHSC . . . and with CHCs. It is important to educate Congressional delegations about these actions and the accompanying need for continued financial commitment to . . . these safety net programs.’

At the local level, each of us needs to be active in policy development. We need to link with NHSC in our states, especially through its loan repayment, SEARCH and Ambassador programs. Links with CHCs in the state can begin with collaborating on recruitment and retention planning, and include clinical rotations for students in CHCs. It is important to educate Congressional delegations about these actions and the accompanying need for continued financial commitment to the support of these safety net programs. AHEC/HETC is about ACTION. Armed with the stories and information in the articles in this edition of the Bulletin, you will be well prepared to act.

By Laurie Wylie, MA, ARNP

Ms. Wylie is Executive Director of the Western Washington AHEC in Seattle and Past President of the National AHEC Organization.

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Reflections . . .

. . . and a Call to Action

By Mick Huppert, MPH

Charles Cranford concludes his historical article on the simultaneous creation of the AHEC Program, the National Health Service Corps and the Community Health Center movement with the dream of imagining how “powerful it would be if these three effective programs along with academic health centers could develop a coordinated legislative agenda.”

Dr. Cranford’s dream is not a whimsical conclusion to a flattering article describing the New Frontier federal efforts of the Lyndon Johnson administration to serve the underserved. Instead it is an essential requirement for our Nation.

Wayne Meyers’s comparable historical account corroborates much of Dr. Cranford’s perspective and lends additional evidence to the continued need of “safety net” services that can be best provided by the Corps, the CHCs and the AHECs working aggressively in collaboration. Dr. Meyers years of experience and his thoughtful reflections in his article are must reads for the AHEC community.

If we are truly to continue to meet the needs of Medicaid and Medicare recipients, and begin to seriously provide care to the 44 million uninsured individuals in this country, all these programs must work together, both at the HRSA level and certainly in the field.

President Bush has pointed us in this direction with his ambitious efforts to expand services to the uninsured through establishing 1,200 new points of service through the Federally Qualified Health Centers (FQHC) program.

This is a substantial commitment of federal effort building upon the 11 million uninsured already served through 750 community-based organizations and more than 3,000 FQHC sites. The six million additional patients who will be served will require the addition of more than 4,000 new health care providers; a daunting recruitment task.

What I hope to accomplish in a few paragraphs is to bring together several themes from the thoughtful articles in this edition of The National AHEC Bulletin. It is important in times of transformation to go back to one’s “roots.” This edition does a creative job in reminding us of the history of the AHEC Program, which shared the birthing room in the late 1960s and 1970s with our brothers and sisters in the National Health Service Corps and the Community Health Center movement. Charles Cranford’s detailed history is an important underpinning to future strategic planning. He captures the interplay between those believing that neighborhood-based services, (including both rural and urban,) were key to improving the availability and accessibility of services and those in the academic sector, who were attempting to meet a growing social obligation as educators to prepare a health care work force for the same purpose. It is important to remember that AHEC and CHC development took place at the same time, sharing similar values and visions.

John Blossom’s heartfelt article clearly demonstrates what being educated in the community can mean for new health professionals, who become dedicated to continuing their careers working in similar sites. His vivid illustrations of learning in the community, and then building further education experiences for the next generation of learners, captures the essence and the power of service learning and the AHEC role in brokering and establishing ongoing programs. Dr. Blossom also reminds us that these sites were the structures that brought health care to disadvantaged populations and communities, in many cases, for the first time.

Ann Roggenbuck and Dean Cleghorn, equally experienced AHEC leaders, provide concrete examples of building upon John Blossom’s remembrances from the 1970s by developing updated academic/community partnerships begun in the 1990s.

Dr. Roggenbuck’s insightful idea to pair a successful AHEC with a community’s need to establish a FQHC is to be commended.
Call to Action

The subsequent win-win situation for both the community and for health professions students is extraordinary. The quality of education made available through the North Country CHC in Arizona involves students from many disciplines; and the planned interdisciplinary experiences will add an important dimension to the community-based health care learning experiences provided at the FQHC.

Dr. Cleghorn focuses on family medicine residency education in a FQHC, noting the complementary nature of the missions of both AHEC and FQHC. This takes us full circle in the history of these two programs as they were almost four decades ago. It is indeed gratifying to see, as in Arizona and California, that in Massachusetts a program funded by the Bureau of Health Professions and a program within the Bureau of Primary Health Care can truly and respectfully work together.

It should not be lost on the reader that Dean Cleghorn’s example captures a very important outcome: residents spend the entire ambulatory education portion of their three-year residency in one FQHC. The residents become grounded in all the essential requirements of the Residency Review Committee for Family Practice, while becoming fully experienced in understanding the complexities and challenges of providing care to the underserved.

Not only do they exit this program, which is a hybrid of AHEC and the FQHC, as competent family physicians, but they graduate with an intimate knowledge and understanding of what it means to work in a FQHC. This is true not only because of solid academics but because they have provided care for three continuous years in this setting.

Construct Teaching Community Health Centers

The essential question is whether these highly successful efforts described in this edition of The National AHEC Bulletin and represented by similar AHEC initiatives sporadically distributed across the U.S. are enough? These programs are representative of “good works” completed by a small but growing number of FQHCs and AHECs. However, they do not make a comprehensive, coherent work force policy.

Four thousand more practitioners are needed to supply the 1200 FQHCs with clinicians knowledgeable and experienced in community health services delivery. The shortage of personnel and the relatively small number of jointly sponsored community-based education efforts highlight the need to go beyond wonderful anecdotes to something more systemic and structural as a work force strategy. Now is the time to bring together the resources and learners from the academic health centers to partner with the experience and service needs of the FQHCs to produce a hybrid effort called: Teaching Community Health Centers.

In studying the success of those programs noted in this edition and many others with which I have worked, I have been encouraged to see that partnerships work when academic health centers are deeply committed to shouldering responsibilities in meeting needs of the underserved.

I also have observed that many FQHCs wish to partner with academic programs,
Call to Action

particularly at with graduate level physicians and nurse practitioner programs, because they perceive tangible benefits to their ability to recruit and retain staff because of the added teaching opportunity.

Moreover, the FQHCs integrally involved in on-site residency education see graduates of these programs staying on at the FQHC, or second best, migrating to another FQHC.

Establish Regional Sites of Excellence

At its core AHEC is a workforce development program. Let us embrace the concept of the “Teaching Community Health Center” and work toward efforts to strategically establish these Centers throughout the U.S. in order to assist the expansion of the FQHC movement and to deepen educational opportunities for learners, who view community service as the next stage in their career.

Furthermore, let’s propose and advocate for the two Bureaus (Primary Health Care and Health Professions) to develop regional “Centers of Excellence in FQHC Workforce Development.”

Drawing on the exciting models that have been created through time-tested experience representing AHEC/FQHC partnerships, it is time we dedicate resources to the construction of five to six regional centers that will include experienced partnerships that reach out to sites that wish to enter into developing Teaching Community Health Centers.

Such “Centers of Excellence in Workforce Development” are critically important in developing pipelines, particularly at the graduate education levels, that can supply the next generation of CHC clinical personnel.

We need ten or 12 incubators throughout the country that can point to clusters of primary care residents, nurse practitioners, pharmacists, etc., obtaining substantial portions of their education in FQHCs.

In Massachusetts, 60 family practice residents are placed for all three of their residency years in FQHCs; this produces up to 20 graduates each year who are “road ready” for FQHC service. This is one example of several graduate level incubators that should be established in each region and which can contribute mightily to the clinician work force needs of FQHCs.

The guiding star for such efforts regionally can and should be the AHEC Program. What needs to propel this effort is collaborative funding provided on an equitable basis from the two Bureaus through a new cooperative agreement program, or as an adjunct to an existing program.

If we envision $750,000 being needed each year for six regional Centers of Excellence, then we are proposing a four-to-five million dollar initiative and that represents a small, but needed, investment in the $1.4 billion FQHC movement.

I look forward to a robust discussion of this idea at future AHEC meetings. I further suggest that the two Bureaus explore the concept internally. We hope the Bureau discussions, spurred on by an AHEC/FQHC fine tuning of the concept, will add Teaching Community Health Centers and regional Centers of Excellence to HRSA’s work force policy in order to support the expansion of FQHCs nationally.

Through this type of collaboration, including involvement with the National Health Service Corps, the vision offered by the authors in this edition can contribute to providing care to those served by FQHCs and to the 44 million individuals without health insurance. Let us work strenuously to attain this end.

‘The guiding star for such efforts regionally can and should be the AHEC Program. What needs to propel this effort is collaborative funding provided on an equitable basis from the two Bureaus (Primary Health Care and Health Professions) through a new cooperative agreement program, or as an adjunct to an existing program.’
I developed an interest in providing medical services to underserved populations during my medical school years in San Francisco (1966 to 1970). Some medical students were caught up in the anti-Viet Nam war movement. I was among them. The sense that as physicians we should do “right” underlay antiwar activities and helped shape our sense of commitment to the medically underserved as well. Our experiences at the San Francisco County General Hospital reinforced our interests. I recall vividly, and with residual horror, the farm worker parents who had driven from the central valley to get care for their infant with diarrhea. As we unwrapped the baby we discovered she had died from dehydration during the two-hour drive to San Francisco!

My internship was at the Fresno County Hospital where there were no Latinos in my class of 18, and only two women. In 1970 California’s safety net was a group of county-funded hospitals that served the needs of the indigent. As a very green intern I was faced with providing care for patients with serious illnesses and few resources. Some nights I would be the only physician on call for all pediatric cases in the hospital.

After internship, I joined a new family practice residency program in Fresno. I delivered babies, cared for gunshot wounds and treated cases of tetanus, rabies, typhoid fever and other illnesses I had previously considered exotic. Most patients were from rural areas and most were Mexican Americans. We relied heavily upon bilingual employees for interpretation; I realized that I would have to learn to speak Spanish. In the last year of my training, I was asked by Clark Jones to help on an AHEC project that sought to increase the number of residents in our program. The AHEC mission at that time was focused on responding to the identified impending crisis of an insufficient number of family physicians for rural and underserved populations. Little did I know.

My first post residency job was in Mendota, California. It was an hour away from Fresno and had no hospital and few community assets. I’d had a similar placement when I was in medical school and I was thrilled.

I was the physician for the poor of a struggling rural town and working out of a storefront. Although there were two private physicians, neither was residency-trained and neither accepted many nonpaying patients. Medicaid had just come into being.

Shortly after I accepted the position at the Firebaugh-Mendota Clinic, I was asked if residents could come to work there with me as part of an AHEC-inspired objective. I was pleased, because the workload was heavy. The idea we discussed centered about our belief that a good clinical experience would attract more family practice physicians to rural practice. It was beyond obvious that family practice physicians were the right group to target.

Most residents liked the experience; they learned to deal with the rural poor, with farm workers who had had no care previously, and to improvise solutions to problems. We saw the 3 “Ds” which prevail to this day (diabetes, depression and dental disease) as well as leprosy, TB, echinococcosis and pesticide poisoning.

(Continued on next page)
A Career of Commitment

The clinic received Regional Medical Program support. As a stand-alone it was quite vulnerable. It had been started by the rural health committee of the Fresno Madera Medical Society, but quickly exhausted the volunteer pool of physicians.

Family Practice was new then and turnover in faculty high. After just two years on the job, I found myself the only remaining faculty member in our program, which had grown with AHEC and other HRSA support to accommodate 18 residents, each of whom spent a month with me in Mendota.

I became Program Director after a six-month search yielded no other candidates. I would hold the position for 17 years.

While strengthening our Mendota rotation, our program added a second training site. We developed the concept of “pathway,” granting a separate match number for rural physician training in the town of Selma. The Selma pathway thrived and was a better educational model for the preparation of rural physicians than Mendota; there was a small hospital and sufficient doctors to share call.

Our training program received important support from AHEC for this development. HRSA Family Medicine Training Grant dollars were also critical to the successes in Selma. Today Selma has a stable faculty, has many graduates of our own program and has supplied physicians to many rural communities in California.

As I completed my tenure as Program Director, HRSA offered a onetime grant cycle for innovations in medical education. Drawing upon my AHEC experience, I jumped at the opportunity to expand training to a federally qualified health center, in this case Sequoia Community Health Center. The grant was entitled the Hispanic Pathway at Sequoia Community Health Center. This idea, built upon experiences at Mendota and Selma, presented challenges of a different sort from the start.

As a mature health center, Sequoia had a board and leaders who were successful fighters for resources and also had definite ideas about management and doctors. We forged a strong alliance, only with difficulty.

The training program offered Sequoia a solution to its recruitment problems and offered the residency program a chance to focus on Latino health care issues and train Latino physicians.

Sequoia struggled, as had Mendota and Selma, but survived, and today is staffed by graduates and provides physicians to many underserved Latino and rural communities in California. This venture received several types of HRSA support, and continues to receive AHEC dollars.

In 1992, I was asked to serve as Associate Dean for the UCSF Fresno Medical Education Program and in that role was responsible for oversight of eight residency programs, medical student rotations and program development.

The most important accomplishment of the following six years was the establishment of the UCSF Fresno Latino Center for Medical Education and Research (LCMER). My former resident, Kathy Flores, my old friend Clark Jones and Dean Haile Debas all participated in the development of this concept. A grant program (Partnerships in Health Professions Education) supported development of LCMER. Amazingly, Kathy was also AHEC Program Director and HETC Program director at the time. The AHEC, HETC and LCMER share values, resources and credit for many exciting developments in research and education in Fresno. Kathy’s vision and energy have been the key to our success.

The past three years I have had the pleasure of joining Kathy and Heather Anderson as AHEC Program director. We have expanded California’s AHEC centers to 10, become very active in state public health and workforce deliberations, and are exploring the relationship between AHECs and bioterrorism preparedness.

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The 10 centers are mostly self-sufficient. Recently, the California Rural Health Association asked us to find a way to reach the many rural communities still underserved by the AHEC. The California Primary Care Association and California Academy of Family Physicians also have been increasingly important AHEC partners.

Two AHEC centers are doing exemplary work in association with community health centers. The San Diego (Scripps) and Shasta Centers bracket California, reaching from San Diego to Redding, a distance of more than 800 miles. Each uses AHEC support to train family practice residents at federally funded community health centers. In San Diego, Latino youths recruited as high school volunteers for the San Ysidro clinic have completed college and medical school and recently finished residency training at their AHEC-supported site. They now provide care at the clinics that earlier cared for them.

In Redding, Center Director Dean Germano is struggling to maintain support for his rural pathway, which is headed by a graduate of the Selma Pathway. The California AHEC, California Academy of Family Physicians and state partners all are rallying to convince the hospital system that operates the local hospital to continue its commitments to the community.

I now teach in the family practice program from which I graduated. The residents with whom I work are from many lands. Women and men, about equal numbers, frequently speak Spanish and other languages. Although many county hospitals in California have closed, graduates of the state’s family practice programs frequently find fulfilling work in federally qualified community health centers, which are the new safety net. These community health centers are a successful, but still underdeveloped, site for training of health professionals. We have seen in California that they have the very real potential to attract disadvantaged youth from communities that are under-represented in the health professions, to draw them to the health professions and to prepare them for practice with underserved communities. All this has been accomplished with energy, vision and support from HRSA-funded programs, including AHEC. California AHEC staff have gotten used to helping to construct a patchwork quilt of financial support for important state programs. Fortunately, our AHEC funding has been relatively stable in recent years. Continued stability — better yet, expansion of funding — is important to the maintenance and nourishment of this partnership.

**Personal Conclusions Drawn from 30 AHEC Years**

1. It is more fun to support change than resist it.
2. Good partners make success more likely.
3. Good partnerships are hard-forged.
4. Implementation requires flexibility.
5. Adversity can contribute to sustainability.
6. Vision is the best place to start.
8. Wisdom can be found in the community; knowledge in academia.
9. The impact of HRSA programs is far greater than their sum.
10. Leaders must serve as personal symbols of the programs they lead.

‘It is in the spirit of the last conclusion that I share these personal thoughts.’
Travels with the Quiet Heroes and Heroines of Health Care

By Carl M. Toney, PA

“AHEC” — It seems as if I heard this term from the earliest stages of my professional career. As a physician assistant (PA) student at Duke University School of Medicine in the late 1970s, I would hear my fellow students talking about going out on “wonderful AHEC clinical rotations” throughout the many rural communities of North Carolina, particularly in the western part of the state.

I understood little at that time about what or who an AHEC was, but my understanding of and commitment to the AHEC concept would, in a few short years, change forever.

In the fall of 1980, after completing residency training in Emergency Medicine, I returned to Duke as a junior faculty member within the Department of Family Medicine. Over the next three and a half years, I became intimately acquainted with the AHECs in North Carolina. Their staffs worked tirelessly helping us to identify and coordinate community-based clinical training sites and housing for our PA and medical students.

What most impressed me about these early collaborations was how important it was to AHEC staff that the students become a part of the communities in which they were training. These staff members were true “experts” on their communities, champions who had the vision to see that the health care issues of the communities they served could, with a bit of caring magic, become the health care issues of the health professions students and faculty whom they placed for training and teaching purposes. The men and women of the AHEC quietly cast “spells” of opportunity, bringing student and patient together to live, learn and care about each other.

By the early 1990s, I had relocated from Durham, North Carolina, to Atlanta, Georgia, and had moved from clinical medicine into the area of health policy and planning, where I did primary care systems development work with the Georgia State Office of Rural Health (SORH). As a Health Manpower Specialist, I worked with rural and urban medically underserved communities, helping them design and implement health delivery services.

Through this work I quickly attained a new level of understanding and appreciation for AHECs as a key interface between the educational missions of the various health professions academic programs and the service delivery support needs of health professionals in practice. Working in close collaboration with key state stakeholders such as local community representatives, SORH, the Primary Care Association, academic institutions, professional organizations and elected officials, AHECs throughout Georgia helped create community-specific health systems that drew on the resources of the community in recruiting individuals to go into health careers.

The AHECs instituted a model of collaborating with academic programs to help create “at-home” satellite clinical educational opportunities: “train in the town where you live and live in the town where you trained.” Employing this model, Georgia AHECs helped weave a health care training-service tapestry that linked rural and urban community-based primary care systems to both academic health centers and Georgia’s extensive, 159-county public health system.

In spring of 1993, while serving as a U.S. Public Health Service Primary Care Policy Fellow, I had the opportunity to serve on the Rural Health Task Force that had been

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Heroes and Heroines

convened as part of the Clinton Administration Health Reform Initiative. Based on my experiences with the North Carolina and Georgia AHECs, and the experiences of other task force members with AHEC systems nationwide, a number of us vigorously advocated that AHECs be positioned as a key interface within the health profession education/health service delivery continuum.

We envisioned that AHECs could serve as health workforce “brokers” actively engaged in helping communities define and secure their unique workforce needs, while at the same time being a component of the evaluation process in terms of outcomes impact.

In this context, many of us viewed AHECs as one of the critical “missing links” in making the evolutionary step from where health care systems were to where the group was advocating the system next needed to go. Although national health system reform did not occur, I believe the initiatives discussed did spread to many quarters around the country invigorating people to explore creative refinements on a local level. In many cases, AHEC leaders and staff were in the forefront of those discussions.

In the fall of 1994, I joined the staff of the Maine Statewide AHEC System, based at the University of New England College of Osteopathic Medicine. This provided me with the ultimate “inside out” view of the AHEC experience. What I found was a small group of dedicated people working incredibly hard to help bring and/or improve health care services to Maine’s many rural, and often isolated, communities.

During the two years that I spent with the AHEC, I witnessed firsthand examples of collaborative interdisciplinary health profession training projects being developed, bringing together disciplines that had previously had little meaningful contact, and who came to the table because of the credibility of the AHEC as a convener. I saw creative health career initiatives ranging from in-depth manuals to summer enrichment institutes reaching out to the rural, the poor and the disenfranchised, offering a hand to a better life for themselves and their communities. I traveled and spoke with AHEC colleagues from New Hampshire to South Carolina; from Minnesota to Washington State; seeing, listening and learning about an endless stream of creative ventures to improve the health status of all.

Since 1996, in addition to my duties here at the University of New England, I have been actively involved in the Association of Clinicians for the Underserved (ACU). ACU is a national organization made up of clinicians and non-clinicians who are committed to improving health care for those across our country who are most in need. As a member of ACU’s board of directors, I have traveled around the country, meeting with front-line health professionals, many of whom are working in the most dire conditions serving their communities. The one constant I find is if there is an AHEC in operation, it is inevitably standing shoulder-to-shoulder with its primary care and public health colleagues to bring about creative solutions to the health care issues being addressed.

The mission of the Association of Clinicians for the Underserved is: To improve the health of the underserved populations by enhancing the development and support of health care clinicians serving these populations. For more than two decades, as kindred spirits, the AHECs have served as a beacon and mentor to that very same mission. Serving as a transdisciplinary melting pot, bringing local stakeholders together, AHECs are the glue that binds — ever present, ever supportive and, for me, truly the quiet heroes and heroines of health care.
Connecticut
Free Mobile Clinic Rolls In For Migrant Farm Workers

By Bruce Gould, MD

Several different populations of migrant farm workers pass through Connecticut each summer. Some live in camps and barracks provided by the growers at the farms. This population may be American citizens, documented or undocumented foreign workers or foreign workers brought to Connecticut on special visas (H2A) supplied through the U.S. Department of Labor when growers cannot find sufficient numbers of American workers to meet their needs.

Lack of access to health care is common to all these different populations of migrant workers. Few if any are insured. The H2A workers who do pay for insurance find that local health care providers do not accept their insurance.

In 1997, the Connecticut River Valley Migrant Farmworker Health Program (CRVMFHP) was born. A year later the Connecticut AHEC Program, working with medical students at the University of Connecticut (UConn) School of Medicine who were looking for service learning opportunities, approached the program staff and developed a Mobile Free Migrant Farmworker Clinic.

The mobile clinic is coordinated by two-to-four medical students each summer. It visits farms three evenings per week, arriving as workers return from the fields. Each summer between 500 and 700 visits are conducted at barracks and camps around the state.

The clinic is staffed by two licensed physicians, Internal and Family Medicine residents and several medical students as well as an array of nurse practitioner, physician assistant (PA), nursing and public health students. High school students from inner-city and suburban communities have participated as part of Health Career Opportunities Programs sponsored by AHEC.

The scope of service provided by the clinic includes blood pressure and diabetes screening as well as primary care for mild and/or self-limited conditions. Diagnoses range from poison ivy eruptions and gastroenteritis to severe hypertension and life-threatening valvular heart disease.

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Patients in need of laboratory or x-ray services or who need more intense treatment or follow-up are referred to one of the partner Federally Qualified Community Health Centers (FQHCs). Outreach workers provided by the CRVMHP work with the students to assure that patients in need of referral are seen at the FQHCs.

Three years ago the University of Connecticut School of Dental Medicine initiated an oral health Free Mobile Clinic that is coordinated by two dental students each summer. Similar to the medical clinic, the dental unit visits migrant camps in the evening, doing oral exams, identifying dental problems and referring patients to the Community Health Centers for appropriate treatment and follow-up. Dental hygiene students and faculty from Tunxis Community College also offer free oral health education and dental cleanings.

Medications are provided from a limited formulary donated by pharmaceutical companies and from the sample closets of participating physicians. Non-formulary medications are dispensed by prescription or by referral to participating FQHCs where medications may be covered by the voucher program.

Since UConn students may use participation in the clinic as fulfillment of their community service requirement for graduation, all physicians with faculty appointments who oversee the care are covered by the medical school liability policy. Students are covered under their individual schools.

The program is coordinated by the staff of the Connecticut AHEC Program at the UConn School of Medicine where equipment is stored. AHEC staff assist the new student leaders each spring in organizing their classmates for the upcoming season, networking with other health professions schools, scheduling clinics at the farm worker camps with the growers, networking with other program partners and tracking medication utilization, etc. All these tasks devolve to the students as the season starts.

Stipends for student leaders are presently provided by the Hartford County Medical Association, but have been provided by the SEARCH program in the past. The medical association also funds the purchase of medication, clinic equipment such as exam room tents, folding exam tables and lighting, and assists students with the recruitment of licensed physicians to oversee the care delivered during the clinics.

More than 100 students from participating schools are involved in the delivery of health care to the migrant population each season — a population that was largely invisible to these health professions schools prior to the inception of the program. Not only are the details of patient interview and physical diagnosis addressed but, more importantly, participation in this effort affords each student a window on the linguistic, cultural, socioeconomic, immigration and other issues pertinent to the delivery of effective care in this complex and diverse population. All this is accomplished while meeting some of the health care needs of this population as part of an integrated system of care at minimal cost to AHEC. What a deal!

### Participating Partners

- Connecticut Primary Care Association
- Mass League of Community Health Centers: Connecticut River Valley Farm Worker Health Program
- Connecticut Council on Occupational Safety and Health (CTCOSH)
- Area Health Education Center Program (AHEC)
- Hispanic Health Council
- Latinos Contra SIDA
- West Indian Social Club
- New York Center for Agricultural Medicine and Health
- University of Connecticut Schools of Medicine and Dental Medicine
- Yale and Quinnipiac Universities Medical, PA, NP programs
- Tunxis Community College Dental Hygiene Program
- South Park Inn Clinic Board
- Bulkeley, Weaver and Simsbury High Schools
- Connecticut Departments of Public Health, Labor and Education
- Hartford County Medical Association

Medical supplies are delivered for the clinic.
AHEC and Family Medicine: Expanding Access to Primary Care

By Thomas J. Bacon, DrPH

The AHEC Program’s commitment to expand access to primary care providers has been central to its mission from the earliest years of the program, both nationally and in North Carolina. In the early 1970s, families in many North Carolina communities had no access to a family practitioner or other primary care provider.

With a major commitment to address the health care needs of underserved areas and to ensure access to primary care, the North Carolina General Assembly in 1974 appropriated state funds to expand the North Carolina AHEC Program to a statewide program, to expand the East Carolina University School of Medicine to a four-year school and to establish the North Carolina Office of Rural Health. Since then, AHEC has partnered with the state’s four schools of medicine and major community hospitals to dramatically increase the number of primary care physicians in the state and, with the Office of Rural Health, to place them in rural and underserved communities throughout North Carolina.

During the 1970s existing residency programs were expanded and new family medicine residencies were formed in four AHECs and at Wake Forest and ECU Schools of Medicine. In the early 1990s, three additional rural-focused family practice residency programs were created in the state.

In addition to family medicine, additional residencies in internal medicine, pediatrics and obstetrics and gynecology were developed at selected AHEC hospitals. All of these AHEC-established primary care residencies shared similar goals of increasing the supply of primary care physicians and increasing the likelihood that graduates would both remain in North Carolina to practice and settle in underserved communities.

AHEC’s commitment to increase access to primary care providers has included a number of other initiatives as well. Some of the earliest nurse practitioner programs were established through AHEC, and AHEC support for nurse practitioner, physician assistant and certified nurse midwifery education continues today.

After more than 25 years of primary care education through AHEC, the impact of

(Continued on next page)
these programs on the availability of primary care providers for North Carolina communities has been significant. Since 1978 nearly 1,500 family physicians have graduated from residency programs supported by AHEC funding, either AHEC-based or at one of the four university medical centers. Of these, 854 are currently practicing in North Carolina.

The map (opposite page) shows the location of graduates of AHEC residencies across the state. Not surprisingly, the heaviest concentration of graduates is within 50 miles of the place where they completed their residency training. At the same time, however, there is a significant dispersion of graduates to all parts of North Carolina, with a substantial number located in rural counties of the state.

In order to determine the impact of these residencies on rural areas, an analysis was made comparing the growth in the physician-to-population ratio in the non-metropolitan areas of North Carolina with comparable non-metropolitan counties throughout the U.S.

The graph (right) shows that in the early 1970s the MD-to-population ratio in rural counties of North Carolina was very similar to rural counties across the U.S. Since then, North Carolina's MD-to-population ratio has improved dramatically relative to the rest of the nation.

Residents who graduated from a program based at an AHEC center are more likely to remain in North Carolina to practice and to settle in an underserved community than their counterparts at one of the university-based programs. Approximately 50 percent of the graduates of the university programs remain in North Carolina to practice, compared to 67 percent of graduates of AHEC family practice residencies.

The impact of the new rural track programs established during the 1990s is even more impressive. Initial results of graduate locations indicate that more than 75 percent of graduates of those programs remain in the state to practice, with a high percentage settling in rural areas.

At a time in which there is a decreased interest in primary care among medical students in the U.S., primary care training programs of all types must be strengthened in order to assure a continuous supply of the right kinds of primary care providers to serve our growing population.

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The AHEC Program has benefited in other ways from having these graduates placed throughout North Carolina. Many graduates of AHEC residency programs serve as preceptors and regularly take students in family medicine and other disciplines into their practices. Graduates also are often the coordinators of AHEC Continuing Medical Education programs in their communities and area hospitals.

Access in North Carolina

Access in North Carolina

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As a state that is both growing in population and aging, the demand for primary care services in North Carolina will increase significantly in the years ahead. The AHEC Program remains committed to maintaining a strong focus on primary care education and to partner with other educational institutions and agencies to meet the state's primary care workforce needs for the 21st century.

Growth in the MD/Population Ratio in Non-Metropolitan Counties in North Carolina and the U.S.
Georgia

Improving Community Health Through ‘Hands On’ Approach

By Daniel S. Blumenthal, MD, MPH

Practicing high-quality medicine in an underserved community means doing more than caring for one sick patient at a time. It also requires analyzing the health problems of the entire community and planning programs to address those problems.

To prepare future physicians for this expanded role, Morehouse School of Medicine and the Southeastern Primary Care Consortium/Atlanta AHEC have collaborated over the past decade on a unique community-based course. The course represents the interface between medicine and public health and demonstrates the role an urban AHEC can play in medical education.

The first-year Community Health course also represents the consistency between the mission of the School of Medicine and that of the AHEC: both focus on the health of minorities and the needs of underserved communities.

The course meets for one half-day per week throughout the academic year, with groups of 8-10 students assigned to underserved inner-city Atlanta communities. Each group is supervised by one or two full-time faculty members who collaborate with a “community liaison” person from a community agency or community organization. The AHEC plays a crucial role in helping to build the academic-community partnership needed to support the course.

Students spend the first semester conducting a health needs assessment using surveys, focus groups, health department data, and other methods. They drive (or walk) through the community conducting a “windshield survey” and may knock on doors or approach customers in convenience stores to learn opinions about local health problems. They use the methods that they have learned in their classroom-based epidemiology course to analyze this information.

At the end of the semester, students participate in a mock legislative hearing conducted by a committee of real legislators in a hearing room at the state capitol. Representatives of each student group offer testimony on health problems in their community, make recommendations on public policy approaches to remedying those problems and respond to questions from the committee.

In the second semester, each group of students plans, implements and evaluates a health promotion intervention that responds to one or more of the problems identified in the first semester. Projects have ranged from behavior change initiatives (violence...
‘Hands On’ Approach

(Continued)

Learning from Community Interaction

From the Community Health course activities, students learn not only techniques of community health needs assessment and health promotion, but also principles that will serve them well in any practice setting. These include:

- **The health problems** of underserved communities — and the disparities in health status between white and minority populations — are addressed most effectively through prevention at the community level.

- **In any partnership** with a community, the community is the senior partner. Community representatives make the major decisions regarding what is an appropriate educational or health promotion activity in that community.

- **It is not acceptable** to study a community and then leave. Communities have no real interest in being studied. There must be a “payback” in the form of an activity that benefits the community.

- **Major improvements** in community health can be made both by health promotion interventions and by policy and legislative measures. We may insist that people take more responsibility for their own health through improvements in health behavior, but we should also insist on improvements in “conditions under which people can be healthy” created by public policy initiatives.
Ohio

AHEC in the Age of Terrorism

By Churton Budd, RN, EMT-P; Kelly Burkholder-Allen, RN, MSEd; Paul Rega, MD, FACEP, and Kathy Vasquez, MSEd

Since 9/11 and the anthrax attacks of 2001, the medical infrastructure of the United States must not only consider itself on the front-line in terms of recognition and response to a terrorist attack, but also, as a target. Yet, despite attempts to provide education to all segments of the medical infrastructure, results have been sporadic, piecemeal or non-existent.

Further, in the post 9/11 homeland security development, the national AHEC program with its well-developed, operational and mature community-based infrastructure, has been largely ignored as a vehicle for rapid deployment of bioterrorism education and training for the country’s health professionals. In fact, the AHEC program has been left out of the Bush Administration’s budget for the past two years.

With a small funding award in the fall of 2002 from the federal AHEC pilot program for bioterrorism education, the Ohio AHEC program set out to use the AHEC infrastructure and an existing training curriculum to quickly deploy bioterrorism education in four regions of Ohio. The course utilized “BATELS” — Basic Anti-Terrorism Emergency Life-saving Skills, written by members of the Toledo Area Disaster Medical Assistance Team’s Center of Education and Research.

In early 2002, the Medical College of Ohio, recognizing that education of its medical students was deficient in terrorism and weapons of mass destruction (WMD) training, requested the authors of BATELS to provide a compulsory eight-hour overview to third-year medical students. Residents from various specialties were also invited. Based on evaluations and pre- and post-test results, the course was highly successful.

With younger students, BATELS also has proven to be highly adaptable. In the summer of 2002, BATELS was included in the curriculum of CampMed, a health career development program sponsored by the Medical College of Ohio AHEC. Evaluations by the students reported that many of the topics, potential for events which are now part of their world, were explained to them and placed within context.

The effects of terrorism are not limited to highly populated geographical areas. The transmissibility of bio-agents, the global transportation network and the specific aims of terrorists can place any and every community at risk. Realizing this, the Ohio AHEC program, representing four AHEC program offices and eight AHEC centers, believed that BATELS would be a worthwhile component in the health care education of its constituents, especially in underserved communities.

(Continued on next page)

Basic Anti-Terrorism Emergency Life Support (BATELS)

1. Disaster Definition
2. Disaster Injury Patterns
3. Field Management of a Multi-Casualty Incident
4. Blast Injury
5. Crush Injury
6. Hospitals and Disasters
7. Decontamination and Personal Protective Gear
8. Radiation Injuries
9. Chemical Warfare Agents
10. Bioterrorism
11. Critical Incident Stress Management
12. Personal and Family Preparedness
13. Skill Stations
The Age of Terrorism

As a result of success with another collaboration with the Ohio Primary Care Association (OPCA) which represents the state's federally qualified, community and migrant health centers, the Ohio AHEC project approached the OPCA to partner on a proposal for the AHEC Bioterrorism Supplemental funding in the summer of 2002.

Four hundred clinicians are employed among the 99 sites affiliated with the OPCA. Although at the outset it was understood that it would be a challenge to draw clinicians away from minimally staffed health centers, there was interest in the content and a sense that health centers could be a vital treatment location for victims of a terrorist act. The proposal was approved and funded.

BATELS training stresses anti-terrorism recognition and response within a framework of the fundamentals of disaster management. It also recognizes that no one specific segment of the medical infrastructure can successfully manage an incident without interacting with other governmental and non-governmental agencies. Therefore, every attempt is made to ensure that the audience is multi-disciplinary; the instructors include a nurse, a paramedic and a physician with decades of disaster experience and education.

BATELS has a two-fold objective. The first recognizes that the learner is a potential victim of terrorism and provides him/her with tools to mitigate against and prepare for a terrorist attack. The second objective is to provide medical education to care for the victims of terrorism.

A key aspect of the grant is to include a second day train-the-trainer course targeted to community college faculty. This is expected to yield multiple benefits: to expand the capacity among Ohio's health professionals to teach basic concepts associated with bioterrorism, to provide specific module content and to provide some assurance of the sustainability of bioterrorism education after the conclusion of grant funding.

From February through May 2003, the BATELS course was conducted at two suburban locations in close proximity to concentrations of urban OPCA clinicians and two rural sites. A total of 181 people from all areas of the medical infrastructure attended. Fifty six received the train-the-trainer instruction. The mean pre-test score for all four venues averaged 46.6 percent and the post-test average was 77.8 percent. In addition, more than 90 percent of the evaluations demonstrated that both the course contents and the instructors were excellent.

Together, AHEC and BATELS have enlarged the training capacity for bioterrorism education in Ohio. Plans are in place to maintain communication with this new trainer cohort to provide guidance and assist them in their teaching efforts.

The challenge remains to continually modify and expand this instruction and to present it to more of the nation's infrastructure personnel in various formats such as web-based instruction, as well as face-to-face seminars. The greater challenge may be for AHEC to be funded consistently at a level that maximizes its educational infrastructure. AHEC can do it and do it well.

The Age of Terrorism

(Continued)

Participants in the bioterrorism response training examine a mock map of their community.

Project Goals Met

1. The AHEC network was a simple, cost effective and efficient infrastructure.
2. BATELS was easily adaptable to a variety of settings and health professionals.
3. The number of trainees exceeded projections.
4. With the increased number of trainers, sustainability is assured.
5. The collaboration between two HRSA-funded programs demonstrated the interdependence of safety-net networks.

Dr. Rega, author of “Bio-Terry, A State Manual to Identify and Treat Diseases of Biological Terrorism”, is an Emergency Medicine physician and the founder and Senior Medical Officer of OH-IDMAT.

Ms. Vasquez is Director of the Ohio Statewide AHEC program, and the Medical College of Ohio Office of Rural Health and AHEC. She is also a member of the National AHEC Bulletin Editorial Board.
Arizona Community Health Worker Training and Competency Recognition

By Donald E. Proulx, MEd, and E. Lee Rosenthal, MPH, PhD

Nationally, community health workers — popularly referred to as "promotores," community health advisors, community outreach workers and community health representatives — help to fill health care and human services gaps in medically underserved and resource-poor communities. They are particularly effective in reaching rural, minority and socio-economically disadvantaged populations. Individuals who serve as community health workers most often lack traditional academic preparation. These "promotores," in fact, offer unique skills and cultural competencies that are invaluable to public health work, and they constitute an untapped opportunity for the recruitment of health care professionals and for workforce development in medically underserved areas.

In 1998, the U.S. Department of Education awarded a Fund for the Improvement of Postsecondary Education (FIPSE) grant to the University of Arizona AHEC Program to develop and validate a community college core competency-based education program for community health workers (CHWs). The project also attracted the interest of the Health Resources and Services Administration’s Bureau of Health Professions and its associated Health Education and Training Centers (HETC) funding.

Now known as "Project Jump Start," the project created a partnership among four community colleges, two rural AHECs, one Border HETC and multiple community health and human service agencies to establish a college-responsive curriculum for CHWs. The curriculum was designed in accordance with national guidelines for core roles and competencies, evaluation and career progression. The resulting 16-credit basic certificate program has been implemented and evaluated, and the core curriculum has been validated by actively practicing CHWs.

Council of the American Public Health Association (APHA) passed a resolution in 2001 calling for educational institutions to "develop and support effective training curricula for community health workers and their supervisors."

The CHW field is ripe for leadership in the area of education standards as it transitions from local on-the-job training to a few agencies and higher education institutions offering credit-bearing curriculum. There is no system-wide institutional approach to CHW education and training programs. These nontraditional students need an entry-level program that validates the unique characteristics and competencies they offer to their communities, rather than imposing academic requirements which are unrelated to their work.

A wide variety of approaches to the education of CHWs has allowed many best practices to flourish in the field, however, these practices have not been widely shared. Lessons learned in Project Jump Start regarding collaborative work with faculty and administrators in multiple campuses at the state level can be transferred to the coordination of multiple players at the national level.

A panel of collaborators gave presentation on best practices at the 2002 meeting of the American Association of
Community Health Worker

Community Colleges. A “Competency-Based Core Curriculum Guidebook,” published in 2002 by the Arizona Jump Start Project, and Arizona’s final evaluation report to Department of Education, are being widely disseminated.

To impact rural and underserved areas effectively, credit bearing CHW training must be delivered in the affected-community sites.

A Call for National AHEC and HETC Leadership

It is time to develop a coordinated approach for college-responsive CHW training. Institutions that have experience and lessons to share could offer training involving faculty, administrators, community partners and students.

The initiative would develop a compendium of curricula for distribution to adapter institutions as well as a plan for further dissemination of lessons learned through a national meeting and possibly the establishment of a website.

The Arizona AHEC led a discussion to establish a “National Community of Practice” Initiative during a community health worker college-supported network meeting held in conjunction with the American Public Health Association Meeting in San Francisco November 16, 2003. An application for FIPSE support has now also been submitted to help fund this initiative. If funded, the initiative would engage a cohort of model programs of excellence as a national technical assistance team to support adapting institutions in their development of college-responsive curricula for community health workers.

AHECs and HETCs can be particularly helpful to postsecondary institutions developing college responsive training for CHWs. When it comes to workforce development, they are close to the employment market.

Role playing as part of their training are Arizona Community Health Workers, from left, Lourdes Fernandez, Ada Mendoza and Elsa Coccu.

*AHECs and HETCs can be particularly helpful to postsecondary institutions developing college responsive training for CHWs. When it comes to workforce development, they are close to the employment market.*

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In 1994, the New Jersey AHEC began a service-oriented Community Medicine initiative that places third-year medical students from the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine (UMDNJ-SOM) into a wide variety of community sites throughout southern New Jersey. Participating organizations offer crucial services to Latino-migrant farm workers, African American populations, prisons, hospices, in-and out-patient addictions facilities and youth and geriatric centers. Originally a one-week course, it has since expanded to two weeks.

The program goals are to increase knowledge of cultural, social and economic issues that impact health care delivery in underserved populations through direct observation and interaction with diverse communities. SOM and AHEC faculty co-teach initial classroom sessions in which the medical students learn about cultural, ethnic, psychosocial and economic diversity. The students also meet with representatives of an underserved community and participate in a simulated patient experience.

The subsequent community-based rotations allow the students an opportunity to interact with clients and patients on a personal level and “hear their stories.” Finally, the students share their experiences during debriefing sessions with the NJAHEC facilitators. Much of what they relate emphasizes the importance of good listening and communication skills.

Community Medicine rotations also expose students to new approaches to care delivery, including patient-focused activities at a local hospice. In addition to witnessing “positive dying,” students get an understanding of the interdependent roles of health care providers and how inter-disciplinary team management benefits the patient.

During debriefing sessions, students have expressed a need for more information about palliative care in their course curriculum. As a result of these comments, the Department of Family Medicine prepared a Health Resources and Services Administration (HRSA) grant proposal to create an interdisciplinary clerkship in the third year and a palliative care clerkship in the fourth year. The NJ AHEC Interdisciplinary Institute will be integral to the planning, implementation and evaluation of these clerkships along with the Family Medicine faculty.

In the ten years since this project’s inception, the program has not only enriched (Continued on next page)
Making the Connection:

and expanded the students’ knowledge of underserved populations, but has led to new educational collaborations between NJAHEC and the Department of Family Medicine based on the predoctoral needs identified on both the student and community host site evaluations.

The Department has used student and community host site data to identify the critical health care needs of medically underserved communities and to initiate and implement the necessary medical training for students, residents and faculty to meet these needs. HRSA funding is crucial to the success of these predoctoral service rotations and the other related programs. NJAHEC and SOM look forward to building even stronger collaborative partnerships and sharing this learning model with other universities and AHEC programs.

Camden Senior Wellness Program

The integration of an AHEC community health program into UMNJ’s curriculum by becoming a Community Medicine site

What do a group of senior citizens, an AHEC nurse, an AHEC program coordinator, a few third-year medical students and wellness have in common? More than the students or the staff ever thought possible. The AHEC Senior Wellness Program provides health education, assessment and referral services to a racially and ethnically diverse group of senior housing residents who are rich in life experiences and frequently present with serious health concerns.

Camden City has a population of 79,900 and is one of the nation’s most economically and socially depressed cities. Camden has a predominately minority population with 53 percent African American and 39 percent Latino. It is critical that people recognize differences and understand one another. Reducing cultural and communication barriers in health delivery is key to reducing racial and ethnic health disparities.

The Senior Wellness Program was one of the community programs chosen to host the students for the Community Medicine rotation.

AHEC staff collaborate with the Camden Housing Authority and the medical students to offer health assessments and referrals, listen to seniors’ concerns, help the seniors “take charge” of their own health care and present health education programs.

The Senior Wellness Program staff oversee the medical students’ visits to seniors and document findings in each senior’s Wellness Workbook. The Senior Wellness Workbook is a binder complete with health history, current assessments such as blood pressure, blood sugar level and weight as well as senior-related health topics, resources and contact information.

Providing long-term solutions, not just episodic care, is the key to this invaluable experience. The students are asked not only to observe the community culture and the psychosocial and economic issues, but also to think about future-oriented strategies: What can be done to help the seniors take control of their own health? The students learn the skills and collaboration required to assist seniors in finding comprehensive care and appropriate resources. The reward is helping seniors develop and maintain life’s most valuable gifts — independence with wellness.

In his daily journal, a student wrote: “One senior was found to have very high blood pressure and a serious ulcer on his leg. He lives alone and had not seen a doctor in several years... I was very concerned about... potential for osteomyelitis... and call(ed) my Family Medicine Preceptor...who also practices in Camden...it was decided that the patient would be best served by (going) to the Emergency Room. This was agreeable to the gentleman, who knew his health was in a state of decline. I felt good about being able to directly apply my medical knowledge and intervene to help this senior get some much-needed care. It was very interesting to note how well medicine and social work complemented each other...in order to provide...long-term solutions [AHEC staff follow-up and referrals to social and health care services post-emergency room visit] to this gentleman’s problems.”
...creating the safety net of health care for the underserved
North Carolina
The Community Plunge:
Putting Voices and Faces to the Statistics

By Anita Pulley, MSN, RN

In order to address the primary health care needs of the underserved, physicians must be able to step out of the culture of medicine, even if only briefly, and seek to understand the life experience of the people they serve and the community context within which their patients live. Northwest AHEC, one of the nine regional AHECs in the North Carolina AHEC Program, and the Wake Forest University School of Medicine Department of Pediatrics collaborated to create a “community plunge” to introduce pediatric residents to this vital perspective.

Wake Forest University School of Medicine is in Forsyth County, an urban county with increasing diversity and many challenges, yet many assets. The economy, once dependent on the tobacco and textile manufacturing industries, is in transition, and the unemployment rate hovers around 5.2 percent.

A community plunge is an experiential learning opportunity designed to expose learners to particular issues as they impact a community.

A plunge involves getting out of offices, clinics and institutions and going into the community, talking directly to people in the community (not agency heads and those serving the people). A plunge is not telling them what you are going to do for them, but listening to their stories and perspectives to broaden your own understanding. A plunge will move you and/or your group into positive action, in partnership with community members and leaders to meet needs and tap into assets.

It is a way for community members to be the teachers, sharing what they know about living in the community. It is a reality check. It is a way to put faces and voices to the statistics.

In July 2002, Northwest AHEC implemented curriculum changes to enhance the advocacy experiences of medical residents. Staff designed the community plunge as part of the orientation of first-year pediatric residents to the advocacy curriculum. The plunge explored selected historical, social, cultural and economic perspectives and the ways they have strengthened and challenged the community.

Special emphasis was placed on aspects that influence the health, education and care of children and on the importance of using an assets-based model in practice.

The plunge has three components: a predetermined, scripted windshield tour; four focus groups with parents of children served by the pediatric residents; and a debriefing session. It is designed to strengthen the residents’ ability to address key health and social needs of the children and families of the community and to look for family and community assets and strengths that can be mobilized to address health and social needs.

Specific goals of the plunge are to: 1) orient pediatric residents to the community itself; 2) establish a foundation for understanding the social, cultural and other non-medical factors that influence the health of children in the community; 3) gain an understanding of the evolution of health care, economics and race relations in the city; 4) allow physicians, in a non-clinical setting, to learn from the people they will be serving; and 5) create an attitude of empathy and openness to listening.

In 2000 the population of Forsyth County was 306,067; 68.5 percent were Caucasian and 25.6 percent were African American; 6.4 percent of the population were Latino, an 800+ percent increase since 1990. Eighteen percent of children age 0-5 live in poverty and more than 22,000 children aged

(Continued on next page)
The Community Plunge

0-17 are eligible for Medicaid. Although changing, segregated housing patterns still exist. AHEC staff felt it was important for the pediatric residents to see the disparity between poverty and wealth and to have an accurate mental image of the neighborhoods in which many of their patients lived.

The windshield tour included wealthy neighborhoods where industrialists lived in the 1800s and power brokers live today; key historic sites; the public transportation/bus hub; important community assets such as African American churches, neighborhoods, landmarks and parks; the Latino community business district and housing; health and human service facilities; selected special programs and services for children; selected schools; and low-income housing projects and low-income neighborhoods.

To be able to talk to the people who lived in these communities, AHEC staff arranged focus groups of low-income parents at four sites. In the second year of the plunge, the focus groups were adjusted to gain the perspectives of teenage mothers and parents of special-needs children. Focus group questions centered around the challenges families with children face, the sources of strength to face those challenges, their experiences with well-child and sick-child care, behaviors of pediatricians that are helpful in the care of the children, and behaviors of pediatricians that are not helpful.

The community participants were eager to share their perspectives and many shared insightful comments and stark realities about their lives. They all expressed gratitude and a measure of surprise that the doctors wanted to talk to them.

The debriefing session allowed the residents and faculty to share and assimilate their experiences. Poignant discussions ensued about poverty, racial issues, the hopes and dreams that these parents had for themselves and their children, the miscommunications and misperceptions that exist between the community members and the medical community and the ways in which better relationships could be forged.

The community plunge proved to be an effective and efficient way to introduce pediatric residents to the community and to the perspectives of the people they serve. This methodology could be adapted to address any community, any issue and the learning needs of any group of health professions students, residents, professionals or other leaders who are willing to ask “what can the people of this community teach me?”

Following the “Community Plunge” focus groups, pediatric residents said:

“It (the minority neighborhood) is right in my backyard, but I’d never been there before. I’m obviously not a part of it and I never felt that as much as when I drove through. Yet I’m their doctor.”

***

“. . . I was just astounded at the poor communication....it was amazing what they thought was going on with their health care... They thought we were hurried and in a rush because they had Medicaid, yet I don’t even know who has Medicaid. I’m tired and working all the time regardless, and I show it. But it was amazing to hear what they thought was going on and it was not. It was poor communication, and I learned to communicate better...that’s one of the most important things in a doctor.”
New York

User Friendly Data System Serves AHECs and Partners

By Steven Schreiber, PhD

For many in the AHEC community who deal on a daily basis with student rotations, pipeline programs and continuing education, mentioning the word “data” creates a certain amount of unease. Add words like “geocode,” “age-adjusted rates” and “confidence intervals” and eyes begin to roll, fingers begin to tap and minds begin to wander. What, after all, do data have to do with addressing the real-world problems of health workforce shortages, poor health status and inadequate access to care? A lot. Community health needs assessments, grant applications and HPSA designations, to cite a few examples, all depend on data. The question is not whether underserved communities need data but how to provide those communities with data that are accurate, complete, up-to-date and, above all, user-friendly.

The New York State AHEC System began in 1998. From the start, it was decided that the need for health, social and educational data could best be served by placing the collection and distribution of the data in one office. This would avoid each AHEC center acquiring data, purchasing mapping software and gaining the expertise necessary to interpret, use and present the data.

For the past two years the Eastern Regional Office has served as the data resource center. It provides census, health care, health workforce and educational data to each of the AHEC centers as part of a standard data set and also makes available specialized data sets and analyses on request.

One example of specialized data provided to the AHECs was a mailing list of registered nurses developed from the state licensure file that was used to target a mailing for a continuing education program. Another example was a map of health care facilities that was included in a workforce retraining grant application.

The data resource center is also providing data analysis and mapping services to New York State’s primary care association as it develops a statewide strategic plan for primary care service expansion. The plan is required by the federal Bureau of Primary Health Care as a condition for applying for grants to develop new community health centers and satellite clinics.

‘AHECs can play a key role in helping underserved communities to access and analyze data that are vital for planning and program development. The increasing availability of the internet and user-friendly mapping applications is greatly expanding the possibilities for that role.’

The data center also has developed a website called “AHEC Tools” that enables the user to employ state-of-the-art but user-friendly data analysis and mapping tools.

(Continued on next page)
User Friendly Data System

friendly mapping tools to select and analyze a wide range of health, social and educational data. Users access data by clicking on the map of the particular geographic area in which they are interested. The area can include a county, a ZIP code, a census tract, a school district, a rural health network, a health professional shortage area, a medically underserved area or a legislative district. The census, health or educational variable of interest is then selected.

For example, to determine the percentage of the population under the poverty level in ZIP code 12186, users select “ZIP code” in the window called “Target Geography.” This produces a map of all the ZIP codes in New York State. Using the magnifying tool the user zeroes in on ZIP code 12186 and clicks on that area on the map. The user then clicks on the regional data bar and has the choice of either health data (hospital discharge and birth statistics) or census data. Census data include totals and percentages for gender, age, race, ethnicity, poverty and non-English speaking populations.

Users also can create new areas by selecting multiple units at one time, for example, three ZIP codes that make up a particular community. New totals and rates will be computed for that community, and compared to statewide averages.

Point data can also be selected for any of the above mentioned geographic areas. Point data include the location of physician and dentist practices, hospitals, clinics, public and private schools and educational institutions that offer health professions training.

Another feature of the website allows the user to define areas based on actual driving times from hospitals and clinics. Using this feature, it is possible, for example, to accurately identify the number of people over the age of 65, the number of poor or the percentage of minority populations who live within a 30-minute drive from a particular clinic or hospital. The tables and maps produced by the website can readily be downloaded for further analysis and presentation.

Currently, the use of the website is limited to the AHEC system but it may be made more widely available in the future. “AHEC Tools” is still being implemented within the New York State AHEC System. Initial reports from AHEC centers on the use of the website have been enthusiastic and supportive. One center is using “AHEC Tools” to identify physicians in HPSAs as part of the HPSA redesignation process. Another center has used “AHEC Tools” to acquire social and demographic data for a grant application. Once the above mentioned statewide strategic plan for community health center expansion is adopted, AHEC centers are expected to use “AHEC Tools” to provide individual community health centers with health and social data necessary to apply for federal grants to expand services.

AHECs can play a key role in helping underserved communities to access and analyze data that are vital for planning and program development. The increasing availability of the internet and user-friendly mapping applications is greatly expanding the possibilities for that role. The future is exciting to behold.
Concerned by a rapidly growing number of federally designated Health Professional Shortage Areas (HPSAs) and a doubling of the number of uninsured rate, a coalition of organizations formed the Hawai`i Health Workforce Hui (the Hawaiian word for “group”) in 2000.

The Hui identified a threefold mission: (1) to improve communication and collaboration between members and other entities concerned with health workforce issues in the state; (2) to construct a clear and comprehensive picture of the health workforce situation in Hawai`i; and (3) to formulate strategies for policy and programming based on this assessment.

Improving Communication and Collaboration

In addition to its periodic face-to-face meetings, the Hui quickly established a listserv whereby information could be shared and virtual discussions had. The partners also agreed to centralize and cross-link information resources on the web. AHEC’s website was established as a central site for employment listings and other recruitment information. This website is currently being expanded to a comprehensive statewide resource site on workforce, providing links to community, state, regional, and federal information and technical assistance.

Constructing a Picture of the Health Workforce

A current health workforce assessment, covering clinical, allied and public health professions statewide was seen as a fundamental task for the Hui. With valuable input from the other partners, the Hawai`i/Pacific Basin AHEC has taken the lead on this effort. After conducting a review of previous workforce studies, which tended to examine a single profession group or geographic area, AHEC has conducted two surveys of health organizations and other key informants. The first round occurred in 2001 and the second — still ongoing — in 2003.

(Continued on next page)
In order to maximize resources and reach, this survey has been primarily e-mail based. Survey questions have sought to ascertain both hard numbers of present and projected vacancies as well as structural issues behind these workforce gaps.

Preliminary findings from the current round have revealed some structural issues which would be amenable to direct efforts by the Hui, and other "global" and systems issues around which the Hui hopes to generate a statewide health workforce dialogue in the hopes of indirectly effecting change.

Content analysis of three open-ended questions has, to date, elicited the following ranked structural issues (the third of these is specific to the health professions schools where AHEC finds one of its central roles):

Barriers to Recruitment and Retention: 5 Most Frequently Cited

<table>
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<tr>
<th>Barriers</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Noncompetitive Salary</td>
<td>80%</td>
</tr>
<tr>
<td>General Shortage of the Profession</td>
<td>70%</td>
</tr>
<tr>
<td>Intense Job Demands</td>
<td>60%</td>
</tr>
<tr>
<td>Stringent Qualification Requirements</td>
<td>50%</td>
</tr>
<tr>
<td>Lack of Promotion Opportunities</td>
<td>40%</td>
</tr>
</tbody>
</table>

Barriers reflected both local and national conditions. Overwhelmingly, non-competitive salaries were cited as the prime barrier. The situation is particularly profound because the cost of living in Hawai‘i is quite high. Other frequently cited barriers included macro-level phenomena apparent in the local labor market: the national shortage of nurses and other professionals and the widespread trend of greater job stressors with fewer rewards such as patient contact.

Trends Impacting Workforce: 5 Most Frequently Cited

<table>
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<tr>
<th>Trends</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing Health Context</td>
<td>80%</td>
</tr>
<tr>
<td>Expansion of Services</td>
<td>70%</td>
</tr>
<tr>
<td>Aging Workforce</td>
<td>60%</td>
</tr>
<tr>
<td>State Economic Downturns/Unemployment</td>
<td>50%</td>
</tr>
<tr>
<td>Institutional Growth</td>
<td>40%</td>
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Respondents felt a changing health context — shaped by Hawai‘i’s aging population, advances in technology allowing for care of more medically fragile populations, the growing “ice” (crystal methamphetamine) epidemic necessitated an expansion of services and greater demand for skilled professionals. Other challenges to workforce development including Hawai‘i’s aging health care providers, the absence of the training pipeline once enabled by the SPH, and a continuation of the state’s bleak economic picture.
Fundamental to the study was to understand how UH’s health professions schools could best contribute to workforce development. AHEC found open-ended responses both a validation of its current programs and the need to expand or replicate such efforts. Noteworthy were calls for promoting health careers in schools and heightening collaboration and communication among the university, health agencies and client populations. This latter role suggests the need for a sustained mechanism or process for employers to provide feedback to educational institutions regarding education policy and curriculum development.

Strategies for Policy and Programming
Based on this survey and cumulative assessment efforts, Hui partners are now working towards advancing a select set of strategies. By leveraging existing resources and combining with like-minded efforts, these approaches maximize institutional energy and remain cost effective. The Hui’s goals for the next year include:

- Collaborating with the Hawai`i Rural Health Association to conduct a project designed to enhance cultural competence using community indicators;
- Intensifying marketing of the National Health Service Corps among health care agencies and prospective scholars;
- Investigating the feasibility of a State Loan Repayment Program;
- Joining the Rural Recruitment and Retention Network (3R Net); and
- Focusing on retention of health professionals in rural and underserved communities through the use of employee satisfaction surveys in health organizations.

Hui Partners

- The Hawai`i Primary Care Office
- The Hawai`i Primary Care Association
- Hawai`i/Pacific Basin AHEC
- The Hawai`i State Office of Rural Health
- The Native Hawai`ian Health Scholarship Program
- The Hawai`i Quentin Burdick Rural Inter-disciplinary Training Program
- The Native Hawai`ian Health Care Systems
- The U.S. Public Health Service Regional Advisor
- The University of Hawai`i School of Medicine Family Practice and Community Medicine Residency Program
2003 Leadership Workshop
Portland, Oregon
The Role of Health Centers
In Training Health Professionals

By Dan Hawkins

Recently, I was privileged to attend a very special event in conjunction with the annual celebration of Health Centers Week. At the Mile Square Health Center, located in the heart of Chicago’s West Side, thousands came to enjoy the festivities at the center’s 12th annual Health Fair and to thank their Congressional Representative, Danny K. Davis (D-IL), who is both the product of what we still call the health centers “movement” — as a young man in the early 1970s, he was a senior staff member at Mile Square — and one of the leading supporters of health centers in the Congress today. Rep. Davis founded and co-chairs the Congressional Health Centers Caucus.

The celebration had a second dimension — a tribute to the decade-long partnership between Mile Square and the University of Illinois at Chicago Medical School. As a result of that partnership, Mile Square is a key training ground for 18 family medicine and ob/gyn residents. An additional 10 medical students, 10 certified nurse midwifery students and 10 nurse practitioners also train there.

While the events surrounding that celebration were unique, in many ways they represent only the latest in a long and growing string of collaborations and partnerships among health centers and a whole panoply of health professions education and training programs across the country. What brings these two vital sets of players in our country’s health care system together is, I believe, a confluence of both shared values and complementary needs.

From humble beginnings rooted in poor and minority communities 38 years ago, America’s community health centers have grown to serve some 14 million medically underserved Americans in more than 3,500 communities across the nation. The demographics of their patient population — 90 percent low income, 80 percent either uninsured or on Medicaid, 65 percent members of minority groups and one-third who communicate in a language other than English — mean that health centers face some of the toughest, most complex primary health care problems of any ambulatory provider group.

Yet the record shows that the care they provide is exceptionally good, resulting in improved health outcomes, lowered costs and significant reductions in health disparities for the low-income and minority populations they serve. It’s no wonder, then, that the work of health centers has received increasing recognition and support from a majority of the Congress, and President Bush as well, who are working together to double the number of people served by health centers over the next five years.

On a broader scale, these proportions closely parallel those of the country’s public and teaching hospitals, and the Area Health Education Centers (AHECs), which share with health centers the mission to be of service to their communities, especially to those most in need. And as today’s teaching programs grapple with the need to move more training and more health care services, out of inpatient facilities and into community-based ambulatory care settings, health centers have also realized that they alone cannot hope to meet even a fraction of their patients’ health care needs without viable partnerships. So, like the proverbial “Strangers in the Night,” they have proceeded from “exchanging glances” to “taking chances” on collaborative endeavors that can at once substantially improve the quality and continuity of care for those they serve and bring some, at least limited, relief from the financial strains they feel.

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Role of Health Centers

2003 National Association of Community Health Centers Survey

The NACHC examined the extent of these partnerships and the challenges they face. One-third of all health centers responded. Major findings include:

1. Nearly three-fifths (57 percent) of centers indicated that they are partnered with their local AHEC programs, offering community-based primary care training opportunities for students and benefiting from the AHECs’ continuing education programs. More than 40 percent of the centers also participate in National Health Service Corps’ Student/Resident Experiences and Relations in Community Health (SEARCH) program activities in their states.

2. More than 76 percent of responding health centers were involved in the training of health professionals, including medical students, medical residents, dentists, nurse practitioners, nurses and physician assistants. This is roughly the same level as in 1997, when 83 percent indicated that they were involved in such training activities.

3. Some 42 percent of responding health centers were engaged in medical residency training efforts, up from 36 percent in 1997. An average of more than seven residents trained at each of those programs, greater than the average (6.4) recorded in 1997. At that rate, thousands of medical residents spent some time in a health center as part of their residency last year.

4. Almost three-fifths of responding health centers — and the vast majority of those offering the medical residency training programs — also indicated that they were involved in the training of medical students, suggesting a strong link between undergraduate- and graduate-level training. And more than two-thirds of health centers reported participating in training programs for nurse practitioners, nurse midwives or physician assistants.

5. More than 16 percent of health centers indicated that they participate in dentistry training, averaging six dental students per site. This would equate to hundreds of dentistry students — a significant portion of each year’s graduating dentists.

6. 84 percent said sponsoring teaching programs at their local health centers aided their local efforts to recruit and retain qualified health professionals; 85 percent said that it gave them a chance to influence the students’ career practice decisions; and more than half of the respondents pointed to enhanced community respect and improved staff satisfaction that flowed from their involvement in teaching activities.

The one serious, continuing problem noted in the survey is that centers overwhelmingly cited the cost (to them) of participating in those activities, especially lost staff productivity as the biggest disadvantage. While in some cases the centers receive some financial help from their partners, only 45 percent of health centers with residency programs indicated that the teaching hospital or training program paid any portion of their training costs.

Herein lies perhaps the greatest barrier to any expansion — and potentially even to the continuation — of these vital partnerships. Health centers understand the importance and value of their involvement in health professions training, not only to the country’s future health care workforce but also to their ability to successfully recruit and retain quality clinicians consistent with their own growth plans. But without improved financial support, it is possible — even likely — that these training programs may well end up on the cutting room floor, the victims of pressures to focus on direct patient-care costs. If that were to happen, the sad result would be a weakening of the entire health care safety net for millions — perhaps tens of millions — of uninsured and underserved Americans.

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Arizona
Teaching/Training Embraced as Core Component of Mission

By Rick Swanson

In 1996, North Country Community Health Center (North Country) was founded by the Executive Director of Northern Arizona Area Health Education Center (NAHEC), Ann Roggenbuck, MPH, MBA, PhD. With Dr. Roggenbuck’s vision for integrating service delivery and teaching/training, she brought the AHEC along to be part of the fledging community health center. NAHEC would reside in a “Training and Outreach” Division at North Country where it would be possible to prosper as part of a primary care based organization.

A lack of state funding during a six-year period placed a heavy burden on the Northern Arizona AHEC (NAHEC). If NAHEC had survived at all, it would have been as a much weaker organization than it has become as part of a comprehensive community health center under the leadership of Dr. Roggenbuck.

“The relationship would help protect NAHEC from the ups and downs of AHEC funding, and it would provide synergy with the primary care environment at the community health center,” Dr. Roggenbuck recalls.

Pre-established AHEC relationships with academic institutions quickly led to North Country’s reputation throughout the state as a progressive teaching/training organization. North Country has since grown to be a six-site, multi-provider practice (medical, dental, mental, pharmacy) projecting approximately 40,000 patient visits in the next fiscal year. Teaching/training activities at the community health center have expanded in this synergistic environment and economies of scale have been achieved.

North Country provides clinical rotations for MD and DO students from the University of Arizona College of Medicine, the Arizona School of Health Sciences and Arizona College of Osteopathic Medicine. Family Nurse Practitioner students from Northern Arizona University (NAU) do rotations at North Country, and nursing and health promotion students from NAU are assigned to North Country outreach programs such as well women health check, prenatal outreach and diabetes education. Dental hygiene students do internships and externships at North Country’s dental clinic, and North Country has started providing residencies for dentists. Physician assistant students, pharmacy, MPH and MBA students are all part of the mix. The Arizona Association of Community Health Center’s SEARCH Program, funded by the National Health Service Corps, is an active partner.

Flagstaff, home to NAU, is an expensive place to live, and student housing is a challenge. North Country used its borrowing power to purchase a condo that the AHEC leases for student housing. The condo is near the Center, allowing several students from different academic institutions to complete rotations at the same time. When available,

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Teaching/Training Embraced

this student housing option is offered to students completing rotations in other community practice sites as well.

Teaching and training responsibilities play an important role in provider recruitment and retention in community health centers such as North Country. All providers expressing interest in working for North Country are queried about their interest in teaching/training as part of routine role responsibilities.

North Country providers seem to take pride in sharing their knowledge and experience with the next generation of providers and serving as mentors to them during their rotations. In an effort to avoid preceptor burnout and keep provider interest in teaching/training high, Center providers routinely rotate teaching/training responsibilities. The Northern Arizona AHEC Center staff like the way it works. They appreciate the convenience of having a clinical site that embraces teaching and training as core components of their mission. Dr. Roggenbuck said, “The AHEC career training coordinator can count on North Country to take students on a regular basis and provide them with consistently good clinical experiences.”

North Country recently joined a community health center diabetes collaborative, which will offer health professions students excellent training in disease management. Future disease management collaborative opportunities include hypertension, asthma and depression. Recent involvement with a Radiation Exposure Screening and Education Program (RESEP) will soon offer an environmental student experience for those interested.

A NAHEC goal for this fiscal year is to develop an interdisciplinary training experience at North Country that will be an option for students enrolled in any health professional training program at any collaborating academic institution. The experience will offer interdisciplinary training within the community health center (medical, dental, mental, pharmacy, health education, etc.), and will teach the student how to work within a multidisciplinary environment in an interdisciplinary way. The students will learn how North Country providers work in collaboration with other entities within the community (private practice, hospital, ancillary services, public health, Indian Health Service, etc.) to ensure comprehensive patient care. In addition, a community-based experience will teach the students how to make a population-based contribution to a community.

This expanded model of community-based interdisciplinary student training is not new in theory. One of NAHEC’s sister AHECs, Southeastern Arizona AHEC (SEAHEC) in Nogales, has developed a noteworthy multidisciplinary program called Nuestra Comunidad, Nuestra Salud (Our Community, Our Health), which matches students with promotoras in border communities.

Also, the statewide Arizona AHEC program has launched a pilot program, Clinical Communities, which matches medical students from the University of Arizona with “community preceptors” and community projects in addition to their work with their clinical preceptors.

As part of a community health center and with the support of organizational leadership, NAHEC has an opportunity to pilot, refine and institutionalize the interdisciplinary teaching model at North Country.

It will require intensive involvement by North Country’s staff and consistent oversight by NAHEC throughout each student experience. However, the payoffs could be huge. Students will experience an integrated interdisciplinary program that reaches out into the community. Preceptors will benefit from the satisfaction of being involved, and patients will benefit from the integrated care.

North Country’s Medical Director, Andrew Saal, MD, is pleased with the synergy. “Having the regional AHEC office within our community health center has been a tremendous boon to everyone,” he said. “Our mission includes education as well as empowerment; the AHEC programs help us carry this philosophy into the community. In essence, the AHEC program is the embodiment of our primary care mission throughout Northern Arizona.”

John Keith, a fourth-year Northern Arizona University Nursing Student, said, “My clinical experience at the community health center has been interesting and rewarding. As a nurse, I hope to continue to help others in a medically underserved community.”

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Massachusetts Patient Care and Education: Complementary Missions of Family Health Center

By G. Dean Cleghorn, EdD

Greater Lawrence Family Health Center (GLFHC) is a Section 330 Community Health Center in Lawrence, Massachusetts. As of the 2000 census, the Lawrence population was more than 60 percent Latino, predominantly from Dominican Republic and Puerto Rican backgrounds. Since the early 1980s GLFHC has provided primary care for more than 80 percent of this underserved population.

After its first decade of providing services in this community, GLFHC broadened its mission from solely patient care also to include health professions education. In 1991 the Health Center became home to the Merrimack Valley AHEC, and shortly thereafter launched into uncharted territory for a community health center — the establishment of the first CHC-sponsored residency program.

Through the Merrimack Valley AHEC (MVAHEC) and the residency program, educational activities are everyday events at Greater Lawrence Family Health Center. During the year 2002-2003, the health center provided rotations for three nursing students, 17 clinical medical students, four pre-clinical students and two physician assistant students, and also provided internships for 23 high school students interested in health professions careers. Continuing education for health professionals and in-patient and out-patient learning for family practice residents are part of the fabric of the health center’s daily life.

The dual clinical/educational mission of GLFHC, crafted by community leaders, provided fertile ground for growth in many areas. At GLFHC, like elsewhere, tension develops between education and patient care when resources become constricted. Nevertheless, balancing the tension created tremendous growth through the years. Some of the growth areas for GLFHC are briefly described below — a distinctive combination of factors in a unique community organization.

Collaboration with Lawrence General Hospital

From the beginning of the residency program, Lawrence General Hospital has been an active partner as the in-patient base for residency training. The affiliation involves a long-term agreement between the health center and the hospital regarding operation and financing of the residency program. Candidates for the competitive three-year program are top medical graduates, seeking to train in family medicine, who have demonstrated a commitment to medically underserved populations. To date, nearly a third of the graduates have chosen to stay and practice in Lawrence and have joined the hospital’s medical staff. Residents are either bilingual or take intensive courses in Spanish.

Lawrence General provides substantial support to the Lawrence Family Practice Residency Program for salaries, capital outlays, space and service, not including the significant costs in time spent by physicians, nurses, nutritionists, social workers and technologists in educating and training resident physicians. More than 200 of the hospital’s medical staff teach residents in staff offices, in lectures and on rounds. A special arrangement with CMS enables the health center to receive federal funding from the hospital for the residency.

The Lawrence Family Practice Residency has filled all eight resident positions on match day, nine of 10 times. In 2003, the residency program graduated its eighth class and welcomed its tenth full class of eight first-year residents — the Class of 2006. This raised the total number of participants over the life of the program to 77. More than 80 percent of the 51 family

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practice residency graduates have gone on to work in underserved communities, with most working in Community Health Centers.

**Further Collaboration**

**Universities:** For the residency program and other academic endeavors, GLFHC affiliated with both Tufts University and the University of Massachusetts (UMass). The initial residency affiliation with Tufts evolved for many reasons, including the budding potential of family medicine at the university in the early '90s and because of long-standing ties with many specialists in the Lawrence area. Tufts University medical students benefit from seeing primary care practice at GLFHC as it is integrated into a community health care network. It is one of only a few similar opportunities for these students.

From the outset, the Massachusetts AHEC state office also facilitated the beginning of the new residency. However, it was not until 1998 that the University of Massachusetts/GLFHC developed a formal affiliation agreement. The UMass/GLFHC affiliation continues to expand activities in connection with resident and student education, faculty development and research, especially because of the shared vision to improve the health and health care for underserved populations. Many community faculty members have regular or clinical faculty appointments at one of the universities.

In addition, the Merrimack Valley AHEC is helping to prepare Latino nurses, in collaboration with multiple nursing schools, through longitudinal approaches to student development and ultimate entry into nursing practice.

**Research:** The residency expanded its academic program to include community-based research, funding for which now exceeds $1 million annually. The faculty includes two fellowship trained research physicians and six other faculty members actively engaged in research. Current research regarding diabetes in Latinos in Lawrence is funded by the Centers for Disease Control and Prevention program, Racial and Ethnic Approaches to Community Health (REACH) 2010. It has generated interventions in the health center to increase adherence to accepted guidelines for the care of diabetic patients. Other interventions through a dozen collaborating community agencies are showing promise to increase diabetic control, increase exercise and change dietary habits of community members.

**Community-Based Faculty Development:**

GLFHC is a continuing collaborator with the University of Massachusetts Medical School's community-based faculty development program. New physician faculty members routinely participate in the annual series of Community Service-Learning Projects

Residents and students have completed many community service-learning projects, some of which continue to add value to the community. For instance, free health care for homeless individuals, which began as a resident project, continues as an ongoing service of the health center. Below are further examples of service-learning projects conducted by residents:

- **Reach Out and Read,** a literacy project which brings free books and volunteer readers to pediatric patients;
- **Teen Pregnancy Prevention,** a support group for teen parents;
- **Parent Enrichment Program,** a series of bilingual parenting classes;
- **Leadership Adventures,** a dropout prevention program teaching self-esteem and leadership skills to tenth-grade students through workshops, volunteer experiences and outdoor activities;
- **North Common Community Garden,** the transformation of an abandoned site into a community flower and vegetable garden;
- **Let’s Kick Butts,** a smoking cessation program for at-risk high school students;
- **Eat Healthy, Eat Well,** nutrition workshops focusing on healthful eating habits for diabetics;
- **Gay, Lesbian and Bisexual Youth,** a support group and peer network for teens.
workshops to improve teaching skills. Since 1996 the Regional Advisory Committee for this program has included a GLFHC representative.

**Bottom Line: Expanded Health Care for a Latino Underserved Population**

While the Latino population of Lawrence has doubled in the past decade, the number of patients at GLFHC grew from about 10,000 to more than 35,000. The number of providers grew from nine to more than 50. The number of employees has grown from fewer than 100 to more than 400. An emphasis on obstetrical care by family practice residents and physicians has led to a substantial reduction in infant mortality in Lawrence. Prior to the expansion of prenatal services with the advent of the residency program and many more family physicians providing OB care, the Lawrence infant mortality rate was double-to-triple the state average. With the advent of the residency program, the Lawrence rate has been as good as or better than the state average.

Many clinical programs are provided through GLFHC to meet health needs of the community. The breadth of services now available is substantially more extensive because of the sheer size of the health center as a resource to the community. Collaboration has always been a critical element in the development of these programs; however, the advent of collaboration across clinical programs AND education clearly accelerated the progress GLFHC has made in the past decade.

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**Exploring CHC-AHEC Linkages**

Community Health Centers (CHCs) currently have many linkages with AHECs and HETCs, and both programs are exploring additional ways to collaborate. AHEC Branch Chief Louis Coccodrilli, MPH, presented the following statistics and partnering suggestions during the NAO 2003 Leadership Workshop in Oregon.

- In 2000, there were 548 CHCs serving as AHEC training sites, up from 474 in 1999.
- Today the number of satellite sites is estimated between 800 and 1,000.
- In 2001, more than 3,000 health professions providers received AHEC Continuing Education credits at Community Health Centers.

**CHCs-AHECs: Current and Potential Involvement – Ways to Collaborate**

- **Needs Assessment:**
  - Perform needs assessment of learning needs specific to the CHC; add to calendar
  - Ask CHCs: “What do you need?” Listen and work to fulfill those needs

- **Preceptor Training:**
  - Provide CHC preceptor training to CHC providers to expand training capacity
  - Make the training directly applicable to their needs

- **CE Delivery**
  - Notify CHC providers of AHEC sponsored CE (related to CHC needs)
  - Training should be in friendly formats, with alternative plans made if needed, e.g., evenings, weekend, CD-ROMs, web-based content

- **Other:**
  - Assistance with CHC expansion and new starts
  - Assist with grant development, JCAHO accreditation, quality, coding, and HIPPA
  - Work with CHCs on Presidential Initiatives, e.g., Diabetes Detection Initiative (DDI)
The objective of the pediatric dental fellowship program administered by the University of Maryland Dental School is to place trained pediatric dentists into community clinics such as local health departments and Community Health Centers to provide clinical dental care services to underserved children.

The program represents an innovative solution to address the issues and great need associated with access to dental care services for children.

In Maryland, there continues to be a shortage of dentists, especially in rural areas. Because of low reimbursement and other issues, most private sector clinicians do not participate in Maryland’s State Medicaid program.

This is further complicated by the critical shortage of dentists trained to treat young children (ages 0-5). Although there are 100 pediatric dentists in Maryland, there are only four active specialty providers on the state’s expansive Eastern Shore, an area roughly 250 miles from north to south.

Since 1999, this novel partnership has enlisted many pediatric dentists who have foreign undergraduate degrees and have dental disease and lack of access to dental care has been identified as one of the most critical health concerns on the Eastern Shore of Maryland. Many children suffer from a severe, rapidly developing pattern of dental disease called Early Childhood Caries (ECC). ECC is one of a number of dental diseases in children that can lead to pain, nutritional problems, below average weight, poor self-esteem, lost school days, a delay in reaching developmental milestones, such as speech, and diminished readiness to learn.

Through partnership of the University of Maryland Dental School Department of Pediatric Dentistry, the Department of Health and Mental Hygiene, Office of Oral Health, the Choptank Community Health System (a Federally Qualified Health Community Health Center) and the Eastern Shore AHEC, many underserved children living on the Eastern Shore now have access to specialty dental care.

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Pediatric Dental Fellowship

completed an accredited dental residency program in the United States. Yet they are still completing either the entire dental school curriculum or a fellowship in an underserved community, completing either the entire dental school curriculum or a fellowship in an underserved community.

These Dental Fellows provide comprehensive dental care services to underserved children at extramural public health sites for a minimum of two years. Fellows are also given the opportunity to participate in teaching and research activities at the University of Maryland Dental School.

Currently there are four Pediatric Dental Fellows and plans to increase the number of Fellows and sites. The fellowship period begins upon the availability of the prospective Fellow and a clinical extramural site. Fellows receive salary and fringe benefits commensurate with a University of Maryland faculty position.

Dr. Luciana Pussetto, an Argentine national who completed her Pediatric Dental Residency at Boston University, joined CCHS's dental program in Spring 2003. She provides advanced care for children with special health care needs and/or behavioral problems, dental exams at local Head Start centers and dental education for Head Start parents in the Choptank Community Health System (CCHS) Federalsburg Dental Center four days a week.

"Working with children on the Eastern Shore as a pediatric dentist has been a very rewarding experience. Our goal is to provide the best care to satisfy their dental needs hoping to make a difference in their lives," Dr. Pussetto said.

Since the Eastern Shore AHEC (ESAHEC) began offering rural rotations to health professions students in 1996, the number of students served has steadily increased. Thirty students participated in 1996, increasing to 204 students during the 2001 - 2002 academic year.

In the AHEC tradition, all health professions students are welcomed at the ESAHEC. While the majority of students are from the University System of Maryland, students represent a variety of programs from other colleges and universities, including medicine, dentistry, pharmacy, nursing, social work, physical therapy and physician assistant training.

The ESAHEC provides housing and an interdisciplinary curriculum for the rotating undergraduate dental students. These rotations are designed to enhance understanding of the region, develop interprofessional dialogue and collaboration and increase awareness of other health professions and their services. Additionally, the ESAHEC has provided support and comfort to Dr. Pussetto, CCHS's Fellow, in her move to rural America — a time of social isolation. “The AHEC 'plants' a Fellow's roots," she said.

The CCHS dental program serves as one of a few preceptor sites for many fourth-year University of Maryland dental students. Now that the health center has a visiting pediatric dental fellow, extern students will be exposed to specialty dental care as well as community-based dentistry.

Because so many children with extensive dental disease require dental rehabilitation under general anesthesia in a hospital setting, the goal of the next initiative for the collaborating partners is developing operating room services for these children. Stakeholders will be invited to a meeting in support of development of an Eastern Shore Hospital Dentistry Program.
Role of NHSC Ambassador is ‘Perfect Fit’ for AHEC

Faculty mentors can make all the difference in a student’s selection of and preparation for a career dedicated to those in need. The National Health Service Corps (NHSC) is building partnerships with health professions schools across the country in order to promote careers in primary care and to support and train NHSC Scholars and other interested students. These partners, known as NHSC Ambassadors are a vital link in the NHSC goal of meeting the nation’s need for highly trained, culturally competent primary care clinicians.

NHSC has invited AHEC members to become Campus-Based Ambassadors or help recruit new Ambassadors in what HRSA calls “a logical step.” Nearly two dozen of the 484 NHSC Ambassadors are representatives of the AHEC/HETC network.

Vermont: David Little, MD

Dr. David Little, Associate Director of the Vermont AHEC Program and faculty member in the College of Medicine, Department of Family Practice, University of Vermont, chose to become an NHSC Ambassador because it was a good fit.

Dr. Little was already working to inspire and counsel students to pursue a career in family medicine, especially among the underserved, through a Family Medicine Interest Group and by facilitating student exposure to rural clinics in the summer between first and second year through the “Summer Doc” program.

“It was a natural progression, and I was doing the very things an NHSC Ambassador would want to do anyway,” Dr. Little maintains. “Counseling students in career and scholarship choices takes up about 10 percent of my time. Guiding students to consider an NHSC Scholarship was already built into the total picture.”

Of a class of 93 students entering the program every year, Dr. Little estimates that between eight and 12 will follow a career path in family medicine and possibly dedicate themselves to filling in the health care access gap in Vermont. To this end, he not only promotes the NHSC Scholarship Program, but also the Freeman Foundation Scholarship, a benefit offered to students who agree to practice in Vermont after graduation and residency. According to Dr. Little, it is possible for students to hold both scholarships at the same time.

“If there is one piece of advice I can share with other NHSC Ambassadors, it is to get involved with their local AHECs. That way they open a natural conduit for their NHSC Scholars to get the experience they need in a highly effective environment,” Dr. Little said.

On campus, Dr. Little maintains an open door policy for all his students, whether they choose to see him personally or prefer the less formal and more available attention of his administrative assistant.

For Dr. Little, being an NHSC Ambassador adds to his mission of guiding medical students into family medicine as a rewarding lifetime career path.

Connecticut: Bruce Gould, MD

As Program Director for the Connecticut AHEC Program, being an ambassador for the NHSC is a “no brainer” for Bruce Gould, MD. “So many of our AHEC activities double as NHSC ambassador programming,” he said. “Being an ambassador is really all about being a role model and mentor to

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NHSC Ambassadors

health professions students in caring for underserved populations and making sure that students understand the rewards and joy of caring.”

Whether it’s working at his clinic in the north end of Hartford, Connecticut, working with medical students at homeless shelter clinics, serving as advisor and preceptor at the migrant farm worker outreach clinic or helping students plan the University of Connecticut National Primary Care Week activities, Dr. Gould I wears his ambassador hat along with his AHEC, Medical School, clinician and other hats/roles. “Being an ambassador is a natural extension of calling and commitment to help others as a physician and AHECer...and makes my mother proud to boot, he said. “What a deal!”

Illinois: Rajesh Parikh, MD, MPH

Dr. Parikh is Director of Clinical Education at the Illinois Health Education Consortium (IHEC/AHEC) and Adjunct Clinical Associate Professor in Family Medicine at Midwestern University. He also is a NHSC Ambassador.

“In my role as NHSC Ambassador,” he said, “I have promoted the Illinois Student/Resident Experiences And Rotations in Community Health Project (or SEARCH) as a means for students to learn about health issues of the underserved.

“I have also encouraged health professions students to explore a career of public service. My professional responsibilities of advancing the AHEC mission have been fulfilled in part through acting as a NHSC Ambassador and, in doing so, I have also gained immense personal satisfaction.”

Arizona: Lane Johnson, MD, MPH

In 1987 Lane Johnson, MD, MPH, was hired as Medical Director of United Community Health Center (UCHC), a consortium of rural clinics spread out between Tucson, Arizona, and the Mexican Border. He drove about 2,500 miles a month. “Clinics were basic,” he said, “it was me and my stethoscope. It was a great experience in learning to depend on my clinical intuition, and to live with clinical ambiguity and uncertainty.”

Dr. Johnson said it was also an opportunity to develop community-based primary care programs that reflected community needs: parenting classes, after school programs, programs for the elderly. “I learned how to use existing community organizations such as churches, schools and service organizations in a place where organized social services often did not exist,” he said. “In addition, we were able to continue the development of a clinical quality measurement program that demonstrates continuous improvement every year.”

Dr. Johnson said he finished medical school with about $80,000 in financial obligations and loans. The salary offered at the community health center was about two-thirds of what he would be offered in an urban setting. “I spent three years fulfilling my Arizona Medical Student Loan obligation, and two years on the NHSC Loan Repayment program,” he recalls. “The support I received from these programs certainly helped in making my decision to work in and stay at the rural site.”

As Medical Director for the Arizona AHEC, Dr. Johnson said he now views the issues of rural and medically underserved populations from a larger perspective. “The situation in much of rural Arizona has become even more difficult,” he said. “Increasing costs, decreasing revenues, increasing malpractice and a worsening economic climate have made the provision of medical care to rural and underserved areas even more precarious.

“While there will be increased funding to develop more community health service sites (up to 30 percent over the next five years) it will become more difficult to find the clinical staff to serve in them. In the long term, the NHSC Scholarship program can help fill the need, but in the short and intermediate time frame, loan repayment must be available to help fill the gap. Efforts to recruit primary care residents and midlevel clinicians to rural and underserved areas are essential. We must also begin to look at interdisciplinary models to help fill the gaps. While technologic advances are important, it is the provision of primary care services in rural and medically underserved communities that will make the most difference in advancing the health of these populations.”
Illinois

SEARCH Program Creates Successful Team Approach

By Mithra Zaucha, MPH

The Student/resident Experiences And Rotations in Community Health (SEARCH) Program, funded by the National Health Service Corps (NHSC), is a nationally recognized program in which qualified health professions students and primary care residents are offered health care training at community and migrant health centers (C/MHCs) and other urban and rural underserved areas.

The program evolved out of the NHSC Fellowship for Primary Care Health Professionals project, which began in 1994 and is currently funded in 22 states. The purpose of SEARCH is to increase recruitment and retention of health care professionals in health professional shortage areas (HPSAs) and medically underserved areas (MUAs) by expanding the number of high quality, service-linked training opportunities in these communities, enhancing the teaching capacity of community health centers (CHCs), and exposing students and residents to community-based health systems.

Since 2000, the Illinois Health Education Consortium/AHEC and the Illinois Primary Health Care Association (IPHCA), the trade association for C/MHCs in Illinois, have collaborated and co-managed the SEARCH program in the state.

This partnership creates a successful team approach among academic institutions, community health centers, health professions students and primary care residents. It also provides students/residents with employment contacts for working in underserved areas, since participation in the Illinois SEARCH program gives a student/resident a higher priority level in the IPHCA’s job recruitment list for CHCs.

The program is designed for health professions and primary care residency students from either Illinois or out-of-state institutions to complete an elective or a required clinical/non-clinical rotation at a CHC, under the supervision of a CHC provider. Students and residents have represented 43 institutions/programs, 20 of which are from Illinois.

Although the program is funded by the NHSC, the Illinois project encourages students/residents who are not part of the NHSC to participate. By doing so, more students/residents have learned about the NHSC and have been exposed to working in underserved areas.

During the first year of funding for the program, 180 students/residents completed clinical rotations at the participating Illinois CHC sites. In the second year, the program was restricted to students/residents interested in primary care, lowering the number of participants to 100. Additional requirements added for the second and third years resulted in a more intensive experience for the students/residents.

In addition to the CHC rotation and any academic program requirement of their home institution, the students/residents must complete the SEARCH curriculum, which consists of a community assessment, a cultural assessment and a half-day orientation on community health issues. The student/resident completes the assessments by gathering quantitative and qualitative information about the community and its culture. The orientation is a forum for students/residents to discuss the purpose

(Continued on next page)

Ms. Zaucha is Clinical Education Coordinator for the SEARCH Program at the Illinois Health Education Consortium/AHEC.
SEARCH Program

of the assessments, cultural competency and issues relevant to the underserved, such as health insurance. The curriculum was designed to provide SEARCH participants with a glimpse at the entire community they are serving during their rotation; it also teaches students to look beyond the one-on-one patient/provider interaction.

During the past two years, the program has gathered short-term evaluations that have noted positive outcomes. Approximately 49 percent of the second-year students/residents responded to evaluation questions; 72 percent said they are considering doing primary care in an underserved area. In addition, 100 percent of respondents said they would recommend the program to other students.

As of September 2002, 49 percent of third cycle participants responded to evaluation questions, with 67 percent stating that they are considering doing primary care in an underserved area, 48 percent stating that they are considering applying for the NHSC and all would recommend the program.

Additionally, a long-term tracking system is being implemented to determine the type of residency or employment the Illinois SEARCH participants choose.

The Illinois Health Education Consortium/AHEC is proud to have a program that truly addresses the root safety net mission of AHECs. This program provides students and residents valuable hands-on clinical and community health experiences within underserved communities. This training experience gives them an awareness of the problems that exist within underserved areas.

A History of Collaboration

• The Illinois Health Education Consortium (IHEC)/AHEC has collaborated with the Illinois Primary Health Care Association (IPHCA) since the early 1990s.

• IPHCA represents more than 40 Community Health Centers (CHCs) with about 170 different clinical sites serving underserved communities throughout Illinois.

• The most significant issue that IHEC/IPHCA partnership has addressed is the issue of recruitment and retention of health professionals in CHCs. In part, this matter being addressed through the co-management of the National Health Service Corps (NHSC) funded Illinois Student/Resident Experiences And Rotations in Community Health Project (or SEARCH).

• Since SEARCH's inception in 2000, more than 300 students from different disciplines have participated in clinical and community health education experiences at CHC sites; more than 40 providers have undergone intensive faculty development training; at least 14 CHC sites have developed formal academic linkages with health profession training programs that has even further enhanced their capacity for training students/residents as well as providing continuing education for clinical staff.

• Preliminary evaluation from participating students, preceptors, and academic institutions have been very positive about SEARCH's impact in influencing student choices of residency and residents selection of CHC as preferred practice setting for the future. It is also clear that the involvement of CHC clinicians in these education enterprises has reinforced their decisions to continue their own practice in these settings.

By Rajesh Parikh, MD, MPH
The health professions’ educational system has been roiled in recent years as it responds to: changes in the health care delivery system that require the development of new health professions disciplines, the challenges of interdisciplinary educational and health care delivery approaches, the new emphases on initial and continuing professional competency, changing population demographics including an increasingly culturally diverse population and the aging of America, new concerns about the quality of professional practice and medical errors, and recurrent concerns about the size and distribution of the health workforce. The health professions’ educational system as it currently exists must be reexamined and redefined to address these issues.

What role can AHECs and HETCs play in designing the health professions’ educational system of the future so that it is responsive to these issues? In the Autumn 2004 issue of the National AHEC Bulletin, AHECs are asked to respond to recent recommendations made concerning the health professions’ educational system, health workforce and health care practice made by several august bodies. These reports include those of:

- Institute of Medicine (IOM), which in April 2003 released *Health Professions Education: A Bridge to Quality*. The report states that physicians, nurses, pharmacists and other health professionals are not being adequately prepared and there is insufficient assessment of their ongoing proficiency. Educators and accrediting agencies should ensure that providers develop and maintain proficiency in five core areas: delivering patient-centered care, working as part of interdisciplinary teams, practicing evidence-based medicine, focusing on quality improvement and using information technology.

- U.S. Department of Labor (DOL), which, in its most recently published *Occupational Outlook Handbook, 2002-03 Edition*, describes job duties, working conditions, training and educational requirements, earnings, and job prospects in a wide range of occupations, including vital information on job trends and the skills and qualifications that will be needed by workers in the future.

- The National Advisory Committee to the Secretary of Health and Human Services and the Congress on Interdisciplinary, Community-Based Linkages latest report.

**First Call for Articles for Autumn 2004 Bulletin**

**The Changing Health Professions’ Educational Landscape: AHEC Responds**

The health professions’ educational system has been roiled in recent years as it responds to: changes in the health care delivery system that require the development of new health professions disciplines, the challenges of interdisciplinary educational and health care delivery approaches, the new emphases on initial and continuing professional competency, changing population demographics including an increasingly culturally diverse population and the aging of America, new concerns about the quality of professional practice and medical errors, and recurrent concerns about the size and distribution of the health workforce. The health professions’ educational system as it currently exists must be reexamined and redefined to address these issues.

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- The National Advisory Committee to the Secretary of Health and Human Services and the Congress on Interdisciplinary, Community-Based Linkages latest report.

**Deadline for First Draft is June 15, 2004. Send to Robert Alpino, MIA: alpinorj@evms.edu**
AHEC Program and Center Contact Information

ALABAMA AHEC
Phone: (251) 461-1800
Web site: http://ualvm.ua.edu/ruralmed/RuralAlabamaAHEC.html

AHEC Centers:
• Southwest, (215) 679-7778
• Rural Alabama, (205) 348-1345
• Southeast, (334) 670-5735

ARIZONA AHEC PROGRAM
Phone: (520) 287-4722
Web site: www.azahec.org

AHEC Centers:
• Southeast, (520) 287-4722
  www.azahec.org/centers/seahec/
• Western, (928) 627-9222
  www.azahec.org/centers/wahec/
• Northern, (928) 774-8341
  www.azahec.org/centers/northern/
• Eastern, (928) 425-3261 ext. 1141
  www.azahec.org/centers/eastern/
• Maricopa, (520) 318-7151 ext. 213
  www.azahec.org/centers/maricopa/

ARKANSAS AHEC PROGRAM
Phone: (501) 686-5260
Web site: www.uams.edu/ahec/ahec1.htm

AHEC Centers:
• South Arkansas, (870) 862-2489;
  www.uams.edu/ahec/AHEC22.HTM
• Northeast, (870) 972-9603
  www.uams.edu/ahec/AHEC23.HTM
• Pine Bluff, (870) 541-7611
  www.uams.edu/ahec/AHEC23.HTM
• Northwest, (479) 521-8260
  www.uams.edu/ahec/AHEC24.HTM
• Fort Smith, (479) 785-2431
  www.uams.edu/ahec/AHEC25.HTM
• Southwest, (870) 779-6000
  www.uams.edu/ahec/AHEC26.HTM
• Delta, (870) 338-9100
  www.uams.edu/ahec/AHEC27.HTM

CALIFORNIA AHEC PROGRAM
Phone: (559) 241-7650
Web site: cal-ahec.org

AHEC Centers:
• Central Coast, (831) 424-4359
• Drew AHEC, (323) 563-4800
• Multicultural, (323) 780-7640
• Orange County, (949) 863-0030
• San Diego Border, (619) 691-7230
• San Francisco Community, (415) 206-4478
• San Joaquin Valley, (559) 446-2323
• Shasta Community, (503) 246-5704
• South Bay, (408) 289-9260
• Wilmington/Los Angeles Port, (310) 534-6222

COLORADO AHEC PROGRAM
Phone: (303) 724-0360
Web site: www.uchsc.edu/ahec

AHEC Centers:
• Centennial, (970) 330-3608; www.cahec.org
• Central, (303) 733-7227; www.centralcoahec.org
• San Luis Valley, (719) 589-4977; www.slvahaec.org
• Southeastern, (719) 544-7833; www.secahec.org
• Western, (970) 434-5474, Ext. 10; www.wcahec.org

CONNECTICUT AHEC PROGRAM
Phone: (860) 679-3675
Web site: www.connecticutahec.org

AHEC Centers:
• Eastern, (860) 886-1424; www.easternctahec.org
• Central, (860) 233-7561; www.centralctahec.org
• Northwestern, (860) 482-3426; www.ahcecofacareer.com
  www.nwctahec.org; www.healthcareersinct.com
• Southern, (203) 396-8360; www.swctahec.org

DISTRICT of COLUMBIA AHEC
Phone: (202) 994-0659

AHEC Center:
• DC AHEC Center, (202) 638-0252

UNIVERSITY OF SOUTH FLORIDA AHEC PROGRAM
Phone: (813) 974-3507
Web site: www.hsc.usf/ahec

AHEC Centers:
• Gulfcoast North, (813) 631-4350; www.gnahec.org
• Gulfcoast South, (941) 361-6602; www.gsahec.org

UNIVERSITY OF FLORIDA AHEC PROGRAM
Phone: (352) 265-8026
Web site: www.f ahec.org/NFAhec/

AHEC Centers:
• Big Bend, (850) 224-1177; www.flahaec.org/NFAhec/
• Suwannee River, (386) 462-1551; www.srahec.org/
• Northeast, (904) 482-0189; www.nefahec.org/
• West, (850) 682-2552

UNIVERSITY OF MIAMI AHEC, FLORIDA
Phone: (305) 243-2847
Web site: www.flahec.org/directory.html#um

AHEC Centers:
• Miami Dade, (305) 275-6663
• Florida Keys, (305) 743-7111
  www.ruralhealth-floridakeys.org/ahec1.htm

NOVA SOUTHEASTERN UNIVERSITY COLLEGE
OF OSTEOPATHIC MEDICINE AHEC, FLORIDA
Phone: (954) 262-1588
Web site: www.flahec.org/directory/html#nova

AHEC Centers:
• Everglades, (561) 889-1099
• Central Florida, (407) 8892292

Editor’s Note: Information on these pages was requested from the individual AHEC Programs. Some information was provided by the Federal AHEC/HETC Office in Rockville, Maryland.
AHEC Program and Center Contact Information

MERCER COLLEGE OF GEORGIA AND THE MEDICAL COLLEGE OF GEORGIA GEORGIA STATEWIDE AHEC NETWORK
Phone: (706) 721-8331
Web site: www.mcg.edu/ahec/
AHEC Centers:
- Three Rivers, (706) 660-2499; www.threeiversahec.org
- Blue Ridge, (706) 235-0776
- Foothills, (770) 533-6866; www.mcg.edu/ahec/fthills
- Magnolia Coastlands, (912) 871-1050
- SOWEGA, (229) 439-7185; www.sowega-ahec.org
- SPCC-Atlanta, (404) 761-7900; www.atlantaahec.org

MOREHOUSE SCHOOL OF MEDICINE AHEC, GEORGIA/ALABAMA
Phone: (404) 752-1624
Web site: www.msm.edu
AHEC Centers:
- Southeastern Primary Care Consortium/Atlanta AHEC, (404) 761-7900
- Magnolia Coastlands, (912) 681-0371
- Southwest Georgia (Sowega), (229) 439-7185
- Three Rivers, (706) 660-2730
- Blue Ridge, (706) 235-0776
- Tuskegee, (334) 727-0550 ext.3586; www.tahec.org

HAWAII’/PACIFIC BASIN AHEC
Phone: 808-956-9761
Web site: www.ahec.hawaii.edu
AHEC Centers:
- Ke Anuenue, (808) 935-8658
- Na Lei Wili, (808) 246-8986
- Palau: 011-680-488-2001

ILLINOIS HEALTH EDUCATION CONSORTIUM/AHEC
Phone: (312) 996-9989
Web site: www.ahec.org
(All Centers can be accessed through this web address)
AHEC Centers:
- Latino Communities, (312) 355-3446
- Immigrant/Refugee, (312) 996-9880
- Ujima, (630) 515-7422
- Western Illinois, (217) 223-0452
- Northern, (815) 395-5849

INDIANA AHEC PROGRAM
Phone: (317) 278-8833
Web site: www.ahec.iupui.edu
AHEC CENTERS:
- West Central, (812) 237-9688; www.indstate.edu/wci-ahec
- Northwest, (219) 980-6561

KENTUCKY AHEC
Phone: (502) 852-7159
Web site: www.louisville.edu/medschool/ahec
AHEC Centers:
- Purchase, (270) 762-4123; www.purchaseahec.org
- West, (270) 824-3442; www.westahec.org
- South Central, (270) 745-3325; www.wku.edu/scahec
- Northeast, (502) 778-1607
- Southern, (859) 985-7302; www.mc.uky.edu/ahec/sou.htm
- South Central, (859) 655-8037; www.mc.uky.edu/ahec/ncahec.htm
- Southeast, (606) 439-6791; www.mc.uky.edu/ahec/seacahec

LOUISIANA STATE UNIVERSITY AHEC
Phone: (504) 568-4006; www.lsuhs.edu
AHEC Centers:
- Southeast, (985) 345-1119; www.selahahec.org
- Southwest, (337) 989-0001; www.slwhahec.com/

LSUHSC - SHREVEPORT AHEC PROGRAM OFFICE
Phone: (318) 675-6571
Web site: www.ahec-lsuhsc-s.org (Under development)
AHEC Centers:
- North, (318) 686-2441; www.nlahahec.org
- Central, (318) 443-2855; www.slcahahec.com/

MAINE STATEWIDE AHEC PROGRAM
Phone, (207) 283-0170, ext. 2353
Web site: http://www.une.edu/com/ahec
AHEC Center:
- Acadia Health Education Coalition, (207) 733-4821

MARYLAND AHEC PROGRAM
Phone: (410) 706-1742
Web site: http://ahec.umaryland.edu
AHEC Centers:
- Western, (301)-777-9150; www.esahahec.org
- Eastern Shore, (410) 221-2600; http://www.esahahec.org

MASSACHUSETTS STATEWIDE AHEC PROGRAM
Phone: (508) 856-4305
Web site: www.umassmed.edu/ocp/programs/ahec.cfm
AHEC Centers:
- Pioneer Valley, (413) 787-6756
- Boston, (617) 534-5258
- Central, (508) 756-6676
- Southeastern, (508) 583-2250 ext. 214
- Merrimack Valley, (978) 685-4860
- Berkshire, (413) 447-2417; www.berkshireahec.org

MINNESOTA AHEC
Phone: (612) 625-3972
Web site: www.mnahec.umn.edu
AHEC Center:
- Northeast, (218) 362-6153; www.mnahec.umn.edu
### AHEC Program and Center Contact Information

#### MISSISSIPPI AHEC PROGRAM
Phone: (601) 984-5411  
Web site: under construction

**AHEC Centers** (contact Program Office for information):
- Delta
- Southwest
- Philadelphia

#### KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE MISSOURI AHEC PROGRAM
Phone: (660) 626-2887  
Web site: www.mahec.org

**AHEC Centers:**
- Northeast, (660) 385-6491; Web site under construction
- Southeastern, (573) 785-2444; www.semoahec.org
- Southwest, (417) 836-8348; www.ahec.smsu.edu

#### ST. LOUIS UNIVERSITY MISSOURI AHEC PROGRAM
Phone: (314) 577-8527  
Web site: http://medschool.slu.edu/comfam/index.phtml?page=sluahecprogramA

**AHEC Center:**
- East Central, (314) 721-9979  
  www.ecmoahec.org/ecmoahec.html

#### UNIVERSITY OF MISSOURI - COLUMBIA AHEC PROGRAM
Phone: (573) 882-0068  
Web site: www.hsc.missouri.edu/~ahec/muahec.shtml

**AHEC Centers:**
- Mid-Missouri, (573) 364-4797; www.midmoahec.org
- Northwest, (816) 271-7146  
  www.heartland-health.com/body.cfm?id=1257
- West Central, (816) 889-5055, ext. 308; www.wcmoahec.org/

#### NEBRASKA AHEC PROGRAM
Phone: (402) 559-8946  
Web site: www.unmc.edu/RHEN/ahec.htm

**AHEC Centers:**
- Central, (308) 856-6427; www.cn-ahec.org
- Northern, (402) 644-7253; www.nnahec.org

#### NEVADA AHEC PROGRAM
Phone: 775-784-4841  
Web sites: www.unr.edu/med/saheclk.html and www.highsierraahec.org/

**AHEC Centers:**
- Northeastern, (775) 738-3828
- Southern, (702) 318-8452; www.unr.edu/med/saheclk.html
- High Sierra, (775) 827-2432; www.highsierraahec.org/

#### NEW HAMPSHIRE AHEC
Phone: (603) 650-1931  
Web site: www.dartmouth.edu/~ahechome/

**AHEC Centers:**
- Northern, (603) 444-4461; www.nnhahec.org/
- Southern, (603) 895-1514; www.snhhec.org/

#### NEW JERSEY AHEC
Phone: (856) 566-7133 or (856) 566-6069  
Web site: www.njahec.org

**AHEC Centers:**
- Shore, (856) 697-2967
- Garden, (856) 507-7860 or (856) 507-7868
- Camden, (856) 963-2432  
  www.camden-ahec.org/ca-index.html

#### NEW MEXICO AHEC PROGRAM
Phone: (505) 272-2095  
Web site: http://hsc.unm.edu/som/outreach/Dept/ahec.html

**AHEC Centers:**
- Southern, (505) 646-3441; www.nmsu.edu/~soahec
- Montanas del Norte, (505) 454-2583

#### NEW YORK AHEC PROGRAM
Phone: (716) 898-4699  
Web site: www.ahec.buffalo.edu

**AHEC Centers:**
- Western New York Rural, (716) 898-4699; www.r-ahec.org
- Northern, (315) 267-3229; www.careersinhealth.org
- Hudson-Mohawk, (518) 480-2432; www.HMAHEC.org
- Central, (607) 736-1090; www.cnyahc.tweny.rr.com
- Bronx-Westchester, (718) 889-5055, ext. 308; www.wcmoahec.org/
- Brooklyn-Queens-Long Island, (718) 797-1558
- Erie-Niagra, (716) 878-5907
- Catskill-Hudson, (607) 547-3134

#### NORTH CAROLINA AHEC PROGRAM
Phone: (919)966-2461  
Web site: www.ncahec.net

**AHEC Centers:**
- Area L, (252) 972-6958; www.arealahec.dst.nc.us
- Charlotte, (704) 697-6523; www.citahec.org
- Coastal, (910) 343-0161; www.coastalncahec.org
- Eastern, (252) 744-8214; eahec.ecu.edu
- Greensboro, (336) 832-8025; www.gahc.org
- Mountain, (828) 257-4400; www.mtn.ncahec.org
- Northwest, (336) 713-7700; northwestahec.wfubmc.edu
- Southern Regional, (910) 323-1152; www.SouthernRegionalAHEC.org
- Wake, (919) 250-8547; www.wakeahec.org

#### OHIO STATEWIDE AHEC PROGRAM
Phone: (419)383-4272  
Web site: www.ohioahec.org

**AHEC Centers:**
- Bryan, (419) 636-1131  
  www.mco.edu/org/stateahec/region1.html
- Lima, (419) 227-4803  
  www.mco.edu/org/stateahec/region1.html
- Sandusky, (419) 626-7789  
  www.mco.edu/org/stateahec/region1.html
- Canton, (330) 244-3293  
  www.mco.edu/org/stateahec/region3.html
- Summit/Portage, (330) 972-6957  
  www.mco.edu/org/stateahec/region3.html
- Eastern, (330) 629-6375  
  www.mco.edu/org/stateahec/region3.html
- Consortium Health Education in Appalachia Ohio, (614) 593-2292;  
  www.mco.edu/org/stateahec/region5b.html
- HEALTH-UC, (937)378-4171; www.healthuc.edu/
AHEC Program and Center Contact Information

OKLAHOMA AHEC PROGRAM
Phone: 918-582-1989
Web site: www.ahec.okstate.edu

AHEC Centers:
• Northeast, Tulsa Community College (918) 595-8404
• Northwest, Rural Health Projects, Inc., (580) 213-3172
• Southeast, Carl Albert State College, (918) 647-8611
• Southwest, (580) 581-2852
www.seokhec.org/info.htm
• OSU Community Health and Education Center, (918) 582-1989 or (918) 607-4078
www.ahec.okstate.edu/research/ahec/ochec.htm

OREGON STATEWIDE AHEC PROGRAM
Phone: (503) 494-6602
Web site: www.ohsu.edu/ahec/

AHEC Centers:
• Northeast, (541) 962-3800; www.eou.edu/neoahec/
• Cascades East, (541) 617-2685; www.cascadeseast.org/
• Oregon Pacific, (541) 737-8600; www.opahec.org/
• Southwest Oregon, (541) 672-1945; www.healthuoregon.com/
• Columbia Willamette, (503) 691-9088

PENNSYLVANIA STATEWIDE AHEC PROGRAM
Phone: (717) 531-4327
Web site: www.collmed.psu.edu/pa_ahec

AHEC Centers:
• Northwest, (814) 453-6551; www.nwpaahec.org/
• Southeast, (610) 430-7500
• Northcentral, (750) 724-9145; www.ncpaahec.org
• Southwest, (412) 247-0184; www.southwestahec.org/
• Southcentral, (814) 344-2222
• Northeast, (570) 945-5623; www.nepaahec.org/
• East Central, (610) 379-2001

SOUTH CAROLINA STATEWIDE AHEC PROGRAM
Phone: (843) 792-4431
Web site: www.scache.net

AHEC Centers:
• Lowcountry, (803) 943-5052; www.lcahec.com
• Mid-Carolina, (803) 286-4121; www.midcarolinaahec.org
• Pee Dee, (843) 777-5353; www.peedeeahec.net
• Upstate, (864) 349-1160; upstateahec.org

TEXAS (EAST) AHEC PROGRAM
Phone: (409) 772-7884
Web site: www.etxahec.org

AHEC Centers:
• Brazos, (254) 753-4392; www.bahec.org
• Coastal, (409) 933-0021; www.cahec.org
• DFW, (972)719-4900; www.dfwhc.org/ahaec
• Greater Houston, (713) 592-6411; www.ghahec.org
• Lake Country, (903) 877-5788; www.ldahec.net
• Pecan Valley, (361) 576-2337; www.pvahec.org
• Piney Woods, (936) 468-6901; www.pwahec.org
• Prairie, (940) 369-7808

TEXAS (SOUTH) AHEC PROGRAM
Phone: (210) 567-7813
Web site: www.uthscsa.edu/ahec

AHEC Centers:
• South Central, (210) 567-7818; www.alamoahec.org/
• Lower Rio Grande Valley Academic Health Center (956) 365-6103
• Mid Rio Grande Border Area, (956) 712-0037
• Winter Garden Border, (830) 775-4500
• South Coastal, (361) 902-4487

UTAH AHEC PROGRAM
Phone: (801) 585-1940
Web site (all centers are linked to this site): www.ahec.utah.edu

AHEC Centers:
• Southwest, (435) 865-8453
• Crossroads, (801) 957-3939
• Northern, (801) 626-7468

VERMONT AHEC PROGRAM
Phone: (802) 656-2179
Web site: www.VTAHEC.org

AHEC Centers:
• Northeastern, (802) 748-2506; www.nevahec.org/
• Champlain Valley, (802) 527-1474; http://cvahec.org/
• Southern, (802) 886-2115
www.southernvermontahec.org/

VIRGINIA STATEWIDE AHEC PROGRAM
Phone: (804) 828-7639
Web site: www.ahec.vcu.edu

AHEC Centers:
• Blue Ridge, (540) 568-3178; www.brahec.jmu.edu
• Southside, (434) 395-2861; www.lwc.edu (search: AHEC)
• Southwest, (276) 782-1236; www.swvahec.org/
• South Central, 434-369-7703; www.scahec.org
• Rappahannock, 804-493-0818; www.rahec.net
• Northern, (703) 549-7060
• Eastern, 757-746-6167

WEST VIRGINIA STATEWIDE AHEC PROGRAM
Phone: (304) 347-1243
Web site: www.wvsom.edu/ahec

AHEC Centers:
• Southeastern, (304) 647-6298
• Eastern, (304) 264-1327; www.hsc.wvu.edu/ahec
• Southwestern, (304) 384-3273
AHEC Program and Center Contact Information

WISCONSIN AHEC SYSTEM
Phone: (608) 263-1712
Web site: www.ahec.wisc.edu (all centers are linked to this site)

AHEC Centers:
• Milwaukee, (414) 226-2432
• Northeastern, (920) 652-0238
• Northern, (715) 675-7899
• Southwest, (608) 265-0637

WWAMI: WASHINGTON, WYOMING, ALASKA, MONTANA, IDAHO
Phone: (206) 543-6020

AHEC Centers:
• Alaska Center for Rural Health, (907) 786-6589
  www.auroraweb.com/ahec/
• Idaho Rural Health Education Center, (208) 336-5533
  www.mtnstatesgroup.org/rhec/main.html
• Montana State University, (406) 994-6001
  http://ahec.msu.montana.edu/mtahec/
• Eastern Washington, Washington State University
  (509) 358-7646; www.sppoke.wsu.edu
• Western Washington, (206) 441-7137
  www.qwest.net/~wwahec/
• Wyoming, (307) 766-2496
  http://uwadminweb.uwyo.edu/WWami/ahec/ahec.htm

HETC Program and Center Contact Information

There is a separate section in the AHEC authority for programs similar to the basic AHEC project, but that are focused on specialty target areas or populations. There are two types of HETCs: Border and Non-Border HETCs.

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

ARIZONA HETC PROGRAM
Phone: (520) 318-715
Web site: www.azahec.org

HETC Centers:
• Southeast, (520) 287-4722
  www.azahec.org/centers/seahec/
• Western, (928) 627-8222
  www.azahec.org/centers/wahec/

CALIFORNIA BORDER HETC
Phone: 559-241-7650
cal-ahec.org

HETC Centers:
• Los Angeles Basin, (310) 534-6222
• Multicultural, (323) 563-5853
• Orange County, (949) 824-8932
• San Diego Border, (858) 822-0462
• San Joaquin Valley, (559) 466-2323
• San Bernardino/Imperial, (909) 696-5292

FLORIDA BORDER HETC
Phone: (954) 262-1588

HETC Centers:
• Gulfcoast North AHEC/Hillsborough-Pasco HETC,
  (813) 631-4350; www.gnahec.org
• Gulfcoast South AHEC/Southwest HETC,
  (941) 361-6602; www.gsahec.org

NEW MEXICO BORDER HETC
Phone: (505) 272-2095

CALIFORNIA BORDER HETC
Phone: (505) 272-2095

HEALTH EDUCATION TRAINING CENTERS ALLIANCE OF TEXAS (HETCAT)
Phone: (915) 774-4927

Editor’s Note: Information on these pages was solicited from the individual HETC Programs. Some information was provided by the Federal AHEC/HETC Office in Rockville, Maryland.
HETC Program and Center Contact Information

Non-Border HETC grants are made in areas of acute need in other locations, such as frontier areas, Appalachia, inner cities, etc.

DELTA UNIDAD HETC PROGRAM, ARKANSAS
Phone: (501) 686-6260
Web sites: Under construction
HETC Centers:
• Southwest, 870-779-6000
• Delta, (870) 338-9100

UNIVERSITY OF KENTUCKY - EASTERN KENTUCKY HETC
Phone: (859) 323-8018
HETC Centers:
• Purchase, (270) 762-4123; www.purchaseahec.org
• West, (270) 824-3442; www.westahec.org
• South Central, (270) 745-3325; www.wku.edu/scahec
• Northwest, (502) 778-1607

GEORGIA HETC PROGRAM
Phone: (404) 752-1624
Web site: www.msm.edu
HETC Centers:
Web sites: all can be accessed through www.mcg.edu/ahec
• Southwestern Primary Care Consortium, (404) 761-7900
  www.mcg.edu/ahec/atpsc.htm
• Magnolia Coastlands, (912) 681-0371
• Southwest Georgia (CC
• Blue Ridge, (706) 802-5232

UNIVERSITY OF LOUISVILLE - KENTUCKY HETC
Phone: (502) 852-7159
Web site: www.louisville.edu/medschool/ahec
HETC Centers:
• Southern, (859) 985-7302;
  www.mc.uky.edu/ahec/sou.htm
• North Central, (859) 655-8037;
  www.mc.uky/ahec/ncahec.htm
• Northeast, (606) 784-2432; www.neahec.org
• Southeast, (606) 439-6791;
  www.mc.uky.edu/ahec/seahc

KANSAS HETC PROGRAM
Phone, (913) 588-1641
Web sites: http://www2.kumc.edu/midwife/hetc/hetc.htm
HETC Centers:
• U. of Kansas Nurse-Midwifery Program, (913) 588-1683
• Birth and Women’s Center, (785) 232-6950
• Birth and Women’s Health Center, (620) 567-2627
• Healthy Options for Planeview, (316) 651-5357
• Northwest Kansas AHEC, (785) 628-6128
• Sterling Medical Center, (620) 278-2123
• University of Kansas Department of Dietetics and Nutrition, (913) 588-5363
• University of Kansas Department of Family Medicine, (913) 588-1986

OREGON HETC PROGRAM
Phone: (503) 494-4248

WASHINGTON HETC PROGRAM
Phone: (206) 543-6020
HETC Center:
• College of Rural Alaska, (907) 474-6640

WISCONSIN HETC PROGRAM
Phone: 608 263-1712
The National AHEC Program Office

AHEC Branch
Division of Interdisciplinary, Community Based Programs
Bureau of Health Professions, Health Resources and Services Administration
Parklawn Building, Room 9 - 105,
5600 Fishers Lane,
Rockville, MD 20857

Phone: (301) 443-6950
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Requests for copies should be directed
to the AHEC project office in your state or the NAO.
Call for Articles for Spring 2004 Bulletin
The AHEC/HETC Story: Our Communities’ Perspective

The past ten years have been an increasingly dynamic period of change in the health care delivery system of the United States. In the midst of such change and constrained budgets, AHECs and HETCs have stepped up to the plate, enhancing system resources, creatively filling gaps in services and continuing to educate health professionals.

While AHECs across the country share a common mission and set of core programs, they have adapted these programs to meet the unique needs of the communities and regions they serve. As members of the AHEC “family,” we’ve been telling our own stories for more than 30 years. The Call for Articles for the Spring/Summer 2004 NAO Bulletin departs from our norm and invites you to submit articles written by your customers and academic and community partners. Let’s have them tell their compelling stories of how AHEC and HETC programs are:

- Successfully engaging communities in creative new partnerships
- Applying technology tools
- Securing the right health workforce mix
- Enhancing health workforce capabilities to be more efficient and effective in meeting needs and sustaining local health systems
- Providing students with opportunities to work with the underserved
- Educating providers on emerging health issues and
- Expanding opportunities for disadvantaged and minority young people to enter health careers

Go to your board members; community health professionals; current or former clinical education students; federal, state and local elected officials; community health centers; nursing homes; hospitals; boards of education and the average citizens whose lives you touch on a regular basis. Help them tell their stories. We know how ambitious this undertaking will be, maybe even difficult, but the power of this issue will be immense. These impact stories will make an indelible impression on policy makers, funders and other decision makers.

Deadline for First Draft of Articles: January 15, 2004

Please submit drafts and accompanying materials to Steve.Shelton@utmb.edu and khummel@allconet.org

For Editorial Guidelines, see the NAO website: www.nationalahec.org
The AHEC Mission
To enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships.

The HETC Mission
HETCs provide community health education and health professions training programs in areas of the U.S. with severely underserved populations such as communities with diverse cultures and languages. Borders HETCs target health care workforce needs to address the population in close proximity to the U.S.-Mexico border and Florida using a bi-national approach to border health issues. Non-border HETCs are located in other seriously underserved areas of the country.

www.nationalahec.org

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