Community-Based Approaches to Health Promotion
Community-Based Approaches in Health Promotion

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The impact of lifestyle risk factors on the nation’s health and wealth is staggering: between one-half and two-thirds of premature deaths in the United States are caused by just three risk factors: poor diet, physical inactivity and tobacco use. In the last 10 years, obesity rates have increased by more than 60 percent among adults with approximately 60 million adults considered obese today.\textsuperscript{1,2}

We also know that lifestyle risk factors are directly related to medical costs. The September 2000 issue of the American Journal of Health Promotion reported that approximately 25\% of all employer medical costs are caused by lifestyle factors. Emerging research shows the value may be closer to 50\% today.

Medical care costs are reaching crisis levels, and some major employers are actively exploring discontinuing medical insurance coverage if costs are not controlled. The percentage of employers offering health insurance has dropped by 13\% between 2000 and 2005.\textsuperscript{3} The Federal Government has the same cost problems with its own employees, and the cost to Medicare will only increase as baby boomers retire and increasing numbers of beneficiaries are diagnosed with lifestyle-related illnesses.

It is essential to address health and medical cost problems to help Americans stay healthy. The promising news is that public and private sectors are starting to do more in the area of health prevention and health promotion. For instance, the Medicare Modernization Act of 2003 included several new prevention initiatives for Medicare beneficiaries. Also in recent years Congress and the administration have worked together to pass legislation to establish grants to provide health services to improve nutrition, increase physical activity and prevent obesity.

However, despite the success of many health promotion programs, there is a quality gap between the most effective and most common programs. This occurs because many professionals are not aware of the best practice methods. Furthermore, the data from these programs reach only a small percentage of the population and have difficulty in creating lasting change.\textsuperscript{4}

Earlier this year, I introduced the Health Promotion FIRST (Funding Integrated Research, Synthesis and Training) Act. The Health Promotion FIRST Act would build the foundation for a coordinated strategy to develop the science of health promotion, synthesize research results and share findings with researchers, practitioners and policy makers. The bill directs the Department of Health and Human Services to develop strategic plans on the following:

\begin{itemize}
  \item How to develop the basic and applied science of health promotion;
  \item How to synthesize health promotion research into practical guidelines that can be easily shared and taught and;
  \item How to foster a strong health workforce for health promotion activities.
\end{itemize}

Additional funding also is provided for the Centers for Disease Control and the National Institutes of Health to supplement current activities related to health promotion research and dissemination.

I believe that Health Promotion FIRST would assist Congress and the Administration in developing health promotion programs for the next decade. Strengthening the nation’s health promotion activities and infrastructure, however, also will require the collaborative efforts of many partners. The Area Health Education Centers (AHEC) program provides a nationwide platform where academic health programs, K-12 schools, health care providers, and community health and development stakeholders are already working together to solve community health and workforce problems through health professions education and health promotion activities.
A National Plan to Put Health Promotion FIRST

Across the nation, for example, AHECs work with partners to provide health education and promotion services, particularly targeting the most vulnerable medically underserved populations. AHECs work with other stakeholders to offer health fairs, community health screenings and health education outreach activities designed to prevent disease, promote healthy and safe lifestyles and empower individuals to improve the health of themselves and their families. In underserved communities across the nation, as in cities such as East Chicago, Terre Haute and rural Bedford, Indiana, AHECs have participated in wide-ranging community outreach initiatives to provide education, health promotion, screenings, and counseling.

To help train tomorrow’s health care professionals, many of these outreach programs are staffed by nursing, medical and allied health students and faculty recruited by AHECs in partnership with local health professions programs. In this way, citizens and health partners create a health promotion “learning laboratory,” where students learn communication, cultural competency and health promotion skills necessary for health professionals. Through service, they learn best-practice health care that helps manage chronic diseases like diabetes and asthma. By slowing or preventing the debilitating effects of these diseases, our clinicians improve patients’ lives and reduce health care costs.

One of the most effective ways to improve health promotion is to equip practicing clinicians with the health promotion information and techniques. In particular, clinicians who provide linguistically and culturally appropriate health care can promote healthy behaviors and prevent disease more effectively. Like their colleagues in Indiana, where each AHEC works with communities to arrange continuing education and distance learning for local clinicians, AHECs around the country have a long history of offering local clinicians high-quality continuing education focused on disease prevention, chronic disease management and primary care. Particularly for clinicians serving in America’s Health Professions Shortage Areas (HPSA) and Medically Underserved Areas (MUA) in rural and urban America, the continuing education, advanced library and information tools and distance learning networks sponsored by local AHECs provide a critical link to best practices, supportive colleagues and information to support effective health promotion in communities.

And AHECs effectively evolve with their communities to respond to emerging needs, equipping local clinicians with skills and information to help communities stay healthy. Like AHECs around the country, West Central Indiana AHEC has vigorously responded to public health continuing education needs. Examples include broad dissemination of bioterrorism and all-hazards trainings for local health professionals and participation in Rural Automatic External Defibrillator trainings with Southeast/South Central Indiana AHEC, hosted by the Hoosier Uplands Economic Development Corporation, where staff were recently certified as Stanford University Chronic Disease Management Program Master Trainers. These Trainers now provide workshops to local health professionals and others on how to conduct effective smoking cessation classes.

Most importantly, the AHEC network in the United States is skilled in developing partnerships to meet the health promotion needs identified by communities. By participating in local health workforce and community health needs assessment activities, AHECs are in a unique position to work with academic health centers to translate best-evidence research into community-based education initiatives and to tailor these techniques to the unique needs and strengths of each community.

In Indiana, for example, Governor Mitch Daniels has challenged Hoosier citizens, businesses, schools and communities to “Log On and Lighten Up.” By joining the state’s web-based INShape Indiana program, Hoosiers get connected with local services and events that help them make healthy choices. To disseminate these key messages, AHEC presenters will incorporate health promotion messages into Kids into Health Careers presentations to schoolchildren, develop health promotion resources that Indiana teachers can use across the curriculum, and embed community-based health promotion projects into AHEC clinical education, mentoring, and job shadowing activities across the state.

AHECs have a track record of effective partnership, with health care, education, government, and community organizations at all levels of government. As the Indiana AHEC system enters its fifth year, I’m proud of its history and evolving role in improving access to quality health care for Hoosiers. Together, the Health Promotion FIRST bill and the AHEC network offer a powerful partnership to improve health promotion and increase the nation’s health and wealth.

References


Community-Based Approaches to Health Promotion

Rosemary Orgren, PhD, and Catherine Russell, EdD

This issue of the NAO Bulletin is devoted to the work AHECs and HETCs do to promote the health of their communities. Preparing current and future health professionals, working with young people, and addressing health education needs at the community level are all core AHEC/HETC program areas that provide rich opportunities for helping people increase control over and improve their health. In the face of alarming levels of lifestyle-related health problems and escalating healthcare costs, health promotion has become an imperative. In this issue, you will find that AHECs and HETCs respond to this imperative in numerous and creative ways.

Two lead articles set the tone for this issue. In the first, Senator Richard Lugar provides compelling data on the negative impact of lifestyle risk factors on our health, and discusses the need for both private and public sector solutions. He describes the efforts of Congress, which he prompted with the introduction of the Health Promotion FIRST (Funding Integrated Research, Synthesis and Training) Act, to strengthen health promotion activities and infrastructure. Senator Lugar also highlights some of the successful AHEC and HETC health promotion activities.

In the second lead article, which you will find in the “centerfold,” Joxel Garcia, MD, Deputy Director of the Pan American Health Organization, provides a fresh perspective on health promotion by defining health as “resource for everyday life...a basic element and substrate that allows individuals and communities to fulfill their dreams, hopes and aspirations.” Dr. Garcia draws our attention to the complex interplay among the many variables that contribute to health, and the importance of individuals’ responsibility for both their own health and the health of their communities. He also notes the particular suitability of health promotion efforts founded on partnerships such as those represented by the AHECs and HETCs.

We are very pleased to note that many articles in this issue were submitted by first-time Bulletin authors and community-based staff. Addressing issues of fitness, nutrition, smoking cessation, the environment, oral health and more, these authors describe endeavors that illustrate the extensive scope of our programs. They also illustrate the value of partnership (every project described is a microcosm of the community-AHEC/HETC partnership model) and the breadth of the educational continuum we cover with programs for middle school students, health professions students, practicing healthcare providers, and community members. The “Spirit of AHEC” feature further highlights unique community partnerships that are a hallmark of the AHEC/HETC network.

We know you will enjoy reading this issue and hope you will share it broadly with your colleagues and partners. As Senator Lugar noted in his article, AHECs and HETCs help “citizens and health partners [to] create a health promotion ‘learning laboratory.’ ” Let us continue to nurture this learning laboratory with the ideas and insights of this issue’s authors.
Teaching Clinical Prevention and Population Health: A Leadership Opportunity for the National AHEC System

David Garr, MD; Robin Harvan, EdD; and Suzanne Cashman, ScD

Healthy People 2010, a compendium of the nations’ health goals, contains Objective 1-7, which states that there should be an increase in “the proportion of schools of medicine, schools of nursing and health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.” In January 2003, a task force composed of two representatives from each of seven clinical health professional organizations met to begin drafting a common curriculum framework related to clinical prevention and population health that would be relevant for all clinical health professions. The organizations represented on this Task Force included advanced practice nursing, allopathic medicine, dentistry, nursing, osteopathic medicine, pharmacy, and physician assistants. The Association of Teachers of Preventive Medicine and the Association of Academic Health Centers have coordinated the work of this Task Force since its inception. Advisory input has been provided by the Student Health Alliance, the Association of Schools of Public Health, and the Community-Campus Partnerships for Health. The Task Force has met twice yearly since 2003, supplementing in-person meetings with email exchange and conference calls.

The goal for this multiprofessional task force, called the Healthy People Curriculum Task Force (HPCTF), has been to advance the teaching of clinical prevention and population health in health professions education programs. The first product has been the publication of “The Clinical Prevention and Population Health Curriculum Framework (CPPH).” The Framework is relevant for all seven participating clinical disciplines and spans all years of health professions education. It is divided into four components: Evidence Base of Practice, Clinical Preventive Services–Health Promotion, Health Systems and Health Policy, and Community Aspects of Practice. (See Table on pages 6, 7.)

The need for an integrated curriculum in clinical prevention and population health has never been greater. The increasing prevalence of diabetes, hypertension, and obesity, the concern about a potential worldwide epidemic from new strains of influenza, and threats from terrorists are just some examples of topics that need to be addressed in the education of future health care professionals.

The national AHEC system has a unique opportunity to contribute substantially to the teaching of at least two components of the CPPH Curriculum Framework: “Clinical Preventive Services–Health Promotion” and “Community Aspects of Practice.” The former content area pertains primarily to the...
Teaching Clinical Prevention and Population Health

provision of preventive services when individuals are seen in clinical facilities. The latter area relates to population health-related educational content that, for the most part, is best taught in community-based teaching sites.

The “Clinical Preventive Services–Health Promotion” curriculum component parallels the clinical content and skills domains established by the U.S. Preventive Services Task Force, which include screening, counseling, immunization and chemoprevention. Many AHECs are already providing educational opportunities for students and preceptors in these clinical content domains, for example, in approaches to patient-centered, culturally competent communication and care.

A fundamental mission and purpose of the national AHEC system focuses on the “Community Aspects of Practice” curriculum component, that is, community-responsive health care and community preventive services, including health literacy and cultural sensitivity. AHECs are well-positioned to offer community-based educational opportunities related to environmental and occupational health, as well as to model effective facilitation for creating and sustaining partnerships for health care and healthy communities.

The CPPH Curriculum Framework has been disseminated to a large number of health professions education programs in the U.S. It is fair to assume, however, that some health professions education programs are still not familiar with its existence. The AHEC staff that interfaces with health professions education programs can provide information to the appropriate faculty members about the existence of the CPPH Curriculum Framework and convey the willingness of the AHEC program to assist with the integration of this curriculum content into the educational program.

Clinical prevention and population health are likely to become ever more important areas for emphasis in the delivery of health care services in the coming years. The future health care workforce will need to be trained to assist with the provision of preventive services and to work with others in their communities to address the health needs of populations. As more students leave the confines of their campuses to work in community settings, AHECs across the country have the opportunity to play a major role in preparing the workforce for the future by linking with health professions education programs and their academic health centers.

The CPPH Curriculum Framework can serve as a foundation upon which to build an even more vibrant and indispensable future for the national AHEC system.

References


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Teaching Clinical Prevention Curriculum Framework for Evidence Base of Practice

1. Epidemiology and biostatistics
   - Rates of disease
   - Types of data
   - Statistical concepts

2. Methods for evaluating health research literature
   - Study designs
   - Quality measures
   - Sampling and statistical power

3. Outcome measurement, including quality and costs
   - Measures of mortality
   - Measures that include quality of life/utility
   - Measures that include cost
   - Measures of quality of health care

4. Health surveillance
   - Vital statistics/legal documents
   - Disease surveillance
   - Biological, social, economic, geographic and behavioral risk factors

5. Determinants of health
   - Burden of illness
   - Contributors to morbidity and mortality

Clinical Preventive Services—Health Promotion

1. Screening
   - Approaches to testing and screening
   - Criteria for successful screening
   - Evidence-based recommendations

2. Counseling
   - Approaches to culturally appropriate behavioral change
   - Clinician-patient communication
   - Criteria for successful counseling
   - Evidence-based recommendations

3. Immunization
   - Approaches to vaccination
   - Criteria for successful immunization
   - Evidence-based recommendations

4. Chemoprevention
   - Approaches to chemoprevention
   - Criteria for successful chemoprevention
   - Evidence-based recommendations
### Health Systems and Health Policy

1. **Organization of clinical and public health systems**
   - Clinical health services
   - Public health responsibilities
   - Relationships between clinical practice and public health

2. **Health services financing**
   - Clinical services coverage and reimbursement
   - Methods of financing of healthcare institution
   - Methods of financing of public health services
   - Other models

3. **Health workforce**
   - Methods of regulation of professions and health care
   - Discipline-specific history, philosophy, roles, responsibilities
   - Racial/ethnic workforce composition including under-represented minorities
   - Relations of discipline to other healthcare professionals
   - Legal and ethical responsibilities of healthcare professionals

4. **Health policy process**
   - Process of health policymaking
   - Methods for participation in the policy process
   - Impact of policies on health care and health outcomes including impacts on vulnerable populations

### Community Aspects of Practice

1. **Communicating and sharing health information with the public**
   - Methods of assessing community needs/strengths and options for intervention
   - Media communications
   - Evaluation of health information (including literacy level and cultural sensitivity)

2. **Environmental health**
   - Sources, media, and routes of exposure to environmental contaminants
   - Environmental health risk assessment and risk management
   - Environmental disease prevention focusing on susceptible populations

3. **Occupational health**
   - Risks from employment-based exposures
   - Methods for control of occupational exposures
   - Exposure and prevention in healthcare settings

4. **Global health issues**
   - Roles of international organizations
   - Disease and population patterns in other countries
   - Effects of globalization on health

5. **Cultural dimensions of practice**
   - Cultural influences on clinicians’ delivery of health services
   - Cultural influences on individuals and communities
   - Culturally competent health care

6. **Community services**
   - Methods of facilitating access to and partnerships for health care
   - Evidence-based recommendations for community preventive services
   - Public health preparedness
Preparing Current and Future Health Professionals

Tobacco Growth Versus Smoking Cessation in North Carolina

Bethany Picker, MD

Southern Regional AHEC trains medical residents to implement a brief clinical intervention for smoking cessation that demonstrates promising results among pregnant women.

In the heart of the Carolinas tobacco is ubiquitous. This is the first place in my career where I have to remember to ask all patients about smokeless tobacco; I had never seen women chew tobacco before I moved here. That, coupled with the fact that North Carolina has the lowest cigarette tax in the nation, makes the problem of tobacco addiction an especially significant one. Southern Regional AHEC in Fayetteville, North Carolina, is the home of a Duke affiliated family medicine residency. We decided to combat this problem in our prenatal population through direct education of the patients, as well as educating the physicians on best practices.

In 2004, the Surgeon General’s report cited maternal smoking in pregnancy as an important preventable cause of morbidity and mortality. In 2003, national estimates of smoking in pregnancy ranged from 11-18%. Locally, the North Carolina Center for Health Statistics reports that 26% of women are smokers before their pregnancies and 14% are still smoking in their third trimester.

The Healthy People 2010 target rate for smoking during pregnancy is <1%. Is there anything we can do to move toward the Healthy People 2010 goal? The Cochrane Review of medical literature reviewed randomized and quasi-randomized trials of smoking cessation programs during pregnancy and concluded that these programs reduce smoking, low birth weight and preterm births. Despite the recognition of the effect of brief clinical interventions during pregnancy, these guidelines are not routinely and consistently followed by primary care physicians. All is not lost, however. Another 2004 study showed that reported use of best practices by residents in their training program corresponded with physicians being twice as likely to utilize these practices in their post-residency practice sites. This supports AHEC’s long-standing use of train-the-trainer models to promote health.

Through a grant by the March of Dimes, Southern Regional AHEC developed the Clinicians Make a Difference Program. This program was developed based on best practices and had a two-pronged approach: (1) counseling services were offered to all women who either were identified as smokers during their pregnancies or had environmental tobacco exposure, and (2) residents were trained to do timely office-based interventions during the prenatal visit.

First, we assessed the current situation within the residency clinic. It was discovered that first-year residents received one lecture on tobacco cessation based on the US Department of Health and Human Services best practices. Clinically, all patients were asked about smoking on every visit as part of the routine intake questions. Patient educational handouts were available, but not routinely used, and there wasn’t an assessment of environmental tobacco exposure.

Next, we tried to create an environment that would increase the likelihood of truthful disclosure, allow for patient initiated discussions and serve as visual reminders for both clinical staff and patients. We developed a system of chart identifiers with reminders on the interventional method (the 5A’s: Ask about tobacco use, Advise to quit, Assess willingness to quit, Assist in quit attempts, Arrange follow-
Tobacco Growth Versus Smoking Cessation in North Carolina

up), placed posters in every exam room and procured pregnancy-specific patient education handouts. We developed a curriculum for the residents that addressed attitudes toward counseling, brief behavioral intervention techniques, and evidence regarding efficacy of these techniques. The curriculum included interactive media, role-playing and brainstorming to address perceived barriers. We worked with the nursing and ancillary staff involved with prenatal care to encourage participation and the success of the project.

In order to evaluate success, we had to determine our baseline data. We reviewed charts from the 12-month period in which we were not doing the intervention using the previously existing chart documentation regarding smoking history. We, therefore, could determine personal smoking risk of our pregnant patients, but not environmental tobacco smoke exposure. We then compared this to the same 12-month period in which we were intervening. Very few of the women elected to meet individually for smoking cessation counseling. Any change that could be seen was therefore thought to be due to the physical changes in the clinic (chart identifiers, posters, etc.) and to the education of the residents.

Analysis of the data showed that the two groups of women were similar with regard to age, marital status, Medicaid use, and parity in education. Although there were many variables within each group, and there were differences in smoking rates of both groups when divided by age, women were twice as likely to have smoke-free visits during the intervention group as during the historical control period.

We had enough data to compare visits, but not enough to determine sustainable changes in outcomes, the real reason to implement the program. However, based on the evidence that already exists, decreasing prenatal smoke exposure has dramatic effects on outcomes, and it can be inferred that by improving the likelihood of smoke-free visits, this program improved the health of our pregnant women and their newborn children.

References


4 North Carolina Center for Health Statistics at http://www.schs.state.nc.us


The results of this project demonstrate that even used imperfectly, programs designed to offer brief clinical interventions for smoking cessation in pregnancy do work. A follow-up one year later will be conducted to determine the staying power of the educational intervention.
Preparing Current and Future Health Professionals

Preparing Current and Future Health Professionals

Provider Training for Changing Habits (PiTCH)

Seiji Yamada, MD, MPH; Kelley M. Withy, MD; and Shaun P. Berry, MD

Evidence-based practice and provider input guided development of a curriculum to increase behavioral counseling in the office setting.

Tobacco consumption, poor diet, and physical inactivity continue to be the major causes of preventable death in the U.S. The obesity epidemic continues to worsen, as does worldwide consumption of nicotine. The Hawai‘i/Pacific Basin AHEC believes that we can have no hope of reversing these trends without a concerted effort that involves society as a whole. Messages that patients receive in the consulting room, the waiting room, and from the office staff must be consistent with those that they receive from their families, friends, neighbors, and those that they receive from the mass media. Furthermore, we believe that these messages must be culturally sensitive, followed by positive reinforcement and easily administered in a brief office visit in order to be successful. We, therefore, set out to research how this can be done. We have since implemented an educational program to give healthcare providers and their staff the knowledge and tools to easily and quickly encourage behavior change in patients.

Because of their credibility and authority regarding health issues and long-term relationships with their patients, healthcare providers play a central role in motivating patients to adopt positive lifestyle behaviors. However, fewer than a quarter of physicians assess and counsel patients about tobacco use, and only 42% of obese adults report that health care professionals advised them to lose weight. In fact, during the 1990s fewer than 45% of patients with obesity, diabetes, hyperlipidemia, or heart disease received counseling regarding diet during clinical encounters, and fewer than 30% of patients received counseling regarding physical activity. Failure to perform such preventive counseling has been attributed to time constraints, lack of reimbursement for counseling services, and limited knowledge about nutrition and nutritional counseling among physicians. However, in order to prevent the morbidity and mortality that arise from tobacco use, poor diet, and physical inactivity, the adoption of healthy lifestyles must be encouraged at every possible opportunity.

Therefore, in 2003, the Hawai‘i/Pacific Basin Area Health Education Center partnered with the Hawaii Department of Health, Queen’s Physician Group Foundation, Ke Anuenue AHEC, Hawaii Primary Care Association, and Starr Siegle Advertising to develop and deliver an educational campaign known as Provider Training for Changing Habits (PiTCH). The mission of the PiTCH program was to encourage and empower providers to easily send a consistent message about health to all citizens of Hawaii by collaborating with school communities and the state of Hawaii’s mass media social marketing Start Living Healthy campaign. The Healthy Hawaii Initiative, implemented with funding from Hawaii’s tobacco master settlement, encourages (1) eating better, (2) getting active, and (3) living tobacco free in an effort to improve lifestyle choices by promoting simple and consistent lifestyle modification messages to all people of Hawaii.

The first step for the PiTCH Project was to research existing resources and evidence-based literature. The Hawai‘i/Pacific Basin AHEC staff then established a task force of representatives from academia, the department of health, physicians, nurses, nutritionists, the public health community, local legislative members, insurers, and the private sector that met regularly during 2003 to review and adapt national and state guidelines and programs for smoking cessation, nutrition, and exercise counseling for local needs. Our partners include the Hawaii Primary Care Association,
Provider Training for Changing Habits (PiTCH)

the Queen's Physician Group, Subway, Inc., and Starr Siegle.

In order to assess the needs of the unique population of Hawaii, this group organized 14 focus groups of healthcare providers across the state to examine the role of education in clinical practice. Participants were asked about barriers and facilitators of providing patient education and techniques that local providers have found to be useful.

Focus group results demonstrated that most physicians are not comfortable discussing prevention on a first visit, but primary care providers who have a longitudinal relationship with their patients utilize this relationship to promote the adoption of healthy lifestyles. Of necessity, primary care providers personalize the messages that they give to their patients, and find that positive reinforcement and cultural adaptation of the message increase their perceived success. In the office setting, teamwork was described as necessary to succeed in prevention counseling, because of the long-standing time demands of medical care and the lack of financial incentives to counsel patients. Although staff members were very willing to assist in delivering health messages, they felt that the initiative to implement an education program had to be initiated by the primary healthcare provider. Once this happens, staff felt empowered to participate and educate patients.

The task force incorporated the results of focus groups of healthcare providers convened to discuss their experiences with counseling patients regarding their lifestyles. Community groups then reviewed the curriculum for cultural competence and local relevance. The curriculum was developed to be delivered in an office-based setting (in a similar manner to pharmaceutical representatives) in 10 minutes. It was then expanded for larger group activities to a one-hour session with more details, background and time for questions and answers. The PiTCH handout is available to other organizations that would like to develop a similar curriculum at the Hawaii AHEC website.

Between 2003 and 2005, the curriculum has been delivered to over 2,000 providers including physicians, nurses, social service providers, pharmacists, office staff, and health professional students statewide. In addition, the PiTCH presentation was modified for delivery to lay community groups such as the Boys and Girls Club of Hawaii and groups of retirees. The PiTCH presentation has been delivered to promote workplace wellness to employers such as the Department of Public Safety.

Evaluation of the presentation via pretest and posttest has demonstrated a significant increase in knowledge. Providers indicated that the PiTCH presentation has encouraged them to address preventive topics with their patients. Finally, smoking, activity, and obesity statistics across the state are being tracked to determine changes in behavior as a result of the Healthy Hawaii Initiative.

References


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Integrating Health Promotion and Disease Prevention into a Family Medicine Clerkship

Donald J. Sefcik, DO, MBA; Rajesh Parikh, MD, MPH; Carol Spector, MS, MHPE; Margaret Kirkegaard, MD, MPH; Margaret Lechner, RN, MS; and Kristine Healy, MPH, PA-C

Significant curricular enrichment was achieved through the collaborative efforts of the Illinois Health Education Consortium/AHEC and a multidisciplinary healthcare team at Midwestern University.

The Department of Family Medicine at Midwestern University/Chicago College of Osteopathic Medicine (MWU/CCOM), in collaboration with the Illinois Area Health Education Center (AHEC) Program, initiated a major curricular enhancement in June 2002 integrating the 8-week MS3 FM clerkship and the 4-week community medicine rotation (an Illinois AHEC Program) into a single 12-week clerkship in Family Medicine/Community Health. Merging the two rotations enabled an expansion in the number of didactic hours from 10 to 33. We use the added didactic time to introduce new curricular topics that emphasize population-based prevention practices employing the Community Oriented Primary Care (COPC) model and Healthy People 2010 objectives. Developed with the assistance of the AHEC, the new curriculum maintains a strong focus on culturally competent communication skills, behavioral issues (smoking, alcohol, drug abuse, and eating disorders), cultural diversity, and health disparities. Other Healthy People 2010 focus areas covered in the new curriculum include access to quality care, diabetes, heart disease and stroke, family planning, obesity, disease prevention, respiratory infections, hypertension, substance abuse, and public health. We also added several new seminars and workshops including: Introduction to COPC, Serving the Underserved, Introduction to the Biopsychosocial (BATHE) Model, and Practicing Evidence-Based Medicine.

A primary objective of the new program is to place a significant number of CCOM students in primary care and family medicine clinics in underserved areas. The Illinois AHEC was able to assist the department in finding sufficient community sites to place the MS3 students. The AHEC has successfully recruited many community sites in underserved areas through its SEARCH (Student/resident Experiences And Rotations in Community Health) Program, a grant sponsored program whose purpose is placing medical students/residents in underserved areas where they can utilize the skills they are learning in the classroom. With AHEC assistance, 35-40% of the students were placed in underserved areas for their 12-week experience in Family Medicine/Community Health.

The new curriculum requires students to complete a COPC project. Students develop projects with facilitation by an AHEC faculty member at their assigned clinics. Preceptors are asked to assist their students in defining the project. These projects are generally health promotion and disease prevention oriented. They include education and screening for STDs, diabetes, osteoporosis, and colorectal cancer, as well as educational projects on managing asthma, tobacco use, drug abuse, child neglect, and family planning. One group of students succeeded in obtaining a handicapped parking space for the community clinic in which they were working. Another project, Oral Health Screening in Preschool Children, developed by three students at an AHEC SEARCH site, was submitted to the 2005 Department of Health and Human Services Secretary’s Award for Innovations in Health Promotion, where it received first place (See box on next page).

To assist students with their projects, and to provide additional resources to their community...
Integrating Health Promotion and Disease Prevention into a Family Medicine Clerkship

preceptors, the Illinois AHEC assisted the Department of Family Medicine in creating a new Community Health Resource Room (CHRC) with a new website. Students can easily find demographic material about the community in which their clinic is located. They can also find many online resources as well as books and videos available in the Resource Room for information about the population for which they are providing care and which they target with their projects. Our community preceptors also utilize the website and a preceptor listserv was recently created. The website also showcases some of the outstanding student projects.

In the three years since the enhanced and expanded program was implemented, nearly 500 students (approximately 165 per academic year) have participated in the clerkship and didactic program. Program evaluation has been accomplished through student surveys, focus groups, preceptor interviews and nominal group technique (NGT). Student evaluations have been quite positive. Overall, the program has an 80% student approval rating. Student evaluation of the COPC project was below 50% the first year, but has risen to nearly 70%. One of the goals of this program is to increase the number of graduates who go into primary care. A recent survey of our 2004 and 2005 graduating seniors indicated that CCOM continues to send over 40% of its medical graduates into primary care residencies.

This program is funded by two grants from the Health Resources and Services Administration (HRSA). Midwestern University recently received continuation funding for another three years. With continued collaboration between the Midwestern University Department of Family Medicine and the AHEC Program, future objectives include developing a new integrated service learning curriculum for the medical students and new campus community partnerships that will benefit both the community and the medical students.

Three CCOM students, Shelly Batra, Sandra Krussel, and Nicole Malek, were honored at the 23rd Annual Secretary of Health and Human Services Award Ceremony for Innovation in Health Promotion and Disease Prevention, where they received a first place award for their project “Oral Health Screening.” The goal of their project was to reduce the percentage of dental caries in children ages 3-5 by performing oral screenings on children ages 0-3, providing parental education regarding good oral hygiene, and offering timely dental referrals. The students completed their study at a local Head Start Program and found that 52% of the 3-5 year olds evaluated had dental caries. The students hope that biannual screening of the 0-3 year olds plus parental education and dental referrals will reduce that percentage.
Nutritional Values of Traditional Foods:
A Joint Project of the Siletz Tribal Health Center and the Oregon HETC Program
Sally Henry, MA, RN, FHCE

As the first state to have a Native American HETC, Oregon utilizes health profession students to research and present food sources in order to replace Americanized processed food with traditional food sources in the Native American diet.

In the Oregon Health Education and Training Center (HETC) program, Oregon Pacific AHEC provides leadership for a public health initiative pairing Oregon State University Masters of Public Health Promotion and Education interns with tribal health centers around the state. Since 2002, the AHEC facilitated a planning process for clinics to identify health issues important to their tribal members. The clinic staff, particularly Native community health representatives, serve as culture experts to the MPH interns who then use their skills to develop appropriate training materials which ultimately become property of the tribes.

Oregon Pacific AHEC is the facilitator of the community-driven health information process. Staff meet with designated tribal health staff and conducts an assessment to identify a project before each intern is identified. In that way, the focus is on what the community identifies as special interest of the student. The intern is housed in the AHEC office and closely supervised to ensure that the first responsibility is to the tribe. The concept of being truly responsive to the culture was difficult for some students. One intern repeatedly used such phrases as “I think I want to do XX” or “I’ve decided that YY will be the design.” As she was coached to present several options to the tribal clinic staff and to elicit their feedback, her understanding of working effectively with cultures different than her own grew in a very real sense.

Last year, the Confederated Tribes of Siletz Indians requested assistance in creating education tools to support a traditional tribal diet which is high in protein and low in fats and carbohydrates. With healthy meals and a naturally active lifestyle, American Indians and Alaskan Natives (AI/AN) had few chronic illnesses prior to their interactions with European Americans. But American Indian diets have dramatically changed in the last century and the incidence of diabetes and obesity is now at epidemic proportions. Cardiovascular disease is the leading cause of death for all AI/AN. Diabetes rates are 2.6 times that of the total population, and in some communities 40-50% of adults have diabetes.

One provision of nineteenth-century treaty agreements between native tribes and the U.S. government was the government’s agreement to supply food to tribal members in exchange for the lands where Native Americans had hunted and fished for centuries. To this day, these U.S. Department of Agriculture “commodity foods” are a staple of the American Indian diet. Although there have been attempts to improve their nutritional value, they are generally highly processed and contain large amounts of fats, carbohydrates and salt. Coupled with inexpensive, nutrition-poor “fast foods” which are also eaten in large quantity by today’s tribal members, today’s American Indian diets have led to soaring disease rates.

After the Siletz Culture Department identified such specific northwest indigenous foods as salmon and camas bulbs, the intern researched their nutritional components. Cooking tips and historic facts were included in the table-top poster and individual food flyers were produced. The poster was displayed at the Siletz culture camp and at their summer pow-wow and
Nutritional Values of Traditional Foods

<table>
<thead>
<tr>
<th>Native Name</th>
<th>English Name</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>gus</td>
<td>camas bulb</td>
<td>Low in fat; a single bulb provides 1 gm fiber and 13 gm carb</td>
</tr>
<tr>
<td>lhuk</td>
<td>salmon</td>
<td>High in omega-3 fatty acids as well as protein, calcium and B-vitamins</td>
</tr>
<tr>
<td>dee-chi nes</td>
<td>blackberries</td>
<td>Low in fat; very high in fiber, vitamin C and antioxidants</td>
</tr>
<tr>
<td>des-chu</td>
<td>elk</td>
<td>Very low in fat; excellent source of protein, iron, phosphorus and zinc</td>
</tr>
</tbody>
</table>

Nutritional components of Native American foods.

hundreds of the flyers have been distributed to tribal members and guests. The HETC intern also visited the tribe’s diabetes support groups to discuss her findings. As the tribe had been focusing on traditional foods in many of its cultural events, this project was seen as an enhancement and enthusiastically received.

Since 2002, OP AHEC and OSU public health interns have completed initiatives for several other Oregon tribes:
- *Well Woman Program* for the Cow Creek Band of Umpqua Indians;
- Hepatitis C publications and trainings for the Confederated Tribes of the Umatilla Reservation;
- An assessment of tribal member health needs for the Confederated Tribes of Siletz Indians;
- *Case Management Sourcebook* for the Klamath Tribes.

While there are just three interns per semester in the program, one decided to continue working with Native Americans after graduation and is now on a Navajo reservation in New Mexico.

Other aspects of the Oregon HETC program have addressed additional health issues for Native Americans by utilizing the skills of the expansive AHEC network. Under the lead of Northeast Oregon AHEC, emergency response services (EMS) have been assessed and an on-going coalition of tribal EMS directors continues to discuss ways to best integrate with other emergency resources in rural and frontier areas. The Community Capacitation Center of the Multnomah County Health Departments has trained tribal community health representatives (CHR) in popular education techniques and hosted the first Oregon CHR network meetings. The Oregon AHEC Burdick Interdisciplinary Training program expanded to place medical, nursing, dietary and public health students in Siletz and Umatilla health centers.

This successful partnership has led to other AHEC/HETC opportunities as well. In fact, tribes have already asked for health profession student clinical rotations and health administration interns. Health provider continuing education on native foods is under consideration and additional methods of distributing information throughout the U.S. Indian Health Service are being explored.

As the first Native American HETC, the Oregon initiative is multifaceted and growing. Upcoming years will see expansion to the remaining four recognized tribes in Oregon and stronger collaboration with the Northwest Portland Area Indian Health Board. Creative linkages between Native American health centers, public health academic institutions, AHECs/HETCs and local health departments can produce truly culturally-appropriate health information with members of a community with some of this country’s most severe health disparities.
HOPE Program Simultaneously Promotes Oral Health Care and Dental Careers

Dana S. Smith, LMSW, MPA; Rhonda Randolph, BS; Karen Curry, BA; Ekiria Collins, MSE, CHES; Sandra Pettway, BS; and Alexander M. Reyna Jr., AA

Preparing Current and Future Health Professionals

This article showcases the benefit of three entities working together to provide oral health education and dental career awareness to middle school students through programming provided by dental students.

“Dental care is the most frequent unmet health need of children and dental caries is the single most common chronic childhood disease (oralhealthamerica.org).” Being strongly committed to addressing both individual oral health issues and the dental professional shortage, the Greater Houston AHEC worked closely with eighth graders of Stafford Middle School in Ft. Bend County, Texas, and first year students at the University of Texas Dental School in Houston to promote dental health and increase awareness of dental careers.

Through our longitudinal program called H.O.P.E. (Health Occupations Preparation and Exploration), we expose middle school students to a variety of careers in health by engaging them in interactive classroom sessions. For example, to learn about providing care to the elderly, students are involved in a session called “Experience Gerontology” where they participate in activities that simulate limited dexterity, speech, and vision. On the other hand, to learn about dentistry, students are led through an activity where they make dental molds of their own teeth. The activity is followed by an in-depth discussion of dental careers and what steps students need to take to pursue such careers. Included in the discussion is information about classes to focus on in high school, the importance of volunteering, and applying for grants and scholarships for college.

Recently, UT dental students provided oral health education presentations to eighth graders at Stafford Middle School for an additional emphasis to our program. As a requirement for their community training course, Introduction to the Prevention of Oral Diseases in Individuals and Populations, first year dental students conducted presentations where they shared details about oral health and dental careers. In the end, the dental school students talked with eighth graders about why they chose dentistry and how persons in the dental care field can have fulfilling careers while having a significant impact on the community.

We selected Stafford Municipal School District as one of our intervention schools because of the demographics of the student population. Eighty-four percent of Stafford Middle School students are ethnic or racial minorities. According to the Oral Health America website, there are dental health disparities between minority populations and the Anglo population. Therefore, we know that our target group of mostly minority students is especially in need of preventive oral health care.

As we consider the impact and value of our programs and interventions with Stafford Middle School students, we rely on feedback from the faculty and administrators. Their statements include the following:

“These sessions have been a comprehensive enrichment to my science classes.”

“This program has had a great impact on our students enrolled in our AVID (advancement
HOPE Program Simultaneously Promotes Oral Health Care and Dental Careers

via individual determination) classes. They are in a position academically to move into demanding health professional programs.”

“The HOPE program is an exciting opportunity to promote health careers and health literacy for this group of students.”

Overall, we believe that this collaborative initiative between the Greater Houston AHEC, the University of Texas Dental School in Houston, and Stafford Middle School is one that can be used as a model for future programs. The act of placing dental school students in such an environment provides them with community experience and helps them hone their communication and patient education skills, while they gain sensitivity to serving underserved populations. Meanwhile, awareness among middle school students of opportunities in dentistry is being increased. Also, it helps young people with their career decisions and it moves more students into the pipeline of this career shortage area. Lastly, educating adolescents at Stafford Middle School on oral health issues and prevention is a step to help in the reduction of minority health disparities.

Middle school students learn about oral health and dental careers.
Every day in the news we read or hear something about health issues related to lifestyles such as obesity, lack of exercise, smoking cigarettes, and drinking excessive alcohol becoming more prevalent throughout our society. Youth who become healthcare professionals will see people every day who have health problems that are caused or exacerbated by unhealthy lifestyle choices. The Northwest Missouri AHEC challenges youth who participate in the AHEC Career Enhancement Scholars (ACES) Program to become role models in the promotion of health and wellness for their peers and for their future patients and clients.

The ACES Program is our statewide youth recruitment pipeline in Missouri funded by the Missouri Department of Health and Senior Services and the Primary Care Resource Initiative. We have approximately 225 students involved with the ACES Program statewide and another 125 students involved in the ACES+ Program for undergraduates interested in pursuing primary healthcare careers. The ACES+ program is composed primarily of undergraduate students who transitioned from the high school program.

We asked a cardiac rehabilitation nurse to speak to our students at a regional workshop for our AHEC Career Enhancement Scholars (ACES) Program. Instead of telling the students what she did as a career, she ran them through a series of “exercises” and challenged them to be role models of good health. That became a challenge to our center as well—to continually challenge students who participate in our health career programs to start role modeling “healthy habits” for others. Three students have done just that.

A nutritional and exercise workshop was conducted through the ACES program and participants were asked to incorporate the information they learned into their daily lives. We had given each of the students an inexpensive pedometer and challenged them to get in their 10,000 steps a day. Traci Harr, a junior of the Maryville High School, shared the information with her parents who work as health professionals at a local hospital. As a result of sharing this information, her parents arranged to have all nurses receive pedometers for Nurses Week (May 2004). Traci also gave the presentation to one of her high school classes as a project.

Another workshop was held for the ACES program and the day was entirely devoted to wellness. Students were challenged to make a presentation to their peers, younger children, church group, or whomever they wanted. Kristin Ripperger and another junior high student, Jennifer McKnight, developed a program for children called Jump into Foods and Fitness (JIFF). Kristin and Jennifer presented JIFF at the Avenue City Elementary School (a small rural school of 120 students) and one of four elementary schools in the Savannah School District (a school district of almost 2400 students). Their workshop focused on the importance of exercise, healthy eating, and had a hands-on station where the young students were taught about oral hygiene and healthy snacking. The elementary students also made refrigerator magnets with healthy comments and played hopscotch to show that anything you do can be exercise. At the end of the program, students signed commitment cards saying they would eat healthy and exercise regularly in their daily life. Kristin and Jennifer had the students take a pre- and posttest to see how much they learned. Questions included the identifica-
Jump into Foods & Fitness

tion of the main food groups, appropriate amounts of daily exercise, and the importance of breakfast. The results showed that the students’ knowledge increased by 20 percent comparing the difference between the pre and posttest scores.

The Heartland Wellness Connections assisted Kristin and Jennifer in designing and implementing JIFF. “I was impressed at the way they had taken information from a workshop that they had attended and customized it to the age group they wanted to affect,” said Kim McManus, a nurse with the wellness program. They then went on to give a full presentation at a regional competition of the Family, Career & Community Leaders of America (FCCLA) in February 2005. Kristin and Jennifer received a Gold Rating and went on to the FCCLA state competition in April. There they received the Top Gold Award and were selected as the Missouri National Representatives for the Focus on Kids Category. The presentation was also in a national competition and received a gold medal. A day of wellness led to many young children learning about nutrition and exercise and provided two high school juniors with opportunities to tell this story across the state.

“I was impressed at the way they had taken information from a workshop that they had attended and customized it to the age group they wanted to affect,” said Kim McManus, a nurse with the wellness program.

Jennifer McKnight (l) and Kristin Ripperger (r) display their award-winning JIFF presentation.
Setting the Scene for Environmental Advocacy
Michelle Urbano, MA, MPH; Madeleine Kangsen Scammell, ABD; and Tanya Tillett, MA

For the last four years the Boston University Superfund Basic Research Program Outreach Core (BU SBRP) and Boston Area Health Education Center (BAHEC) have helped spice up the summer of 100 teenagers by delivering a message of environmental responsibility in an empowering way. BAHEC works with universities, local public school systems and community agencies to recruit students ages 14-18. Participants come from more than ten underrepresented neighborhoods in Boston, and speak over a dozen languages including Cantonese, Cape Verdean Creole, Mandarin, Haitian Creole, English, French, Portuguese, Spanish, Vietnamese, Polish, Hindi, Arabic, Igbo, and Yoruba. The diversity of the students reflects Boston’s changing demographics.

The environmental health disaster scenarios are conducted at the beginning of BAHEC’s Youth to Health Careers (Y2HC) Summer Program, along with a health expo that features careers in public health. In each scenario, students are presented with an environmental health situation and must work through possible questions and concerns that might arise. Acting in the roles of public health officials, students interview different people who could be affected by the event, from a concerned resident to an environmental expert to a business owner. These different roles are played by BU SBRP investigators and Boston University School of Public Health faculty members with expertise and training in various fields including economics, neurology, toxicology, epidemiology, statistics, and ecology. After interviewing these stakeholders the students (acting as public health officials) must present their final decisions to the community members.

Scenarios encourage students to form, express, and support their own opinions, which they do with great enthusiasm. The students get very excited when defending their decisions, and although we do not set the scenario up as a debate, it often turns into one. Each team defends their decision as if it were the real thing. Students participate in actual scenarios modeled after workshops public health officials conduct to prepare themselves for a public health emergency. Students learn how complicated public health decisions are and how quickly they must be made in times of crisis.

Scenarios in the past have included dioxin-contaminated chicken and pesticide spraying to control West Nile Virus, both of which teach the students to identify possible sources of risk for each environmental hazard, and provide...
Setting the Scene for Environmental Advocacy

insight into the media's role in influencing public opinion. In this scenario, students consider the possible dangers of spraying pesticides in neighborhoods, which is an issue of ongoing concern in Boston.

In the case of the dioxin-contaminated chicken, the scenario begins with a summer picnic. BAHEC students are asked to imagine a picnic at which they are eating a lot of great food. A PowerPoint presentation is given with the different foods served at the picnic (e.g., chicken salad, potato salad, fried chicken, burgers, barbequed chicken, fruit salad, chicken/meat kabobs, chicken burgers). They get the picture, a lot of chicken. The following day they read an article in the local, very reputable paper: Widespread Chicken Contamination. Through role playing, the students become Public Health Officials and are introduced to the people they will interview during their investigation. The characters are introduced first by their professional name and actual affiliation, and then by the character they will be playing. The characters are: Fred Pucker, CEO, Pucker-Up Poultry; a representative from the Alabama Department of Public Health; a representative from the US Food & Drug Administration; a Concerned Resident of Massachusetts; and a Public Health Scientist with expertise on dioxin.

The students/public health officials examine the processing and distribution of the food to investigate where the contamination might have originated. They also discover what role government agencies play in protecting the public's health by regulating different phases of food production.

These exercises provide a meaningful learning experience for the students by placing them in roles they might not normally find themselves in—environmental expert or public health official, for example. They also give the students a glimpse at potential public health careers beyond the familiar ones such as nurses, doctors, or pharmacists.

The program partners are continually adapting and improving the program model in a manner that can be easily replicated. Recently the dioxin-contaminated chicken scenario was presented to thirty environmental health educators at this year’s Environmental Protection Agency - Community Involvement Conference in Buffalo, NY.

BAHEC, a program of the Boston Public Health Commission, is part of the Massachusetts AHEC Network, supported by the University of Massachusetts Medical School.

(Note: a version of this article was first published in the August 2005 issue of “Environmental Health Perspectives.”

Michelle Lee Urbano, MA, MPH, is the Director of the Boston AHEC.

Madeleine Kangsen Scammell, ABD, is a doctoral candidate in the Department of Environmental Health at Boston University School of Public Health, and project manager of an NIEHS grant titled, “Community Environmental Health Research: Finding Meaning.”

Tanya Tillett, MA, is an associate news editor for Environmental Health Perspectives, the journal of the National Institute of Environmental Health Sciences, one of the National Institutes of Health.

Boston AHEC students learn about chicken processing from “Mr. Fred Pucker, CEO of PuckerUp Poultry.”
California has a fun way of educating its school children and the general public about the daily quality of air and advising the level of outdoor activities based on health conditions.

Starting in 2004, the AHEC-anchored program has arranged for AQI Flags to be flown over 200 schools and school district offices. The colors of the flags alert parents and children to air quality. Each participating site is e-mailed or faxed the day’s air quality. The corresponding flag is then flown.

Four flag colors (green, yellow, orange, and red) correspond to air quality that is good, moderate, unhealthy for sensitive groups, and unhealthy. The quality of air impacts the amount of outdoor activity that is safe. Green, or good air quality, means that anyone can participate in outdoor activities. As air quality deteriorates (AQI deteriorates from the safe range of 0 -50 to between 51 and 100) and the yellow flag is flown, those who are “extremely sensitive” to air quality such as severe asthmatics, or those with advanced cardiac or respiratory diseases should limit outdoor exposure and avoid prolonged exertion such as running. The orange flag warns that anyone with respiratory or cardiac diseases should avoid outdoor exertion. The red flag advises all to reduce prolonged outdoor exposure and/or heavy exertion.

The flag system not only helps parents and schools determine if outdoors PE is safe for children on a day-by-day basis, but it also makes a visible statement to the entire community about air quality. The flags are flown just under the American and California flags. This clever program has been inexpensive to implement, has created stronger partnerships, and is improving the health awareness of an entire geographic area.
**Dangerous to Breathe**

The local AHEC, using tools familiar to AHECs all over the nation, has found a most effective way to educate and improve local health. Those AHECs in areas with similar air quality problems are invited to contact the San Joaquin Valley Health Consortium for more information.

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**What is AQI?**

The AQI is an Index for forecasting and reporting daily air quality. The AQI tells you how safe or polluted the air is, and warns us of any associated health concerns.

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### Air Quality Flag Program components

<table>
<thead>
<tr>
<th>AQI</th>
<th>Air Quality</th>
<th>Color of Flag</th>
<th>Cautionary Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50</td>
<td>Good</td>
<td>Green</td>
<td>Air quality is “Good”. Outdoor activities permitted.</td>
</tr>
<tr>
<td>51-100</td>
<td>Moderate</td>
<td>Yellow</td>
<td>Outdoor air is “unhealthy for extremely sensitive” children and adults, especially those with severe asthma and those with respiratory or heart diseases, should consider limiting outdoor exposure and avoid prolonged exertion, such as running.</td>
</tr>
<tr>
<td>101-150</td>
<td>Unhealthy Sensitive Groups</td>
<td>Orange</td>
<td>Outdoor air is “unhealthy for sensitive” children and adults. Active children, adults and people with respiratory diseases such as asthma, or heart disease should limit prolonged outdoor exertion.</td>
</tr>
<tr>
<td>151-200</td>
<td>Unhealthy</td>
<td>Red</td>
<td>Outdoor air is “unhealthy” for everyone. Sensitive and/or active children and adults and people with respiratory diseases, such as asthma, or heart disease should avoid prolonged or heavy exertion outdoors. Everyone else, especially children, should reduce prolonged or heavy exertion outdoors.</td>
</tr>
</tbody>
</table>

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**Did you know that in the state of California, an estimated 800,000 children, or one in seven, are affected by asthma?**
The Florida AHEC Network as a Vehicle for Tobacco Prevention Education

Anita Smart, MEd; Barbara Richardson, RN, PhD; and Steve Bronsburg, MHSA

In the PIPSA program, health professions faculty and staff practice their role as health promoters by delivering age-appropriate tobacco prevention messages.

How do 7,000 future health professional students and 230,000 middle-school students receive creative health messages about tobacco prevention? The Florida AHEC Network delivers! Through established partnerships in their regions, the AHEC programs and centers have provided statewide access to the Partners in Prevention of Substance Abuse (PIPSA) Program.

Conceived in a state that prioritized youth tobacco prevention, PIPSA had its beginnings at the University of Florida Health Science Center (UFHSC). With initial 1997 funding from the Josiah A. Macy Foundation and Florida’s Ounce of Prevention Fund, principal investigators Venita J. Sposetti, DMD, and Parker A. Small Jr., MD, assembled an interdisciplinary team of faculty members to develop the PIPSA curriculum and engage the support of their colleges. A vital goal was to bring health professions students to the forefront as future leaders of community health promotion. The importance of AHEC in establishing the community connections was recognized from the start.

The PIPSA program is unique in that it brings together faculty and students from dentistry, medicine, nursing, pharmacy, and health professions to focus on health promotion. Beginning each year with the Afternoon of Learning, all of the students assemble to learn about tobacco use and prevention. National figures, such as Jeffrey Wigand of “Insider” fame and Mississippi Attorney-General Mike Moore, have joined with local experts to engage the students’ interests on topics such as the pharmacology of addiction, the politics of tobacco, and the challenges of making behavioral changes.

Following the large assembly, each student joins a group with four students from other disciplines to collaboratively work through problem-solving scenarios presented in interactive modules. Approximately two hours are spent completing the small group activities, which include techniques to support behavior modification for addicted patients as well as health promotion strategies with youth.

The importance of tobacco prevention and the provider’s role in community education are reinforced as the health professions students complete a Day of Service/Applied Learning. Teams of students venture out to middle-school classrooms to present to 11-13-year-olds, who can relate to these health professional students better than to their typical adult guest speakers. At this stage, community partners are essential. From the beginning, the PIPSA initiative has relied on AHEC Centers and other school-related partners to secure middle school classrooms for the presentations.

Health professions students are prepared for this new role in community education during the Afternoon of Learning as the presenters include techniques for working with middle school students, which are then reinforced in the small-group activities. About a week prior to the visits, teams are given their school assignments along with a teaching kit containing a videotape, a teaching guide, and teaching aids. Examples of aids from previous kits include a stack of newsprint money to represent the cost of smoking a pack-a-day each year, a straw that is held in the mouth while running in place to experience the constriction of tobacco-damaged airways, and “death dice” that have two sides (1/3 of the six sides, representing the ratio of the one in three
The Florida AHEC Network as a Vehicle for Tobacco Prevention Education

smokers eventually killed by tobacco) bearing a red skull and crossbones to illustrate the risk of mortality from tobacco. Teachers are also provided with an educational gift, such as a poster or booklets that can be used in the classroom. Three discrete sets of materials, which are refurbished in each cycle, have been developed so that no middle school student is subjected to “old stuff” during these annual visits.

Successful implementation of the PIPSA Program at UF, coupled with the identification of youth tobacco prevention as a state priority, encouraged other AHEC programs in Florida to join the effort. Nova Southeastern University and the University of South Florida, led by their AHEC programs, have implemented PIPSA at their own universities for the last four years, while the University of Miami and Florida State University have tailored their own tobacco prevention efforts. In 2002, West Florida AHEC brought Okaloosa-Walton College on board and is currently inducting the University of West Florida. These expansions over the last five years have resulted in an average of 1,178 health professions students traveling to area classrooms, reaching an average of 40,510 Florida middle school students each year.

Each AHEC Program modifies the activities for its own Health Science Center, customizing kit materials for the local community and enlisting the support of community partners. The move to a statewide effort has resulted in valuable programmatic contributions from each AHEC Program. The close collaboration has also enabled collection of the impressive impact numbers, which are used for reporting activities and accomplishments.

Maintaining this vital, growing program has challenges. As state priorities have changed over the years and other external funding sources have been depleted, the UF AHEC Program and the Florida AHEC Network have become the primary funding source for PIPSA. As distance learning programs have evolved, new groups of students have been incorporated into the program at off-site campuses, requiring more assistance from other AHECs and community partners. Although middle school teachers consistently rate the program as one they want repeated, it is often difficult to secure classroom time due to competing priorities and school criteria for external speakers.

The Florida AHEC Network, through the PIPSA program, has enhanced the education of health professional students, modeled the role of health professionals in community-based health promotion, delivered age-appropriate tobacco prevention messages to middle school students, and provided health careers role models to middle schoolers. The PIPSA process of bringing interdisciplinary groups of students together to learn about a health promotion/disease prevention challenge, developing a framework of cooperation in communities, and then having students provide the health education with creative teaching tools could be employed to address many other pressing health problems. Preventing obesity and decreasing alcohol abuse are definitely on that “short list.” With the Florida AHEC Network serving as the vehicle to take these efforts statewide, the health education component of our mission is finally being realized for the impact it can have in Florida.
INShape Indiana: The Indiana AHEC Program Accepts the Governor’s Challenge to “Log On and Lighten Up!”

Angela Holloway, MHA

Accepting a governor’s challenge to get Indiana residents in shape, AHEC plans multiple ways of integrating the governor’s concept into their existing health career programs.

On a warm, sunny day in July 2005, Indiana Governor Mitch Daniels launched INShape Indiana, a web-based program that encourages Hoosiers to set and monitor goals for developing healthier lifestyles. The site also links Hoosiers to local resources to support their efforts to become more physically fit, adopt healthy nutrition habits, and stop tobacco use. Citing the significant barriers to health that Indiana faces, Gov. Daniels challenged Hoosiers to “log on and lighten up” at www.INShape.in.gov.

“We have all heard the sad statistics - when it comes to our health, we are first in the things we want to be last in, stated the governor. Indiana is at or near the top nationally of every negative health measure, including obesity, the smoking rate, and the many afflictions that accompany them: high blood pressure, diabetes, cancer, heart problems and stroke.”

In addition to resources and information, the INShape Indiana website offers Hoosiers an electronic platform where individuals and groups can log on and register by answering a brief personal health status survey and setting key health goals. Every two weeks, participants receive an email message, prompting them to update their progress. A series of incentives, including free access to Indiana State Parks, discounts at local grocery stores, and recognition ceremonies, encouraged motivation.

Indiana AHEC promoted the INShape Indiana website in an email communication to statewide staff and program advisory board members. Meanwhile, Indiana AHEC Program registered with the website as a “Program and Partner” group, and individuals around the state have helped promote the AHEC mission by affiliating their INShape Indiana registration with the Indiana AHEC Program.

The Indiana AHECs are introducing the INShape Indiana website, resources, and health literacy messages into Kids Into Health Careers (KIHC) program content. The KIHC program reaches students, teachers, guidance counselors, school administrators, and parents with classroom presentations about health and health careers; health and science enrichment programs for students interested in health careers; and a variety of mentoring, job shadowing and other support programs. These KIHC activities are presented to schools and students with a high proportion of students from under-represented ethnic and racial minorities, and/or educationally and economically disadvantaged backgrounds. In this way, KIHC and INShape Indiana health literacy

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INShape Indiana messages effectively target individuals at high risk for health disparities, poor health behavior choices, and who are more likely to care for rural and underserved communities when and if they enter health professions practice.

Indiana’s AHECs arrange enrichment and clinical training experiences for health professions students in a variety of disciplines. These often include community health outreach or service learning projects. INShape Indiana offers resources and topical priorities that students and faculty supervisors can use to conduct community health projects, around INShape Indiana messages related to obesity, fitness, nutrition, and tobacco cessation. Activities are intended to empower students to make personal change, effect change in those around them, and engage in community health initiatives that have the potential for a wide impact on health literacy. These are also ideal “learning laboratories” where health professions students exercise skills in communication, cultural awareness, and health education. West Central and Northwest Indiana AHEC have also had great success recruiting health professions students to serve as mentors for younger students, and will apply this strategy to enrich INShape Indiana student community health outreach projects.

The Indiana AHEC Program is a key partner in a state partnership grant to improve minority health recently awarded to the Office of Minority Health at Indiana State Department of Health. The Partners Recruiting Opportunities for Minority Student Education (PROMiSE) Project expands health careers outreach, academic enrichment, and cultural competency training to under-represented minority high school and undergraduate health professions students. INShape Indiana priorities will be built into the PROMiSE program’s capstone community health outreach projects for these future minority health professionals. Each of Indiana’s AHECs will participate in rolling out the PROMiSE project statewide over the next five years.

INShape Indiana health literacy messages will also provide raw material for a curriculum and toolkit to be offered to 25 Indiana K–8 teachers in summer 2006. The Life Sciences Teachers’ Workshop, under development by Indiana AHEC, Indiana Hospital & Health Association (IHHA), and Indiana science teachers, will equip teachers to integrate health information, health science content, and health careers information across the curriculum in ways that are linked to Indiana Academic Standards. Once developed, the IHHA Life Sciences Teachers’ Workshop and materials can be disseminated across the state through partnerships with IHHA member hospitals, AHECs, the Hoosier Association of Science Teachers, Inc. (HASTI), K–12 schools, and higher education partners.

Indiana University School of Medicine student leaders, other health professions training programs across the state, and Indiana AHEC Program are coordinating 2005 National Primary Care Week (NPCW) events focusing on “Breaking Down Barriers: Health Literacy in Community Health.” The Indiana AHEC Program has facilitated the integration of INShape Indiana initiative into 2005 NPCW activities and facilitated planning meetings between the State Health Commissioner and medical student leaders to operationalize this connection. The Indiana AHEC Program has successfully linked health professions students with state leaders to receive a proclamation recognizing Primary Care Week from Governor Mitch Daniels.

Broad-based health promotion initiatives like INShape Indiana become particularly powerful when community stakeholders buy in, adopt, and implement them. By leveraging the power of community resources, being creative, and having a rich understanding of local needs, Indiana AHECs are helping Hoosiers explore and learn new health behaviors. By embedding INShape Indiana into clinical training and youth recruitment, outreach, and enrichment activities, the Indiana AHEC Program is ensuring that the principles and messages of INShape Indiana will “shape” tomorrow’s healthcare professionals into effective, skilled community clinicians.

Indiana AHEC Program Director James Springer notes, “We immediately saw the link with the AHEC Program and our mission when we heard Governor Daniels’ announcement of INShape Indiana. We felt like the Indiana AHEC Program was positioned well to disseminate this information across the state and are looking forward to seeing the initiative take hold.”
Health Promotion in

The World Health Organization (WHO) has been actively working to promote and implement health promotion programs around the globe. On November 21, 1986, the first International Conference on Health Promotion took place in Ottawa, Canada. The conference, as well as its charter's intent, was to channel the positive energy coming from all parts of the world that were seeking ways to improve the health of people worldwide. As a result of the conference, health promotion was defined as the process of enabling people to increase control over and to improve their health.

**Ottawa Charter for Health Promotion**

Health was presented in the Ottawa Charter for Health Promotion as a resource for everyday life, not the objective of living. The understanding and appreciation of this concept is vital for us, the people, to move beyond the historic perception of health as a lack of disease or illness.

Health is more than an objective in life; it provides the means to move forward as an individual, as a group, or community, no matter how large or small. Health, or better defined as the public health of a state, nation, region, or global community, is a basic element and substrate that allows individuals and communities to fulfill their dreams, hopes and aspirations, while at the same time giving sustainability to any developmental process of their community. That resource known as health is then a constant denominator in any equation that seeks to improve the lives of people in any community, no matter if it is a developmental process at the macro or micro level.

**AHEC’s mission is more than the improvement of the community’s health beyond the physical or mental components. Its public health approach brings participation and active responses.**

The acceptance of health, as an important cofactor in the developmental process of communities and nations, is of utmost importance, not only for public health professionals but for everyone, from leaders to policy makers, from community advocates to the corporate and private sector, from academia to religious groups. The need to understand and take health into consideration and make it a part of the planning processes and activities would allow for a more sustainable process, no matter what field they work in or what the objectives are.

If health is a major cofactor of any developmental activity in a community, then health promotion is the engine that moves health to be understood by every member of the community; thus allowing each one to be active participants in their own health status, as well as the health status of their community.

The Ottawa Charter for Health Promotion presented us with some basic prerequisites for: peace, shelter, education, food, income, a stable ecosystem, sustainable resources and social justice and equity. A closer look at them makes it easy to realize that health is not an isolated silo, but a necessary interdependent resource to reach our full potential as a community. The interdependency and the multiple variables that affect the public health need to be worked together in a systematic manner, and not in a piecemeal or independent fashion. Policy makers need to understand this concept if policies that affect their communities are to succeed. Community health, or public health, needs to be part of the continuous dialogue within the community and its members. It cannot be relegated to a specific moment in time. It needs to be included in every agenda: transportation, trade, commerce, national security, welfare, and development. If health is
to be part of the continuous dialogue within the community, then health promotion becomes the vehicle that allows health to move forward and help achieve the full developmental potential of the community. If it’s an all-inclusive process then everybody needs to understand, not only what their own needs are, but also their neighbor’s and partner’s, thus creating a system rich in accountability.

Presently, many dialogues related to health use public health as a synonym for health care when in reality health care is just one component of the public health of a community. This confusion presents a philosophical problem in itself. When the dialogue related to services and coverage, and their measures of success are based on the two, then we lose the opportunity for a true systemic approach that encompasses the active participation of an individual and the community in the process. I am not debating here the importance of insurance and healthcare services; on the contrary, I support the expansion of services and access by all members of the community. What I argue is the need to expand the definition to be more inclusive in which all the components of public health are integrated, such as prevention, health and disease surveillance, health analysis, epidemiology, and health promotion among many others.

**AHEC’s Mission**
The mission of AHEC—to improve health outcomes by creating partnerships in education and healthcare, provide support to healthcare professionals, and strengthen the quality and supply of healthcare providers—reflects those same principles of strengthening the health of not only the individual but of the entire community. The involvement of multiple sectors of the community in the training of healthcare personnel, who understand the cultural, educational, social, and economic issues affecting the community served, brings the real possibility of improving healthcare outcomes, as well as the quality of services provided. Furthermore, the community involvement with academic centers opens the door to new opportunities for the community to integrate with academia, as well as to create ownership of healthcare processes by the community. AHEC’s mission is more than the improvement of the community’s health beyond the physical or mental components. Its public health approach brings participation and active responses. The success of any process is dependent on its actual sustainability. Therefore, it is important for an understanding by all policy leaders and stakeholders of how the integration of academia, health systems, and the community in a framework is sustained with resources, and will create the actual possibility of developmental fulfillment of a community. AHEC programs are one of the processes that have helped our communities to better serve themselves in matters, not only of their health, but also in their wellness and development.

**References**

Plan now to attend so you don’t miss these exciting speakers:

- **Greg Mortenson**: Founder of the Central Asia Institute, winner of 2003 Freedom Forum Free Spirit Award. His work in Pakistan is “changing the world one girl at a time.”
- **Suki Terada-Ports**: Founder of the Family Health Project, asks the question “So who are the ‘others’ at the table?”
- **Jennifer Brewer**: Operations Manager with Fierce, Inc., talks about “fierce communication” and succeeding – or failing – “one conversation at a time.”

### Conference Fees

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For Hotel and other Conference Information, check out our website at: www.unmc.edu/rhen

"In the middle of it all"

Funded in part by the Bureau of Health Professions, HRSA/HHS
West Texas AHEC Helps Area Rural Schools Improve Students’ Health Behaviors

Pam Danner, MBA, and Shannon Kirkland, MBA

West Texas AHEC helps schools meet a new state mandate to incorporate health and fitness into the elementary school curricula by 2007. As a new AHEC program in the region, this partnership has served as a catalyst for additional activities in the surrounding school districts.

Children and adults are increasingly more overweight across the United States, and concern exists about increased risk for Type 2 diabetes, high blood pressure, cardiovascular disease, some cancers, and other diseases that lower life expectancy and the quality of life. National attention focuses on the causes of excess weight and obesity and on ways to combat expanding waistlines.

The Centers for Disease Control notes that children of obese parents are more likely to have weight issues. If both parents are obese, the child has an 80% chance of being obese. If one parent is obese, the child has a 50% chance of being obese. According to the National Institutes of Health, overweight children are significantly more likely to be overweight adults. An obese 10-year-old child has a 70-80% risk of being an obese adult.

Childhood obesity in Texas has become a critical concern. According to the Texas State Department of Health Services, almost 39% of Texas 4th graders are overweight or at risk for being overweight. That percentage does not decrease significantly by high school, with approximately 29% of 11th graders overweight or at risk of being overweight. In addition, the prevalence of overweight and at risk for being overweight is higher among Texas’ African-American and Hispanic children for all age groups, with the exception of African-American 8th grade boys.

Healthy habits that have a positive effect on weight maintenance begin during childhood. According to data from the Centers for Disease Control, more than 60% of young people eat too much fat, and less than 20% eat the recommended five or more servings of fruits and vegetables each day. In addition, it was found that only 8% of elementary schools, 6.4% of middle schools and 5.8% of high schools provide daily physical education.

Texas state law now requires elementary schools to implement by 2007 a coordinated school health program approved by the Texas Education Agency to prevent obesity, cardiovascular disease, and Type 2 diabetes in elementary school students. The program must provide four components: health education, physical education and physical activity, nutrition services, and parental involvement.

Currently, there are four available coordinated school health curricula that are approved by the Texas Education Agency: Bienestar Health Program, CATCH (Coordinated Approach to Child Health), The Great Body Shop, and Healthy and Wise.

About CATCH

CATCH stands for Coordinated Approach to Child Health (formerly known as Child and Adolescent Trial for Cardiovascular Health), which was the largest school-based health promotion study ever done in the United States. The curriculum is designed to prevent sedentary behavior, poor dietary choices, and tobacco usage at the elementary school level.

Research from the initial and subsequent studies showed that CATCH worked.
West Texas AHEC Helps Area Rural Schools

Students who participated in CATCH consumed less fat and had higher levels of physical activity—even as 8th graders, three years later—than non-participating students. Not only did students’ healthy behaviors improve, there were also noted improvements in the schools: CATCH cafeterias served meals that were lower in fat and physical education classes were more active.7

The CATCH program includes K-5th physical education “CATCH PE,” heart health classroom curricula and family components for 3rd, 4th, and 5th grades; an “Eat Smart” school nutrition program guide for school cafeterias; and Family Fun Night activities. The purpose for the family activities is to engage the parents in the healthy lessons that the children learn at school so that they can help reinforce healthy choices at home. Classroom curriculum has just become available for K-2nd grades, and West Texas AHEC is working to help schools add this component.

The CATCH classroom component is designed to align with other core subjects, providing age-appropriate lessons and activities that allow students to incorporate information and skills learned in other subjects. For example, while students learn in science how the heart pumps blood through the body, the CATCH activity teaches them how exercise helps to make the heart healthier—and students get a chance to practice math skills by measuring and graphing their resting and active heart rates.

West Texas AHEC Involvement

Because the state law requiring a coordinated school health curriculum was an unfunded mandate, many school districts have struggled with implementation. This need presented an opportunity for the West Texas Area Health Education Center (AHEC) Program to work directly with school leaders in a different capacity than the traditional health careers promotion classroom presentations. In addition, it offered the West Texas AHEC a means of developing a significant outreach to promote healthy living, which is one of the Program’s four key strategies.

In 2003, the AHEC of the Plains, an independent center of the West Texas AHEC Program, submitted an application to subcontract with Texas Tech University Health Sciences Center (TTUHSC) on its Centers for Disease Control diabetes grant for $50,000 to provide the curriculum and training for school districts in the South Plains region of West Texas. The TTUHSC Office of Rural and Community Health also contributed $25,000 of state funds to the project.

Since then, the West Texas AHEC Program has expanded its outreach to assist 46 rural elementary schools across the South Plains, Panhandle, and Permian Basin regions of West Texas by

• providing the curriculum at no cost;
• providing some new PE equipment;
• organizing curriculum training to meet the state mandate;
• assisting with CATCH Parents’ Nights; and
• assisting with the collection of BMI (Body Mass Index) data.

While the initial rollout of the curriculum provided an immediate benefit to the participating schools as well as their 22,000 elementary students, the continued collection of BMI data may yield more significant information about children’s health. The potential value of this data remains to be seen.

Researchers with the Texas Tech University Health Sciences Center’s Office of Rural and Community Health, which hosts the West Texas AHEC Program, developed a database for schools to use in collecting and
West Texas AHEC Helps Area Rural Schools

As a new AHEC program in the region and with a service population that generally has never heard of an AHEC, there has been a need to lay groundwork for building relationships and promoting AHEC programs. Assisting elementary schools with implementing the comprehensive health curriculum has opened the door in many of these school districts for the West Texas AHEC to provide other services including opportunities to serve on school health committees, opportunities to introduce elementary school leaders to the science enrichment program and Hands-On Science, and more direct access to high school audiences with health careers promotion presentations.

The assistance that the West Texas AHEC Program has provided with the school health curriculum has enhanced the Program’s legitimacy with educators across the region, facilitating close working relationships with administrators and teachers.

The 46 participating schools have been collecting BMI data since the beginning of implementation, so that baseline data and annual data will be available to assess improvements. The initial 12 schools are in the process of collecting their second year’s BMI data, and the other schools are in process with their baseline data.

It is anticipated that implementation of CATCH in these rural school districts will yield the same results that the initial CATCH school-based study did: improved outcomes in healthy food intake and increased physical activity, even years later. The other possible avenue for study, which continues to be developed, focuses on differences in overweight and obesity for rural versus urban populations.

As a new AHEC program in the region and with a service population that generally has never heard of an AHEC, there has been a need to lay groundwork for building relationships and promoting AHEC programs.

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The Weight of the World Is on Our Children
... An Epidemic of Childhood Obesity and Physical Inactivity

Maggie Turnbull, MA/Wed, MT (ASCP)

In 2001, I attended a Health Promotion Day in Columbus, Ohio, where a representative from the Center for Disease Control (CDC) talked about a “quiet crisis.” He continued to say that our country was facing a problem of epidemic proportion, “Childhood Obesity and Physical Inactivity.” Sedentary lifestyles and poor dietary choices were producing an increasingly large number of overweight young people at risk for early onset of chronic illnesses. He shared alarming statistics that illustrated the rise of obesity over the past 40 years.

The speaker said the Surgeon General had issued a “Call to Action” challenging the health and education communities to join together and find innovative solutions to this “growing problem.” He talked about programs the CDC was promoting called “Walk Your Child to School Day,” and the “Walking School Bus,” where kids are escorted to and from school by crews of parents.

After some consideration, I decided the Lima/Medical University of Ohio AHEC would respond to the call and presented the “growing problem” and the “Walking School Bus” concept to our board for their approval. Family practitioner Dr. Peter Clemens pointed out that a one-day event would perhaps elevate awareness, but would not affect a lasting change and recommended we work toward a long-term solution to the problem.

Following his suggestion, we focused our efforts on a physical activity program knowing that many schools no longer had daily recess and/or PE programs due to time constraints within the classroom. In addition, we knew of a principal in eastern Ohio who documented positive changes in behavior, fewer visits to the school nurse and improved academic performance after incorporating short walks during the school day.

A few months later, we implemented a walking program at a small elementary school in Allen County. We also sent health facts on “footnotes” home each week to inform parents. At the end of the one-month pilot, we surveyed all involved and gained insight that would guide further program development.

After our successful pilot, we approached a Lima City school having a disproportionate number of kids from disadvantaged families. We knew they were more at risk for obesity. We also had an opportunity to educate parents about low-cost nutritious foods and how to access the services of the local food bank.

In October, we joined efforts with the local health department, AAA and the Neighborhood Association and kicked off a year-long program with a “Walk to School Day.” Each month a planning committee decided on a destination, activities and simple rewards for students exhibiting some extra effort. They also planned activities for students needing some modifications.

In November, the kids began a trek from Plymouth, Massachusetts, to Lima, Ohio, by jumping off a stepping-stone made in their art class. During December and
The Weight of the World Is on Our Children

January they roller skated home from the North Pole. In February they visited the birthplaces of Washington and Lincoln before heading to the nation’s capital for a sightseeing tour. In March, students studied the Iditarod and walked the equivalent miles of the famous dogsled race, and in April, while studying the Underground Railroad, they retraced the steps taken by those escaping to the North.

We also encouraged participation from teachers, staff and parents so students would see a supportive atmosphere that would help motivate them throughout the year. The art teacher displayed laminated posters and maps having mileage markers. Nutrition Services displayed colorful posters in the cafeteria. The school nurse provided BMI (Body Mass Index) information on all second and third graders. Older students helped calculate miles walked, skipped, hopped, or rolled.

At the end of the year, the school family planned an Olympic Field Day to reward their achievement, walking over 10,000 miles. Thanks to the effort and commitment of the entire school and the PE teacher, Aaron Patterson, we had another successful program.

This past year, having a successful pilot and a year-long program under our belt, at the suggestion of a family practitioner Dr. Alok Krishna and Brenda Jennings, the school nurse, we presented our “Lifestyles of Champions” program to the administration of the Kenton City School System. Kenton is a rural community of 4000 in a Health Provider Shortage Area (HPSA) of Hardin County where unemployment continues to rise as large employers leave the area.

We decided to focus more on the nutrition component and enlisted the assistance of the dietitian from the Hardin Memorial Hospital, Carol Dyer, who gladly agreed to participate.

In addition, we invited third-year medical student, Rocky Pittman, from the Medical University of Ohio, studying with Dr. Krishna to join us in the food pyramid presentations in March. He commented:

… What amazed me most signifi-
cantly was how interested the children were in nutrition and healthy lifestyles in general. I had always assumed that the children needed coercion to eat healthy … was I wrong! This was a lesson that I will carry into my future practice.

Perhaps through this experience we have motivated a future physician to become interested in addressing this problem in his future practice. At the very least, he was able to observe firsthand that one to two of every 20 children in each second grade class were already obese and another three to five were noticeably overweight.

Table 1. Prevalence of overweight among children and adolescents ages 6-19 years, for selected years 1963-65 through 1999-2002

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2Data for 1963-65 are for children 6-11 years of age; data for 1966-70 are for adolescents 12-17 years of age, not 12-19 years.
To spread the word further, we asked for support from the Kenton City Times, who wrote several articles alerting their readers to the “growing problem,” highlighting our activities during the school year and conveying a simple message, “healthy kids learn better.” Knowing informed adults are the best role models, we encouraged the community to become more physically active during the summer months by joining a walking program such as the one currently sweeping the nation, America on the Move (AOM).

On a larger scale, we became involved in Action for Healthy Kids (AFHK), an initiative established in 2002 to further the goals of the Healthy Schools Summit. Through AFHK we learned about CATCH (Coordinated Approach to Child Health), a researched-based healthy lifestyle program that originated at the University of Texas in 1996. Through a grant, the Ohio Department of Education and The Children’s Hunger Alliance introduced the program to Ohio. I became a CATCH trainer and joined a team of 20 educators, who will promote and implement this program in schools in our eight-county area in 2005-08.

Another opportunity presented itself with the signing of the Child Nutrition and WIC Reauthorization Act, making it mandatory for all local education agencies participating in the National School Lunch Program to form Wellness Councils and write Wellness Policies by June 2006. This law was enacted to address childhood obesity by promoting healthy eating and physical activity through changes in the school environment. When I became a trained Health and Wellness consultant last fall, I knew that we could help implement the changes, and by seizing this opportunity, we would be moving closer to the goal: A solution that will someday remove the “Weight of the World” from our children.
Conducting Community Outreach

Childhood Obesity Prevention: A Healthy Beginning
Jan Richter, EdD, CHES, and Becky Hall, EdD

A community health outreach nutritional program targeting minority and underserved women who are pregnant is an early intervention program to improve the likelihood of mothers providing their infants and toddlers with proper nutrition.

The Delta Area Health Education Center (Delta AHEC) is a seven-county health education outreach program of the University of Arkansas for Medical Sciences (UAMS). It is an invaluable link between UAMS and the most economically oppressed and dispossessed area of the state known as the Arkansas Delta. Ninety-eight percent of the Delta region is identified as medically underserved and the average per capita income is 20% lower than the state average and 37% lower than the national average. One of the primary missions of the Delta AHEC is the deliverance of direct health education to consumers and the facilitation and coordination of educational partnerships and resources among the communities it serves.

The Delta AHEC employs a unique approach in achieving its mission of improving health through education by helping people help themselves, and has established an early intervention program entitled “A Healthy Beginning” to positively affect and prevent obesity in the children of the Delta. Funding for this program was acquired through The Blue and You Foundation for a Healthier Arkansas. This foundation is a charitable organization established by Arkansas Blue Cross and Blue Shield to promote better health in the state. The Foundation’s specific purpose was to provide funding for health education outreach programs that focused specifically on childhood obesity prevention.

A Healthy Beginning is a program designed to serve expectant mothers in the Delta. Mothers play a significant role as they implement their parenting practices with their children. A Healthy Beginning targets women who are underserved due to poverty and lack of health insurance and women who are disadvantaged due to ethnic disparities or low literacy. It includes school dropouts, single-parent households and pregnant teenagers.

Two major factors place families at risk for poor nutrition and poor health. One is poverty and the other is maternal obesity. Expectant mothers who are both socio-economically challenged and overweight are more likely to have obese children at 2-4 years of age. Poor food intake by toddlers can result in impaired cognitive development, growth retardation, and childhood obesity. According to the US Bureau of Census Quick Facts 2000, 37% of the residents in the Arkansas Delta live below the 100% poverty level. The combination of poverty and maternal obesity compounds the health dilemma already facing the mothers and children of the Delta.

Nutritional education aimed at parents can improve the nutrition and dietary practices of toddlers, which can have long-term effects. Although community programs for rural, low income families with young children are unable to address all the problems facing these families, specifically designed nutrition education could enhance a child’s healthy growth and development. Findings suggest that a caregiver’s knowledge can affect the dietary quality of toddlers by decreasing fat intake and increasing fiber intake. Therefore, interventions to enhance a caregiver’s knowledge can affect the dietary quality of toddlers and should be considered in interventions to...
Childhood Obesity Prevention: A Healthy Beginning

enhance toddler nutrition and prevention of childhood obesity.1

Targeting the period before a mother conceives, during her pregnancy, or in the early years of her child’s life can prevent obesity by interrupting an intergenerational cycle that promotes obesity.1 According to the Journal of Nutrition Education a study in 2003 confirmed that knowledge and attitudes positively relate to dietary quality and further stated that mothers who are most knowledgeable about nutrition demonstrate the most positive feeding behaviors toward toddlers.2

Through A Healthy Beginning, Delta AHEC offers expectant mothers a 12-week course on nutritional education and parenting skills. The program is designed to improve the nutrition and dietary practices of mothers to help them prevent their children from growing up to be obese. To complement the initiative, the Delta AHEC contracts with three community health workers who identify and recruit expectant mothers into the program, assist with nutrition education training, and make home visits when follow-up is needed.

Another assumption to program success is the incorporation of the community health worker (CHW) who ethnically reflects the community and acts as the backbone of the initiative’s applied interventions.

It has been documented that CHWs provide cultural mediation between their communities and health service systems; provide informal counseling and social support; provide culturally and linguistically appropriate health education; advocate for individual and community needs; assure people get services they need; build individual and community capacity; and, provide referral and follow-up services.4 This dynamic is essential to the success of this initiative. The CHWs are local residents in the counties the Delta AHEC serves. The Delta AHEC uses its resources to provide each CHW with ongoing education and technical assistance.

In order to achieve the program goal, an advanced nurse practitioner, registered dietitian and the project director developed a 12-week curriculum including weekly lesson plans. The nurse practitioner and the CHWs arranged meetings in the surrounding counties with local physicians who deliver babies to enlist their help in referring participants to the program. Other staff were directed to network with the county health department, local places of worship, rural hospitals, clinics, and other health agencies to inform them of this program and to enlist referrals. In addition, the program advertised in county newspapers and on local radio stations. The first cohort of participants, primarily referred by physicians, totaled 25 mothers-to-be.

Participants attend a weekly one-hour session taught by the Delta AHEC staff and CHWs. The topics to be covered in the 12-week cycle include: diet and exercise; breast feeding and formula feeding; infant feeding the first three months; why we weigh and measure babies and the plotting of growth charts; reading food labels and using the information for healthy eating; meal preparation and food safety that includes two cooking sessions; fruits and vegetables purchasing and preparation; food guide pyramid for children and adults; the importance of calcium and iron; fat facts and fast food; and healthy recreation for the family that incorporates smoking abstinence.

*A Healthy Beginning* program participants.
After attending the first one-hour session, each mother received a diaper bag. After each of the following sessions the participant is given a small incentive such as a medication spoon, nutritional reminders, baby wipes, or a small baby book to place in their diaper bag. Those who attend six sessions draw for a $50 grocery certificate; and upon completion of the 12-week course, participants who have attended each session draw for a $100 gift certificate for baby items. If a mother delivers during her 12-week course, a home visit is made by the registered dietitian and the CHW providing additional nutrition education. Additional home visits will be made when a mother misses a class to teach the lesson missed and to determine why the participant did not attend. Additional home visits may be requested by the participants at any time. At the close of the 12-week training cycle of classes, a graduation program with a guest speaker is held.

The next cohort of participants is then initiated and continues for three months, followed by a third cohort.

Evaluations of each session consist of a short pre- and posttest of lessons learned with a final evaluation judging the overall program content, effectiveness, and participant satisfaction. Participants are also encouraged to attend free prenatal exercise classes offered by the Delta AHEC (with a physician’s consent form). Smoking cessation classes are also offered and child care is provided.

A quasi-experimental longitudinal research design is being implemented to study the effectiveness of the program. The first cohort will conclude and post survey will be administered January, 2006. The evaluation will generate useful and meaningful data about the program.

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Zydeco, Politics, and Outreach: Embracing Health Promotions in South Louisiana

Jeanne Solis, Robin Boyles, and Bootsie Durand, MS

Southwest Louisiana AHEC bridges popular culture and political priorities to promote health through cost-effective interventions that respond to documented needs in the region.

Louisiana’s “laissez les bons temps rouler” lifestyle and cultural traditions strongly influence behaviors. Locals know it, grantors know it, and tourists love it. But poor health status and statistics result in part from poor personal choices about preventable health conditions.

Just as the new Louisiana Governor, Kathleen Blanco, was making health care a state priority in 2004, Louisiana was ranked 6th highest in AIDS case rates and 11th in the number of new HIV infections for 2003. Following the Governor’s March 2004 Health Care Summit, regional Health Consortia were formed to create solutions for health. With the Consortia barely formed, Louisiana received another health-message bomb. The United Health Foundation released its 2004 State Health Status list showing that Louisiana had again dropped in rank to #50 in the country.

As state government healthcare interest was heating up, the Southwest Louisiana AHEC staff and Board members were selected by state senators to serve as members of the regional Governor’s consortia during 2004-05. In this leadership capacity, AHEC representatives strengthened partnerships with private, public and governmental representatives to increase local health promotions activities.

Gary Wiltz, MD, was serving as President of the SWLAHEC Board in the mid-1990s when opportunities arose for diversifying AHEC programming. An avid runner and wellness advocate, Dr. Wiltz encouraged the staff to pursue new grant funds for health promotions projects that would complement the core AHEC mission of career education. Due to documented needs in the region, those first projects focused on HIV Prevention, Tobacco Prevention, and Drug-Free...
Focus on HIV/AIDS Prevention

African Americans account for 32% of the overall population in Louisiana, yet the rate among African Americans is 74% for new detections. With this in mind, SWLAHEC staff made the decision to focus its HIV prevention efforts among African Americans. Considering that between 5,000 and 6,000 youth worldwide between the ages of 15 and 24 become infected with HIV each day, SWLAHEC Board and staff also felt it was imperative to focus on this age group in its prevention efforts.

SWLAHEC has been providing regional HIV prevention services through a contract with the Louisiana Office of Public Health HIV/AIDS Program since 1997. Interventions have included street outreach, condom availability and distribution, venue-based outreach, counseling, testing and referral services to underserved communities. In 2004, SWLAHEC staff made 1,428 HIV/AIDS outreach contacts in Louisiana Region IV at a direct cost of about $14 per contact.

With this experience in HIV prevention and the multitude of community partners that were generated, SWLAHEC was successful in obtaining a federal grant from the Centers for Disease Control and Prevention from 2000-2004. This funding provided street outreach and small group intervention programs to African American youth ages 15 to 24 through the Resources of HIV/AIDS Prevention (RHAP) project. The risk factors being targeted were primarily unprotected heterosexual sex with multiple sex partners.

Over the four-year life of this project, AHEC made 51,421 outreach contacts with African American youth exhibiting high risk behaviors, at a direct cost of about $13 per contact. Surveys obtained during outreach efforts showed that 45% of the youth that obtained HIV information had a greater perception of their risk of HIV while 14% increased their condom use. Eighty-seven percent of those youth that were sexually active and surveyed in the communities in which the outreach had been provided indicated that they had used a condom at their last sexual encounter.

Another component of the RHAP project was the utilization of a small group intervention, “Becoming A Responsible Teen (BART),” to youth at out-of-home placement and high-risk environments such as juvenile detentions, youth shelters, or housing developments. The BART curriculum focused on helping youth reduce their risk of HIV by increasing their skills to refuse sexually risky behavior by handling social and sexual pressure, to communicate assertively, and to negotiate safer sex practices with potential partners. Pre- and post-assessments given to each AHEC participant indicated that knowledge of HIV risk among participants increased by 22%.

As the CDC grant funding for the RHAP project was ending, yet with a desire and a substantiated need to sustain the project, SWLAHEC researched ways to continue HIV prevention services and expand them to include more participants. Combining experience in HIV prevention with experience in substance abuse prevention activities such as the Life Skills Training program and Tobacco Control and Prevention, SWLAHEC obtained a grant from the Substance Abuse Mental Health Services Administration to provide small group interventions focused on the integration of HIV and substance abuse prevention among youth during 2004-2009.

The SHIP project (Substance Abuse HIV Integration Prevention) began with a strategic planning phase in which approximately 50 individuals representing community organizations varying from faith-based entities, academic institutions, community-based organizations, and law enforcement agencies participated. Through this process, 12 curricula were reviewed by the partner’s

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Schools activities through subcontracts with state agencies.

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Curriculum Task Group, and four were selected for implementation targeting African-American youth ages 11-18: Street Smart, All Stars, Making Proud Choices, and Making A Difference. Key selection criteria were for curricula that were evidence-based and culturally appropriate for use in small group settings at youth-serving organizations, faith-based settings, juvenile detention settings, and after-school groups.

The goals of the SHIP project are to reduce substance abuse among young people and to reduce the transmission of HIV among young people. This project is being evaluated by measuring the knowledge, attitudes and behavior of those participating by utilizing a pre and posttest questionnaire with program participants. Community collaborators include Teen Courts, housing authorities, alternative schools, and Boys’ and Girls’ Clubs. Trained group facilitators work with youth exhibiting high risk behavior at community sites, therefore decreasing the barriers to accessing health information.

During 2004, HIV and substance abuse prevention education was provided to 229 target youth.

From 2003-2005, SWLAHEC has been among nine agencies in the country funded by the CDC to participate in the Social Networks AIDS Prevention (SNAP) demonstration project. Of the funded agencies, SWLAHEC is the only project with a rural HIV testing focus. A core intervention is use of the OraQuick rapid testing method. Social Networks Strategy occurs when people infected with HIV work with staff to recruit network associates to be tested for HIV. During 2004, 61 individuals were tested for HIV; cumulative testing through 2005 shows a 1% new detection rate locally.

Additional HIV/AIDS prevention program funding was awarded for 2004-2009 from CDC for implementation of the Promise program. This prevention program uses role model stories, outreach and testing interventions. During 2004, the initial program focus was on training staff and engaging in a community identification process. SWLAHEC has been the only agency in southwest Louisiana offering the OraQuick® ADVANCE test since 2004. A Mobile Health Unit RV has been added to reach the rural and underserved communities prioritized for outreach through strategic planning by local partnerships during 2005 and approved by CDC. The Mobile Health Unit was also utilized for testing in partnership with the Region 5 Office of Public Health during the 2005 National HIV Testing Day.

**Did you know?**

“Zydeco” is a popular accordion-based musical genre and remains a relevant means of cultural expression for the Creoles in Southwest Louisiana.
Embracing Health Promotions in South Louisiana

The Southwest Louisiana AHEC as well as AHECs in Louisiana and surrounding Gulf Coast states were profoundly affected by Hurricane Katrina. They have also been heavily involved in a wide array of relief efforts. The National AHEC Bulletin plans to highlight some of those efforts in the Spring/Summer 2006 issue.

Reader’s Forum

The NAO Editorial Board welcomes your comments on editorials, articles, and other information contained in the National AHEC Bulletin, or on themes you’d like to be considered in the Bulletin. Although comments to the Reader’s Forum are reviewed by the NAO Editorial Board, all signed submissions of opinion belong to the author(s) for which neither the NAO Editorial Board nor the NAO takes responsibility. Only letters that include your name, work address and phone number will be published. Comments of 250 or fewer words have the best chance of being published and may be edited. Comments may be sent by e-mail to editor@nationalahec.org, by mail to NAO, 109 VIP Drive, Suite 220, Wexford, PA 15090, or by fax to 724 935-1560.
A Border Health Education Training Center (HETC) Program in Arizona Addresses Binational Health and Environmental Issues

Binational community health initiatives are described along the Arizona-Sonora, Mexico Border.

Annual National Community Health Worker Conference
The Regional Center for Border Health, Inc. has sponsored and organized the National Community Health Workers/Promotores Conference in collaboration with many local, state, and national organizations with an average of 450 attendees. The Regional Center for Border Health, Inc./Western Arizona Health Education Center (RCBH/WAHEC) was pleased to announce the 8th Annual National Community Health Workers/Promotores Conference in Phoenix, Arizona on August 23-26, 2005.

This National Conference is not simply an opportunity to come together and meet new friends from a diverse multicultural background. It is a call to action to unify our efforts and become a workforce with one strong voice, united nationwide, to impact policymaking officials – local, state, and federal – to act on behalf of the underserved and disadvantaged families and communities that we represent. This effort recognizes community outreach workers as an integral part of the health care delivery network system and other related fields. With this annual conference, we proudly create a unique forum for community health workers and leaders of agencies and organizations to network, empower, support, inform, unify, and enhance our knowledge and strengthen our efforts in serving our communities nationwide.

This educational and uplifting annual conference has the major goals of providing opportunities to:

- Enhance the capabilities of the Community Health Worker National Network Association/Red Nacional de Promotores de Salud;
- Increase the quality of life and eliminate health disparities by providing a variety of health educational training and informational sessions that will best prepare CHWs to address and meet their communities’ needs.

Conducting Community Outreach

Amanda Aguirre, MA, RD, is the CEO/President of the Regional Center for Border Health, Inc. in Somerton, Arizona.

Dr. Jose L. Munoz applies the first immunization doses.
Center-HETC has sponsored quarterly meetings for the Binational Health and Environment Council in San Luis R. C. Sonora, Mexico/Yuma County, Arizona, in coordination with the Yuma County Health Department and Servicios de Salud/Hospital General, San Luis R. C. Sonora, Mexico.

Several subcommittees have been formed by health providers in both public and private practice from both sides of the Arizona/Sonora border to discuss and develop plans to address different border health-related issues and needs. Subcommittees include Oral Health, Maternal & Child Health, Adolescent Health, Continuing Medical Education, Environmental-Occupational Health, First Responders/Bio Terrorism, Communicable Diseases, Mental Health, and Women’s Health.

**Binational Oral Health Initiative**

On September 15 & 22, 2004, the Binational Oral Health Screenings Program took place in Somerton and San Luis, Arizona. The health screenings were provided to young children attending preschool and elementary school by Rudy Valenzuela, Clinical Director of the San Luis Walk-In Clinic, and reached a total of 104 children. A total of 400 school-age children have participated in the oral health assessment campaign.

On April 4, 2005, Dr. Valenzuela provided a training to dentists from Servicios de Salud de Sonora Hospital General in San Luis R. C. Sonora, Mexico. The purpose of the training was to take a family survey and to provide oral health education to parents and their children to improve oral health among children, to decrease the number and frequency of cavities, and introduce basic oral health assessment skills.

**Binational Immunization**

*Nuestros Niños Campaign*

A mock immunization kick-off event took place as a commencement of the Third Binational Health Week. This activity took place at Friendship Park located right on the border of San Luis, Arizona, and San Luis, Mexico. Charming preschool-aged children from both sides of the border participated in the mock immunization kick-off event dressed in medical attire.

On October 11, 13, and 16, 2004, the Binational Immunization Campaigns were held. Free immunizations were administered at the San Luis Walk-In Clinic, the Somerton Senior Center, and in Yuma. Approximately 200 immunizations were administered. During that same week of October 11-16, 2004, across the border, Hospital General/Servicios de Salud de Sonora in Mexico held their own immunization campaign in San Luis R. C. Sonora, Mexico.

A Promotora Outreach project designed to improve and address the issues of availability and accessibility of health care and the well-being of children is the “Nuestros Niños (Our Children)” Community Household Census and Immunization Campaign. Since 1998, this door-to-door household census and immunization campaign has helped to identify families without medical insurance, children with incomplete immunizations schedules, pregnant women needing prenatal care and families in need of social and healthcare services. In
Binational Health and Environmental Issues

2004, the “Nuestros Niños” Campaign reached 1,310 families in San Luis, Somerton and Yuma, Arizona. RCBH promotores also assist parents and caretakers in their children’s enrollment process into the state’s insurance program. We have enrolled 3,287 people between 2002 and 2004. In 2005, the “Nuestros Niños” Campaign administered 553 immunizations during two campaigns.

Women’s Health
On, October 14, 2004 the 4th Annual Binational Pink Tea (Té Rosa Binacional) was held. Approximately 150 women received prevention education, which stressed the importance of early detection of breast and cervical cancer. This event was held in San Luis, R.C. Sonora, Mexico. A noticeable comment about this event is that three generations of women participated from a single family. On October 24, 2004, The Yuma County Pink Tea took place. One hundred and twenty women attended this event and not only celebrated life and acknowledged the strength of character and perseverance of breast cancer survivors, but also learned about the importance of early detection and self-examination.

Emergency Preparedness
In April 2005 the Binational “Bombero” (firefighter) Program took place. Firefighters from San Luis R. C. Sonora, Mexico, received a 40-hour training by the Yuma Fire Department staff. The purpose was to increase the number of trained first responders along the border. Some of the subjects taught included: how to handle incidents involving weapons of mass destruction; rescue techniques in confined spaces; incidents involving hazardous materials; and security through personal protection equipment. The “Bombero” program continued from April 26–29, 2005. Regional Center for Border Health, Inc./WAHEC-HETC partnered with the Rural Metro Fire Department, City of Yuma Fire Department, and Unidad Municipal de Protección Civil de San Luis R. C., Sonora, Mexico.
A Northeast Ohio Community Promotes Social Change “One Step at a Time”

Sue Leffard

The Healthy Valley Alliance is a long-term partnership that has taken on the task of community design to prevent the type of urban sprawl that is known to limit or prevent physical activity in the neighborhood.

In 1994, the Mahoning Valley in Northeast Ohio joined over 1,200 other communities in the United States when they created Healthy Valley 2000 – a collaboration between the Valley’s boards of health, hospitals, physicians and other community leaders who shared a concern for improving the community’s health. The Healthy Valley Alliance (HVA) is a partnership of organizations from the public and not-for-profit sectors collaborating to focus attention and resources on health problems identified as priorities through the Healthy Valley 2000 community health assessment and planning process. The Eastern Ohio Area Health Education Center, located at Youngstown State University, Youngstown, Ohio, has been a member of the Alliance almost since the beginning.

In 2003, the National Center for Environmental Health (NCEH) of the Centers for Disease Control (CDC), in partnership with the National Association of County and City Health Officials (NACCHO), awarded funding to eight local public health agencies to serve as PACE EH demonstration sites. PACE EH (Protocol for Assessing Community Excellence in Environmental Health), provides a methodology to provide local communities with guidance for identifying and addressing environmental health issues. The Mahoning County District Board of Health, also a member of the Healthy Valley Alliance, was one of the sites chosen to pilot this project, in partnership with the HVA.

The results of the Healthy Valley PACE EH Project were released to the public in a formal report in December 2004. To identify public health concerns, residents of the Mahoning Valley were asked to complete a survey that listed many health issues. The Mahoning Valley PACE EH project team identified the three areas of greatest concern: drinking water quality, indoor air pollution, and urban sprawl, particularly with regard to the risk of illness associated with physical inactivity. Coincidentally, the HVA had chosen as their most recent focus obesity and the underlying factors – poor nutritional habits and lack of physical activity. This was the perfect opportunity for the HVA to promote the development of initiatives that result in measurable improvements in the problem area of inactivity identified by the Healthy Valley PACE EH project.

The consequences of physical inactivity are well documented. In Mahoning County, over 23% of children aged 6-11 are overweight, compared to a national average of 15.3%. The number of overweight students in Mahoning County increased from 13.9% in 1999 to over 20% in 2004. Some researchers believe this will be the first generation in modern history to have shorter, less healthy lives than their parents. Urban sprawl often presents barriers to physical activity, contributing to an increased risk for obesity, heart disease, diabetes, arthritis, and other chronic diseases. Barriers include the absence of sidewalks, bicycle paths, access to parks and playgrounds, heavy vehicle traffic, and environmental stressors (i.e. high rates of neighborhood crime). Older persons and those with disabilities often have less access to recreational activities.
A Northeast Ohio Community Promotes Social Change “One Step at a Time”

The final Healthy Valley PACE EH report made the following recommendations: 1) decrease the proportion of adults who do not engage in leisure activity; 2) increase the number of children who walk to school; and 3) by 2006, begin building all new residential subdivisions with sidewalks. In their approach to putting the recommendations into practice, the Healthy Valley Alliance charged Eastern Ohio AHEC with the educational piece of the plan, as continuing education and health promotion has been the Center’s forte for almost 30 years.

The first educational effort is a full-day conference planned for a wide variety of professionals in business, health care, education, urban planning, and transportation. It is Eastern Ohio AHEC’s intent that a multidisciplinary conference approach to community health challenge community professionals to become proactive in their individual roles. The purpose is to explore elements of community design as they relate to the health of individuals where they live, work and play. The program addresses a variety of environments, including schools, worksites, parks and recreation areas, and community models, as well as intrinsic motivational factors. The participants will discuss the connection between the environment, inactivity, and obesity, and the importance of planning for active living. Overall, the conference will identify challenges and opportunities in research, practice and policy efforts to promote physical activity through the environment.

Continuing education efforts are needed for public health officials in urban planning to become more credible advocates for zoning officials when considering the public health implications of land use decisions. Similarly, county road engineers, planning commissioners, home builders associations, school boards, and local state legislators need new expertise regarding the public health impact of land use decisions.

In addition to the initial conference, the Healthy Valley Alliance requested EOAHEC to help facilitate implementation of the PACE EH recommendations regarding urban sprawl.

The ultimate test of the value of the Healthy Valley Alliance conference and coalition plan remains to be seen at this time. There has been great interest and support at the local and national levels to this point, however, and conference speakers hail from the CDC in Atlanta, Active Living by Design from the University of North Carolina, and General Motors Health Services Division in Detroit. According to the Mahoning County Health Commissioner, “the key is that coalitions are built to implement the recommendations in a timely manner. And Eastern Ohio AHEC is up for the challenge.”
Heart of the Delta: A Cardiovascular Disease Program

Sharon L. Greene

Phillips County is located deep in the rural southeastern part of Arkansas. The dusty roads, sparse transportation, and lack of jobs have created a climate of distrustful apathy in this once flourishing community. Helena-West Helena, the county seat for the area, lies in the heart of the Mississippi Delta. And, like the Mississippi River that runs along side it, the community is complex and multi-layered. Research has shown that health statistics in places such as this are just as depressing as the unseemly bleak outlook of the community as a whole.

According to a statement from the Center for Disease Control and Prevention, as quoted in the 2002 Phillips County Cardiovascular and Diabetes Risk Factor Survey Summary, coordinated by the Arkansas Department of Health’s Center for Health Statistics and Arkansas Minority Health Commission, “heart disease and stroke are, respectively, the first and third leading causes of death in Arkansas. Diabetes is the seventh leading cause of death in Arkansas. They are the principal causes of cardiovascular disease death and are also major causes of disability.” The survey goes on to say that “the counties in the Arkansas Delta have been shown, in previous studies, to have the highest rates of death from cardiovascular disease in the state.” They include high percentages of African American Arkansans living in poverty, and cardiovascular disease is the leading cause of their death. African Americans are more than twice as likely as white and Hispanic Americans to have been told they have diabetes. But, a luminous beacon of light is in the community, Rev. Arthur Hughes.

Rev. Hughes is greatly respected in the community for his many years of being the voice of the underserved. He has worked on a vast array of projects and programs such as the tobacco education and cessation program through the University of Arkansas at Pine Bluff’s Minority Initiative Sub-Recipient Grant Office, moderator of his region’s Baptist Church Association, and minister of a thriving local church. Last fall, he added health promoter to the long list of tasks he and his staff have undertaken.

Hughes is not considered an extremely tall man (he probably stands about 5’10” in his stocking feet), but when he starts talking about something he is passionate about, such as better opportunities and fairer treatment for African Americans, this grandfatherly looking man appears to gain height and girth. Instead of seeking retirement like a lot of men his age, Hughes is now rolling up his sleeves and starting on a new mission.

Hughes is collaborating with the Delta Area Health Education Center’s (Delta AHEC) The Heart of the Delta cardiovascular (CVD) education program. The mission of this program is to educate people on the value of wellness visits with their doctors, lifestyle changes and proactive measures when it comes to their own health. To initiate these services, Rev. Hughes has invited health educators from the Delta AHEC into local churches to offer health screenings, educational resources, and follow-up education to a segment of the population that has an extraordinarily high rate of death and complications due to CVD.

Through this partnership with Delta AHEC, Rev. Hughes serves as a liaison in the community to find other ministers that will open their churches to this outreach, help spread the word about the benefits of preventive health for minorities, and advocate for people in the faith-based community. Sharon L. Greene is the Director of Minority Community Outreach with the Delta AHEC in Helena, Arkansas.
community to take a more proactive stance regarding their health. The Delta AHEC has also incorporated programs of the American Heart Association and has received support from the Helena Health Foundation.

Of the seven AHECs in Arkansas, the Delta AHEC is the newest. And just like the complex and multi-layered Mississippi River, it also has a myriad of opportunities and obstacles. It has been hard to establish a medical clinic in the area because of its rural location. But Delta AHEC is determined to be a catalyst of change in its region and a decision was made to focus on teaching the community skills it needs to be proactive in healthcare choices.

A surprising development for Rev. Hughes came in March when, through a health screening he was hosting, he was found to have elevated glucose levels. Rev. Hughes made an appointment with his physician and it was determined that he had diabetes. His doctor started him on a treatment plan and over the past few months Rev. Hughes has lost 28 pounds and has truly become a role model for his congregation.

One of the stumbling blocks that quickly became apparent to the Heart of Delta Program was the difficulty many people experience in navigating the healthcare system for follow-up care. Some solutions have been to refer people with high glucose levels to the Delta AHEC’s Diabetes Education Clinic for further evaluation; to offer prescription and emergency assistance for medicine (emergency assistance is through a grant from the Helena Health Foundation); and to assist people in finding services from other programs for disease management. Plans are in development to utilize community health workers for further health education and follow-up of participants.

The Delta AHEC has established itself as an innovator in Arkansas with its many outreach programs. In February of 2006, we will move into a new state-of-the-art wellness center. The center will be more than a new building; it will be a symbol of hope for many people.
The Thrill of the Drill
Kathy Ellis and Cassandra Ellsberry, MT, MEd

It was a hot June day in Macon, Georgia. Tattnall Square Park was busy with teenagers playing tennis and younger children playing tag. Across from the park at Alexander II School, a group of students was working on a summer science project. As I stood in the park watching the busy activities of its visitors, someone rushed out of the school. Cassandra Ellsberry, the science teacher, shouted “someone please call 911!” Immediately I noticed smoke coming from one of the second-floor windows.

The Bibb County Campus Police were the first on the scene. They anxiously directed traffic allowing access to the school for the emergency responders. Macon Police arrived to assist with the task of traffic control. Mercer University Campus Police also responded. In less than ten minutes, the Macon/Bibb Fire Department pulled onto the school grounds. There were several fire trucks, rescue vehicles, hazardous materials team, and others that I had never seen responding to this emergency.

When I turned to look back, Ms. Ellsberry was courageously leading her class down the stairs and away from danger. As I continued to observe, I noticed her informing one of the firemen that two students were missing. The paramedics from the Medical Center of Central Georgia (MCCG) arrived while the fire department responders were making their way to the second-floor classroom with their fire hoses and stretchers.

Firemen began to enter the building to search for the missing students. Other firemen carried hoses and fire equipment to control the fire.

While the firemen were controlling the fire and searching for the missing students, the MCCG trauma team was setting up a treatment station at the park. By this time bystanders were everywhere. The local media was on the scene asking questions about what was happening. Paramedics were escorting the students and their teacher to the trauma shelter. The Macon/Bibb Area 4 Command Center was prepared to take control of this situation when called upon. The Army National Guard also responded.

As I wandered closer to lend an ear to what was happening at the trauma shelter, a crowd had convened around the shelter. The two missing students were found and were now being treated by the trauma team. All of a sudden people started to applaud...the wounded students rose from the stretchers. Someone shouted “Good drill,” another “the thrill of the drill!” It was all an exercise!

The event was a disaster response drill orchestrated by Cassandra Ellsberry, Health Careers Recruiter and the summer camp instructor with Three Rivers AHEC. The event was the brainchild of Angela Smith, Director of the Career Placement Center at the MCCG in Macon. “Wouldn’t it be...”

Sister of victim looks at her brother with concern.
neat to stage a mock disaster to let the students see what really happens?” Angela stated. Cassandra took the idea and turned it into reality. The objective was to make students aware of the various healthcare professionals who would respond in case of a disaster…and that they did.

The student participants were from the Med Vac summer health careers camp sponsored by Three Rivers AHEC with assistance from Mercer University School of Medicine, Bibb County Board of Education, and the Medical Center of Central Georgia. The disaster drill was just one of many activities scheduled for the campers that week. At the conclusion of the drill, students were able to talk with the responders and learn more about their various roles during the disaster. While the students interacted with the responders, the fire chief conducted a debriefing session with representatives from each response team. Observations and notes were made from each team concerning procedures and/or if changes needed to be implemented.

This drill served two purposes. First, the students were able to observe up-close and personal the health professionals responding to a disaster without the element of harm. They saw health professionals in action and in roles that they may never encounter. Second, the drill was an excellent exercise for Macon’s disaster response teams to practice their emergency plans. As the saying goes, practice makes perfect. And as we say, the result of this practice will be future responders.
Community Health Partnership Project: Changing Behavior One Step at a Time

Ansley Mora

Community health workers are trained to educate and monitor cardiovascular disease in an African American community in North Sarasota County.

More than three years ago, the Florida AHEC Network/Florida Border HETC collaborated with the Florida Department of Health to begin a Community Health Worker (CHW) program on cardiovascular disease prevention. A CHW train-the-trainer model was used to train Florida AHEC Network staff, who were then tasked with training local CHWs to venture out and teach others about this important topic. CHW training programs were developed at each of the ten AHECs in Florida.

After attending the train-the-trainer program and completing the planning process, Gulfcoast South Area Health Education Center (GSAHEC) created the Community Health Partnership Project. The Community Health Partnership Project links GSAHEC staff and resources with community partners to identify, train, and build the skills of CHWs in our service area. The CHWs also have the skills and motivation necessary to educate and inspire other individuals in their communities to adopt changes and take better control over their cardiovascular health.

The training model that GSAHEC developed is customized to meet community needs. It includes an overview of cardiovascular disease; the risk factors, prevention strategies, definition of and rationale for CHWs; roles of CHWs; program expectations; community resources and service information; adult learning principles; presentation skills and practice; reporting guidelines; safety issues; evaluation and data collection. Appropriate resources and incentives are identified for each community.

At the same time GSAHEC was looking for partners, Sarasota Memorial Hospital’s Newtown Wellness Program (NWP) was looking for AHEC. The Newtown Wellness Program, funded by a Closing the Gap grant, is designed to prevent premature deaths due to cardiovascular disease among residents of Newtown, a predominantly African American neighborhood in North Sarasota County. Vital statistics in Sarasota County indicate that a disproportionate number of African Americans die of heart disease compared to Caucasians of the same age. One of the goals of the NWP is to promote sustainable behavioral changes by drawing on members of the community to reinforce program objectives, hence, the need for CHWs. Darlene M. Jenkins, MD, Project Coordinator for the NWP, contacted GSAHEC to discuss the potential for partnership. Two and one-half years later, we have forged a true Community Health Partnership with The Newtown Wellness Program.

The vision of the NWP is based on the concept that “health is more than the absence of disease, and includes the full range of quality of life issues.” Partnering with the residents of the Newtown community and working through Task Force members, the NWP provides quality health education and health promotion activities to improve the health and promote the adoption of healthy living habits by all African Americans living in North Sarasota County.

Ansley Mora is the Community Education Coordinator for the Gulfcoast South AHEC, Inc., in Sarasota, Florida.
Community Health Partnership Project

CHWs help by providing health education and reinforcing positive health behaviors to community members who may not otherwise be fully involved.

Since our partnership began with NWP in 2003, we have offered five train-the-trainer programs for CHWs. Many of the initial CHWs trained are still teaching community members about cardiovascular disease prevention. In total, these trained CHWs have provided presentations to 416 community members in the Newtown area. Evaluations and comments from participants show encouraging results. Participants cite specific examples (eat less salt, join the walking club, etc.) of how they will change behavior to lower their risk for cardiovascular disease. The NWP went a step further and trained experienced CHWs on blood pressure screening and delegated a caseload for each CHW to monitor and refer to their health care provider when needed. The dedication and commitment to this effort has been remarkable.

After each CHW training, GSAHEC and NWP staff discuss ways to improve the training, the participation, and the skills of CHWs. Recently we began using seasoned workers to assist in the training of new recruits. We have plans to train CHWs on breast cancer and diabetes awareness in the near future.

Partnership is a key word in this business, and we found an excellent partner with the Newtown Wellness Program. These dedicated CHWs have inspired many others to take the first step.
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Requests for copies of the Bulletin should be directed to NAO Headquarters.
“Outcomes and Impacts: The Successes of AHECs and HETCs”

Since 1972, AHEC programs and centers have been actively pursuing their mission “to enhance access to quality health care, particularly primary care and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships.” Similarly, since 1990, HETC programs have provided “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.” In this Call for Articles, the Editorial Board of the *National AHEC Bulletin* formally invites AHECs and HETCs to come forward and tell their stories of success in achieving measurable outcomes (end results) and impacts (lasting change) in relation to mission.

In times of large-scale systemic upheaval and increasing competition for ever sparser resources, it is imperative that our programs and centers speak louder and clearer than ever before in terms of tangible quantifiable results. Despite the challenges of measuring long-term results of programs addressing complex, multifaceted issues, AHECs and HETCs have succeeded in quantifying successes. It’s time to highlight those wins.

The *National AHEC Bulletin* requests outcome/impact-oriented articles that focus upon initiatives with established track records of enhancement, improvements and/or expansion in:

- Developing healthcare personnel, especially primary care providers, serving in underserved areas
- Impacting the career choices of health science students
- Improving quality and enhancing the professional environment for practice
- Strengthening service resources in rural and other underserved areas
- Expanding access to current health information resources
- Increasing the number of underrepresented minorities successfully completing healthcare training programs
- Reducing border health disparities and/or cultural barriers to equitable care.

**First Draft Submission Due: Feb 15, 2006**

Email articles to: editor@nationalahec.org

Questions? Ken Oakley 585-344-1022 koakley@r-ahec.org or Sally Henry 970-330-3608 shenry@cahec.org

**Special Section Addendum:**

Were you “on the ground” after Hurricanes Katrina, Rita or Wilma? Please describe your emergency responses—immediate impacts!
The National AHEC Organization Mission

NAO is the national organization that supports and advances the AHEC/HETC network in improving the health of individuals and communities by transforming health care through education.

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. Border HETCs target healthcare 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.

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