Oral Health, Mental Health, and Geriatrics: The Growing Challenges
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Training for What’s Ahead

Joel E. Davidson, MA, MPA, and Tina Fields, PhD, MPH

With luck, we’ll all be old one day. And for those of us fortunate to have health insurance for and access to oral and mental health services, many of us will reach old age without having to worry about how and where we’ll get those services, when and if they’re needed. But for millions of Americans, that just isn’t the case. Oral and mental health services already are in short supply in many areas of our nation, as witnessed by the 3,440 Dental HPSAs and the 2,374 Mental Health HPSAs, and the demand is growing. Clearly, the oral health and mental health workforce has not kept up with the increasing demand for services.

At the same time there is increasing demand for oral and mental health services, America is rapidly aging. In 2003, the number of Americans age 65 and above was estimated at nearly 36 million people. And it is expected to grow to 72 million, or almost 20% of the population by 2030. This is going to require a health care workforce that better understands the dynamics of aging and receives training specific to an increasingly elderly population.

This issue of the National AHEC Bulletin explores these three health care areas by examining the current and projected needs each one has, and showing how AHECs and HETCs are reaching out and working in their communities and with academic institutions to begin addressing these rapidly growing areas.

Howard Bailit, DMD, PhD and Tryfon Beazoglou, PhD in their lead article for the Oral Health section raise important concerns about access disparities to oral health care faced by low-income, rural, and minority populations, despite their contention that the oral health of Americans has never been better. They recognize the important role that our programs can play in assisting dental schools in organizing community clinic rotations for dental students and assisting clinics with staff training, recruitment, and implementing best delivery practices. The articles that follow show how AHECs have developed innovative programs and partnerships with communities and academic centers, often serving as the lead organization, in bringing much-needed oral health care services to the underserved while providing valuable training and experience for students enrolled not only in oral health programs, but in others, as well.

The Mental Health section gives us a moving first-person account of the devastation that untreated mental illness can have on individuals and families. U.S. Senator Gordon Smith (R-OR) relates his son Garrett’s battle with mental illness and his ultimate suicide. His family’s experience has led Senator Smith to champion mental health efforts at the federal level and he notes several important pieces of legislation promoting the development of statewide suicide early-intervention and prevention programs, and providing equity in provider reimbursement for mental health services for providers and health care facilities. He encourages us to

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The National AHEC Organization supports and advances the Area Health Education Centers/Health Education and Training Centers (AHEC/HETC) network in improving the health of individuals and communities by transforming health care through education. The National AHEC Bulletin is published semi-annually by NAO.
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partner with our respective state's agencies to help provide education and awareness through our networks and to assist with training health professions students and faculty. Following Senator Smith’s article, Dennis Mohatt and Mimi B. McFaul raise the call for a fundamental transformation of public behavioral health systems by addressing the multiple aspects of workforce development. Focusing on rural and frontier areas, they paint a sobering picture of the workforce challenges ahead. They discuss seven goals that respond to the workforce needs by broadening the definition of workforce, strengthening it, and developing workforce support structures. Two articles complete this section. The first one shows how an AHEC took the lead in integrating mental health services into twelve nonprofit primary care clinics in North Carolina. The second one shows how an AHEC-sponsored social work internship at community health centers in New York City has become a tool to retain social work graduates to work in underserved neighborhoods.

The Geriatric section leads off with an article by Elyse A. Perweiler, MPP, RN, and Thomas A. Cavalieri, DO, that puts into perspective the impacts that our rapidly growing 65-plus age population will have on our society and challenges us to be more creative to meet the increasing healthcare demands of the elderly as federal resources for training and education shrink. They clearly see an important role for our programs and call on our responsibility as healthcare professionals and educators to ensure that healthcare providers are trained to address the complex special needs of the elderly. The articles that follow demonstrate creative approaches to training health professions students and professionals in caring for the elderly and how the elderly themselves help in the education process, and show the importance of collaborating with others to accomplish more than we can do alone.

Two last thoughts are in order here: First, we want to thank everyone who submitted an article to the NAO Editorial Board for consideration. We called and you responded. It is gratifying to receive and exciting to read all those articles about programs addressing the challenges that this issue focuses on. Second, the Editorial Board wants to remind everyone that we welcome your comments about any of the articles, editorials, or other information in this or any edition of the National AHEC Bulletin. If you have a comment, you may send it 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.

“Many thanks” from the AHEC/HETC Network

A long-time leader of the AHEC/HETC movement, Mike Byrne, retired during 2006, and this transition warrants a special “thank you” from the National AHEC Organization. Though involved with the AHEC program from its inception, Mike’s AHEC work began in earnest in 1984 at the University of Louisville and he has remained actively involved ever since – particularly through his highly effective leadership in AHEC’s national legislative agenda and the authorization process. Thank you, Mike, for your uniring efforts and effective leadership. Your accomplishments within your own highly successful and respected AHEC and HETC Programs and with the national program continue to inspire your colleagues and give us a legacy on which to build.
The Supply of Dental Services: What Are the Issues?

Howard Bailit, DMD, PhD, and Tryfon Beazoglou, PhD

Although substantially more oral health providers and services are anticipated by 2020, it may not address oral health disparities and access to care issues.

The oral health of the American people has never been better, and race- and income-based oral health disparities have declined dramatically in the past 35 years. These health status improvements are the result of community-level prevention programs (e.g., water fluoridation, more effective dental treatments including sealants, and better personal behaviors). Still, large access disparities continue, and most untreated dental disease is seen in low-income, rural, and minority populations. These disparities received national attention in the Surgeon General’s report (2000), The Oral Health of the Nation.1

Supply of Dental Services

The supply of personal dental services for the general population is influenced primarily by the number and productivity of dentists. There are approximately 150,000 dentists now delivering care to the United States population2 and 4,650 dental graduates enter the workforce each year.3 Relative to the growth of the population, the number of dentists will decline about 6% between 2000 and 2015.4 This decline is the result of a 34% reduction in the number of dental school graduates that occurred between 1982 and 1993, when seven dental schools closed and many reduced their class size.4

Longer term, there is going to be a large increase in the number of dental schools and dentists. Since 2000, three new dental schools have opened and at least four more are in development. In about 10 to 15 years, the number of dental school graduates is likely to increase to 5,500-6,000 per year. This may be a low estimate, since additional schools are likely to open as nontraditional private universities see financial opportunities in starting dental schools with large classes, charging high tuition, and having low per-student educational costs. By 2020, the number of dentists will grow faster than the population, increasing the dentist-to-population ratio.

Another possible source of new dentists is foreign dental graduates. Almost all states require foreign graduates to enroll in a U.S. dental school for at least two years and obtain an American dental degree to be eligible to take state or regional licensing examinations. As a result, there are relatively few foreign-trained dentists with U.S. dental degrees in the dental workforce. This situation could easily change if states allowed foreign dental graduates who complete residency programs in the United States to take the licensing examination as they do foreign medical school graduates. This issue is of great concern to organized dentistry, especially in states such as California, where Hispanics make up a significant and growing percentage (i.e., 25-30%) of the state’s population. In response to access complaints from their Hispanic constituents, legislators have proposed that Mexican-trained dentists (dentists trained in Mexico who do not have a U.S. degree or U.S. license) be allowed to work in public clinics. This legislation was enacted but was never implemented. The issue of foreign-trained dental graduates is far from resolved, however. As the political power of Hispanics and other ethnic groups with many under served constituents increases in state legislatures, it is likely that some arrangements will be made to allow more foreign-trained dentists to practice in the United States.

Another supply-side issue is the changing gender of dentists. By 2020, about 30% of dentists will be female.5 Although female dentists are equally as productive as male dentists when treating patients, they spend about 15% less time in the workforce over their careers than male dentists. This will result in a decrease in the number of retired dentists by 2020, which will increase the number of patients in need of care.6

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The Supply of Dental Services: What Are the Issues?

professional lifetimes, because more work part-
time (30% female vs. 15% male). Thus, to
maintain the supply of dental services, larger
numbers of dentists are needed to offset the
increasing number of part-time dentists.

Productivity
The productivity of dentists is increasing at the
rate of about 1.3% a year. Dentists are able to
provide more services per unit time because
they are using more space (dental operatories),
employing more administrative and allied dental
health personnel, and expanding the duties of
dental hygienists and dental assistants.

Dental hygienists are an
important source of practice
productivity. About 70% of
solo general dentists employ
one or more full- or part-time
hygienists. In many states,
ygienists can treat patients
without practice owners
being present, as long as they
follow dentist-prepared
treatment plans. This is called indirect
supervision, and hygienists can see patients
even when the dentist is not in the office,
substantially increasing the total patient
capacity of practices.

In a few states, such as Connecticut, hygienists
can work independently (without indirect
supervision) in public facilities, providing care
usually to low-income patients and billing
public insurers and patients for their services.
In one state, Colorado, hygienists can open
independent private practices and compete with
private dentists. Although the data are limited,
few hygienists are working independently in
public facilities or in their own private practices.

Practice productivity also increases with the
employment of more dental assistants and the
expansion of their clinical duties. Ninety
percent of solo general dentists now employ
one or more dental assistants, and in many
states, the clinical duties of these assistants are
being expanded.

Recently, a new type of dental allied health
worker, the dental therapist, has begun
providing care to Alaskan natives. Therapists
are modeled after the New Zealand dental
nurse and are trained in a two-year program to
provide dental care to children, including filling
and extracting teeth. In Alaska, they are often
located in small, remote villages, where they are
in telephone contact with supervising dentists.
The American Dental Association has opposed
the use of dental therapists politically and
legally, arguing that they are inadequately
trained to provide irreversible procedures (e.g.,
filling teeth) and that the state dental practice
act in Alaska does not permit anyone but
dentists to provide these services. Alaskan
natives argue that dental therapists now
provide services in some 40-plus countries and
have proven records of effectiveness and safety.
They also argue that state dental practice acts
do not apply to them because tribal lands are
sovereign nations. At this time it appears that
the Alaskan natives are going to prevail and
that dental therapists will become part of the
dental workforce on tribal lands in Alaska and
probably other states which have tribal lands.

It is difficult to precisely estimate the effect of all
these changes taking place in the dental delivery
system on the supply of dental services. As a best
guess, the supply of dental services will increase
slowly until 2015 and then increase dramatically
from 2020 to 2030. The major drivers for the
greater supply will be more U.S. and possibly
foreign-trained dentists and large gains in
dentist productivity resulting from the more
effective use of allied dental personnel.

Supply of Dentists and Access Disparities
There is a common belief that the production of
more dentists will result in greater access to
dental care by underserved patients. Suppos-
edly, a greater supply of dentists will reduce the
rate of increase in dental fees, making care
more affordable. While the rate of increase in
fees will diminish with more price competition,
it will have a limited effect on access to care for
the underserved.

Even with somewhat lower fee increases, most
low-income patients will not be able to afford
dental services from private practitioners. In
the average general practice, 60% or more of
monies generated from patient care cover
overhead expenses. Dentists can lower their
fees only so much before they start losing

Relative to the growth of
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about six percent between
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An increase in the supply of dentists will make dental care more affordable for large numbers of middle-income families that have resources to purchase services from private practitioners. Thus, a greater supply of services does benefit some population groups.

AHEC Programs

AHEC programs have the opportunity to significantly increase access to dental care in at least two ways. First, more dental schools are sending senior students and general and pediatric dentistry residents to community clinics caring for the underserved. Students are much more productive in these settings than in traditional dental school clinics because community clinics are real delivery systems. If all 56 dental schools had students and residents spend four or five months in community clinics and practices, over one million patients would receive care.

AHEC programs have the background and experience to assist schools in this effort, especially in rural areas. Most dental schools are reluctant to send students, because of the transportation, housing, and other problems associated with rural externships. In North Carolina, the AHEC program has worked with the health professions schools at the University of North Carolina Chapel Hill to organize and manage community rotations. In addition to providing care to the underserved, students and residents learn about career opportunities in community clinics, and a small but significant percentage spend time in these settings after completing their clinical training. Likewise, evidence suggests that clinic providers appreciate having the opportunity to interact with students and residents, and this may reduce staff turnover.

Another opportunity is for AHEC programs to partner with dental schools to support community clinics. This includes assisting clinics with staff training and recruitment and specialty and management consulting services. A recent study reported that community clinics are only half as productive as private dentists.

...there are relatively few foreign trained dentists with U.S. dental degrees in the dental workforce.
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The primary reason is that community clinic dentists use fewer operatories and allied health personnel per dentist. Many clinics could substantially increase the number of services provided if they followed the best delivery practices. AHEC programs need to bring dental schools, community clinics, organized dentistry, and possibly other partners together to address the productivity problems of most community clinics.

In conclusion, for the next several years the supply of dental services will increase slowly, and some middle income families, especially those living in rural areas, may have more dental access problems. Longer term, the supply of dental services will increase substantially, as more dentists enter the workforce and use allied dental personnel more effectively. The greater supply of dental services will have limited impact on increasing access to care for underserved and disadvantaged populations. The basic problem for most underserved patients, including those enrolled in Medicaid, is the lack of purchasing power to pay for dental services. With medical-care cost increases running at two or three times the general inflation rate, few states or the federal government have the resources to significantly increase public support for dental Medicaid programs or safety-net clinics. AHEC programs have an important role to play in assisting dental schools to organize community clinic rotations for senior students and residents and developing partnerships with community clinics to help the clinics operate more efficiently. These interventions will not solve the access disparity problem, but they will make an important and positive contribution.

References


Improving Access to Oral Health Care in Missouri Through AHEC Rotations

Bonnie Branson, RDH, PhD, and Stephanie Taylor, BS

In her 2001 study, Branson found that only 10 AHEC programs indicated a partnership with educational institutions to provide an oral health component in the AHEC experience, and the majority of these experiences utilized dental hygiene students to provide the oral health services. Based on this insight, faculty at the University of Missouri–Kansas City (UMKC) School of Dentistry began exploring and developing options for academic service-learning experiences. Working with Missouri’s regional AHEC offices, UMKC dental hygiene students have been placed at Federally Qualified Health Centers (FQHCs). The AHEC rotations are part of a unique service-learning experience, now in its third year of operation, and have proven to be a positive experience for all involved.

For two weeks in the summer, dental hygiene students participate in rotations to rural and underserved areas in the state of Missouri. These rotations give students an opportunity to experience dentistry away from the confines of a dental school setting. Students rotate to FQHC dental clinics throughout Missouri. Seven regions are visited by dental hygiene students, allowing for oral health services in all geographic areas of the state. Dentists and dental hygienists at the FQHC clinics provide supervision while the dental hygiene students render routine dental hygiene treatment including head-neck and oral exams, exposing dental radiographs, treatment planning, oral hygiene education, scaling and root planning, and community education programs. In addition to treatment at the FQHCs, the dental hygiene students provide community dental education programs for groups from day care centers, summer camps, and senior centers; they also develop and present adult education. These experiences create an opportunity for students to interact with a population that may never be seen in the traditional dental office setting. Students become more aware of the diversity of our population and the role of public health as demonstrated by comments such as, “I never really knew how many poverty-stricken people there are out there,” and “I finally understood what public health is.”

Student Feedback

Comments made by dental hygiene students after completing summer AHEC rotations in 2004 and 2005 include “I really had an awesome experience,” and “It made me feel as if I chose the correct profession.” One student commented, “I learned what it is like to work alongside a dentist in a real clinic setting,” and “It was great to know I could have a professional opinion.” Comments such as these confirm that the mission of AHEC is being met.
Improving Access to Oral Health Care in Missouri Through AHEC Rotations

The program’s objectives focus on students’ familiarity with 1) the similarities and differences between private practice and public health clinics; 2) assessing, planning, implementing, and evaluating an oral health education program; 3) working with a diverse population; and 4) understanding the ethics of delivering health care to a whole community versus individual patients. Additionally, the rotations seek to continue to develop the students’ clinical skills under supervised instruction.

The rotation objectives are evaluated using various measurements, including student journals, task records and post-program surveys. Results from the 2004 and 2005 student surveys indicate that objectives for the program have been met. This feedback can be seen in the results from an 11-question survey displayed in Table 1.

Most notable were the responses to statement number two, which addressed population diversity (objective number three). The response averages for this statement, which asked the students to rate their feelings regarding “I became more aware of the needs of underserved populations through this experience,” for 2004 and 2005 were 1.19 and 1.17 (out of a possible 1 for Strongly Agree).

Table 1. Student feedback for summer AHEC rotations.

<table>
<thead>
<tr>
<th>Post-Program Student Survey Statements</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participation in the rotation helped me to better understand material from lectures and readings.</td>
<td>3.1</td>
<td>2.39</td>
</tr>
<tr>
<td>2. I became more aware of the needs of underserved populations through this experience.</td>
<td>1.19</td>
<td>1.17</td>
</tr>
<tr>
<td>3. I could have learned more by spending more time in the clinic or classroom than in a community experience such as this.</td>
<td>3.3</td>
<td>4.13</td>
</tr>
<tr>
<td>4. My fears/apprehensions were eased by the AHEC and clinic personnel.</td>
<td>2.6</td>
<td>2.13</td>
</tr>
<tr>
<td>5. I learned more than I expected I would.</td>
<td>2.5</td>
<td>2.26</td>
</tr>
<tr>
<td>6. This rotation helped me to build confidence in my clinical skills.</td>
<td>2.5</td>
<td>1.78</td>
</tr>
<tr>
<td>7. This rotation helped me to define my personal strengths and weaknesses.</td>
<td>2.6</td>
<td>2.22</td>
</tr>
<tr>
<td>8. Working at the FQHC helped me to see the importance of the dental hygienist as a member of the dental team in community settings.</td>
<td>2.7</td>
<td>1.26</td>
</tr>
<tr>
<td>9. This rotation helped me to understand my role in total patient care.</td>
<td>2.7</td>
<td>1.65</td>
</tr>
<tr>
<td>10. The AHEC rotation experience made me more aware of my own biases and prejudices.</td>
<td>2.8</td>
<td>2.3</td>
</tr>
<tr>
<td>11. The AHEC rotation made me see employment in a rural setting as an option for me in the future.</td>
<td>3.6</td>
<td>2.6</td>
</tr>
</tbody>
</table>
**Improving Access to Oral Health Care in Missouri Through AHEC Rotations**

Also notable was the fact that the students in the 2004 rotations responded with a neutral opinion (3.6-no opinion) to the statement “The AHEC rotation made me see employment in a rural setting as an option for me in the future.” This response raises the question whether the opportunities for dental hygiene employment were thoroughly emphasized to the students. The rotation group from 2005 shows improvement in this area.

Other outcomes include the amount of care provided to the residents of Missouri and the placement of graduates in rural and public health settings. It is estimated that $45,000 worth of dental hygiene time and $90,000 worth of dental hygiene services were provided each summer the program has been in operation. Additionally, four graduates have been employed at FQHCs and two have joined the public health service as a result of the program.

**Recommendations**

As with any new program, suggestions for improvement have been made that include reorganization of paperwork and requests for earlier and more frequent communication with all persons involved. These suggestions have been addressed with each new set of student rotations.

Changes include strategies aimed at opening lines of communication and making the individuals involved in the experience feel more connected to one another. This included the development of a computer-based site to house all forms and information related to the rotation (Blackboard platform). This site was made accessible to all students, faculty, and AHEC coordinators. Also, an on-line (Centra-One Platform) symposium was held in the spring of 2005 with the AHEC coordinators to discuss issues for the next rotation. In the spring of 2006 phone conferences were held for students and AHEC coordinators to converse before the actual rotation. Revisions in the distribution of paperwork included sending student profiles to the AHEC coordinators via hard copy and electronically. These profiles now include a student photo and biographical information to create a more personal connection.

**Ongoing Support**

To support learning and a community connection, students complete a community profile and research report to create a stronger correlation to public health and the oral health objectives in Healthy People 2010. These papers are part of the graded didactic instruction the students receive in the Principles of Public Health course.

In addition, division-wide support of the faculty is an important component of the rotations. In order to foster faculty involvement, faculty members visit the students while on rotation to provide oversight. These visits enhance faculty support for the program. Moreover, the success of the summer rotation is dependent on the faculty’s ability to understand and support these activities. For this reason, the dental hygiene faculty travel to the rotation sites to provide oversight and also to serve in a consultation capacity to the FQHC staff. By going to the remote sites, faculty are able to address student questions in the setting where the issue arises and to incorporate these scenarios into subsequent lectures in the public health course.

In summary, this program represents a win-win situation for UMKC dental hygiene students and individuals requiring oral health care in underserved areas of Missouri. The rewards are enormous for both the dental hygiene students and the FQHC patients. AHECs that currently are not working with dental hygiene students should be encouraged to develop meaningful partnerships to provide a foundation for future collaboration.

**Reference**

Oral Health

Innovative Service Learning Models: The Use of AHEC Partnerships to Increase Oral Health Access in Rural Mississippi

Stephen L. Silberman, DMD, MPH, DrPH; Neal Demby, DMD, MPH; Susan L. Dietrich, DMD; and Sandra Hayes, MCS, MPH

A plan is in place to address the dental shortage in Mississippi by developing a partnership between the MS AHEC, University of Mississippi School of Dentistry, and the Lutheran Medical Center of Brooklyn, New York. Although the program is just being initiated, the authors believe that future data will demonstrate the effectiveness of the program.

Maintaining an adequate oral health workforce in Mississippi has been a challenge for many years despite the state legislature’s establishing a dental school that accepted its first class in 1975. Even with the increased number of dentists educated within the state, the workforce has not been able to keep up with growth of the population; hence, the need for oral healthcare providers has increased, most notably in rural areas. Mississippi is a rural state with only 20% of its citizens living in cities with a population greater than 20,000 and 53% living in areas classified as rural. This sparseness of the population is one of the major factors in the geographic maldistribution of healthcare providers.

Efforts to increase access and promotion of quality oral health care have created a partnership that includes the Lutheran Medical Center of Brooklyn, New York, the University of Mississippi Medical Center (UMMC) School of Dentistry, and the MS AHEC. The program that developed is an attempt to address the critical oral health workforce shortage in Mississippi. This program could be used by AHECs as a model for similar programs. This article describes the development of the program; a future article will report on results of the implementation.

The Lutheran Medical Center (LMC) is the educational sponsor of four dental residency training programs which are accredited by the American Dental Association Commission on Dental Accreditation. For almost three decades, LMC has forged partnerships with CHCs throughout the country as a strategy to increase access to care by placement of full-time residents in extramural practice settings for one or two years of advanced clinical training. This is consistent with the mission of LMC in its role as an institution without walls - to increase access and assure equity in oral health care for community residents. The LMC Department of Dental Medicine has been training dental residents since 1974. Currently, the geographic areas of clinical training sites include Alaska, Arizona, Metropolitan New York City, Upstate New York, Hawaii, Maryland, Massachusetts, Michigan, Mississippi, New Mexico, Rhode Island, and Tennessee.

In order to assure access and equity in this educational model, the LMC Department of Dental Medicine established an innovative distance learning curriculum. Approximately 130 hours of synchronous didactic education is provided via live video teleconferencing on a weekly basis, and asynchronous methodologies such as online literature reviews occur via online discussion forums/threads. Over one year of training a general dentistry resident will provide approximately 1,500 patient visits, and the LMC Dental Residency Network of residents provided over 100,000 patient visits in 2004. These data demonstrate that dental residents are an alternative resource to address workforce shortages in CHCs that result in increased access to oral health care to the most vulnerable populations.

The perspective of the CHC dental directors on implementing a service-learning environment with the LMC has been positive as demonstrated by the results of a comprehensive 2005 survey of CHC dental directors who supervise and mentor LMC dental residents. Furthermore, when surveyed about the impact of the residency training program on increasing access to oral health care and the impact of the residency on recruitment and retention, 80% of the dental
Innovative Service Learning Models

directors indicated that the involvement in the residency program assisted in improving access to oral health care at the health center, and 71% of the dental directors indicated the residency assisted in improving the recruitment and retention issues for the health center.

Similarly, a 2005 alumni study examined a longitudinal cohort of all general dentistry graduates of LMC’s General Practice Residency and Advanced Education in General Dentistry (AEGD) residency programs. Data suggest that residents who train in underserved areas develop future practice patterns and a commitment to caring for and integrating underserved populations within these areas. In addition, the graduates treat more complex cases, tend to use specialty referrals less frequently, and provide an access portal for oral health services to the underserved.

Program Plan

For this program to work it was necessary to find a CHC that would provide a good model for the future development of other AEGD residency programs in Mississippi. In order to enlist the pilot CHC, the Mississippi AHEC presented the LMC program to CHC directors at the Mississippi Primary Health Care Association annual meeting. As a result, the Greater Meridian Health Clinic (GMHC) was a strong advocate and requested that it be considered as the pilot. It was the first to step forward among six interested sites and among the most eager to participate. However, it was the combination of the rural sites served by this urban program and its existing affiliation with the School of Dentistry’s public health rotation for predoctoral students that made this the ideal model site.

The Greater Meridian Health Clinic operates three dental facilities and one mobile unit. Two of the sites are in rural locations while one is located in a small town. Two of the GMHC dentists have completed advanced training in general dentistry at the University of Mississippi and a third is a graduate of the dental program. Based on data obtained in July 2006, GMHC serves approximately 15,252 people per month. Of that number, about 15%, or 2,304, receive dental services. The patient population consists mainly of minority patients and persons considered disadvantaged. Approximately 27%, or 4,143, are covered by some form of insurance.

Prior to contact with the Mississippi Primary Health Care Association, there were a number of meetings between the AHEC Director and the School of Dentistry (SOD) to describe the program, address concerns, and prepare affiliation agreements. From beginning to end, this process took about one year. It is important to note that we employed the rules and regulations of the State Dental Board and were able to move forward without any input from local dental societies because the SOD is affiliated with the program and the CHC staff holds faculty appointments.

The initial recruitment of graduating dentists was not as successful as hoped, primarily due to the late startup. However, since the LMC model has a rotating start date, it is still possible to enroll recent graduates at a later time. We expect to recruit two graduates for next year’s program due to a more concrete marketing plan. The future looks bright for bringing AEGD programs to rural areas, and plans are under way to develop another dental residency program as soon as the first residents are accepted into the program. Since many of the CHCs have only a single dentist on staff, they would not be able to host an AEGD dental site. However, by combining multiple small clinics and having the dental residents rotate among the sites, we will be able to bring more AEGD programs to the rural areas of Mississippi.

Expected outcomes of this program include an increase in workforce recruitment and retention into rural areas and an increase in access to dental care. We project that when this program and future programs at other CHCs are functioning, there will be at least five residents at any one time providing dental service in the rural clinic sites. This would translate to about 7,500 visits annually. In addition, these programs will provide educational opportunities for practitioners, residents, and staff through the distance learning portion of the LMC AEGD program. Patients will also benefit through this process when special dental health education topics are offered.

In summary, this article presents a plan that will be implemented in the near future. The program is designed to reflect the mission of the University of Mississippi Medical Center, respond to contemporary health policy, and establish a model that will break traditional and geographic boundaries. The Mississippi AHEC will continue to expand this program to include new AEGD programs at other CHCs.
Northeast Indiana AHEC Dental Clinic Provides Service Learning Opportunities for Dental Hygiene Students

Nancy K. Mann, RDH, MSEd

The Indiana University-Purdue University Fort Wayne School of Health Sciences (IPFW) in collaboration with the Indiana University School of Medicine established the Northeast Indiana Area Health Education Center (NEI-AHEC) in October 2005. Located in Fort Wayne, NEI-AHEC works with community partners in health care and public health, K-12, and postsecondary education to increase exposure to health careers among disadvantaged and underrepresented minority youth and to provide community-based clinical education opportunities for students enrolled in health care education programs.

One example of NEI-AHEC’s community collaboration is the monthly Allen County Health Disparity Coalition’s Prevention Clinic that began in January of 2006. Screening services at the clinic include weight, blood pressure, blood glucose, cancer, cholesterol, HIV, oral, and others. Oral health exams are conducted by IPFW dental hygiene students and faculty in a room equipped by contributions from the local dental society. Dental screenings are vitally important due to the mouth-body connection since oral diseases can affect health and well-being throughout life.

The IPFW dental hygiene students assist the NEI-AHEC in reaching three strategic goals: 1) Enhancing the curriculums of health care provider students by offering ‘hands-on’ learning experiences; 2) Promoting access by all citizens in the area to quality health and dental care; and 3) Working with underrepresented populations to provide dental screening, case management, health education, and referral via service learning and collaborations with area health care providers.

Results of the screenings reveal a great need for increased access to dental care in urban Fort Wayne despite two free or reduced-cost clinics in the city. The population living immediately around NEI-AHEC has not traditionally sought dental care at the other two sites for reasons including long waiting lines in the walk-in clinic and a six-month waiting list at the other clinic. The dental screenings conducted by the IPFW students and faculty demonstrated that the population residing near the clinic was willing to come for dental care and that the population had a critical need for services.

To meet the identified need and provide learning opportunities for dental hygiene and dental assistant students, IPFW sought additional resources to equip two dental rooms in the NEI-AHEC site. With equipment valued at $30,000 generously donated by dentists throughout the northeast region who were either remodeling their offices or retiring from practice, IPFW was able to equip two dental exam rooms and a processing lab. The equipment included dental chairs with pole-mounted lights, four stools, tray stands, two X-ray machines, an automatic film processor, an air compressor for air and suction, and an autoclave. Further donations of ultrasonic scalers
Northeast Indiana AHEC Dental Clinic Provides Service Learning Opportunities for Dental Hygiene Students

provide students with the opportunity to treat patients and perform assessments, therapeutic and preventive services, education, and referral. The dental clinic opened on October 2, 2006, and is run by IPFW Dental Education Department staff and faculty.

One student noted, “The dental screenings were an eye-opening experience. This was the first time that I actually saw an abnormal mouth, besides pictures. These people were so thankful for what we were doing. It was just a great feeling helping out our community. I think the site is a great location. It gives us the opportunity to go to the community instead of them coming to us. I think this is going to be a great learning facility.”

At the same time students are gaining valuable experience in the clinic, they are also educating patients of all ages through the dental public health class at IPFW. In the Community Dental Hygiene course, the students observe specific target populations and design a custom program for that group based on needs. Within a class, the dental hygiene students serve 10 varying target groups based on a needs assessment. For instance, since dental jewelry for the mouth (“grills”) is popular among urban Hispanic and African-American middle and high school-aged students, the dental hygiene students investigated and presented information that taught proper care for teeth and cautioned against ill-fitting mouth jewelry. The students had to demonstrate cultural sensitivity for hip hop, the genre of origin for mouth grills, and remain nonjudgmental, while at the same time providing an important health message for the middle schoolers.

In other community rotations, students visited third-grade classrooms, Head Starts, and local Amish parochial schools with appropriate messages on oral health. At the end of spring semester 2006, the class had presented oral health information to 5,000 individuals and distributed toothbrushes and toothpaste to all audiences. The largest groups to receive the message were third graders and sixth graders. Tobacco prevention information was included in every presentation as everyone can benefit from that message.

The current class of IPFW dental hygiene students is assessing oral health needs of pregnant women in a prenatal class, youth in a detention center, children at an orphanage, and residents at nursing homes. This project has opened students’ eyes to the chronic problem of dental disease in low-income populations.

As Indiana attempts to address health care professional shortages, from the inner cities to the rural areas, and to educate citizens about health problems, the NEI-AHEC is proving to be a valuable partner by initiating collaborations between the university and community health care agencies. Starting with oral health issues seems a logical approach. After all, a healthy Indiana needs healthy communities, and the mouth is the right place to begin.
Pregnant women with periodontal disease (PD), a chronic bacterial infection of the mouth characterized by inflammation of the gums, bone loss, and eventual tooth loss, have a 4.3-7.9% higher risk of preterm, low-birth-weight (PLBW) deliveries than women with no evidence of PD.\textsuperscript{1,2,3} While this finding has significant research support, there has traditionally been little attention paid to dental care during the gestational period, especially in underserved communities.\textsuperscript{2}

During the summer of 2006, a team of four students from the University of South Florida Area Health Education Center and Gulfcoast South Area Health Education Center’s Interdisciplinary Community Health Scholars (ICHS) program partnered with the Healthy Start Coalition of Sarasota County, Inc. to assess needs, develop resources, and launch a program to increase awareness of the importance of good oral care for pregnant women and reduce periodontal disease in pregnant women.

The ICHS program is an annual 8-week summer training program for 16 health professions students from the USF Colleges of Medicine, Nursing, Public Health, the School of Social Work, and undergraduate pre-health professions programs. Since 1999, four interdisciplinary teams have worked with medically underserved communities/populations and community partners to 1) develop a better understanding of issues of health care in underserved communities; 2) participate as members of interdisciplinary health care teams; and 3) help local communities develop ideas for improving health. In 2006, Gulfcoast South Area Health Education Center’s Sarasota ICHS team of two social work students, one public health student, and one medical student worked under the guidance of the Healthy Start Coalition’s Contract/Quality Manager, Jennifer Highland, MPH, RN, to 1) assess the availability of oral health care for pregnant women in Sarasota County; 2) determine the level of unmet need for oral healthcare education of expectant mothers and women of childbearing age; and 3) develop instructional materials to educate the community on pregnancy and oral health.

The ICHS team undertook an evaluation of the quality and quantity of oral health care resources for low-income, pregnant women in Sarasota County by incorporating the Asset Based Community Development (ABCD) Model. ABCD is a community-driven development tool, as opposed to one developed through external agencies. It evaluates existing community structures and queries providers to determine the assets of the community and then utilizes these assets for development within that community. The ICHS team identified the Sarasota County Health Department (SCHD) as the primary dental care provider in Sarasota County that accepts Medicaid patients. The team then interviewed both healthcare professionals and expectant mothers visiting the Sarasota County Health Department about oral health and pregnancy.
USF Interdisciplinary Community Health Scholars
Focus on Dental Needs in Sarasota, Florida

The survey for expectant mothers and women of childbearing age was administered in both English and Spanish by two of the ICHS students at the Sarasota County Health Department’s obstetrics/gynecology waiting room and in the Healthy Start waiting room.

A total of 34 women were interviewed between the ages of 20 and 36 with a median age of 23 years: 14.7% of the women were African American, 29.4% were Hispanic, and 55.9% were Caucasian. The women were asked a range of questions concerning their beliefs about the importance of oral health care while pregnant, their personal oral healthcare habits, the availability of dental care providers, and their means and methods of paying for dental care.

Of the women interviewed, only 26.5% of them believed there was a relationship between oral health and the health of their babies. None of the women interviewed were aware of a possible correlation between periodontal disease and preterm, low-birth-weight infants. However, 59% of the women responded that they considered their overall oral health important but did not visit the dentist regularly because of one of the following factors: cost, lack of dental insurance, and/or a lack of time and opportunity. Thirty-four percent of the women had no dental insurance and 37% of the women had Medicaid, which covers only emergency dental care and dentures for adults but no preventive care. Thus, 73% of the population interviewed were either uninsured or underinsured for preventive dental care.

Of all the women interviewed, an overwhelming 42.4% responded that they visited the dentist only during emergency situations or that they never went to the dentist. Approximately 85% of the women claimed to brush at least twice a day, but of these women, fewer than half reported that they flossed.

Of the eight healthcare providers interviewed, five were providers of obstetric care and three were dental care providers. All of the dental care providers were aware of the importance of good dental hygiene for pregnant women and considered the evidence supporting the relationship between PD and PLBW deliveries to be significant. However, several of the obstetric care providers questioned a correlation between PLBW deliveries and PD. Over half of the obstetric care providers agreed that their patients rarely broached the subject of oral health with them and, while the providers recognized that oral health is important, they did not counsel their patients on its importance to the health of the baby. Both the dental care and the obstetric care providers interviewed also agreed that it was extremely difficult to get appointments at SCHD or find private obstetric or dental care providers in Sarasota County willing to take Medicaid patients. Only 3-4% percent of the SCHD patients are able to schedule an appointment with a periodontal specialist at the Health Department because the waiting list can be over 4 months and an estimated 60-70% of the women seen at SCHD have some degree of PD. The providers at SCHD were also able to identify only one private dental care provider in Sarasota County that accepted Medicaid patients.

The survey results revealed that expectant mothers in Sarasota County were largely unaware of the relationship between oral health and the health of their babies and had not been informed of a possible correlation between periodontal disease and risk for preterm, low-birth-weight infants, and that some medical care providers were unsure of the relationship as well. Using the data gathered from the interview process, the ICHS team created two educational presentations on the importance of good dental hygiene during pregnancy and the possible correlation between PD and PLBW. One presentation was created for healthcare providers and one for women...
of childbearing age. The team used these presentations to educate both the healthcare professionals and expectant mothers in Sarasota County on three important subjects: 1) the importance of proper oral health care in women; 2) the need for healthcare providers to educate pregnant women on the importance of proper dental hygiene; and 3) the need to increase the number of dentists in Sarasota County that accept Medicaid. The first 2 community presentations were given to a total of 48 expectant mothers in the Sarasota County Health Department waiting rooms. The final presentation was given to over 15 health professionals at SCHD. The ICHS team also developed brochures for the coalition to disseminate in waiting rooms and to expectant mothers and a newsletter for the coalition to provide to health professionals. The brochures provide information on good oral health care and its importance to pregnant women and new mothers. The newsletter provides health professionals with statistics on periodontal disease and preterm low-birth-weight infants, barriers Sarasota County women face in accessing dental care, the impact premature births have on Sarasota’s local health care systems, and suggestions for how healthcare professionals can address the issues Sarasota County women face in accessing care and receiving information about the importance of good oral health care.

The Healthy Start Coalition of Sarasota continues to utilize the presentations and the materials the ICHS team developed to educate medical and dental students, healthcare providers, and women of childbearing age on the possible correlations between periodontal disease and preterm, low-birth-weight infants. Thus, the USF AHEC ICHS service learning program for health professions students provides practical experience in working with interdisciplinary teams, establishes a skill set needed for future work with underserved communities, and benefits communities by providing assets and resources not previously available to underserved populations.

References


The Molar Express: Improving Access to Dental Services in Northern New Hampshire

Alice Muh, BS, RN, CCM; Nicole LaPointe, MSW; and Martha McLeod, MOE, RD, LD

The Molar Express mobile dental clinic van is successfully providing preventive, diagnostic and restorative dental services to children in northern New Hampshire, and serves as a training site for dental hygiene and dental assistant students.

The Molar Express is a mobile, public health dental clinic owned and operated by the North Country Health Consortium (NCHC) of Littleton, New Hampshire. The clinic began providing services to northern New Hampshire’s target population of Medicaid-eligible children in the summer of 2005. The Molar Express is based on a model developed in North Carolina. A customized truck transports two complete dental operatories, consisting of high-quality equipment adapted to be easily portable, to North Country (Northern Grafton and Coos counties) locations such as government offices, schools, and health centers. The equipment is then unloaded at the designated site and the clinic is set up. A full range of preventive, diagnostic, and restorative dental services is provided. Although the services are primarily for children, adults eligible for the Molar Express sliding-fee scale are also seen as time allows.

Access to Dental Health Care
Challenges to access to care [in rural areas] include lack of dentists, inadequate supply of dentists who accept Medicaid or other discounted fee schedules ... and socioeconomic nature of rural populations (poverty, low educational attainment, cultural differences, lack of transportation) ... Low income children have two times greater prevalence of dental caries when compared to other children. This describes the current situation in New Hampshire’s North Country. Fewer than 20 dentists serve the area and many of them do not accept Medicaid. This scarcity of oral health providers translates into substantial barriers to oral health care, even for those families that have private dental insurance. Many of the over 4,000 North Country children who are Medicaid eligible have never seen a dentist and are suffering the consequences by displaying poor oral health and poor overall physical health. Moreover, socioeconomic data for the region reflect an adult population suffering from tooth loss at a rate approaching 50% higher than the state average.

The consortium’s 2,500 square mile northern New Hampshire service area is designated as a Medically Underserved Area (MUA), a Health Professional Shortage Area (HPSA), and a Dental Health PSA (DHPSA) by the Health Resources and Service Administration (HRSA). The population density of the North Country is 75% lower per square mile than the state average. According to recent census data, almost 31% of North Country residents live below 200% of the federal poverty level compared with 19% statewide; nearly 29% of children in the North Country are Medicaid eligible compared to 18% statewide.

Role of the Northern NH AHEC
The Northern New Hampshire AHEC (NNH AHEC) is a program of the North Country Health Consortium (NCHC) and serves health and human service organizations and educational institutions in New Hampshire’s rural northern tier. It provides continuing education for health professionals, health literacy awareness and training, support for health professions students and preceptors, and health awareness programs. In addition, the NNH AHEC serves as the convener of rural health working groups that seek collaborative solutions for addressing healthcare disparities in New Hampshire’s North Country. Northern NH AHEC provided funds and expertise to bring the health providers together for strategic planning around regional health needs and solutions. The group developed a list of key health issues that had potential for regional solutions, including access to oral health services.
The Molar Express: Improving Access to Dental Services in Northern New Hampshire

Conception to Implementation
In 2001 a North Country Oral Health Working Group, made up of task forces from three community coalitions, was convened by NNH AHEC. Its purpose was to look at how the oral health needs of the population might be met using a regional approach. NNH AHEC staff submitted an Endowment for Health Theme Grant, on behalf of the group that would fund current planning and explore what was needed to set up a mobile service using the North Carolina Access Dental Model. A mobile model was chosen due to the lack of public transportation. The endowment was unable to fund the group but encouraged it to apply for strategic planning and needs assessment funding. NCHC submitted a Strategic Planning Grant to the endowment in 2002 to conduct a needs assessment for the target population and to plan the mobile model. After conducting community forums to assess priorities, the endowment set about developing a statewide oral health plan that was eventually published in October 2004. In March 2004, NCHC submitted a theme grant that was awarded three years of funding for the Molar Express. In addition to the Endowment for Health grant, funding was also received from New Hampshire's Medicaid program, the Cogswell Trust, Delta Dental, and North Country Hospitals FLEX funds. The result of several years of research, planning, and grant seeking is the Molar Express, a regional mobile oral health clinic model providing dental care to the underserved population of northern New Hampshire.

When plans for the Molar Express were being developed, patient education was considered a critical component of the services to be provided. Critical to the success of the Molar Express is the strengthening of public understanding of the meaning of oral health and the relationship of a healthy mouth to a healthy body. Therefore, education and training in oral health care for both consumers and providers is a part of the Molar Express's overall work plan. There are now programs to provide basic information to patients and families.

Northern NH AHEC is providing training for the staff of the Molar Express to present programs for schools and primary care providers to increase awareness and screenings at an earlier age. In a key workforce development area, an internship program with the Molar Express for dental hygienists and dental assistants has been developed with the long-term goal of developing an internship program for dentists as well.

Outcomes
Since the summer of 2005 the Molar Express has seen 550 unduplicated patients—over 90% of whom are children. These patients have received 3,537 dental procedures including oral evaluations, X-rays, prophylactic treatments including fluorides and sealants, fillings, and extractions. Services have been provided in over 15 locations. To date, the Molar Express is averaging eight clinic days per month. The average cost of a clinic is $1,600 per day. Reimbursement for Medicaid patients is 70% of net billed charges. Sliding-fee patients pay 40-60% of the amount billed. Money received through grants has helped offset the costs for this year. Services are provided by contract dentists and dental hygienists, staff dental assistants, and a practice manager. Staffing for each clinic is one dentist, one hygienist, and two dental assistants, who also serve as registrars. The first intern started this fall.

The Molar Express is a work in progress, and the scope of services continues to evolve. In a recent local needs assessment, affordable oral health care remained at the top of the list of unmet healthcare needs. Although the Molar Express has had a positive impact in the region, it is clear that there is a need to increase the average number of clinic days each month and increase services to adults. Medicaid-eligible children have been the primary target because services provided are covered by the state. There is no such coverage for adults. To offset the costs of improving access to care for adults, grant support and creating partnerships have been pursued. Challenges that continue are recruitment and retention of dental providers, securing access to additional clinic sites, and implementing an electronic medical record. Yet despite these challenges, the Molar Express has demonstrated that a regional mobile model is an efficient way to provide services in a rural area and it is a model that can be replicated.

References
1 Rural Healthy People 2010 (2003). Texas A&M University Health Science Center, Southwest Rural Health Research Center. Volume 1, p. 200.
2 Ibid.
Meeting the Oral Health Needs of a Rural Community Through Collaboration and Determination

Shelba Scheffner, MPH, CHES; Debra Youngfelt, BS, CHES; and Rebekah McFadden, RN, BSN, CSN

Eastcentral Pennsylvania AHEC, leading a multi-partner dental access project, gained federal funding to provide oral health care for Medicaid-eligible children and shows how AHECs can serve as leaders to encourage other agencies to address health care disparities.

Through a partnership between Eastcentral Pennsylvania AHEC (ECPA AHEC), a local hospital network, and a visionary collaborative called Carbon County Partners for Progress, restorative and preventive dental services will become a reality for Medicaid-eligible children in Carbon County, Pennsylvania. ECPA AHEC was established in 2000, with Carbon County being one of the five counties in its region. This county, which covers approximately 500 square miles, is largely rural, with a population of approximately 59,000 people. The Carbon County Health Profile provided by the Pennsylvania Department of Health (2005) indicates that 12.9% of the population of the county is eligible for medical assistance.

How It All Started
Initially a group of local business leaders, politicians, employers, and school officials convened to discuss how to stimulate economic growth in Carbon County. They determined that there were many issues that warranted attention if quality of life in the county were to improve.

The process began with the incorporation of a new organization, named Carbon County Partners for Progress. Shelba Scheffner, executive director of ECPA AHEC, became one of the early members of Carbon County Partners for Progress. Local State Representative Keith McCall secured funding for a community needs assessment that involved approximately 300 participants. The countywide planning workshop formed four separate task forces: Education, Economic Development and Heritage, Leadership, and Health and Human Services. The Health and Human Services Task Force identified numerous local health challenges, including a significant lack of dental services, both preventive and restorative, for the Medicaid-eligible population of Carbon County. The needs assessment found that none of the 27 dentists who practice in Carbon County accepted Medicaid as insurance payment for dental services. This health care disparity became a priority for Partners for Progress. It further brought about additional partnerships which focused on improving oral health care services to the low-income population.

The Health and Human Services Task Force formulated a Dental Initiative Committee with the sole purpose of addressing its vision to facilitate restorative and preventive dental services to children with Medicaid in Carbon County. ECPA AHEC took the first step by applying for Health Professional Shortage Area (HPSA) status through the Pennsylvania Department of Health.

Dental Initiative Committee members established an affiliation agreement whereby ECPA AHEC would be the lead agency responsible for the administrative oversight for the Dental Access Project. Debra Youngfelt, health educator for ECPA AHEC, was engaged through State Health Improvement Plan (SHIP) grant money to lead the committee and perform many of the tasks. The provision of oral health services in Carbon County promotes the AHEC mission, “to enhance access to quality health care, particularly primary and prevention care, by improving the supply and distribution of health care professionals through community/academic educational partnerships.”

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Meeting the Oral Health Needs of a Rural Community Through Collaboration and Determination

Based on all of the data collection and research, the Dental Initiative Committee members felt that a school-based mobile dental van would be most effective in providing dental services. A review of literature also supported this decision. In a research study by Siegel, Marx, and Cole (2005), consumers and providers were surveyed to determine perspectives on access to dental care for Ohio Head Start children with the goal to assess the need and appropriate strategies for action. The researchers found that Head Start staff and dentists felt that poor appointment attendance negatively affected children receiving care, but parents/caregivers said finding accessible dentists was the major problem. A school-based mobile dental van removes the barrier of access/transportation to services in the rural county and removes the barrier of poor appointment attendance.

Dental Initiative Committee members have partnered with the Blue Mountain Health System (BMHS) to serve as the administrative organization. Whereas Carbon County Partners for Progress, as a nonprofit corporation, has raised funds to purchase a mobile dental van, equipment, and supplies and hire personnel to staff the van, the organization does not have the ability to purchase and manage the operation of the van. BMHS agreed to act as employer for the dental van staff and provide liability insurance, vehicle insurance, office space, and general office supplies and other services, as needed, to the van and its staff. Liability insurance and vehicle insurance will be funded by dental initiative money but coordinated through BMHS.

Show Me the Money
The next monumental task was to develop a budget for the program. Approximately $350,000 was needed to purchase the dental van, purchase all of the dental equipment, and pay salaries for a dentist, dental hygienist, and van driver/office manager for the first six months. The task of researching available funding opportunities became the priority of the Dental Initiative Committee. The Pennsylvania Department of Health Primary Challenge Grant worth $150,000 was written and submitted. One of the criteria for submission of the Challenge Grant was obtaining matching funding through the community. Through massive fundraising efforts on the part of the Dental Initiative Committee members and unprecedented community support, the matching funds were obtained. The community engaged in all types of creative fundraising activities, from a countywide dress-down day to a comedy night. The Challenge Grant monies were approved as well.

Committee members have projected that after the dental van functions for two years, it will be financially self-sufficient through independent billing to Medicaid if it provides services to at least 1,000 children twice during the school year. The project will be sustained through Medicaid billing of services and through continued fundraising efforts with established community partnerships.

Undoubtedly, many unforeseen challenges face the Dental Initiative Committee and AHEC in the years to come as the mobile dental van begins providing services. Yet this group of concerned community partners remains confident in the strength of its partnership and spirit of collaboration and indeed is looking forward to these challenges. The AHEC mission to increase access to quality health care has been exemplified by this partnership. ECPA AHEC is proud of its role in this exciting initiative and looks forward to sharing the progress and successes of the project.

References

For over 10 years, the Southeast Pennsylvania AHEC (SE PA AHEC) has provided health professions students with community-based training. In 2005–2006, SE PA AHEC supported 219 medical students, 36 physical therapy students, 37 nurse practitioners, 34 physician assistants, and 16 allied health students in primary care community-based training.

The Southeast Pennsylvania AHEC (SE PA AHEC) serves five counties in which a large number of minority and underserved populations resides. Although the southeast region has higher incomes than any other county in the state, it has higher rates of poverty and higher numbers of persons receiving medical assistance payments than the remainder of the state. One approach to meeting the healthcare needs of this region involves the recruitment and retention of primary care providers and health professions students to community-based healthcare facilities. With primary care practitioners continuing to be in short supply in Pennsylvania, the SE PA AHEC provides health professions students training experiences in family practice, internal medicine, pediatrics, dentistry, and other primary care fields.

One example of how SE PA AHEC successfully prepares students in the community-based healthcare environment is the training relationship with Community Volunteers in Medicine (CVIM), a non-profit community-based corporation in Chester County. CVIM serves the primary care medical and dental needs of the uninsured and underinsured working poor, many of them Latinos, and has a volume of over 800 patients per month. What is unique about this clinic is that it is staffed by doctors, nurses, podiatrists, dentists, dental hygienists, social workers, and pharmacists who donate 100% of their time and services at CVIM.

SE PA AHEC has partnered with CVIM for over six years and has supported both dental hygienists and dental students in their oral health training both at the CVIM clinic and off site at satellite locations. Over 40 dental students from Temple University School of Dentistry and dental hygienist students from Harcum College have completed their clinical training at CVIM. With over 110 patients seen weekly, the clinic benefits by having the students actively participate in the dental procedures. The dental students are encouraged, under the supervision of a dentist, to perform a wide variety of dental procedures on both children and adults, including periodontal therapy, biopsies, root canals, fillings, and extractions. The dental hygienist students, under supervision, perform teeth cleanings, fluoride varnishes, and dental sealants, while providing health education to each patient. The students also learn the importance of volunteerism while being exposed to ‘hands-on’ learning experiences.

The fluoride varnish program is especially unique to CVIM, as it is the only clinic in the county that performs this procedure free of charge, and SE PA AHEC’s support of the program is essential to its existence.

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Training Oral Health Students in Culturally Competent Care at a Community-Based Volunteer Health Clinic

Fluoride varnishes have been applied to over 1,500 children from two school districts both at CVIM and at various Head Start locations throughout Chester County. Although there are no statistics indicating the success of this program, primarily because of the transient population, Alberta Landis, Director of Dental Services at CVIM, notes a decrease in hospital visits and referrals for dental-related issues as a result of the education, exams, and varnishes performed by CVIM staff and student volunteers.

In addition to a decrease in hospital visits, Landis and staff have attributed a significant improvement in oral hygiene care of each patient to the education and care received at CVIM. This is evident at three to six months after the initial dental appointment. Children especially benefit from the oral health and nutrition education. While waiting for their visits, each child who comes to the clinic receives oral health messages and nutrition education while playing with arts and crafts.

Though most children are bilingual, many parents cannot speak or understand English; interpreters are available if needed by the staff or students. The CVIM staff receives continuing education, including diversity training, which is an important component of this program. In addition, Landis recently visited the Guanajuato area of Mexico with a select group of professionals and toured hospitals and clinics in the area. These experiences are communicated to the students who train at the clinic, reminding them of the Latino culture and how it applies to the dental care and treatment of these individuals. For example, it is not uncommon for the entire family to attend a dental appointment and to be present during the examination and procedures being done. Therefore, when scheduling appointments, it is important to consider the needs of the patient to include family members at the time of treatment. A DVD is available to patients that explains every aspect of dentistry in both Spanish and English.

As a result of the collaboration between the AHEC and this community-based volunteer clinic, students enrolled in oral health, dental, and allied health programs receive valuable training and gain experience with underserved communities where they are needed most.
Persistence and Partnerships Pay Off in Improving Oral Health Services on Maryland’s Eastern Shore

Jacob Frego

The Eastern Shore AHEC was the nucleus in aligning partners for three initiatives to address oral health needs, resulting in the submittal of the outreach grant.

The Eastern Shore AHEC, located in Cambridge on Maryland’s rural Eastern Shore, has been involved in three distinct oral health initiatives which are now coalescing to improve oral health services.

The first initiative began in 2002 when the Tri-County Council for the Lower Eastern Shore of Maryland (a regional government economic development and planning agency) assembled a coalition including the Eastern Shore AHEC, a community college, county government, a federally qualified community health center, county health departments, and an acute community hospital to address the region’s estimated shortage of 38 dental hygienists. No dental training programs were located within the region, and statewide there were only three, with the closest program 150 miles away.

After a series of meetings the coalition concluded that despite the desirability and importance of establishing a dental hygienist training program, local resources were insufficient to do so. However, a unique solution was devised—if the region could not develop a dental hygienist program, then existing state resources would be utilized to export dental hygienist candidates out of region for training and then have the graduates return for service within the region. Details of this arrangement are as follows:

• Two qualified students per year from the local community college would be guaranteed admission to Allegany College’s dental hygiene program, a two-year program in western Maryland.

• Student costs for housing, tuition, books, labs, and other fees, averaging $12,000–$13,000 per student, would be paid for by a Workforce Investment Board and the Three Lower Counties Community Health Center (TLCHC), a federally qualified health center (FQHC).

• In return, the students agreed to return to the region and practice for at least two years at TLCHC or another agreed upon site.

This unique approach has now been operational for two years with two students graduated and employed and three in the pipeline. It will soon be augmented with a four-year dental hygienist training program as this initiative has spurred the University of Maryland Dental School (UMDS) to establish a dental hygienist program in the region. Wor-Wic and Chesapeake Community Colleges will serve as the didactic educational sites and TLCHC as the clinical training site. The AHEC will incorporate the students in its clinical education program. The University program became operational in the fall of 2006 and is unique in that students will receive their first two years of training at the community colleges and their second two years from the University of Maryland via distance learning. Students will be required to travel occasionally to the University in Baltimore to consult with their advisors, a
round trip of over 300 miles. Presently the two-year training program at Allegany College will remain an educational option, but student expenses will not be reimbursed.

A second oral health initiative occurred in 2004 while the dental hygienists program was still under development. Wicomico County received a one-year HRSA planning grant to address oral health needs within a multicounty area. This initiative, called Eastern Shore Oral Health Action Network (ESOHAN), had the primary objective to develop an organized network addressing disparities in access to and utilization of oral healthcare services primarily affecting children and low-income families. Oral health care for Medicaid patients was extremely limited with some of the involved counties having no providers accepting them. ESOHAN assembled a large committee to undertake this work, including members who were working on the dental hygienist shortage. Ultimately a model of care will be developed engaging private-sector dentists to provide service to Medicaid children. Again, the Eastern Shore AHEC was a strong partner in this effort by bringing to the table regional issues and contacts.

In spring of 2005, about midway through the ESOHAN planning grant, the Eastern Shore AHEC assembled a review team to discuss the opportunity of submitting to HRSA an oral health outreach grant. In the center’s view, the dental hygienists program and the ESOHAN planning program had demonstrated the region’s commitments to oral health issues. In addition, substantial data had been developed by the ESOHAN project documenting a need for expanded oral health services particularly for the Medicaid child. Lastly, a consortium of agencies was in place and could be drawn upon to assist in an outreach grant project. Based upon these criteria, the decision was made to submit a grant. The Eastern Shore AHEC was the nucleus around which this decision was made, and it brokered the arrangement resulting in the submittal of the outreach grant. This is the third oral health initiative, called Eastern Shore Children’s Regional Oral Health Consortium, or CROC.

Under the CROC proposal a consortium was established including partners who had collaborated on the earlier dental hygienist program and the ESOHAN planning project. Consortium members include:
• The University of Maryland Baltimore College of Dental Surgery (UMBCDS).
• Shore Health System’s Dorchester General Hospital—an acute community
Persistence and Partnerships Pay Off in Improving Oral Health Services on Maryland’s Eastern Shore

hospital.
• Three Lower Counties Community Health Center, Inc.—an FQHC serving the region.
• Choptank Community Health System, Inc. (CCHS)—another FQHC within the region.
• Eastern Shore AHEC—the lead agency and responsible for the administration and management of the program.

The CROC proposal contained four primary components:
1) Developing a comprehensive dental center for children in Dorchester County, which has no dental center or dentists in the county accepting Medicaid patients. CCHS is responsible for development of the dental center;

2) Developing a regional hospital-based pediatric dental program for a six-county service area. CCHS is responsible for establishing the program with UMBCDS providing the service of a dental fellow working in the clinic’s operating room. TLCHC will refer to the clinic for evaluation any child in need of complex restoration and rehabilitative care, many of whom presently are transferred to Baltimore for care;

3) Promoting an educational and outreach program directed at Medicaid children and their families will involve contact with schools, dental providers, public health programs, and others throughout the mid- and lower-shore region. The Eastern Shore AHEC is principally responsible for this outreach program. All six counties in CROC’s primary service area have been designated as Dental Health Professional Shortage Areas; and

4) Augmenting the training of dental hygienists on the Eastern Shore by facilitating placement in pediatric settings. The Baltimore College of Dental Surgery, University of Maryland Dental School, and the University of Maryland’s Dental Hygiene Division in conjunction with Wor-Wic and Chesapeake community colleges, will work with the Eastern Shore AHEC to coordinate the placement of dental hygiene students in these settings.

The CROC proposal was approved by HRSA in April 2006. The program is now operational and in the development stage. And while the program is principally targeted at a six-county service area, it is anticipated that program success will provide an opportunity for children from the entire nine-county Eastern Shore area to be welcomed at the clinic. CROC’s success will be measured by the number of children receiving oral health services, the number of dental hygiene students seen by the center’s clinical education program, and the number of educational outreach programs presented and health care providers trained.

What began as a workforce issue on the shortage of dental hygienists and evolved into oral health planning has culminated in the CROC proposal promising to bring substantial improvement in children’s oral health service to the region. The network of the Eastern Shore Oral Health Action Network will assist in the educational outreach, and the dental hygienist students will be working with the Eastern Shore AHEC in rotations through the new dental center. These activities are all traced to continued persistence in reaching the objective of improving oral health services and adaptability and flexibility when working with many partners to achieve the objective.

...if the region could not develop a dental hygiene program then utilize existing state resources and export dental hygienist candidates out of (the) region.
Integrating Oral Health Into Primary Medical Care

Malone Steele

New Hampshire AHEC has been involved in an oral health initiative that integrates oral health education and prevention interventions into well-child visits.

New Hampshire is frequently ranked as one of the healthiest states in the nation. Yet, as oral disease is now considered an epidemic in the country, it also is a growing problem in the state. New Hampshire’s low-income residents suffer disproportionately from this preventable oral health disease. Adding to the challenges of oral health services in New Hampshire is the rapidly growing minority population, which has both cultural and language differences that present obstacles to care.

Recent data from 16 New Hampshire school-based dental programs indicate that among 7,069 second and third grade students screened for dental disease, 24% had untreated decay, 51% had a history of decay, and 39% had dental sealants. Data from the statewide 2004 Oral Health Survey of Third-Grade Students found similar results. During development of New Hampshire’s “Oral Health Plan: A Framework for Action in 2002,” statewide town meetings revealed that many general dentists felt unprepared to treat young children, especially those with extensive dental disease.

The dental workforce presents daunting challenges for the state. New Hampshire has approximately 450 practicing dentists and only 18 pediatric dentists. In 2003, only 60 dentists accepted Medicaid clients and each of these dentists treated 100 or more Medicaid patients. Sixty-five towns and several census tracks in Manchester (comprising 20% of the state’s population) were federally designated Dental Health Professional Shortage Areas (DHPSA). Currently, insured patients experience a six-to-eight-month waiting period for nonurgent dental appointments. Half the dental practices in New Hampshire report a shortage of hygienists. Approximately half of the state’s practicing dentists are over 50, and 20% are over 60. Dental workforce issues will worsen because each year only two dentists graduate to replace three retiring ones.

To address these needs, New Hampshire has undertaken oral health initiatives in integrating oral health education and preventive interventions into well-child visits. Clinical training in oral health education, preventive interventions, risk assessment, and oral health screening is being provided in the Dartmouth family practice residency and separately with primary care providers in private practice and health centers. The goal of these initiatives is to enable primary care providers to educate parents about the importance of oral health or intervene early during the scheduled prenatal and well-child visits. However, the role of primary care providers in oral health care is still unclear, and there is a lack of information at the provider level about proper oral health screening and standards of oral health care.

The state’s Health and Human Services Department has collaborated with Southern New Hampshire Area Health Education Center (SNHAHEC) to create “Integrating Oral Health Into Primary Medical Care: Early Childhood 0-5 Years Old.” During the first year SNHAHEC completed a literature search of national and statewide oral health and primary care literature for consumers and health professionals and contracted with the New Hampshire Minority Health Coalition to conduct focus groups of health professionals and parents of young children along with a web-based survey. Through this activity, SNHAHEC determined there were limited oral health materials for pregnant women and children under the age of three in the state.

SNHAHEC organized a planning committee consisting of physicians, nurses, dentists, and hygienists to design curriculum for the Lunch and Learn program, “Integrating Oral Health Into Primary Medical Care: Early Childhood 0-5 Years Old,” and to develop low-literacy patient education materials. The learning objectives of the curriculum were to describe the importance of risk assessments and strategies for implementing the assessment in a busy practice, to identify options for providing fluoride, to demonstrate proper oral health screening techniques, and to discuss the anticipatory guidance in relation to
Integrating Oral Health Into Primary Medical Care

the periodicity chart. Focus groups expressed the need for patient education handouts with a consistent message. SNHAHEC designed a patient education handout that has also been translated into Portuguese and Spanish. The programs were marketed across southern New Hampshire to Community Health Centers (CHCs), pediatric practices, and family practices via a brochure mailing. In addition, SNHAHEC marketed the oral health Lunch and Learn series via a monthly bulk email to all its members.

In the first year, 14 Lunch and Learn programs occurred—6 for CHCs and 8 for private medical practices. Four of the medical practices were family practices and four were pediatric practices. SNHAHEC made oral health presentations to the WIC representatives from across the state. In total, 36 providers, 63 nonprovider clinical staff, and 49 nonclinical staff were trained.

SNHAHEC collected 117 evaluations from the participants to discern what additional information was needed. Health providers indicated they would like information on fluoride varnish, xylitol and chlorhexidine, knee-to-knee exam, oral health and pregnancy, and oral health throughout the life span. Physicians also identified the need to learn about sealants and dry mouth associated with special medications and conditions. Health professionals also identified specific ways they would change their behaviors in the workplace, including providing more oral health education and performing oral screenings. From this information SNHAHEC collaborated with the Community Health Access Network to design an “Integrating Oral Health into Primary Medical Care: Middle Childhood Through Adolescents” program. The new program is currently being offered to sites that received the “Integrating Oral Health into Primary Medical Care: Early Childhood 0-5 Years Old.”

SNHAHEC received a positive response to the oral health educational offerings. However, the challenge to refer patients to dental professionals in the community remains. Due to the workforce shortage of dentists, there are not enough resources for patients needing dental care other than the emergency room. Access remains an issue. Many healthcare providers are frustrated that dental professionals either will not accept Medicaid patients or will not see very young children. In recent years, Medicaid dental reimbursement rates have been increased to minimize the financial barrier for participation in the Medicaid program. In addition, the state’s dental director is negotiating with dentists who do not currently accept Medicaid patients to accept even a limited number and thus spread the patient load among more providers.

SNHAHEC feels that expanding this training to dental practices will minimize dentists’ fear of working with young children by offering techniques and resources to enhance practitioners’ ability to provide dental care to young children. They may offer an evening program featuring a pediatric dentist to reinforce key strategies for managing children’s behavior. The attitude of medical professionals can also be a challenge. Often when a dental hygienist has mentored a physician in performing oral health screenings, the physician will delegate the oral screening to the hygienist. This defeats the purpose of actively engaging the physicians to undertake oral screenings as a way of integrating oral health with primary care. SNHAHEC will continue to monitor this phenomenon and identify strategies to shift attitudes about who is responsible for oral health.

Barriers to progress also include financial constraints on Medicaid reimbursement for dental procedures such as fluoride varnish applied by nondental providers. Physicians are interested in providing care for their patients, and SNHAHEC provides them with information about techniques and treatment options that are available. However, given the limited financial resources in New Hampshire, there is limited interest in expanding the benefits for Medicaid beneficiaries. As more physicians seek to provide oral health screening and preventive treatment to their patients, they may create a demand for such reimbursement. We believe that through oral health education and recognition of the value of early dental disease prevention, a grassroots campaign will emerge supporting a change in reimbursement strategy. Medical professionals will join together and make a case for expanded coverage. SNHAHEC is researching Medicaid reimbursement of oral screening and prevention by nondental providers, and it has presented preliminary findings to the state.

SNHAHEC is currently having the Lunch and Learn project evaluated by the New Hampshire Minority Health Coalition to assess what behavior changes have come about from the program. Results should be available by the end of the year.

References

AHEC and ACTS: The Advanced Clinical Training and Service Program with the Colorado AHEC System at the University of Colorado School of Dentistry

Robin Ann Harvan, EdD; Rob Berg, DDS, MPH, MS, MA; and Robert Trombly, DDS, JD

The clinical training of dental students, like that of other health care professionals, has traditionally been intimately connected to the oral health needs of underserved populations. Campus-based dental school clinics provide high quality treatment at fees considerably below the prevailing rates in their communities. The University of Colorado at Denver and Health Sciences Center, School of Dentistry has been no exception in this regard. Like most other schools, however, it is located on an academic medical center campus in a metropolitan area. Since its founding in 1975, the Colorado school has consistently worked with the Colorado AHEC System to broaden its impact by conducting part of its clinical training in rural and underserved urban communities across the state.

Ten years later, in 1985, the school formally implemented the Advanced Clinical Training and Service (ACTS) Program. Through ACTS, all of Colorado’s predoctoral dental students are required to complete clinical training rotations in community-based clinics. The program requires that at least one of each student’s four clinical rotations be completed outside of metropolitan Denver. This ambitious goal has been met for twenty years, but only with the collaboration of the state’s AHEC system.

The Colorado AHEC System has a central program office located on the campus of the University’s academic medical center. The state also has five regional AHECs, each of which is independent and guided by a local board of directors. The central system office has a long history of collaboration with the University’s schools of dentistry, medicine, nursing, and pharmacy and graduate school programs. Designated leaders from each of these schools have served as AHEC liaisons. Together, these AHEC faculty members have collaborated on numerous funded initiatives over the years, directed at a goal of fostering health care practice in underserved areas. Projects have ranged from targeted interdisciplinary continuing education in rural communities to creation of student and practitioner interdisciplinary teams in rural areas to conduct focused health promotion projects.

Program description
The ACTS program has traditionally begun in January of the fourth and final year of the dental predoctoral curriculum. The entire spring semester has been devoted to four clinical affiliations, each lasting about five weeks, for each student. In Colorado, the ACTS program requires each senior dental student to spend a minimum of 100 days providing dental care to underserved populations.

An ACTS dental student assigned to a community-based clinic becomes an unpaid, full-time staff dentist at that clinic. Students provide treatment under direct supervision of the clinic’s staff dentists, each of whom holds both a Colorado dental license and a volunteer faculty appointment in the school’s Department of...
AHEC and ACTS: The Advanced Clinical Training and Service Program with the Colorado AHEC System at the University of Colorado School of Dentistry

Applied Dentistry (the academic base of the ACTS program). A written agreement extends the university’s campus to that dental clinic, allowing for this supervision relationship and for professional liability coverage of the student clinician.

ACTS dental students work with campus-based faculty members to determine the locations of AHEC clinical rotations. Factors in clinical site selection include clinical interests and foci, as well as personal and family needs. As already noted, the program requires that one affiliation be scheduled outside the Denver area. Most students elect to practice at rural sites located as far as four hours from the Denver campus. For these students, the Colorado AHEC program provides valuable support.

The support’s most obvious feature is technical assistance and funding to locate and arrange student housing. Regional AHEC staff work with dental school faculty and staff to ensure that students are placed in comfortable housing for their AHEC clinical rotations. In addition, local AHECs typically are the first face of the local community to be seen by a student from the Denver campus. Regional AHEC staff welcome students to their home-away-from-home. It is not unusual for AHEC center directors to invite new students into their homes for dinner. Finally, regional AHECs provide a valuable link between the University and the practicing community in their areas.

Since the inception of the ACTS program, the first major revision of the program model was implemented in the summer of 2006. The school has restructured the fourth-year curriculum to allow a full year of AHEC clinical rotation opportunities, rather than the last six months of their senior year in dental school. Each student will continue to be required to provide 100 days of treatment, but the experience has been extended from one semester to two semesters. The rationale and benefits of this curricular change included:

- Earlier exposure to community-based clinical learning in underserved settings.
- More consistent patient care scheduling and office staffing at the community-based dental clinics.
- More consistent patient care scheduling and staffing at the dental school clinic.
- More effective service to the State’s safety-net oral health care delivery system.

Program outcomes

As technology has changed since 1985, the methods used to track outcomes in the ACTS program have also changed. Since 1995, student productivity has been maintained in an ongoing database. Dental student class sizes have also changed; from as few as 28 to as many as 50 4th year students are currently enrolled in the dental program. All senior dental students participate in the ACTS clinical rotation program with the Colorado AHEC System. Approximately 50 clinical sites and over 80 clinical preceptors participate in the program.

In 2005–2006, ACTS students provided clinical care at over 27,000 patient encounters that had an estimated market value of $3.4 million. Since 1995, the total estimated value of care provided by ACTS students has exceeded $30 million.

Subjective assessments are also instructive. Each student completes an exit interview with an ACTS faculty member before completing the program. Anecdotally, ACTS students report extremely high levels of satisfaction with the program. They praise the program for providing them with a far broader base of clinical experience than that offered at a traditional dental school. Also receiving high praise from students are the affiliations located outside the Denver metropolitan area. Students report feeling welcome in these communities and many express their gratitude and how enjoyable it was to live in a smaller community.

Tracking graduates of the program demonstrate successful community recruitment and retention of alumni. Figure 1 illustrates where our dental students currently practice. The Colorado AHEC System map (Figure 2) illustrates the counties and areas served by each regional AHEC.

(Continued on page 32)
Conference Photos
Conference Photos
Future directions
The CU School of Dentistry recently reorganized the organizational structure, and among revisions was the creation of a new administrative position for an Associate Dean of Community Affairs and Curriculum. Among respective duties, the Associate Dean for Community Affairs and Curriculum is responsible for the overall administrative oversight of the ACTS program, all community and legislative affairs, and works directly with the Colorado AHEC System director as appropriate. Plans are underway to broaden and expand the partnerships and collaborations of the Colorado AHEC System and the CU School of Dentistry in the following directions:

- Delta Dental Foundation’s Frontier Center- recently established and dedicated to enhancing patient care through collaborative interprofessional initiatives that identify the interfaces between the dental and medical professions and use the expertise of dentists and physicians to improve patient care. The Colorado AHEC System director serves on the Advisory Committee.
- Rural Dentistry Track for Dental Students- developing a separate track for dental students interested in rural practice.
- Colorado SmileMakers Program: Mobile Dental Clinic- program will support oral health care services to underserved children in Colorado. Starting in 2007, this mobile clinic will serve as an additional AHEC clinical rotation experience opportunity for the ACTS Program.
- International Dental Student Program (ISP)- new two-year accelerated program offers qualified graduates of foreign dental programs the opportunity to earn the Doctor of Dental Surgery degree. In 2007, the ISP students will also participate in the ACTS Program, supported by the Colorado AHEC System. In 2007, a total of 70 dental students (20 ISP dental students and the cohort of 50 in the traditional program) will annually participate in AHEC clinical rotation experiences.
- Primary Care Team Education- The School of Dentistry plans to enhance the dental school curricula with learning opportunities and experiences as members of multidisciplinary and interdisciplinary primary care teams. Students from diverse health professions disciplines participate in AHEC sponsored clinical education and will learn, work and live together for a portion of their clinical training in underserved areas of Colorado.
Training Outreach Workers to Deliver Preventive Dental Services in Yap State, Micronesia

Cindy Lefagopal, DDS

Yap AHEC has developed a three-credit course for outreach workers that will enhance their ability to teach oral health education for preschool children who live in the 134 outer islands of the Federated States of Micronesia.

Yap is in the Western Caroline Islands, located between Guam and Palau. It is one of the states of the Federated States of Micronesia. Yap is comprised of the main island and 134 outer islands stretching eastward for about 720 miles. The population of the state of Yap is approximately 13,000 people.

There is one main hospital in Yap and are five community health centers in each municipality; there is limited funding for the medical and/or dental care of residents. In the scatter outer islands, there are 18 dispensaries on different islands. Ninety-eight percent of households have incomes below U.S. federal poverty designations.

Oral disease is one of the leading health problems in Yap. In the whole state of Yap, there are seven dental nurses, one dental technician, and one dentist. Surveys of elementary school children show an average of 3.7 teeth per child affected with caries. With only one dentist for a population of 13,000 people, it is essential to focus our efforts on dental disease prevention, and to reach all those who need preventive services we must do outreach into schools and villages. In 2005, Yap Dental Clinic started an outreach preventive program targeting the following three groups:

- Children in first grade to sixth grade (ages 6–12 years) for dental education, distribution of brushes and fluoride toothpaste, and application (every two months) of fluoride varnish.
- Pregnant women for dental cleaning, fluoride varnish, oral health education, and any other treatment they need.
- Pregnant women are reached in the prenatal clinics and school-age children at the schools by dental nurses. The most difficult group to reach is the pre-school-age children, especially since they need a visit every two months.

With the help of the Yap AHEC, a branch of the Hawaii/Pacific Basin AHEC, we developed a new course for outreach workers to teach the skills needed to deliver, at home, the prevention package for pre-school-age children and to identify problems that need referral to a dentist or dental nurse. This three-credit course was adopted by the College of Micronesia as part of the health assistant vocational curriculum. In May and June 2006, this course was taught to two separate classes at Yap State Hospital (including 10 outreach workers who have been hired by the new Wa’ab Community Health Center in the Yap main islands and 20 outer-island dispensary health assistants and birth attendants). After the training, these nondental personnel were certified to apply fluoride as well as to perform oral examinations on the children.
Our program objective was to provide preventive care and education to 99% of the preschool children, elementary children, and pregnant mothers and to reduce DMFT among these target populations. As of this writing, 50% of children from grades 1-6 have received fissure sealant, compared with 0% from previous years. Every pregnant mother who attends the prenatal clinic for the first time receives fluoride application, oral health education, and any necessary dental treatment. These trainees from our Yap AHEC-College of Micronesia course are now delivering the oral health program to the preschool children.

In conclusion, AHEC has worked with a community health center and a local college to create a unique course that trains outreach workers to address oral health needs of a truly disparate group of individuals whose homes are scattered over a 720-mile stretch of ocean and who have little access to traditional dental services. Clearly, this collaboration demonstrates an effective model to provide preventive dental care services to a unique yet underserved community.
The Epidemic of Suicide: A Personal Story of Loss, Legacy, and Hope

Sen. Gordon Smith (R-Oregon)

Throughout the United States, every 41 seconds, someone attempts suicide. Every 16.7 minutes, someone completes suicide. Every day, hundreds suffer in silence. Simply put, suicide is an epidemic.

Mental illness is a very real disease that if left untreated, too often can take a human life. Yet, in spite of the alarmingly high rates of suicide in our country, mental health continues to fall under a subordinate category of medicine, leaving too many individuals without proper care. To curb this growing epidemic, a great deal of work needs to be done to improve the accessibility, parity and stigma of mental health in America.

My wife and I are among thousands of Americans who make up a fraternity of sorrow, united by the loss of a loved one to suicide. My son, Garrett Lee Smith, courageously battled a mental illness for many years, a battle that ultimately ended when he took his own life on September 7, 2003. His death brought more pain and sorrow upon our family than we thought we could bear. But the goodness and support of countless people has given us the grace to endure our grief, and the strength to face tomorrow.

As I have grown to understand my own son’s struggle with mental illness, I have learned how devastating it can be for individuals and their families. To find further meaning in Garrett’s life, my wife Sharon and I have committed ourselves to helping others who cope with the problems he struggled with daily. We are dedicated to breaking down the stigma of mental illness and educating Americans about the warning signs that are present when someone is considering suicide. No family should experience the pain of losing a child, and no one should face the challenges of mental illness alone.

When Garrett died, I felt the ultimate failure of not having fully understood the depths of his depression or how to help him with his illness. There was a time shortly after his death when I even questioned whether I should continue in public service. Fortunately, I realized that I could use my position in the federal government to help educate my colleagues and the public on the importance of mental health treatment. I couldn’t save Garrett, but I hope my efforts can help save others.

I am grateful to have friends and colleagues in Congress who recognize that this issue doesn’t discriminate along party lines or geographical boundaries. A year after Garrett’s death, Congress overwhelmingly passed the Garrett Lee Smith Memorial Act. This legislation provides federal grants to promote the development of statewide suicide early intervention and prevention strategies intended to identify and reach out to young people who need mental health services. In addition, this bill makes available competitive grants to colleges and universities to create or enhance the schools’ mental and behavioral health programs.

Funding for the Act is directed to three primary elements. The first component is the Suicide Prevention Technical Assistance Center, which is authorized at $5 million for Fiscal Year 2007 to support its mission of providing technical assistance and support to grantees. Additionally, $30 million is authorized in Fiscal Year 2007 to help states and tribes develop and implement statewide youth suicide early intervention and prevention strategies. The funds will help raise awareness and educate people about mental illness and the risk of suicide, help identify young people with mental illnesses and allow states to expand access to treatment options. Finally, $5 million is authorized to fund a matching-grant program to colleges and universities to help raise awareness about youth suicide, as well as enable those institutions to train students and faculty to identify and intervene when youth are in crisis. It also allows for schools to develop a system to refer students for care.

Grants through Garrett’s bill are administered through the Substance Abuse and Mental Health Services Administration (SAMHSA). Currently, thirty states, six tribes, and fifty five colleges and universities have received funds to develop suicide prevention and intervention programs to help alleviate the suicide epidemic.
I am proud that the state of Oregon, as well as three local programs, including the Native American Rehab Association of NW, Inc. - Portland, University of Oregon - Eugene and Blue Mountain Community College - Pendleton, were among the recipients. Although we have made great strides with funding for program participants, we still have a lot of work ahead of us to ensure that all states receive a grant. We must continue to advocate for full funding of Garrett’s bill so no one has to suffer alone.

An important aspect of the Garrett Lee Smith Memorial Act is ensuring that a network of care and services is available throughout every state, including rural areas. An absence of adequate mental health facilities and professionals has led suicide to become the second leading cause of death in rural areas. As mental illness does not discriminate between geographic lines, neither should quality of or access to care.

AHECs can be pivotal in these efforts. I would encourage all AHECs to partner with their state agencies as youth suicide prevention strategies are developed. Education for safety-net and other providers in underserved areas and awareness programs provided through AHEC networks would be crucial to reaching rural and inner city communities. AHECs are in a unique position to assist in suicide prevention as they help train thousands of health professions students and faculty across the country who can help identify and assist persons with a mental illness.

Also to ensure that rural counties have the tools they need to meet the mental health needs of its citizens, I also am proud to be a sponsor of the Rural Hospital and Provider Equity (R-HoPE) Act of 2006. This legislation is designed to ensure rural hospitals, rural health clinics, rural ambulance providers, rural home health agencies, rural mental health providers, rural physicians and other critical allied health clinicians are accessible and paid accurately and fairly. The legislation also contains a mental health provider reimbursement provision that would allow marriage and family therapists and licensed professional counselors to bill Medicare for their services.

In addition to providing greater access to mental health services, our country must work towards achieving mental health parity. Through parity, we can alleviate some of the burden on the public mental health system that results when families do not have access to treatment through their private health insurance plans.

I am pleased that once again Oregon is leading the nation by enacting mental health parity legislation that will go into effect next year. But the federal government must act as well to send a strong message that excluding people suffering from mental illness from health insurance coverage is unacceptable.

I am working to pass a bill that would create parity within Medicare. Presently, Medicare beneficiaries must pay a 50 percent copay for mental health related outpatient services as opposed to 20 percent for all other outpatient care. The Medicare Mental Health Copayment Equity Act of 2005 will take an important first step to achieving mental health parity for Medicare beneficiaries.

Fortunately, congressional awareness of mental health issues has increased over the years. In 2006, Senators Pete Domenici, Edward Kennedy, Tom Harkin and I formed a bipartisan Mental Health Caucus in the Senate. Together we are working to find ways to effect real change, to improve the parity, quality and accessibility of mental health care which will restore dignity to those suffering from mental illness.

As Chairman of the Senate Special Committee on Aging in the 109th Congress, I was fortunate to lead the Senate in studying issues of importance to America’s seniors. The committee has afforded me the opportunity to raise awareness about the prevalence of suicide among seniors and study prevention strategies. Many people are unaware that seniors have a higher rate of suicide than any other age group. Recently, I conducted a hearing in the committee that shed light on successful models of early intervention and prevention, especially in the primary care setting. I look forward to continuing to study this issue when Congress returns for the 110th session next year.

I am pleased to be a champion of this cause, not because I volunteered for it but because I have suffered over it. I believe that we have made great process, but there is still a lot of work ahead of us. It is my hope that Congress continues to work together in a bi-partisan fashion to prioritize mental health and human life. With the united effort of friends, family, and public and private enterprise, I feel that we can bring hope to those who suffer from mental illness and ultimately end the epidemic of suicide in America.
Mental Health and Behavioral Health Workforce: Challenges and Opportunities Including Implications for Rural America

Dennis F. Mohatt, MA, and Mimi B. McFaul, PhD

The President’s New Freedom Commission’s report *Achieving the Promise: Transforming Mental Health Care in America* (2001) indicated that the mental health system is fragmented and called for a fundamental transformation of public behavioral health (mental health and substance abuse) systems. System transformation requires that policy makers, administrators, providers, and other stakeholders address multiple aspects of workforce development. These include recruitment, retention, and training, as well as understanding workforce trends and projections, shifting treatment philosophies, and service delivery models. While these issues are applicable to behavioral health systems across the country, they are brought into sharpest focus when considering rural and frontier areas. This article will address each of these issues generally but will illustrate them concretely as they exist in rural areas.

Defining Workforce

The behavioral health workforce includes professionals in both mental health and substance abuse fields from a variety of disciplines including psychiatry, psychology, social work, psychiatric nursing, counseling, marriage and family therapy, psychosocial rehabilitation, school psychology, and pastoral counseling. These professionals are generally involved in the provision of health promotion, prevention, and treatment services. The workforce includes professionals with graduate training, those with associate or bachelor’s degrees, and persons in recovery and their family members at varying educational levels. In some communities, such as rural areas, where there is a shortage of professionals, other community members become part of the workforce as they are often the first-line responders (e.g., paramedics, primary care physicians, indigenous healers, and law enforcement).

Population and Workforce Trends

Major changes in America’s general workforce are anticipated to continue between now and the year 2025. This change is brought into sharp focus when the percentage of the population entering the workforce is compared with the percentage leaving it. For instance, the Western Interstate Commission for Higher Education (WICHE) Mental Health Program analyzed data regarding population projections from 2000 to 2025 for its 15 member states (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, North Dakota, New Mexico, Oregon, South Dakota, Utah, Washington, and Wyoming). On average, WICHE states will see a projected 21.7% increase in the number of people between the ages of 18 and 64 entering the workforce by 2025. However, the projected average percentage of persons 65 and older (i.e., retirement age) leaving the workforce in WICHE states is a staggering 118%. The implications of this data are clarified when one considers projected behavioral health workforce needs.

Table 1 was created with data from the Bureau of Labor Statistics website and indicates the percentage change (in descending order) in total employment between 2004 and 2014 for 12 behavioral health occupations nationally. Although not all encompassing, this chart...
emphasizes the workforce needs we will be facing in less than 10 years.

At the highest level, we will be facing a 29% increase in workers, with an average need overall of 13% more workers in all fields listed above. It is also interesting to note that this increase will affect the entire training spectrum from on-the-job training up to the doctoral degree level.

Population and workforce trends point to difficulties meeting the behavioral health needs of the population in the coming years. However, when one considers the vast number of places that already have shortages of behavioral health workers, the situation may be even worse. For instance, the Health Resources and Services Administration (HRSA) Bureau of Health Professions tracks workforce shortages for several professions, including mental health. Mental health professional shortage areas (MHPSAs) can be designated using any of the following criteria: 1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); 2) a population group; or 3) a public or nonprofit private medical facility. A single county can have all three. The map below shows that the majority of the country is a designated MHPSA and illustrates the magnitude of the crisis in access to and availability of mental health care for Americans, particularly in rural areas.

One-fifth of America’s population, about 49 million people, lives in rural areas; these rural regions include over 2,000 counties and contain 75% of the nation’s land. Furthermore, research indicates that prevalence rates of mental illness are similar for rural and urban populations, but rural communities lack availability, accessibility, and applicability of service options. Additionally, rural communities are diverse, which makes it difficult for researchers to accept one definition of “rural.” For example, a remote community in Alaska may be culturally and ethnically different from a geographically isolated town in Montana and encounter different behavioral health issues.1

The following statistics from the President’s New Freedom Commission on Mental Health,
Mental Health and Behavioral Health Workforce

Subcommittee on Rural Issues\(^2\) report identified several workforce issues specific to rural communities:

- More than 85% of 1,669 federally designated MHPSAs are rural.\(^3\)
- Few psychiatrists, psychologists, or clinical social workers practice in rural counties, and the ratio of these providers to the population worsens as rurality increases.\(^4\)
- For the past 40 years, approximately 60% of rural America has been underserved by mental health professions.
- The National Advisory Committee on Rural Health\(^5\) reported that the supply of psychiatrists is about 14.6 per 100,000 people in urban areas compared with 3.9 per 100,000 in rural areas.
- These workforce shortages are even worse for specialty areas, such as children’s mental health, older adult mental health, and minority mental health.
- Social service agencies in rural areas are generally staffed by a range of undergraduate and/or graduate level providers and typically do not provide any consistent standards or core competencies.

This is not a new or cyclical phenomenon but rather a chronic situation that has seen little improvement in the past 40 years.

In addition to population and demographic changes, there has been a significant shift in behavioral health services delivery from institutionally centered care to a more community-based care model. This is particularly exemplified in the emerging emphasis on inclusion of the consumer and family members in directing their own behavioral health decisions. Additionally, the use of peer supports and increased access to information through the Internet are altering the relationships among practitioners and family members, who are increasingly serving as the primary care manager for consumers.\(^6\)

The financing of services due to the increase in Medicaid as a funding source has also impacted behavioral health service design and delivery. Money is a fundamental issue affecting the development of an adequate workforce. Education is expensive, health plans favor lower-paid providers, and mental health professionals in the public system often are paid lower salaries. Staffing has been primarily influenced by state practice regulations and insurance reimbursement regulations more than by science or competency.\(^7\)

Frequently, different mental health disciplines have different levels of training.\(^7\) Due to population and workforce changes, both mental health and substance abuse professionals require specialty training to work with populations having unique needs; these include children, older adults, specialty substance abuse disorders, people living in rural areas, and people from different cultures.

Table 2. National strategic plan for behavioral workforce development.

<table>
<thead>
<tr>
<th>Category</th>
<th>Goals</th>
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<tbody>
<tr>
<td>Broadening the Concept of Workforce</td>
<td></td>
</tr>
<tr>
<td>Goal 1</td>
<td>Significantly expand the role of individuals in recovery, and families when appropriate, in participating in and ultimately directing or accepting responsibility for their own care, providing care and supports to others, and in educating the workforce.</td>
</tr>
<tr>
<td>Goal 2</td>
<td>Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.</td>
</tr>
<tr>
<td>Strengthening the Workforce</td>
<td></td>
</tr>
<tr>
<td>Goal 3</td>
<td>Implement systematic recruitment and retention strategies at the federal, state and local level.</td>
</tr>
<tr>
<td>Goal 4</td>
<td>Increase the relevance, effectiveness, and accessibility of training and education.</td>
</tr>
<tr>
<td>Goal 5</td>
<td>Actively foster leadership development among all segments of the workforce.</td>
</tr>
<tr>
<td>Structures to Support the Workforce</td>
<td></td>
</tr>
<tr>
<td>Goal 6</td>
<td>Enhance the infrastructure available to support and coordinate workforce development efforts.</td>
</tr>
<tr>
<td>Goal 7</td>
<td>Implement a national research and evaluation agenda on behavioral health workforce development.</td>
</tr>
</tbody>
</table>
**Mental Health and Behavioral Health Workforce**

**Strategies and Recommendations**

A multi-year effort that included a diverse group of participants to develop a national strategic plan for behavioral health workforce development produced seven primary goals that relate to the following three categories: 1) broadening the concept of workforce; 2) strengthening the workforce; and 3) developing structures to support the workforce. The goals that relate to each category are presented in Table 2.

Broadening the concept of workforce reflects changes in treatment philosophy that emphasize individually tailored treatments based on significant consumer input. Other changes include redefining roles (i.e., who is the main provider of treatment) with increasing emphasis on family members, peers, or other nontraditional helpers. This is critical in rural areas, where “grow your own” initiatives will be a particularly important strategy to recruit “place-committed” people to become the workforce in their town or village. AHEC programs, which are known for their continuing education efforts and “grow your own” programs, could play a vital role in taking this from vision to reality.

Strengthening the workforce implies a focus on activities related to best practices in recruitment and retention, training and education, and leadership development for the workforce. It is important to implement and provide incentives for providers to do not only what is affordable but what is most effective for the treatment population. A healthy work environment with benefits, supervision, and opportunities for advancement will also be important in growing the workforce.

Structural supports for the workforce include, for example, a system for providing technical assistance on workforce practices, improved information technology to assist the workforce especially in rural areas, and a national research and evaluation agenda producing improved information on effective workforce practices. Currently, workforce data are not collected in a consistent manner, which makes reporting across disciplines difficult. A related issue is the current delay of approximately 17 years from when research is released to when it is accepted into the practice environment.

The national, regional, and state efforts currently under way indicate significant momentum behind behavioral health workforce development, particularly in rural areas. Population and workforce trends indicate that the need for behavioral health workers will only increase over the next 10 years. In order to meet these projections, specific strategies need to be employed to broaden the concept of workforce, strengthen the workforce, and build structures to support the workforce. This is particularly true in rural areas, which face a unique combination of factors that create disparities in health care not found in urban areas. Common sense indicates that significant time and effort be put toward developing an effective behavioral health workforce for rural and frontier America.

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References


Integrated Care: The Process of Providing Mental Health Care in Primary Care Practices — The Time Is Now

Sally W. Smith, LCSW, RN

A collaborative effort to address mental/behavioral health for children in western North Carolina has integrated mental health services in 12 nonprofit primary care practices.

In 2003, a coalition of community organizations in and around Asheville, North Carolina, came together to address a growing concern about the lack of comprehensive mental health care for children and families. The group included the medical director of the health department, representatives from community mental health agencies, local management entities that receive state mental health dollars and distribute dollars to the region’s providers, Community Care of North Carolina (Medicaid Managed Care), Buncombe County Medical Society, the regional hospital, Mountain Area Health Education Center (MAHEC), and area pediatric practitioners. They were concerned about the recent closings of a child psychiatric inpatient setting and a local sliding-fee-scale child and family counseling center. This was occurring at the same time that the statewide mental health reform was making it harder for families to obtain mental health services. These issues led this collaborative to apply for funds to provide service to a large group of children and families in a different format.

As a result of this group’s efforts, MAHEC received a two-year grant from the Kate B. Reynolds Foundation to integrate mental health services into twelve nonprofit primary care practices in eight counties in western North Carolina beginning in 2004. The grant was awarded to MAHEC to fund a full-time Integrated Care Project Coordinator with associated supports. It was determined that the center was best positioned to manage this grant for several reasons. First, MAHEC’s family practice residencies through the University of North Carolina have had a strong behavioral health presence for over 25 years. The center has a strong commitment to train their residents about mental health issues and to work side by side with therapists in two family practice residencies and an OB/GYN residency. Second, AHEC has a long history of serving in leadership positions on many statewide groups and committees that work on mental health and Medicaid Managed Care issues, lending credibility, recognition, and trust to the organization at a statewide level. And finally, MAHEC was seen as an impartial and objective organization that could effectively assist the community in its efforts to identify and connect the providers, the services, and the patients in integrating mental health services into medical practices.

Although integrated mental health care was not designed to meet the needs of the patients with severe and persistent mental health disorders (SPMI), it can be a very good choice for many patients where their health and lifestyle are being impacted by depression, stress, anxiety, substance abuse, AD/HD, and other such diagnoses. The Surgeon General has estimated that approximately 20% of the population will need some form of mental health services during the course of their lifetime. Nearly 70% of all health care visits have primarily a psycho-social basis. Recent study suggests that on average, primary care patients with even mild levels of depression use two times more health care services annually than their non depressed counterparts.

It is commonly accepted that integrating behavioral health services into the patient’s medical home has many benefits, including 1) increased likelihood that a patient will follow up...
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and get treatment by the behavioral health person at the practice; 2) increased patient satisfaction; 3) improved patient outcomes; 4) decreased stigma for the patient who is receiving mental health services; and 5) lowered cost of service especially for the highest utilizing patients. Studies clearly show that these considerations can reduce inpatient admissions and inpatient lengths of stay when admissions are necessary.

The Reynolds grant provided dollars to build a clinical, operational, and financial framework that would support integrated care in these 12 practices. Conceptually, the model can be described as the “three-legged stool.” The first leg of the stool provides subsidy dollars to support the hiring of a licensed therapist. The subsidy dollars allow a practice some breathing room until the therapist is fully trained, receiving practice referrals, billing, and beginning to receive reimbursement. The second leg of the stool gives dollars to each of the practices to consult by phone or on-site with a psychiatrist. The psychiatrist does not see the patients directly but builds the capacity of the practice to treat patients with mental health disorders by teaching, consulting and discussing individual cases. The third leg of the stool supports ongoing training opportunities locally, regionally, or on-site for the practitioners to increase their confidence and competence when working with their patients’ mental health needs.

The project, along with several other integrated care efforts within the region, has been very successful. There is growing enthusiasm and interest from across the state in providing more care with this model. Six new behavioral health therapists are now working in area practices, and six different psychiatrists are providing consultation services.

A comprehensive final report will not be submitted to the Kate B. Reynolds Foundation until the end of 2006, yet preliminary information shows that over 400 children and families have already been screened and/or treated as a result of this program. It is expected that this number will grow now that the infrastructure has been fully developed and deployed.

As part of the grant evaluation, there are extensive pre- and post-surveys distributed to the practice staff. Although the post-surveys have not been completed and the final data collected and compiled, anecdotal reports from staff are very positive and optimistic. According to an area primary care physician, “having a therapist on-site has definitely improved the productivity of our physicians.” A local nurse with an extremely active primary care practice adds “I can’t do my job without the therapists.”

Although the Kate B. Reynolds grant ends soon, MAHEC believes in the concept enough to fund the project coordinator permanently. This position will be subsidized through a combination of new grant initiatives and revenue from trainings and workshops presented about integrated care.

The future of integrated mental health care is bright, with some of the best minds and leaders in the state working on ways to further the capacity for patients to be treated holistically in one setting where the entire person is cared for by the same system. Discussions are occurring with universities to consider including integrated care as part of their curricula for psychiatry, social work, and family medicine internships and residencies. In November 2007, Asheville will host the Collaborative Family Healthcare Association national conference, which has a primary focus on furthering the efforts to operationalize the clinical and financial aspects of integrated care. North Carolina is beginning to understand that integrated care can be part of the solution for mental health reform, and all are excited to see what is next on the horizon.

References


AHEC Builds Opportunity for Young Social Workers

Virna Little, PsyD, LCSW-R, SAP

Social work internships at an inner-city Community Health Center provide sought-after and valuable training for students.

Every year, 30-40 students find placements at the Institute for Urban Family Health in New York City to train as social workers. The opportunity to intern at the institute and its community health centers has become one of the most requested placements at many of the local universities. Fordham University, Columbia University, New York University, Yeshiva University, Lehman College, and Adelphi University send undergraduate and graduate students to the institute for on-site, hands-on learning. What makes this AHEC-sponsored program so popular?

“Most students think of doing their internships at social service agencies or hospitals. They have never considered an internship at a community health center,” says Maxine Golub, MPH, regional director of the New York Metropolitan Regional AHEC (NYMRAHEC). “They are often surprised to learn about the varied opportunities the AHEC social work internships offer. Students work at health centers, free clinics, school-based health centers, and sites that provide health care for people who are homeless. It’s a great opportunity for all the students.”

Many people do not realize the amount of training, especially field training, that is required to be a professional social worker. Requirements for an MSW include three internships, with an average of two to three full days in the field for two semesters. The institute offers opportunities for social work students in the areas of general practice, research, clinical work, and administration.

The institute’s social work internships, coordinated by the New York Metropolitan AHEC, place undergraduate and graduate students at community health centers, many of which are located in traditionally underserved neighborhoods in the Bronx and Manhattan. The students are given a variety of assignments, including direct care with patients, outreach to community agencies, or conducting research projects. Interns are a vital and valued part of the psychosocial services department and the centers.

Community Health Centers (CHCs) offer a rich learning opportunity that expands beyond general social services into public health and mental health. The client base is diverse—in age, race, ethnicity, socioeconomic status, and need. Clients come with multiple presenting issues. They may need crisis intervention because they have no food or shelter or because they are living with family violence. They may need concrete services such as food stamps or insurance. They may need clinical services such as therapy for relationship problems, depression, or anxiety. The CHC’s diverse client base provides an excellent forum for first-year students to build a foundation and learn about different services and populations. The kind of diversity seen at community health centers is rare in most intern placements for social work students. Many second-year social work students have the opportunity to provide therapy to adults and children or run anger management or depression groups. In addition to direct patient care, students participate in special learning activities such as in-service training programs for Community Health Center employees and lectures by institute staff members.

At participating CHCs, the social workers and social work students play a critical role on interdisciplinary teams. Social workers collaborate with primary care providers in...
AHEC Builds Opportunity for Young Social Workers

Treating patients and make a tremendous contribution to patient care. Patients form relationships with social workers that help to increase their understanding of medical conditions and improve their adherence to recommended medical treatment.

Our program has been successful in its goal of retaining young social work graduates to work in underserved neighborhoods. We have offered several of our interns positions after graduation, and some have been promoted. “I am grateful for my experience as an intern with the Institute. Many of my peers in school did not get the range of experiences nor have such dedicated supervisors as I was fortunate to have,” says Linda Tillmon, LMSW, now the institute’s regional director of psychosocial services in the Bronx.

We take pride in our internship program and work hard to make sure it is a valuable experience for all our students. Additionally, we are helping to make sure that all social workers who enter the profession are qualified, competent, well-trained professionals. Not only do students receive an excellent internship, but the clients benefit from the services as well. This internship certainly is an example of a strong and lasting relationship between AHEC and a community health center.

Community Health Centers offer a rich learning opportunity that expands beyond general social services into public health and mental health.

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Caring for Our Nation’s Elderly: Challenges for the Twenty-First Century

Elyse A. Perweiler, MPP, RN, and Thomas A. Cavaliieri, DO, FACOI, FACP, AGSF

This article provides a framework for addressing the challenges of caring for a rapidly-growing aging population and reinforces the pivotal role that AHECs will play in meeting the challenges.

An Unprecedented Age Wave
At no time in the history of our nation has the challenge of caring for older individuals been more cogent or more urgent than it is today. By 2030, the size of the 65-plus population will double, reaching over 72 million, or almost 20% of the U.S. population.¹ The long-heralded impact of the retirement of the baby boomers, those born between 1946 and 1964, is almost upon us. This year the first wave of the 78 million baby boomers turned 60. By 2011, Medicare will feel the impact as the oldest members of the baby boom generation reach age 65. Given today’s life expectancy, many of them will live well into their eighties, presenting new challenges for our healthcare delivery system. There will be an unprecedented increase in the 85-plus age group, which is projected to grow from 4.2 million in 2000 to 7.3 million by 2020.²³

Not only is our population becoming older, but it is also becoming more diverse. Projections indicate that by 2030 minorities will comprise 26% of the 65-plus population, up from 18% in 2004. By 2030 the older Hispanic population will quadruple to eight million and the older Asian population will quadruple to four million.¹²³ This unprecedented rate of aging means that not only will our healthcare providers need to be culturally competent and prepared to address issues of healthcare literacy for minority populations, but they will have to be prepared to address aging issues for this population as well. The healthcare delivery system will be challenged to provide new modes of communication and delivery directed at improving access to care for all elders.

Living Longer With Chronic Conditions
Chronic illnesses become more prevalent with aging. Although prevalence of chronic diseases varies by race and ethnicity, 75–80% of those 65 and older have at least one chronic condition and approximately 50% have two or more.⁴⁵ The functional limitations resulting from chronic illnesses such as hypertension, diabetes, arthritis, and heart disease impact quality of life and add to health care costs.⁶ Today, those over 65 represent 13% of the population, yet they are the highest users of health services, accounting for half of all physicians’ visits and half of all hospital stays.⁷ Assistance with activities of daily living such as bathing, dressing, preparing meals, or shopping is needed by 14.3% of those 65 and older and adds to the costs associated with treating the elderly.⁸

Maintaining Independence, Function, and Quality of Life
Historically, our healthcare system has addressed acute, episodic needs. As we look at improving quality of life and empowering the elderly to take more responsibility for their own health care, new systems of home and community-based care are emerging. In order to improve lives, enhance function, and help the elderly maintain their independence, providers must now learn how to encourage older individuals to adopt healthy habits. This will be best accomplished by targeting evidence-based health behaviors such as physical activity, dietary control, weight reduction, and smoking cessation. Research has shown that patients can maintain functional ability through education provided in Chronic Disease Self-Management Programs (CDSMP) and can learn to manage their symptoms, adhere to medication regimens, and adopt healthy lifestyle changes, thus preventing or delaying disability and minimizing the adverse consequences of chronic disease.⁸
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Rebalancing Long-Term Care
Choice and empowerment are the hallmarks of today’s newly emerging home- and community-based services system. The elderly want to remain in their own homes rather than in institutions, but the current long-term care system offers limited options. Under the President’s New Freedom Initiative, the elderly and those with disabilities will now have the freedom to choose where they want to live. As a result, states have begun to rebalance their long-term care systems and reorient Medicaid funds to support home- and community-based services and encourage consumer direction. We must prepare for the long-term implications of these changes for our healthcare system and for the healthcare workforce.

Healthcare Workforce Crisis
The unique challenges of caring for the average 75-year-old, who has three chronic conditions and uses five prescription medications and assorted over-the-counter drugs, are often complicated by both nonclassical presentations of disease and biopsychosocial issues. It requires a special body of knowledge to be aware of these factors, yet today’s healthcare practitioners have had little or no specific formalized training in caring for the elderly. This pervasive gap in training exists across all the health professions. Not only is there a shortage of providers who have been trained to care for the elderly, but there are too few faculty with a background in aging who can train new providers.

A 2005 update of academic geriatric programs in allopathic and osteopathic medical schools conducted by the Association of Directors of Geriatric Academic Programs (ADGAP) indicates that more than half of the academic leaders in geriatrics are not fellowship-trained or do not have a Certificate of Added Qualification (CAQ) in geriatrics. There are currently only 6,600 geriatricians in the nation, but projections indicate that 36,000 will be needed by 2030 to care for the nation’s elders. The fact that the geriatric workforce is in crisis has been documented in nursing, social work, geriatric psychiatry and mental health, physical therapy, and pharmacy. Fewer than 15,000 of the 2.56 million nurses are certified in gerontology, and only 3,500 of the 111,000 advanced practice nurses are gerontological nurse practitioners or clinical specialists. In social work, only 10% of all social work students have had a single course on aging and only 3% of master’s level social work students were enrolled in gerontology programs.

A Call to Action
As the growth of the older population continues to outpace the growth of the nation’s population as a whole, the healthcare workforce will be caring for greater numbers of older individuals than ever before. The implications are clear, as is the mandate for training and education in geriatrics for all healthcare providers. The 2005 White House Conference on Aging affirmed the need for health professions training in geriatrics and addressed the need for a prepared healthcare workforce in two of its top 10 recommendations. Specifically, it supported geriatric education and training for all healthcare professionals, paraprofessionals, health-profession students, and direct-care workers and the attainment of adequate numbers of healthcare personnel in all professions who are skilled, culturally competent, and have specialized training in geriatrics.

Ironically, despite the demographic imperative and the recommendations made by delegates at the White House Conference on Aging, federal funding for education and training in geriatrics was eliminated from the President’s budget in FY 2006. As we advocate for reinstatement of federal funding for geriatric education in the coming fiscal year, as well as other healthcare programs vital to our elderly population, we must continue to train our providers to address the needs of elders and underserved populations.

A Challenge for the Twenty-First Century
As the population becomes more culturally diverse and federal resources for training and education shrink, we must become increasingly creative in order to meet the increasing healthcare demands of the elderly. Our healthcare workforce, including primary care providers and the paraprofessionals who comprise the infrastructure of our healthcare system, must all be trained to address the special needs of the elderly. The challenges of containing healthcare costs, managing multiple medications, navigating fragmented health and community-based service delivery networks,
Caring for Our Nation’s Elderly: Challenges for the Twenty-First Century

caring, and providing long-term care are significant. Rethinking our approach to caring for the elderly, reexamining the resources within the healthcare system, and developing a new system for home- and community-based care are critical. We must create new interdisciplinary teams that will be able to meet and overcome these challenges. Our efforts at training a new healthcare workforce must be redirected to assist culturally diverse and underserved populations in accessing appropriate geriatric care.

A Role for Area Health Education Centers

The focus on self-management of chronic disease and other health promotion strategies is a new approach to independence, choice, and empowerment for our elderly citizens and for their caregivers. As we embark on the President’s New Freedom Initiative, elderly individuals will need assistance in learning how to modify their health behaviors and in accessing available services and resources. The Area Health Education Centers, as a portal to underserved communities, will play a pivotal role in preparing the healthcare workforce to meet the challenges posed by the graying of America.

A number of AHECs have worked to meet these challenges by incorporating Community Health Workers (CHWs) as part of the interdisciplinary team. Known by many names, including Community Health Advisors, Outreach Workers, Promotores, Lay Health Promoters, Lay Health Advocates, and Peer Educators, CHWs are frequently volunteers or part-time workers supported by funding for special projects. Often bridging the gap between health services and communities, CHWs play a significant role in delivery of culturally competent home- and clinically-based health care and are able to address issues related to healthcare literacy, health promotion, and chronic disease self-management programs (CDSMP). The ability of the CHW to forge the way for new partnerships, assist in overcoming language and cultural barriers, and link individuals to nonmedical services often builds trust, leading to improved access to care and better compliance with instructions for medical treatment.

The three New Jersey (NJ) AHEC centers, Camden, Garden, and Shore AHECs, exemplify the partnerships that are needed to meet the complex needs of the increasingly diverse elderly population through varied educational endeavors. Garden AHEC has been providing a series of seminars for seniors on major health concerns, including falls, cancer, and advance directives, and will be adding other topics, such as nutrition and depression. All three NJ AHECs also serve as community service rotation sites for third-year medical students and have recently incorporated community health workers as new members of the interdisciplinary team. The addition of community health workers has put the NJ AHECs in a better position to address concerns about healthcare literacy, to enhance communication and outreach, and to link elderly people to services.

A New Project Empowers Seniors

The Community Health Worker Institute (CHWI), in partnership with the University of Medicine & Dentistry of New Jersey-School of Osteopathic Medicine and its New Jersey Institute for Successful Aging (NJISA), illustrate the role that AHECs can play in health promotion initiatives for the elderly. The CWHI is a Model AHEC grant project awarded to the NJ AHEC with Camden AHEC as the lead agency. Under a new project funded by a grant from the state of New Jersey, the Health Enhancement and Learning Project (HELP) will address common chronic diseases in elderly persons residing in senior housing. CHWs and bilingual peer educators will be trained in the Stanford Chronic Disease Self-Management Program and then will work in collaboration with other health professionals in conducting health assessments for underserved and minority senior housing residents, identifying healthcare needs, and assisting residents in developing a personal healthcare plan. Participants will be enrolled in the Enhance Wellness Program, which provides a web-based registry and reminders for staff to monitor how seniors are doing with their personal health action plans. CHWs will play a key role in helping seniors to complete assessment forms and in providing education about various health promotion strategies, serving as coaches and encouraging seniors to take responsibility for managing their own chronic illnesses.
Caring for Our Nation's Elderly: Challenges for the Twenty-First Century

Social Responsibility and Community Health
As we prepare for the impact of the age wave, it is incumbent on us to embrace the principles of community health and social responsibility. We must address the needs of the population as a whole, yet not neglect the needs of individuals. The underserved elderly merit our attention. As educators and healthcare professionals, it is our responsibility to ensure that all healthcare providers are trained to address the complex special needs of the elderly. New directions for interdisciplinary practice, creative restructuring of healthcare teams, and incorporation of community health workers into home- and community-based practices can facilitate access and break down the barriers experienced by minority and underserved populations. The promotion of successful aging must be done collaboratively, with the physician, the healthcare team, the patient, and the family all working together. Maintaining functional independence and quality of life and the right to choose where one wants to reside and receive health care are the gifts we can give to our nation's elderly. Together we can educate providers and consumers and work as partners. We can and must make a commitment to manage chronic diseases effectively and encourage healthy behaviors, not only for elderly individuals but for the entire population. This is our social responsibility, as well as our medical mandate.

References


Central Coast AHEC—
Working to Support the Growing
Needs of an Aging Population

John Beleutz, MPH, and Steve Lustgarden, MS

Regional collaboration leads to educational initiatives designed to improve geriatric care in California’s Central Coast region.

Healthcare providers and healthcare systems in the Central Coast region of California are not adequately equipped to address the growing demand for geriatric services. To address this problem, the Central Coast Area Health Education Center (CCAHEC) is working to improve access to health care for older adults in Monterey, San Benito, and Santa Cruz counties.

These three Central Coast counties served by CCAHEC are experiencing an increase in the number of elderly residents. Currently 127,000 seniors reside in the tri-county area. Of that population, approximately 35,000 are high-risk seniors whose demand for healthcare services is rapidly increasing. Over the next 30 years, the senior population will more than double to 292,000 while high-risk seniors will increase threefold to 84,000.

At present, there are about 9,000 certified geriatricians and 1,800 MSN geriatric nurse practitioners in the nation for 36 million seniors. Within the tri-county region there are fewer than six geriatricians and only one MSN geriatric nurse practitioner for 127,000 seniors.

As the need for geriatric care has outpaced the supply of health professionals trained in caring for an aging population, CCAHEC has sought to address these access to care challenges by acting as a catalyst for collaboration and programs around geriatric health. CCAHEC’s strategy has focused on the creation of the Monterey Bay Geriatric Resource Center (MBayGRC), an independent nonprofit regional consortium of educational and healthcare organizations. CCAHEC has also created key partnerships with the University of California’s (UCSF) Natividad Medical Center (NMC) Family Practice Medicine Residency Program and Cabrillo College’s Nursing Program.

In 2001, California AHEC provided CCAHEC with funding for the strategic planning and development of MBayGRC. MBayGRC is a unique regional collaboration between 10 organizations that have made commitments to work together to improve access and care for the senior population in Monterey, Santa Cruz, and San Benito counties.

The MBayGRC strategy involves a two-fold approach:
1) To develop interdisciplinary geriatric/chronic care management educational programs for family practice residents, nurses, allied health providers, seniors, and family and informal caregivers; and
2) To develop geriatric/chronic care management centers to provide comprehensive assessments and chronic care management services to seniors and their families and providers that enhance or augment a community-based continuum of care.

MBayGRC’s members include: Health Projects Center/Central Coast Area Health Education Center, Community Hospital of the Monterey Peninsula, Watsonville Community Hospital, Natividad Medical Center, Clinica de Salud del Valle de Salinas, Palo Alto VA Health Care System, UCSF School of Medicine, California State University Monterey Bay, and Cabrillo and Hartnell Community Colleges.
Central Coast AHEC—Working to Support the Growing Needs of an Aging Population

The initial three years of funding from CCAHEC has resulted in a sustainable organization. MBayGRC has generated over $500,000 in additional grants and contracts to support programs.

MBayGRC’s current programs/initiatives include:

- Developing and piloting a geriatric core curriculum for the UCSF family practice residency program at Natividad Medical Center.
- Developing and piloting a geriatric core curriculum for the associate degree in nursing program at Cabrillo College.
- Developing a Geriatric Assessment and Care Management Center at Community Hospital of the Monterey Peninsula’s Behavioral Outpatient facility for older adults with mood disorders and multiple co-morbidities.
- Developing a feasibility study and business plan for a Geriatric Evaluation and Chronic-Care Management Inpatient Unit at Natividad Medical Center.
- Sponsoring annual conferences on Aging and Chronic-Care Management for physicians, nurses, and behavioral and allied health professionals. MBayGRC’s second annual “Aging and Chronic Care” will take place in January 2007.
- Sponsoring workshops/seminars in geriatrics and chronic-care management for healthcare staff and community service agencies that provide support services to family caregivers and the frail elderly.
- Developing a Geriatric Assessment/Chronic-Care Management Center at the Veterans Administration Clinic in Monterey to provide patient services and to serve as a training site for family practice residents and nursing students.
- Sponsoring geriatric fellowships for graduates of UCSF’s family practice residency program at Natividad Medical Center to become MBGRC faculty.

CCAHEC funding has also provided the opportunity for students enrolled in the Cabrillo nursing program to participate in enhanced gerontology didactic and clinical practice experiences. The gerontology-specific theory classes total 16 hours. Clinical practice consists of gerontology-specific rotations in long-term-care facilities, Fort Ord’s Veterans Administration Clinic, Cabrillo College’s Stroke Center, and at community-based agencies.

CCAHEC supports the provision of UCSF/NMC family practice medicine residents with community-based experience at a range of community agencies providing services to the elderly population. Residents spend time working with and learning from agencies providing services such as hospice care, respite care, food for seniors, and adult day care.

Cabrillo College, with CCAHEC support, is currently developing joint simulation training for Cabrillo College nursing students and NMC family practice residents utilizing patient simulators. The simulations will present clinical geriatric case scenarios and will promote collaborative practice and multidisciplinary partnerships in the delivery of patient care. The simulation technology enables the faculty operator to direct a variety of patient events in which variable physiological symptoms unfold and to utilize video replay capability after exercise debriefing with participants.

CCAHEC will continue to engage in innovative programs such as the work at Cabrillo College. Its ability to do so is dependent on continuing creative collaborations through its affiliation in MBayGRC and through partnerships with local academic institutions.
Collaboration on Geriatric Training Reaches Many

Terry Gefell, MSEd, CHES, and Pamela Mayberry

Since 2003, the Finger Lakes Geriatric Education Center (FLGEC) at the Ithaca College Gerontology Institute (ICGI) and the Central New York Area Health Education Center (CNYAHEC) have joined forces to expand and enhance the availability of geriatric training in a 16-county region. As a result of this collaboration, nearly 1,500 health professionals and paraprofessionals have received much-needed training in their local communities.

The collaboration began with the implementation of 11 geriatric trainings held from March through December 2003 across eight counties. In each county, community partner teams worked in collaboration with ICGI staff member Marilyn Kinner to plan the trainings. Each team consisted of 6-10 professionals representing county offices for the aging, skilled nursing facilities, home health agencies, county health and social services departments, and rural health networks.

Program topics addressed a variety of issues faced by caregivers of geriatric patients, such as mental health issues, stress management, understanding and coping with challenging dementia-related problems, geriatric depression, geriatric drug therapy, and balance and gait disorders. In subsequent years, other topics were added, including sexual issues in long-term care, caring for combative residents, and the dying process.

Since the initial program, more than 500 health professionals have been reached, representing the fields of psychology, nutrition, family medicine, nursing, occupational and physical therapy, social work, and more. Nursing staff—namely, certified nursing assistants, home health aides, LPNs, and RNs—constituted the largest segment of the audience.

On-site program evaluation was conducted after each workshop. Evaluations indicated that workshops were very well received; 61% of attendees “strongly agreed” and 39% “agreed” that the information was valuable professionally. Responses to usefulness surveys, sent to attendees three months after the workshops, indicated that most participants applied the knowledge and skills obtained at the training to their daily work. One participant shared, “I learned more about caring for residents and understanding how our residents may be thinking. Most of all, I learned about myself. I learned that I play an important part in these people’s lives. I am sharing their lives as they are sharing mine.”

Marilyn Kinner, Outreach Program Coordinator for ICGI, comments, “Administrative staff
Collaboration on Geriatric Training Reaches Many

of local home health agencies and long-term care facilities made every effort to allow as many frontline workers as possible to participate. The trainings were seen as an opportunity to help staff improve their skills and for administrators to acknowledge the importance of their work.”

Responding to needs identified by community teams, a grant from CNYAHEC in fall 2004 made possible the development of a one-day training, Building a Great Caregiving Team: Leadership Skills for Nurses. The training team consisted of two faculty members from Ithaca College School of Business and a nurse manager from St. John’s Nursing Home. The team developed an interdisciplinary curriculum to address topics such as coaching and mentoring, conflict resolution, and communication skills. Standard leadership skills were made pertinent to the long-term care setting.

In May 2005, the training was piloted with 22 nurses from seven facilities in five counties attending the training. Over 75% of the participants rated the teaching tools and overall workshop as excellent or very good. “I especially appreciated the different perspectives of the lecturers; all information was beneficial for application in nursing,” commented one participant. Due to the success of this offering, additional trainings were offered in 2005 and 2006, reaching an additional 36 nurses.

“With the aging of the population, especially in rural areas, it is clear that health workforce development must reach those professionals and paraprofessionals working with the elderly population on a daily basis. The partnership between CNYAHEC and ICGI has allowed us to offer on-site continuing education in our most rural communities,” explains Joanne Race Borfitz, Executive Director of CNYAHEC.

To make training more accessible, in 2006 three on-line modules were produced on geriatric depression, home safety, and reducing falls. Each training module comes with a printable workbook containing interventions, resources, and references.

In addition to the community-based programs and the on-line modules, CNYAHEC has also supported ICGI’s annual conferences and spring/fall workshop series, reaching an estimated 500 additional health professionals.

Pamela Mayberry, Associate Director of ICGI, describes the synergy between ICGI and CNYAHEC: “The linkage with CNYAHEC enhanced the institute’s rural training initiative. The collaboration increased our geographic reach and allowed us to serve professionals and paraprofessionals in counties where training on critical topics had not been previously available—a perfect example of how organizations with similar goals can combine forces to accomplish more than would be otherwise possible.”
Clinical Training of Medical Students in Interdisciplinary Care Utilizing a Geriatrics Program at PACE (Program for All-inclusive Care of the Elderly)

David Pole, MPH, and Richard Schamp, MD

For four years, Saint Louis University’s AHEC has implemented an interprofessional approach to patient care which allows medical students to experience evidenced-based medicine for older patients who have maintained their independence.

The AHEC Program Office at Saint Louis University (SLU) School of Medicine is located within the Department of Community and Family Medicine (CFM). In addition to working with the East Central Missouri (ECMO) AHEC regional center, the program office has established an interprofessional program committee that has, for the past five years, discussed issues of providing care to the medically underserved, identified issues and barriers to accessing quality care, and worked to place these discussions into curriculum modules of the schools of medicine, nursing, physical therapy, occupational therapy, social work, and public health. Additionally the AHEC program office has worked with CFM faculty to design and implement electives that provide medical students clinical training in the community where they can get firsthand experience caring for the medically underserved and/or participate on interdisciplinary team cares.

Mark Mengel, MD, MPH, Chair of Community and Family Medicine at SLU and the Program Director for AHEC, recalls that “although there continues to be great discussion around the interprofessional model, as a clinician, I have found it challenging, at least, to implement and systematize. My experience with the Alexian Brothers Community Service (ABCS) PACE (Program for All-inclusive Care of the Elderly) in Saint Louis is that they exemplify the interprofessional team approach to patient care.”

In 2002, the SLU Department of Community and Family Medicine developed an affiliation agreement with the PACE program to provide a medical director and hired Richard Schamp, MD, a family practice physician, to function as a faculty member within the department and the medical director for the program. With the demonstrated success of the interprofessional model at PACE, Dr. Mengel worked with Dr. Schamp to create an elective that would enable medical students to experience firsthand the exemplary model of team care demonstrated in this program. Dr. Schamp played a key role in the development of this course and has worked directly with medical students participating in this elective since 2003. Dr. Schamp enjoys working with students in this setting, stating that “this rotation is rich in pathology and opportunities for hands-on care of complicated chronic disease as well as acute illness. In addition to the immersion experience into a unique interdisciplinary care model, students gain proficiency in skills of evidence-based medicine and information mastery in day-to-day practice.” Laura Frankenstein, MD, a family practice physician, who is the current medical director for the SLU AHEC program office and was previously a medical provider at the ABCS PACE program in Saint Louis, states that “students participate in the care of medically and socially complex elders in this comprehensive setting. It may be the first time a medical student has evaluated a patient along with a physical therapist, gone on a home visit with a social worker and a nurse, or...”
Interprofessional Team Approach to Providing Clinical Care

A patient’s healthcare needs often require the input of a variety of professionals in addition to primary medical care providers. Models of professional interaction can be identified based on the spectrum of interprofessional collaboration and coordination and range from independent medical management to interdisciplinary collaborative care.¹

Interdisciplinary collaborative care is not without its challenges. It often requires additional time, and staff need to set common goals, define their roles, and establish open lines of communication. The environment needs to be one in which members are open to learning and appreciate the scope of work of various disciplines. Unfortunately, these interdisciplinary teams often lack institutional support and the support to shift from disease-centered care to patient-centered care.² The ABCS PACE program in St. Louis has met these challenges by having a well-developed system with defined roles and effective communications. Medical students are able to step in, observe, and participate in true interdisciplinary care during a two-week rotation. Students experience the beneficial aspects of collaborative care that address chronic disease management in an elderly population.

What Is PACE?
The PACE model is centered on the belief that it is better for the well-being of seniors with chronic-care needs and their families to be served in the community whenever possible. PACE serves individuals who are aged 55 or older, certified by their state to need nursing home care, and who are able to live safely in the community at the time of their enrollment. Nationally, only about 7% of PACE participants reside in a nursing home; the majority are served on an outpatient basis.

PACE strives to provide the entire continuum of care to seniors with chronic-care needs while allowing them to maintain their independence in their homes for as long as possible. Care and services include adult day care, nursing, physical, occupational, and recreational therapies, meals, nutritional counseling, social work, personal care, and home health care. Other services that are available as needed include audiology, dentistry, optometry, podiatry, and speech therapy. Medical care is provided by a PACE physician and includes all necessary prescription medications.

Interdisciplinary Team (IDT) meetings play an important role at ABCS PACE in developing participant care plans, coordinating the delivery of care, and communication.

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Table 1. Models of Professional Interaction.

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<tr>
<th>Model</th>
<th>Description</th>
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<tr>
<td>Independent medical management</td>
<td>One provider works independently to address all of the patient’s issues with limited input from other professionals.</td>
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<tr>
<td>Parallel multidisciplinary care</td>
<td>Different aspects of a patient’s case (such as therapeutics, rehabilitation, education, social issues, substance abuse) are handled independently by the appropriate experts, rather than integrated care, the patient’s problems are subdivided and treated in parallel.</td>
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<tr>
<td>Consultative model</td>
<td>One provider retains central responsibility and maintains professional independence in patient care while consulting with other professionals as needed.</td>
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<tr>
<td>Interdisciplinary collaborative model</td>
<td>Providers from different professions cooperate by establishing a means of ongoing communication with each other and with the patient and family to create a management plan that integrates and addresses the various aspects of the patient’s health care needs. Providers share mutual goals, resources, and responsibility for patient care.</td>
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Clinical Training of Medical Students in Interdisciplinary Care Utilizing a Geriatrics Program at PACE

Daily IDT meetings occur where staff members touch base about participants’ status, provide updates, make adjustments to care plans, and problem-solve across disciplines to determine priority actions.

Medical Student Experiences
This elective was designed with two primary objectives. The first was to provide medical students with experience managing common problems/diseases including diabetes, heart failure, coronary artery disease, cerebrovascular disease, peripheral vascular disease, osteoarthritis, COPD, depression, thyroid disorders, and common cancers. Also included are issues common in care of the elderly such as dementia, mobility and gait disturbances, urinary incontinence, failure to thrive, pressure ulcers, delirium, polypharmacy, and acute care. The second objective was to provide students an opportunity to experience and participate in interprofessional team care to understand the roles of various healthcare providers and how the physician can, and must, interact with the team to create the most effective care plan for the patient. The patient mix at the ABCS PACE program is 3% inpatient, 90% outpatient, and 7% nursing home/home care. During this two-week rotation, students evaluate approximately 40 patients, participate in daily team meetings, and follow the care of various patients through the process.

Student Learning Experiences with the Interdisciplinary Team (IDT) Meeting
Students participate in the daily team meetings and evaluations of current and potential enrollees. The medical director assigns students to specific patients and the students then work with members of the team to develop care plans for new enrollees. Students participate in reporting to the IDT on updates of current patients’ status and identification of patients’ needs and/or changes in status (medical, mental, psychosocial, and functional). Students work with the medical staff and learn how to coordinate tracking and evaluation of services and care. Students participate in problem solving and experience the challenges of coordinating and clarifying team care when the duties of various healthcare providers intersect.

During the course of the two-week rotation, students assist to develop, modify, and approve patient-care plans including changes in level of care, attendance, and addition or reduction of services. Dr. Schamp meets with students daily and assigns focused readings based upon the case presentation and/or interprofessional-care needs of the patients assigned to the students. Students are able to discuss cases, readings, and learning objectives with the physician and/or team members throughout the afternoons each day. The medical student is assigned times with most of the other disciplines during the elective in order to observe the interdisciplinary process from their perspective.

Within each patient’s care plan, students experience the problems and challenges identified with:
- Addressing participant goals for each problem vs. just the providers’ goals.
- Developing IDT interventions for each problem and how the healthcare providers work together based upon their clinical scope of work and experience.

It may be the first time a medical student has evaluated a patient along with a physical therapist, gone on a home visit with a social worker and a nurse, or been in a team meeting where the van driver has a suggestion that will keep a patient from being hospitalized.
Clinical Training of Medical Students in Interdisciplinary Care Utilizing a Geriatrics Program at PACE

• Clear presentation of the patients’ status and measurable goals for their given conditions.
• How the interventions are best managed and implemented.
• How to assess problems and how goals were either met, not met, or will continue to be pursued.

By the end of this elective, medical students are expected to:
• Describe interdisciplinary roles in the comprehensive care of frail elderly.
• Participate in performing Comprehensive Geriatric Assessments.
• Perform fall assessment and gait evaluations.
• Evaluate and treat common geriatric syndromes.
• Perform behavioral, cognitive, and psychological screening tests.
• Explain key geriatric pharmacology principles.

• Discuss selected ethical issues, including end-of-life care and advance directives.

Students must have successfully completed both the Family Medicine and Internal Medicine Clerkships prior to taking this elective and are evaluated based upon a written paper, preceptor evaluation, and an oral presentation on a mutually selected topic to the PACE clinical staff.

AHEC Role and Student Feedback
The AHEC program office at SLU, as with this example, is involved in the identification of clinical training opportunities in the community, the development of the curriculum and/or clinical experience, and the promotion and recruitment of medical students to participate in the course. Although we have had only a handful of students take this elective in the past three years, the feedback has been very positive regarding the clinical training and the understanding and appreciation for the contributions of different disciplines to improved patient care. AHEC is working to enhance promotion of this elective for medical students at SLU.

References
1 Ruebling, I. (2005). Beyond Sequential Care of Inter-disciplinary Team Care. St. Louis: Saint Louis University AHEC Inter-professional Curriculum Committee.

South Central Kentucky AHEC Partners with Barren River Long-Term Care Ombudsman Program

Lucy Juett, MS, and Ruth Morgan, BSW

South Central Kentucky AHEC and the Ombudsman Program provide unique insights in nursing homes for family practice residents to learn about nursing homes and to understand nursing home residents on a non-medical level.

A 20-year partnership between the Barren River Long-Term Care Ombudsman Program and the South Central Kentucky Area Health Education Center at Western Kentucky University has been working to improve the quality of services to long-term care facility residents and the level of training and knowledge to family practice residents. The partnership began in October 1986 when they came together around three areas of mutual interest: physician training, empowering long-term care residents, and educating families and facility residents who are consumers of long-term care services.

The mission of the Barren River Long-Term Care Ombudsman Program is to improve the quality of life and care of residents of long-term care facilities, while the mission of the AHEC is to promote healthy communities through innovative partnerships.

Physician Training

The South Central AHEC conducts a month-long community medicine rotation for family practice residents through the University of Louisville. While these physicians may care for a few nursing home patients, most of them are unfamiliar with the complicated long-term care environment. Their only exposure to the long-term care setting is when they make their monthly visit to the facility. Through the Ombudsman Program, the family practice residents are provided a full day of training. The day includes a lecture and a trip to a nursing home for a review of the facility’s inspection reports and nonclinical bedside chats with residents of the facility. Physicians are provided with a list of long-term care resources to take with them.

At the end of the day of training physicians are expected to:

• Understand the services of the Long-Term Care Ombudsman Program.
• Discuss the nursing home care planning process and the role of the physician in that process.
• Understand the regulatory guidelines for long-term care facilities.
• Understand statements of regulatory deficiencies.
• Discuss the link between the regulations and the facility staff’s ability to implement physician’s orders.
• Understand how to access nursing home inspection reports.
• Receive a copy of the rights of residents under Kentucky law.
• Discuss the differences in services provided by a nursing facility and a personal care facility.
• Discuss some of the major care issues for nursing homes to include nutrition, hydration, use of restraints, and staffing.

Prior to the training, family practice residents reported no knowledge of the Ombudsman Program and little knowledge of the long-term care environment. Following the training, they...
recognize the program as a valuable resource for themselves, their patients, and their patients’ families; these physicians report a better understanding of the needs of their nursing home patients. The residents rate this experience as one of the highest of the community medicine rotation.

Empowering Long-Term Care Residents
The two agencies also partner to empower nursing home residents to take a more active role in directing their own quality of life and care. Every long-term care facility should have a resident council whose role is to provide a forum where residents of the facility can meet to discuss their common concerns. Through the council, residents can communicate as a group with the facility administration and make recommendations and suggestions or file grievances. The Ombudsman Program staff, aware that many of these councils were not effective, joined with the AHEC to empower these councils.

Since 1998, the agencies have jointly sponsored a day-long conference for delegates of these councils. The conference includes facilitated group discussions with residents about life and care at their long-term care facility. These discussion groups serve as training for council members who return to their facilities and lead similar conversations with members of their respective councils. The AHEC provided seed money for the first two conferences and continues to help plan, coordinate registration, and provide staff for the day of the event. One example of how the conference has empowered residents is when one council submitted a list of grievances to the facility’s operating corporation, resulting in 13 significant improvements in policies and procedures affecting laundry, dietary, nursing, and other services. The council members reported that their actions had resulted in major improvements in their quality of life and that their direct caregivers were proud of them.

At the 2006 conference, council delegates provided a list of barriers encountered when they tried to make meaningful choices about the things that affect them. The dynamics and causes of some of these barriers will be explored further through the partnership.

Joe Garst, Edmonson County Health Care administrator, indicates that the residents who have attended from his facility have a much better understanding of the resident council’s role and how to communicate their concerns to staff.

Ann McKee, President of the Resident Council at Rosewood Manor, notes that participation in the conference has increased resident attendance at meetings and that residents are more educated about their rights, feel freer to speak up, and have a better understanding of how to process their concerns.
South Central Kentucky AHEC Partners with Barren River Long-Term Care Ombudsman Program

Educating Long-Term Care Consumers
The decision to move to a long-term-care facility in the Barren River Area is now easier thanks to a comprehensive consumer guide written by the Ombudsman Program staff and called “Finding Long-Term Care in the B.R.A.D.D.” The AHEC provides funding so that this helpful guide can be distributed free to consumers throughout the 10-county Barren River Area. The guide includes information on the various levels of care offered by long-term care facilities, alternatives to nursing home placement, the limits of Medicare skilled-care coverage, information about applying for Medicaid long-term care benefits, and many helpful consumer tips. It also includes a comprehensive listing of every licensed long-term care facility in the area.

Since this partnership began, more than 160 family practice residents have been educated, over 350 nursing home residents have been trained, and consumer guides have been distributed to 5,500 people. The South Central Kentucky AHEC and the Barren River Long-Term Care Ombudsman Program have forged a long-standing relationship which will continue to grow as they seek new ways to merge the missions of their agencies.
Is the United States facing a health workforce crisis in the near future, such as a shortage of nurses and primary care physicians? Many prominent researchers think so. Recent articles point to a chronic maldistribution of healthcare workers, decreasing job satisfaction, lower reimbursements, a precipitous decline in the choice of primary care disciplines for medical school graduates, and the need for a health workforce that reflects the growing diversity of the country. These factors can have far-reaching implications regarding access to health care, particularly for medically undeserved rural communities and other vulnerable populations groups, such as the elderly, poor and recently arrived immigrant groups. Additionally, with HRSA’s Bureau of Primary Care already in the process of expanding community health centers nationwide, there is an acute need for health professionals committed to caring for the underserved.

Because the AHEC Program’s core mission is to address these very issues, the Spring 2007 edition of the NAO Bulletin will highlight AHEC/HETC program successes in assessing and helping to build the health professions workforce. Articles are solicited that describe effective AHEC/HETC programs, or AHEC/HETC supported efforts, for example:

- Programs that increase the numbers of healthcare providers in rural and underserved areas.
- Programs that improve retention of health care workers in rural and underserved areas.
- Programs that have had an impact on the recruitment of health professionals to Community Health Centers and other safety net sites through strong working relationships with AHEC/HETC.
- Documented AHEC/HETC success stories related to broadening/impacting the diversity of the health care workforce.
- Successful strategies for assessing present and future health workforce needs.
- Programs that have been successful in increasing the number of medical/osteopathic school graduates choosing primary care residencies (special tracks in the medical school curriculum, mentoring programs, state supported incentive programs, etc.) in which AHEC/HETC plays a role.

Deadline for First Draft of Articles: Monday, February 26, 2007

Editorial Guidelines (Bulletin submission guidelines) can be found at the National AHEC webpage: www.nationalahec.org under NAO Bulletin or at:


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

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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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