

THE NATIONAL
AHEC
BULLETIN

A Publication of the National AHEC Organization
VOLUME XXIV, NUMBER 2
Spring/Summer 2008



Urban Health in America:
The AHEC Role

25th Anniversary Issue

Urban Health in America: The AHEC Role

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Improving Lives Through a Deliberate Focus on Urban Health

Stephanie B. Coursey Bailey, MD, MS

When you ask Jackie what she wants to be when she grows up, the 12-year-old Nashville girl proclaims, “I want to be a doctor.” Jackie’s ambition belies her harsh reality — living in an inner city where health disparities are rampant and tragic events, including rape and violence, have marred her childhood. Yet, Jackie’s dream underscores the undying hopes of many urban communities and the urgency to radically change the health care delivery system in America.

This edition of the National AHEC Bulletin focuses on urban health. The articles address such issues as the shortage of healthcare providers, health disparities, the need to focus on emerging health issues and the complexities of urban communities. Jackie’s story is relevant to these key issues. The greatest disparities are magnified by environments that are not promoting health in childhood, thus leading to harmful and seriously diminished health in adulthood. On top of the serious problems impacting urban communities — poverty,

violence, drug abuse, high crime, and homelessness — urban areas are faced with decreasing revenue while having disproportionate rates of sickness and premature death. Jackie’s chances of becoming a doctor are greatly influenced by her environment: the socio-economic factors of “urbaness” and decisions made by her and others around her. They are also predicated on the educational structures and curricula that AHECs and others will need to enhance and support if urban health is truly going to deliver health — and childhood dreams.

How is it possible that 50% of our national healthcare budget pays for care in the last six months of life? How is it possible that the United States spends \$2 trillion on health care each year yet ranks 47th among industrialized nations for health indicators? How is it possible that chronic diseases are on the increase, to the point that this generation of children stands to be the first that can expect a shorter life span than their parents?

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Celebrating Our Milestones, Envisioning Our Future

Robert J. Alpino, MIA; and Joel Davidson, MA, MPA

The first generation AHEC projects funded in 1972 were predominantly rural ones. It wasn’t until the 1976 reauthorization of the AHEC program that Congress “emphasized that improving access to health care in urban underserved areas also was to be addressed by the program. A debate ensued as to the applicability of the tested, rural AHEC model to the urban environment.”¹ The first urban AHECs entered their initial planning year in 1977 and included the University of Pittsburgh and a consortium led by Howard University, with George Washington University and Georgetown University.² It is therefore fitting that the Spring/Summer 2008 edition

of the National AHEC Bulletin examines the activities and achievements of urban AHECs 30 years after they were first developed. Urban AHECs address the same three key missions as rural AHECs but in a manner that is specific to the challenges of the urban environment. For example, in the Practice Support mission, the issue of professional isolation may not be of major concern to urban providers while assistance with cultural competency issues may greatly support urban practice, as cities have always served as magnets for new immigrants to America.

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Editorial Overview

The AHEC Role in Shaping Urban Health Policy

Lisa Mustone Alexander, EdD, MPH, PA

Urban settings are becoming the predominant social community. By the year 2030 in other industrialized nations around the world, it is estimated that more than 80% of the population will reside in cities.¹ A walk through any major American city in 2008 reveals an urban renaissance, with new construction, increased population density and

sadly, more pronounced economic disparities. In Washington, DC, two AHEC centers serve the needs of an urban area that is both remarkably diverse and yet compact. The city covers 61 square miles with a population of 581,530.² Despite population growth and a surge in residential construction, the most current data (2006) represent a 30% increase in the number of DC residents living in poverty, the highest level since 1999.³ With almost 1 in 5 residents living in poverty, health care needs for vulnerable populations are most acute. There are 210,000 medically-vulnerable individuals living in the District of Columbia – this represents 35% of the entire population of the District of Columbia.⁴ The demographic composition of the city is also undergoing change. As seen in Table 1, population figures over the last six years indicate shifts in the racial and ethnic composition of the city's residents.

Fifty-seven percent of emergency room visits over the last five years were due to primary

AHECs are uniquely qualified to strategically navigate the complexities of urban settings because of the depth of their community partners, their ability to analyze health trends and rapidly develop solutions that positively impact health care and influence policy changes for sustainable system reform.

care sensitive conditions.⁵ Like many cities, the distribution of ambulatory services does not meet the health needs of the population, with shortages affecting the young, old, and the chronically ill living in the city's most economically disadvantaged neighborhoods. It is estimated that more than 50% of the city's residents live in Health Profes-

sional Shortage Areas. Approximately 1 in 50 residents are living with AIDS or have been diagnosed as HIV positive. Nationally, 39% of HIV infected people develop AIDS within a year, but in Washington, DC this rate is estimated at 70%, suggesting that most individuals were diagnosed years after being infected with the HIV virus.⁶ The burden of other chronic diseases is also high, with hypertension affecting 27% of the adult population. While diabetes affects only 8% of residents, more die from the disease than in other benchmark cities.

Health policy reform and the "long emergency"

Years of transient leadership in the DC Department of Health took its toll on the department's capacity to effectively track public health indicators and primary care access. Health disparities were widely recognized. The safety net clinics were doing a good job of plugging the dike and doing the best they could to keep the system afloat. The sense of



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Table 1: Demographic Changes 2000-2006

Race/Ethnicity	2000 (%)	2006 (%)
African-American	59.4	54.9
White	27.8	31.6
Hispanic/Latino	7.9	8.2
Asian	2.6	3.4
Two or more races	1.7	1.3

The AHEC Role in Shaping Urban Health Policy

urgency, however, was lost on policymakers and politicians. The DC Primary Care Association (DCPCA), established in 1997, quickly became the primary vehicle for health policy reform efforts. A strategic decision to address the lack of reliable data to document the problems of the uninsured and pervasive health disparities became a top priority. Without it, the task of health policy reform was nearly impossible. In addition, barriers to recruiting and retaining high quality primary care providers served as the stimulus to establish the DC AHEC program in 1999. The DC AHEC, working together with the community health centers, the DCPCA, and community stakeholders, used the power of many to initiate an effort with the Department of Health and the City Council to strengthen data collection.

In 2001, a decision to close the city's only publicly funded hospital was made amidst great controversy. Effective leadership, advocacy, and quality data that documented barriers to primary care access and poor health indicators persuaded city officials to focus on primary care needs and the uninsured. The result was a new publicly funded health insurance program for the city's most vulnerable residents. The program essentially captures those individuals traditionally not eligible for Medicaid but who live in poverty and lack health insurance. Since its implementation, the number of individuals without health insurance has declined. Current estimates suggest that approximately 9% of the city's population is uninsured which compares favorably to other cities of similar size. In order to strengthen the primary care health workforce, the AHEC program, in conjunction with community health centers and other safety net clinics, began to track students and residents during their training and also their subsequent career decisions. Successful data reporting allowed the AHEC and the DCPCA to advocate for a loan repayment program that was signed into law in 2005. The challenge of living in our nation's capital is that while we have significant health workforce needs, DC is ineligible to receive the 50% in matching funds for the contract costs from the federal government. The law governing this program specifically states that only the 50 states are eligible for the matching

grants, therefore excluding the District from receiving these funds. So, while the AHEC can advocate on the local level for health policy reform, we still face national policies that further constrain our capacity to respond to local health workforce needs.

The synergistic partnership between the DC AHEC and the DCPCA has allowed both organizations to address their specific organizational missions while enhancing primary care service delivery. The governing boards of the AHEC centers and the DCPCA have reciprocal representation. Partnerships such as this were relatively uncharted waters for two HRSA-funded programs. During the early stages in our development it was extremely important to have clear delineations of organizational mission and goals along with strong communication networks for the leaders of the AHEC and DCPCA.

Urban health needs: DC AHEC responds

The first DC AHEC Center is located in Ward 8, an area of the city with the highest rates of poverty and the fewest number of primary care providers. The Center focuses on outreach and health education to the young and the elderly. Patient navigators are the primary tool by which the Center achieves this mission. The Program Office plans to work closely with the Department of Health to define the scope of work, and to credential and document the effectiveness of this new legion of health workers. By tracking their activities and patient outcomes, the first steps will be taken to effect a policy change to include the development of a reimbursement mechanism for this activity. The second DC AHEC Center is co-located with the DCPCA's "Medical Homes" initiative. This Center facilitates clinical placements at the community health centers and interfaces with four university health professional programs to achieve maximum equity in assigning all levels and types of students and residents. Both Centers support

Concentrations of poverty and social isolation place added stress on urban health care delivery systems that care for individuals who present with conditions that are often far more advanced and complex by the time they seek care.

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a variety of programs that focus on Kids Into Health Career activities, including a Health and Medicine Academy at Eastern High School in Southeast Washington.

In 2006, health professional students from the AHEC partner schools (Georgetown, George Washington and Howard Universities) began exploring the possibility of opening student-run clinics to meet the unmet needs of the community and to expand the reach of existing primary care clinics. AHEC faculty collectively supported the students by linking them to community groups, assisting with grant preparation, and developing

DC AHEC Urban Health Curriculum Content Domains
Cultural and Linguistic Competency
Social Justice, Ethics, and Human Values
Population-based Health Approaches
Health Promotion/ Disease Prevention
Community Oriented Primary Care
Financing of Health Care
Primary Health Systems and Care Delivery
Leadership and Advocacy
Health Disparities

an urban health curriculum to provide a contextual foundation for their clinical experiences. The curriculum is uniquely designed to prepare students to practice culturally sensitive health care in an urban environment. A special focus on the social determinants of health provides stu-

dents with an understanding of the interplay between economic and social conditions and a patient's health status. Concentrations of poverty and social isolation place added stress on urban health care delivery systems that care for individuals that present with conditions that are often far more advanced and complex by the time they seek care. The curriculum project is an ambitious undertaking that is possible because of the strong inter-institutional relationships facilitated by the AHEC over the last nine years. These close relationships among faculty from different universities and disciplines also provide students with positive role models that will serve them well as future members of the healthcare team. In just eight months, over 120 students and faculty have volunteered in the clinics, serving over 250 patients.

Winston Churchill once remarked that "we shape our buildings and then our buildings shape us." The same can be said for a city — the concrete structures that typify many urban landscapes can hide underlying social conditions that negatively affect the health of its citizens.

AHECs are uniquely qualified to strategically navigate the complexities of urban settings because of the depth of their community partners, their ability to analyze health trends and rapidly develop solutions that positively impact health care and influence policy changes for sustainable system reform.

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Improving Lives Through a Deliberate Focus on Urban Health

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The current healthcare system is in trouble, and in the nation's inner cities it is in crisis. Consider these numbers from the CDC's monitoring of health in the United States:

- Greater than half of black females in this country are obese.
- 17% of all children are overweight.
- Three out of four females with AIDS are women of color – and most are black.
- An estimated 105,000 youth will die from causes related to tobacco use.
- Chronic diseases cause 70% of all deaths.
- Cases of diabetes – one of the deadliest chronic diseases – have doubled in the last decade.
- Motor vehicle crashes are the leading cause of death for teens, accounting for 36% of all deaths in this age group.
- Homicide is reported as the second leading cause of death for young people ages 10-to-24 years old.

The current system is wrought with disincentives (excess litigation, decision-making that often excludes physicians, reimbursement cuts, to name a few), creating an environment where providers prefer to leave the system rather than fight it. Stephen Foreman, assistant vice president for research at the Pennsylvania Medical Society, recently released a study predicting a 25% shortage of physicians in 2020 across most specialties. Clearly, health care delivery in the 21st century needs to be radically different than the one born out of the Industrial Age, a downstream-focused system that too often ignores prevention and protection. We have not created an environment in which Jackie can be healthy enough to realize her dream, and we are destroying the system in which she aspires to build a career.

Public health and traditional health care need to come together to become a value-based health system where healthcare equity is as important as healthcare innovation. This new system must be based on value for the consumer; people choosing health protection as opposed to waiting for illness. This new system must address disparities, create metrics to measure cost and effective-

ness, and reward best practices — and it all needs to happen in a transparent manner. While the particular complexities of the urban communities can be spread over a wide variety of educational subjects, a master's level emphasis on urban health that incorporates study of health disparities, health equity and social determinants should be considered — something to which AHEC can lend its voice.

Fortunately, now more than ever, we are well-positioned to build a more effective network of partners and create a better balance between prevention and providing care. As a nation we are beginning to understand that we cannot continue putting more than 95% of our health resources into disease treatment and care and less than 5% into health protection. This has long been making economic sense to the business community that can't afford to continue to bear the financial burden of offering health benefits that ignore prevention. It is also beginning to make health sense to families and individuals who know "an ounce of prevention is worth a pound of cure," and who desire to protect their children and each other.

A system that thinks in terms of prevention must challenge the "place" where "health" happens. This may be one of the critical reasons why adopting a prevention agenda is so difficult. Prevention is about you and me, in our homes and workplaces and schools. Health is no longer relegated to just the doctor to "fix." Prevention is about policies and laws; about education and commerce; about insurance and transportation; about taxes and agriculture. Prevention is about health in all policies and health in all places — from the crowded inner city to the remote rural countryside.

Like our nation's healthcare system, our health education system needs reform too. The past methods of communication and instruction prescribe very formal channels through which information flows. But today, with 24/7 global access to information, there is the need to join these traditional, credentialed channels of learning with newer



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communication tools and methods that put information directly where people are likely to access it, like cell phones. This is slow to happen and complicated by the plethora of information that does not always translate easily to knowledge and practice.

On top of the serious problems impacting urban communities of poverty, violence, drug abuse, high crime, and homelessness, urban areas are faced with decreasing revenue while having disproportionate rates of sickness and premature death.

The CDC's vision is that every family and every person in America is able to access the support, the tools, the programs, the services and the knowledge that will let them make the best possible choices about protecting their health. We need to have these resources available to people where they

Access alone is not the answer; it needs to be coupled with "access to what." Knowing how information flows and to whom — and that it is the correct and needed information to cause the right action — is the key to navigating and enhancing the highly networked, "small world" realities of the 21st century. I believe these new methods and their translation into healthy outcomes should be incorporated into the agenda for the AHEC of tomorrow.

need them, when they need them, and on a personalized basis.

Health is our most precious resource, and we have a long way to go to get there, especially for those living in the inner cities. Herophilus, the physician to Alexander the Great, stated in 325 BC:

The CDC has developed four overarching Health Protection Goals that are helping those of us who work there to sharpen the focus of our work and nudge the health system forward:

- health for all people at every stage of life;
- healthy people living in healthy places;
- healthy people living in a healthy world; and
- people in all communities protected from infectious, occupational, environmental and terrorist threats.

"When health is absent wisdom cannot reveal itself art cannot become manifest strength cannot fight wealth becomes useless and intelligence cannot be applied." We know that different social contexts influence health outcomes AND that we have the potential to ensure these outcomes are positive. Improving lives through a deliberate focus on urban health is a key strategy. Focusing on little "Jackie" and countless others like her as our "why" allows AHEC and all of us to get closer and faster to the "how."

**AHEC — Connecting students to careers,
professionals to communities, and
communities to better health.**

Celebrating our Milestones, Envisioning our Future

(Continued from page 1)

Included in this issue are lead articles from Dr. Stephanie B. Coursey Bailey, Chief of the Office of Public Health Practice, CDC, who writes about the serious issues facing poor urban communities and the challenges in providing health care and hope to people living there. Lisa Mustone Alexander, Director of the DC AHEC Program Office, shows us why AHECs are perfectly positioned to impact policy changes for sustainable health-care system reform. In addition to articles from many of our urban AHECs describing partnership models in urban areas, mentoring programs they've implemented, and their ability to deliver critical services to urban areas, we've also included an article on the Healthy Communities Movement by Eric Gass, PhD, Assistant Professor at the Center for Healthy Communities at the Medical College of Wisconsin, which provides some historical perspective about the link between communities and health, and an article by Dr. Gloria Wilder, President/CEO of CORE Health, who writes about the new kind of health care leaders – social entrepreneurs – who balance personal life needs with professional life expectations grounded in tenets of social justice. Several invited responses to this article are also included.

This issue also marks the 25th anniversary of the first edition of the National AHEC Bulletin. Volume I Number 1 of the then-titled AHEC Bulletin was published in May 1983. For the last 25 years the Bulletin has been telling the AHEC story (and for many years the HETC story as well) to the program's broad constituencies — politicians, policy makers, grant-makers, health professionals, AHEC and HETC employees, other organizations — the list goes on and on. We believe the original reason why the National AHEC Bulletin was created still resonates today. As noted in the first edition of the Bulletin, "At the National AHEC Conference last August [August 1982], the AHEC project directors discussed the prospect of developing a national newsletter. The purpose of such a publica-

tion was seen as providing a better means of regular communication among various projects throughout the nation. It was also felt that a newsletter could serve as a mechanism for apprising members of the academic world and external audiences of project achievements and for stimulating discussions of issues relative to national policy affecting AHEC objectives."

And in Cherry Tsutsumida's Report from the National Office column on page 6 of the first Bulletin, she quoted the following remarks by HRSA Administrator Robert Graham from the August 1982 National AHEC Conference in Denver, Colorado: "I think AHEC has been able to maintain a sense of movement. It is not just another program, at least in most of the states I have been associated with and in most of the programs that I have come in contact with. It is still perceived by the individuals that work with it, work for it, and are influenced by it, as a movement, a new idea, a reformation, as something which stands for change and something which stands to improve the lot of the health care of the citizens of that state — something which stands to improve the educational programs of those institutions. People in power, people in positions of responsibility and influence, respect the persuasiveness and power of a movement that is truly seeking the interest of the public, and not simply its own self-interest. I think, by and large, AHEC has been able to communicate this and has been able to articulate its goals in terms of the changes and the reformation that it would bring about, and not in terms of narrow institutional or professional self-interest."

Cherry added: "This newsletter will be a success if it can capture the momentum of this movement."

The National AHEC Bulletin Editorial Board looks forward to capturing all of our successes in the next 25 years of publishing the AHEC story.

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History of the Healthy Communities Movement: The Evolution of the Link Between Communities and Health

Eric Gass, PhD

Since ancient times education has been important in maintaining healthy communities. AHECs are uniquely positioned to support local efforts to improve community health.

Ancient Times

Historically, public health and community planning have been related. Ancient Rome had engaged in community planning initiatives that involved public health as far back as 578 B.C., when the Cloaca Maxima sewer system was built.¹ While the sewer was drained into the Tiber River, the waste water was released downstream to avoid contamination of drinking water. By 312 B.C., the population of Rome was so large that clean water had to be imported, thus the Aqua Appia aqueduct was built.¹ Rome also had private sewer systems in the homes of the wealthy, public latrines for the general population, and by the Third Century B.C., heated public baths.² In addition, the Romans had a policy of building cities away from swamps and standing water to prevent malaria by eliminating mosquitoes.³

Prior to the fall of Rome, several epidemics did kill a large portion of both the general population and the army. However, these could not be blamed on contaminated waste water. A plague broke out around 250 A.D. that spread through the entire empire and lasted for decades.⁴ The plague, carried by fleas, was brought to the empire by armies returning from foreign lands. The decimated population never fully recovered and 200 years later, the empire was overrun. Finally, much of the plumbing system, as well as cooking utensils and drinking cups, were made of lead.⁵ Thus, lead poisoning may have been pervasive in this population; a factor that the Romans could not have known about in their day and age.

The Middle Ages

Post-Rome Europe was largely an agrarian culture, with nearby cities serving as the center

of religious life, as well as providing protection from invaders. However, the technology of Rome was not maintained. While one was less likely to be killed by violence or war in the Middle Ages, the plague, polluted water, and unsanitary conditions ransacked Europe. In fact, the water and sewage system of Rome was so advanced that the life expectancy of the average Roman in 30 A.D. was higher than that of the average Londoner of 1300 A.D.⁶ It was not until 1840 that a cholera outbreak in London led to the first set of standardized public health policies to be enacted, focusing on clean water and waste removal.⁷

The United States

Early America was largely rural; East Coast cities were not that densely populated. By 1900, industrialization and immigration created overcrowded, unsanitary conditions in many cities. It was around this time that the United States engaged in the City Beautiful movement, which was a major focus of the 1893 Chicago World's Fair. City Beautiful advocated for low density development, public transportation, parks and gardens, modern sewer and water technology, and open spaces for walking.

As the United States de-industrialized after WWII, urban sprawl and suburbanization seemed to break the link between community development and public health. There was less need for walking space as the car became the prominent mode of transportation. Urban Renewal programs of the 1960s were well-intentioned but misguided. Communities and neighborhoods were destroyed, and their populations relocated under eminent domain laws to make way for highways and public housing developments. While urban



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renewal may have reduced population density and eliminated outdated housing, highway construction made life easier for suburban commuters and industry while displacing the poor and disrupting community life. Those that were not able to move away lived in neighborhoods next to the highway, or close to abandoned manufacturing facilities that moved to the suburbs. These residents were left to breathe polluted air from overcrowded freeways and live in neighborhoods with polluted soil and water.

The Current Healthy Communities Movement

The modern Healthy Communities movement started in 1986 with the Ottawa Charter of the World Health Organization.⁸ The goal of the Healthy Communities movement is to build capacity for health within communities. The focus of the WHO program is not solely on physical infrastructure or local institutions, but on understanding basic human needs. The WHO provides a list of the fundamental conditions and resources for health, which are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.⁹

Compared to other industrialized nations around the world, the United States is unique in that we do not have universal health care. State-level governments play a large role in providing healthcare services and insurance coverage. Thus, it has been proposed that for the Healthy Communities movement to be effective in the United States, health practitioners and administrators must understand the following concepts:

- Federal Devolution (i.e., Individual states providing services) - Healthy communities movements are more successful when the momentum comes from the local grassroots level.
- Community Benefit - Healthcare institutions, primarily nonprofits, must demonstrate community benefit to maintain tax-exempt status.
- Community health and prevention are essential in the managed care environment.
- Community mobilization.

An example of a healthy community program in action is the Strong Rural Communities

Initiative (SRCI) in Wisconsin; which includes the contributions of the Southwest Wisconsin AHEC and the Northeast Wisconsin AHEC. Both AHECs support worksite wellness interventions that involve local public health departments, healthcare institutions, local employers, state government institutions and the two medical schools in the state.

In SRCI programs, each of the four points aforementioned are addressed. For example, the SRCI concept originated from a committee of the Wisconsin Department of Commerce to tie workforce development and productivity to health improvement (Federal Devolution). Funding for these projects has been provided by the Wisconsin United for Health Foundation, Inc.; the asset dispersal mechanism for Blue Cross/Blue Shield United of Wisconsin's conversion from nonprofit to for-profit status. In addition, participating health centers have provided in-kind access to occupational therapists and laboratories for health risk assessments (community benefit). Public health nurses, AHEC staff, and hospital outreach workers have recruited local businesses to provide incentives for prevention and health maintenance activities, implement on-site wellness initiatives, and provide health education for workers and families (prevention). Finally, entire cities and counties have been mobilized through programs related to Healthiest Wisconsin 2010 including a weight-loss competition that is tracked by the local newspaper, a worksite wellness consortium of human resource professionals in one small town, and the participation of the entire police department in a healthy eating and exercise program (community mobilization).

What Can AHEC Do?

There are two main points to take from the history of the Healthy Communities movement. First, as technology has eliminated many of the environmental hazards associated with poor health, such as contaminated water and urban sanitation, the burden of health maintenance and prevention has fallen upon the individual. Thus, the physical environment is secondary to the educational and social environment of the person or family. Second, in the last 20 years, the concept of community has shifted from geographic areas or neighborhoods, to a culturally-based concept. Communities can form around areas

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of interest, places of employment, religious congregations, or shared cultural identity.

Forty years ago, WHO released a technical report entitled *Planning and Evaluation of Health Education Services*.⁸ While the four points outlined by Lund⁷ above may be important to implementing a Healthy Communities program, improving the community's health starts with education. The health education paper predates the launch of the modern Healthy Communities movement by over 15 years, but the guidelines disseminated by WHO regarding health education are still relevant today:

- "Effective health education...contributes to...producing a more conscious, self-reliant, responsive and responsible people... A healthy population can be more energetic, alert and productive in the socio-economic life of a country."
- "...the health education service (i.e., AHEC) may be able to obtain financial and other assistance from universities, professional societies, voluntary organizations, governmental agencies...and others concerned with the promotion of community development."
- "...most countries have long-established social and cultural methods of communicating ideas, experiences, and

information through art, drama, singing and other means (i.e., African dance as exercise). Such channels are often effective in communicating health ideas."

- Personal attributes of the health education specialist include demonstrated leadership ability; initiative and self-reliance; intellectual qualities-creativity, imagination, experimental approach to problems; an interest in social problems; personal and professional integrity; and tact and resourcefulness.

Much like the concept of community has changed over time, future healthcare leaders, in possession of the knowledge and qualities outlined above, are poised to change the concept of access to health care. I propose the new term "Access to Health." This not only means regularly seeing a physician, but includes affordable medication, education, access to healthy foods, safe public areas to exercise, worksite wellness programs, multi-sector involvement, and a workforce that believes in social justice and cultural competence. By working with local health, business, government, and civic organizations, local AHECs can take the lead in improving "Access to Health" through educating both the public and health professionals about this broad definition of health, and the creation of their own local Healthy Communities movement.

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Clinic Consortia-based AHECs: An Evolving Model

H. John Blossom, MD; and Allen Meyer, JD

Establishing AHECs within community clinic consortia is a model that can effectively respond to changing healthcare needs and provider environments.

The California AHEC Program, based at the University of California San Francisco (UCSF) Fresno campus, brings together community and academic interests to improve access to health care and decrease health disparities. The goal of the California AHEC is to improve access to healthcare services by: increasing community-based training of health professions students in California; increasing health workforce diversity; linking AHEC to community, academic and other partners; and expanding the California AHEC Program to areas not currently served.

The California AHEC Program accomplishes its mission through a network of ten California AHEC centers, each located in an underserved area and affiliated with, but separate from, a health professions school.

Beginning in the mid-2000s, the California AHEC Program has increasingly partnered with clinic consortia as AHEC host agencies.

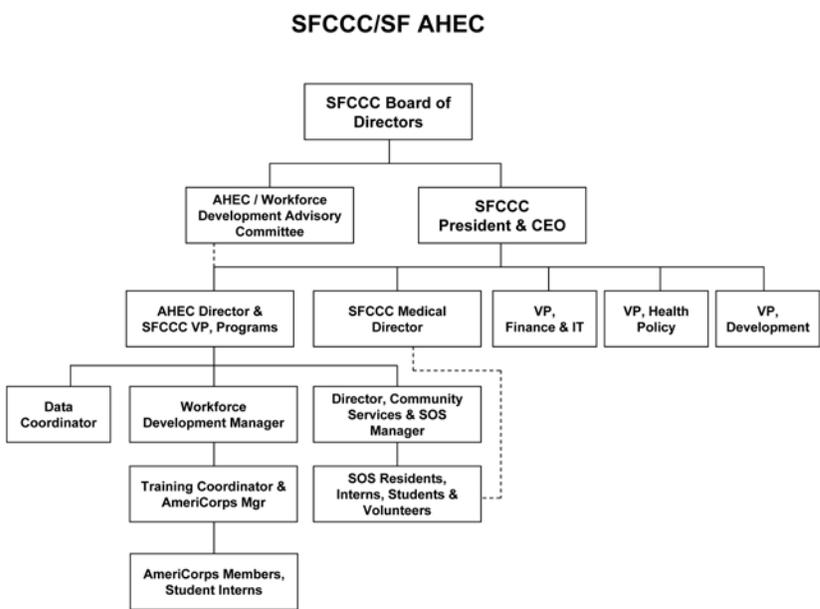
These associations are created by their member nonprofit community clinics to address shared needs and to advocate for common interests. Clinic consortia are especially common in California, representing major metropolitan areas as well as rural and farmland re-

gions. They are increasingly being established in other states as well.

A consortium provides a ready infrastructure for linking workforce development activities and community-based practice. Consortia generally have already put into place systems for identifying community health needs; implementing multi-site programs; and sharing best practices. Co-locating an AHEC within a consortium provides workforce development opportunities in multiple clinic settings, which generally serve a wide range of underserved patients.

There are currently four consortium-based AHECs in California. San Francisco Community Clinic Consortium (SFCCC) has served as an AHEC since 2004. SFCCC's mission is to preserve and promote community-based primary health care to the uninsured and medically needy. SFCCC's partner clinics

Consortium-based AHEC Organizational Structure



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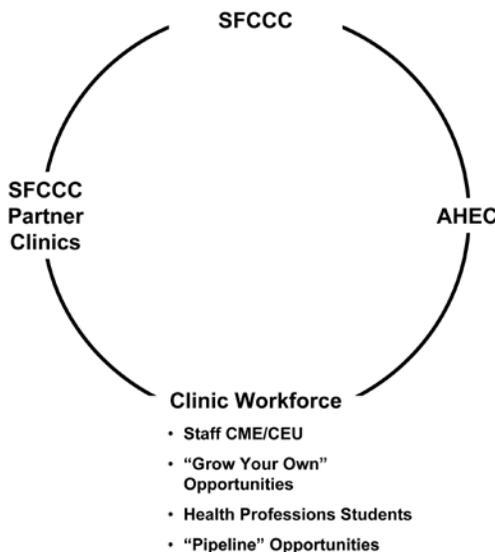
include federally-funded community health centers and Health Care for the Homeless Program providers, free clinics, and community clinics that serve special populations, such as Native Americans, seniors, and women.

The benefit of being an AHEC to SFCCC is that it helps the SFCCC to achieve its strategic goal of developing the healthcare workforce of its partner community health clinics. SFCCC's AHEC affiliation provides it with: base funding for healthcare workforce development activities; increased visibility and expanded access to other resources, e.g., foundations; expanded opportunities for linkages and collaborations, e.g., with academic institutions, job-readiness programs; and state-of-the-art information about workforce development best practices.

Community clinics in San Francisco face a shortage of providers who are committed to working with underserved populations, and who generally are willing to do so for less money than they could earn in a more mainstream practice. Due to the racial and ethnic diversity of San Francisco's population, there is also an on-going need for culturally and linguistically competent staff. Registered nurses and bilingual psychiatrists are currently in especially short supply.

SFCCC's partner clinics benefit from their AHEC programs through: the provision and

*San Francisco Community Clinic Consortium:
Partnerships for Workforce Development*



arranging of continuing education training for clinic providers, specifically targeting their identified needs; the development of "grow your own" opportunities that encourage career advancement among current staff, especially those who come from the community, speak the language, and reflect its racial, ethnic and cultural composition; expanded opportunities to partner with health professions schools for student, intern and residency placements; and creation of a health careers pipeline for those who are interested, or may become interested in pursuing a career in community health.

The San Francisco AHEC has sponsored conferences and workshops on topics such as chronic disease management, geriatrics, documentation of disability, and continuous quality improvement – topics that are of utmost importance to the clinicians of our partner clinics. It is currently collaborating with a local nursing school and a vocational services agency to develop a career ladder program for clinic medical assistants who are interested in pursuing a career in nursing. The Executive Director of one of the SFCCC partner clinics has championed this endeavor as a way of both addressing unmet service needs and providing opportunities for front-line staff to 'climb the career ladder.' While a project like this is too large for the clinic, it's ideal for the Consortium to take on as an AHEC activity.

SFCCC has entered into an affiliation agreement with UCSF's Medical, Nursing, Dental and Pharmacy Schools for resident, intern and student placements in partner clinics and with Street Outreach Services (SOS), the SFCCC's mobile medical program for homeless individuals. A UCSF medical resident who had completed her SOS rotation commented that the experience provided "wonderful insights into the sorts of problems that homeless people face every day. It allows the physician to develop a more empathetic relationship than is possible when trying to care for a homeless person in the crowded, rushed ER." This is exactly the type of AHEC experience that encourages clinicians to care for underserved communities and populations.

In partnership with the National Association of Community Health Centers, SFCCC hosts an AmeriCorps program, the Community

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HealthCorps, which exposes recent college graduates to health center employment opportunities. San Francisco HealthCorps members have an excellent record of matriculating into medical, nursing, public health, and social work schools, and of choosing to practice in underserved communities upon graduation. In the past two years, the San Francisco AHEC has also developed relationships with the local school district and health academies, to arrange for internships and summer employment opportunities for local high school students in SFCCC partner clinics.

Challenges encountered in establishing a consortium-based AHEC include the need to educate the SFCCC governing board about expectations and the quasi-independent status of the AHEC; coordination between AHEC-specific and SFCCC's agency-wide fundraising efforts; and ensuring that AHEC activities do not duplicate or disrupt pre-existing, sometimes long-standing relationships between individual member clinics and various academic programs. As in most cases, clear communication and looking for "win-win" situations have proven to be effective strategies for addressing these challenges.

The disadvantaged communities that are served by SFCCC's partner clinics also benefit from its AHEC activities through: increased availability of care for community residents, especially those who are uninsured, have difficulty accessing care, and have health disparities relative to the general population; academic affiliations and expansion of service opportunities; an increased pool of providers who are committed to serving the community; the provision of health services that are of higher quality (e.g., through continuing education), and culturally and linguistically competent; and through increased employment opportunities for community members who pursue healthcare careers.

As the AHEC movement continues to evolve in response to changing healthcare needs and provider environments, the co-locating of AHECs within community clinic consortia is a model that deserves further examination and consideration.



Dan Włodarczyk, MD, and Tusbar Dunabe, AmeriCorps member, sit inside the Street Outreach Services (SOS) mobile medical van, charting the health services they provide to homeless patients.

A consortium provides a ready infrastructure for linking workforce development activities and community-based practice. Consortia generally have already put into place systems for identifying community health needs, implementing multi-site programs, and sharing best practices. Co-locating an AHEC within a consortium provides workforce development opportunities in multiple clinic settings, which generally serve a wide range of underserved patients.

SFCCC Staff and AmeriCorps members gather just prior to boarding the Street Outreach Services (SOS) mobile medical van.



Connecting Communities to Better Health: AHEC's Role in the *Ventanilla de Salud* Project

Lori Millner, PhD

*The *Ventanilla de Salud*, or Health Window, was developed to assist Mexicans living outside of Mexico. AHEC's role as a trusted and neutral community organization has fostered a unique partnership with the Mexican government to improve the health of this unique population.*

The Dallas-Fort Worth (DFW) Area Health Education Center serves Dallas and Tarrant counties which encompass the heart of the DFW Metroplex. For Dallas County in 2006, the total population was 2.3 million with an ethnic break down of 37% White, 36.8% Hispanic, 20.2% African-American, and 4.2% Asian. Tarrant County's population was 1.6 million with an ethnic break down of 56% White, 24.1% Hispanic, 13.4% African-American, and 4.0% Asian.

As with other large urban centers, the construction, restaurant, and trade industries have been a draw for immigrants and migrants from Mexico and other Latin countries. This influx has been primarily responsible for the growth in the Hispanic population as has the higher birth rate for Hispanics. It is very common among Hispanic families in the DFW Metroplex to have a mix of documented and undocumented relatives of all ages living in the same household.

Health Care Access Barriers for Latinos

There are many barriers that limit access to health care for this large segment of our population. Texas leads the nation in the number of people who are medically uninsured. In the greater Dallas area, a 2005 Rincón & Associates survey reported that 22.3 % of native born Latinos and 42.6% of foreign-born Latinos lacked health insurance. As with other communities served by AHECs, the ethnic backgrounds of the health professionals in the DFW area do not match the communities they serve, resulting in cultural and linguistic barriers for the Hispanic population.

The safety net in Dallas County consists of a large county hospital, Parkland Health & Hospital System, and its Community Oriented Primary Care (COPC) clinics, two community health centers, and a moderate scattering of charitable and low-cost clinics. Tarrant County has fewer resources with one community health center and a public hospital that has recently adopted the practice of providing only emergency care to the undocumented, and extremely limited prevention and primary care services. Tarrant County has some charitable and low-cost clinics as well. Navigating the health care systems in both of these counties can be daunting to those who face cultural and linguistic barriers.

Ventanilla de Salud

In this environment of poor access to care for the Latino population, the DFW AHEC developed a partnership with the Mexican Consulate in Dallas. This partnership began in 2004 with participation in Binational Health Week, a week in October where communities in Mexico and the United States celebrate the health of Hispanics in both countries. As a result of this partnership, the DFW AHEC was asked to serve as the lead agency for a recently developed program, the *Ventanilla de Salud*, or Health Window. This program of the Institute of Mexicans Abroad (IME) is an organization of the Mexican government developed to assist Mexicans living outside of Mexico. The VDS model was approved by the Mexican government in 2002, after an initial program at the San Diego and Los Angeles Consulates. Long-term goals of the program are: to improve the health status and promote disease prevention for all Mexican families; to decrease emergency



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Connecting Communities to Better Health: AHEC's Role in the Ventanilla de Salud Project

care use in the Mexican population by facilitating access to health care and promoting disease prevention; to reduce the levels of underutilization of public health insurance programs of the Mexican population; and to become the center of trusted health information, resources and referrals for Mexican families living in the United States.

The VDS program provides a unique outreach model for Mexicans and Hispanics living in the United States. All VDS programs are physically located in the Mexican Consulate providing a safe and trusting environment. This allows for a captive audience as clients are waiting to access consular services. In Dallas, between 200 and 400 people visit the Mexican Consulate every day. Each consulate contracts with a lead agency, usually a non-profit organization, to administer the VDS. Similar to AHEC, each VDS has specific goals and objectives to meet the needs of the community it serves.

DFW AHEC considered the mission of the organization and the traditional AHEC charges before agreeing to serve as the lead agency of the *Ventanilla de Salud*. The VDS project directly addresses the goal to increase access to care for underserved populations and it addresses the NAO motto: "Connecting communities to better health." AHEC is uniquely qualified to serve as the lead agency as it is a neutral organization not representing any one health issue or workforce issue, has experience in the community serving as the facilitator for various initiatives, and has established relationships with community organizations, social service providers and direct health service providers.

The VDS program provides three primary services to visitors at the Mexican Consulate: health education; information on accessing local health services; and enrollment into public health programs.

The duties of the lead agency are to provide fiscal management of VDS program funds, develop and screen potential partners who can help deliver the services, provide a quarterly report of activities and to seek additional

program funding. Modest funding is provided by the Mexican Consulate for the VDS programs and we have received small donations. Currently, one part-time community health worker and one part-time coordinator, employed by the DFW AHEC, operate this program. New education programs are developed at each VDS by the lead agency and the local IME representatives.

Serving as the lead agency for the VDS not only helps the DFW AHEC increase access to health care for underserved populations, but it provides AHEC with a unique community service opportunity for health profession students with some ability to speak Spanish. AHEC has partnered with students in one of the local physician assistant programs to provide health screenings. AHEC plans to expand this opportunity to other training programs as it provides students with valuable experience serving this population.

Initial Impact of Program

The *Ventanilla de Salud* - Dallas began in mid-December 2007, as a pilot program and was open about one hour a day for the first few months. From January - March 2008, 2,366 people received health education services, 53 people were linked to primary care and specialty care services, 21 received assistance with CHIP enrollment, and 620 were linked to health fairs. Partnerships have been developed with 14 organizations that helped deliver services. The program is now open five hours each day.

Better access to health care and better health for all members of the community are core values of AHEC programs. The *Ventanilla de Salud* program provides an avenue to reach the underserved population of Mexican migrants, immigrants, and other Hispanics. Twenty-two of the 47 Mexican Consulates in the U.S have either established or are in the process of developing new *Ventanilla de Salud* programs. The Capital AHEC in Austin, Texas, also serves as the lead agency for the VDS program in that city. To learn more about the *Ventanilla de Salud* programs, visit http://www.ime.gob.mx/programas_salud/vds.htm.

The Maryland AHEC Program and its Partnership with Urban Community Health Centers

Marita A. Novicky, MA; Claudia Baquet, MD, MPH; and Meseret Bezuneh, MSEd

The Maryland AHEC System partners with community health centers to address health disparities in urban areas through training programs, continuing medical education initiatives, and strategic community partnerships.



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The establishment of the Maryland Area Health Education Center Program (MAHEC) in the 1970s resulted in the creation of its first AHEC Center in 1976, the Western Maryland AHEC (WMAHEC) in rural Cumberland, Maryland—part of the Appalachia region. A second rural center followed in 1996 with the funding and startup of the Eastern Shore AHEC (ESAHEC). While the two rural regions served by these centers illustrate significant health disparities substantiated by numerous Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) designations,¹ the urban Baltimore AHEC (BAHEC) is defined by its HPSAs and MUAs. As the table in this article illustrates, Baltimore's residents are predominantly characterized by poor socioeconomic, health, and educational status which contribute to poorer health outcomes and shorter life spans. The majority of Baltimore's population, and that of the area surrounding the University of Maryland School of Medicine (UMSOM) and MAHEC program office, is African-American and is disproportionately affected by chronic diseases such as diabetes, hypertension, AIDS, and substance abuse. Patients seen at UMSOM's Family and Community Medicine Program and local Community Health Centers (CHCs)/Federally Qualified Health Centers (FQHCs) are more likely to have no insurance, or to be insured by Medicare or Medicaid.

MAHEC, sponsored by the UMSOM, received funding for its first urban AHEC—the Baltimore AHEC (BAHEC)—in 2003 and has worked with this program to build and increase community-based collaboration.

Integral to collaboration is the engagement of local community-based partners—CHCs/FQHCs—that serve as the medical home for medically-underserved residents of Baltimore. While the MAHEC Program established its partnerships with Baltimore CHCs/FQHCs prior to 2003, the implementation of BAHEC has further strengthened these partnerships and collaborative efforts through successful placement of fourth-year medical students for four or eight-week AHEC rotations at inner-city CHCs. The MAHEC Program has also leveraged support and further strengthened partnership efforts through the University of Maryland Statewide Health Network which has provided telehealth equipment at six CHC sites and established the Maryland Research Collaborative—Practice Based Research Network with the Baltimore metropolitan area CHCs.

The strategy of placing students in an inner-city setting not only supports primary care physician workforce needs in an underserved community, but also addresses Healthy People 2010 goals—specifically the objective of improved access to comprehensive, high-quality health care services.²

While the UMSOM and MAHEC have made progress in addressing health disparities in Maryland, significant health disparities continue including: Maryland being ranked 28th by the United Health Foundation in overall population health by state in 2007;³ a lack of adequate healthcare professionals in its urban underserved areas framed by changing demographics with growing numbers of minorities in inner city Baltimore;⁴ a 2007 Health Disparities Report from the Maryland

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Data on Baltimore City, the State of Maryland, and the U.S. for Select Disparity Indicators

	Baltimore Percent	Maryland Percent	U.S. Percent
Female population	53.5	51.6	50.8
Black or African-American	64.4	28.9	12.4
High school graduate or higher	74.2	87.1	84.1
Disability status (5 years and over)	19.2	12.8	15.1
Individuals below poverty level	19.5	7.8	13.3
No health care access/coverage¹	14.2	11.5 ²	NA
Births to teens³	19.9	9.1	12.7 ⁴

Source: U.S. Census Bureau, 2006 American Community Survey.

¹ Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006. Health Care Access/Coverage: Adults aged 16-64 how have any kind of health care coverage.

² Data is for the Baltimore-Towson, MD Metropolitan Statistical Area only.

³ Source: Annie E. Casey Foundation, Right Start: The Condition of Mothers and Babies in the 50 Largest Cities, 2004.

⁴ Source: Annie E. Casey Foundation, Right Start: The Condition of Mothers and Babies in the 50 Largest Cities, 2004; 50-City Average.

Department of Legislative Services, Office of Policy Analysis,⁵ reveals health status indicators used to determine areas of health disparities, including cardiovascular disease, infant mortality, hypertension, diabetes, HIV/AIDS, and cancer, clearly demonstrate marked differences between white and non-white populations residing in Maryland; the difference between HIV mortality rates is enormous at 2.2 per 100,000 for whites and 28.2 for blacks in 2004;⁵ and, there is a lack of access to care due to lack of adequate insurance coverage.⁵

The importance of training future physicians in community-based settings serving vulnerable populations at risk for health disparities cannot be underestimated. The need to have preceptors and physicians in training exposed to the most current principles of cultural competence is paramount for all healthcare providers irrespective of the potential disparities of any specific disease. MAHEC's recognition of these disparities resulted in understanding that CHCs serving the most vulnerable populations in the city are an important conduit for training future health care delivery personnel who can address these disparities.

Most recently, MAHEC collaborated with the UMSOM's Department of Family and Community Medicine in a grant submission to establish a MAHEC-based Residency Program that will place residents in either urban or rural rotations. Urban rotations will be exclusively with CHCs in Baltimore, a move that acknowledges the Institute of Medicine's recommendations that all health professionals be educated to deliver patient-centered care as a member of an interdisciplinary team.⁶ MAHEC will serve a major role as liaison between the Department of Family and Community Medicine and the inner-city CHCs. By working with CHCs in placing students, MAHEC helps address health disparities among vulnerable populations and cultural competence issues through implementation of a specific curriculum with residents as well as faculty preceptors.

Over the last several decades, minority trainees have consistently represented a large proportion of the UMSOM's resident group and often go on to practice among disadvantaged populations in underserved areas of the state and country helping to address the composition and number of minorities in the physician workforce. Rotations in CHCs/FQHCs

The Maryland AHEC Program and its Partnership with Urban Community Health Centers

help provide students and residents with improved preparation to care for vulnerable and challenging populations in safety net settings, improving their job satisfaction and their desire to continue to serve in these type settings.

The continuing education of medical students, residents, and other health professional staff at CHCs is a challenging and ongoing task. Leave time to attend training, lack of quality and timely offerings, and costs associated with earning educational credits are obstacles. MAHEC, working with the University of Maryland Statewide Health Network (UMSHN) has been instrumental in helping solve this dilemma. Through a formal partnership with the Mid Atlantic Association of Community Health Centers and support through the UMSHN, telehealth videoconferencing equipment was donated to six urban CHC/FQHC sites in Baltimore and has been a welcome addition for the CHC staff. The UMSHN and MAHEC have developed and delivered several continu-

The need to have preceptors and physicians-in-training exposed to the most current principles of cultural competence is paramount for all healthcare providers irrespective of the potential disparities of any specific disease.

ing medical education (CME) programs on-site at the CHCs, as well as via video-conference to multiple sites linked through the telehealth/videoconferencing equipment. These CME programs have provided CHC health professionals with current guidelines and cutting-edge science on emerging health

issues and are useful in the quality improvement initiatives of the FQHCs/CHCs.

MAHEC has developed successful strategies for addressing the provision of primary care within its underserved urban Baltimore center. By working with CHCs/FQHCs regarding the placement of medical students in rotations, helping to develop a primary care Residency Program, partnering with the University of Maryland Statewide Health Network, and leveraging resources for obtaining telehealth equipment to provide continuing medical education, MAHEC continues to address health disparities in an urban setting.

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INTERPROFESSIONAL SERVICE LEARNING PROJECT: CHILDHOOD OBESITY

Does your AHEC help train health professions students AND encourage youth to explore careers in health care?

If so, you are in an ideal position to implement an interprofessional service learning project. During the 2007-08 school year, the South Carolina AHEC helped initiate a program where:

- Teams of interprofessional students work with local schools to address childhood obesity and learn how to communicate with young people about health-related topics;
- Health professions students in nursing, pharmacy, medicine, dentistry and health administration serve as the mentors and instructors for these community-based projects;
- Elementary school students participate in activities to encourage physical activity, balanced nutrition and improved health outcomes;
- Schools, teachers and parents are encouraged to take an active role in reducing obesity rates in their communities; and
- Young people are exposed to real-life examples of career opportunities in health care.

For additional information about this project, contact South Carolina AHEC at www.scahec.net or 843-792-4431.

MAKE THE AHEC CONNECTION IN YOUR COMMUNITY!



Am I one of the 25 million youth in this country who are overweight or obese?



Urban AHECs: Looking Back and Moving Forward

The original 11 AHEC programs authorized in 1972 were not directed toward the health personnel problems of the inner city urban areas. With AHEC program reauthorization in 1976, specific authorization was passed by Congress to create and fund AHECs that emphasized improving access to health care in urban underserved areas. It has been 20 years since the National AHEC Bulletin devoted an issue to urban AHECs and their then, new program initiatives. The Fall 1988 edition of the Bulletin contained articles on the history of the urban AHEC movement, as well as profiles of successful urban AHEC projects. What is striking 20 years later is that the same issues related to why urban AHECs were established are still with us today. We thought it enlightening to look back to the Fall 1988 issue and highlight excerpts that focus on why urban AHECs were established and, that despite many successful programs and projects, the urban challenges have become more complex and there remains for urban AHECs, as stated in the 1988 edition, an unfinished agenda.

What were the challenges facing urban AHECs in 1976? As noted by Cherry Yuriko Tsutsumida, MPH, Chief, AHEC Branch, “The American city has been the symbol of the nation’s progress, reflecting cultural, technological and economic successes. However, despite the external glitter of each metropolis, it is also true that the American city is being challenged with an unprecedented multitude of unexpected social and health conditions. In addition to the adjustments that were necessitated by the great migration from rural to urban areas in the 1960s, cities now are seeing homelessness, substance abuse, teenage pregnancy, HIV positives, and a vast array of psychosocial problems. Even certain communicable diseases, such as tuberculosis, which were thought to be eradicated in the 1950s, are now re-emerging in certain parts of the city.”¹ Despite an otherwise glowing report on AHECs by the 94th Congress about the success of rural AHECs, it included solemn language about the lack of AHEC resources directed to health personnel problems in inner city urban areas.

“All of this serves as a prologue to the sustained need to develop partner-

ships between medical schools and communities to address the continued health professions needs within urban areas. The Area Health Education Centers in urban communities provide the mechanism by which healthcare providers and students who will serve in urban areas can be trained, recruited and retained.”² In fact, “A formal relationship between health sciences centers and their urban environments was affirmed at an urban AHEC conference in Cleveland in May 1980. Most felt that urban areas would be receptive to ties with health education entities, because of the healthcare professional shortage in many urban areas and the lack of healthcare resources to many disadvantaged inner city residents.”³

What were the principles then in guiding the development of the “experimental” AHEC programs in addressing the needs of urban areas? Cherry Tsutsumida noted several principles that emerged:

- “Urban AHECs may have more complex difficulties in working to define ‘the community,’ particularly with a population characterized by mobility. Clearly,

“I very much hope...that the administration will be given the flexibility under less rigid terms to consider proposals for experimental AHEC programs in areas posing inherently difficult situations requiring time and ingenuity in programming to achieve progress.”— Charles E. Odegaard, Area Health Education Centers: The Pioneering Years, Carnegie Council, Policy Studies, 1979.

the institutional base of the Area Health Education Center must be firm within the community so the academic health sciences center can enjoy a sense of continuity and reliability within the partnership.

- Urban AHECs, due to the very density and diversity of the population they serve, require that special attention be given to setting priorities in the distribution of resources.
- Urban areas have the advantage of a critical mass within which educational interventions can be formulated. This is particularly useful in developing clinical training sites.
- Urban AHECs must be careful to do a needs assessment since the potential for developing redundant programs, particularly in continuing education, can exist.
- In a general sense, urban leaders may be more specialized. This is to say the ethnic leader on health

issues may not be the same leader on welfare issues.

- Urban AHECs should continue to take leadership in addressing their responsibilities in training future minority healthcare providers.
- Urban AHECs provide excellent opportunities for interdisciplinary training due to the economies of scale.
- The issue of future viability beyond federal funding has not been as strongly resolved with urban AHECs as with rural AHECs. Part of this reverts back to the historical funding sources of health-related activities within cities.

Nonetheless, the AHECs in urban areas have made an important contribution in offering one strategy for addressing the health manpower needs for the healthcare delivery systems in urban areas. Through their responsiveness to emerging community needs

and flexibility in changing priorities, they have demonstrated an ability to be on the cutting edge of health professions education.”

Today, the issues confronting urban AHECs are even more complex than they were when they were authorized in 1976, requiring even more innovative programs and approaches to meeting the needs in urban areas. As an example, several urban AHECs profiled in this edition have developed specific urban health curricula and other opportunities for their health professions students, while other urban AHECs have developed partnerships to address the needs of increasingly diverse populations. This issue only touched upon a few of the increasingly complex challenges facing our urban AHECs. Looking back, the words of 1988 are as true today as they were then: Urban AHECs have an unfinished agenda as they move forward.

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The Dallas-Fort Worth AHEC's Mentoring Program

Jessica Reading, MPH

DFW AHEC's Mentoring Program provides at-risk students with a model for success.

The Dallas-Fort Worth Area Health Education Center (DFW AHEC) is located in the heart of Dallas. While much of Texas is still considered rural, all one must do is glimpse the stunning Dallas skyline with its skyscrapers, high-rise apartments, and factories to see that the city is about as urban as you can get.

DFW AHEC has long realized there are unique challenges trying to reach youth in an urban area. With over 35 school districts in the area, how do you choose which ones to touch? Where can you most effectively use your time in order to elicit the best outcomes?

In 2000, the director of DFW AHEC wanted to develop a method to reach minority students and encourage them to consider entry into a health profession. After months of research that included speaking to parents, students and administrators, DFW AHEC initiated an *AHEC Mentoring Program* at area schools. Many students in these schools did not have a positive role model. Oftentimes, parents, older siblings, other relatives and friends were involved in drugs, prostitution and robbery. At one school where the program is in place, over 50% of students have at least one parent currently incarcerated.

The *AHEC Mentoring Program* was created with the primary goal of increasing the participation of underrepresented groups in the health professions. In addition, the program's goals include an emphasis on student confidence building to help them to pursue their career goals. The program began as a pilot program in the spring of 2000. After the first semester's success, the program was adjusted to run a full school year. The program incorporates class presentations and field trips as well as mentoring from various health professionals.

During the fall semester, the AHEC coordinator visits area middle schools (6th-8th grade) where there are a high number of minority students and selects interested students. Although a high grade point average is not a requirement, the coordinator assures students are passing all courses. This is mainly due to the fact that students will occasionally be removed from academic classes to participate in various activities. Throughout the history of the program the number of students has varied from a low of 15 to over 50 per term with the number increasing as awareness of the program grows among students, teachers and parents.

Mentors are a key component of the program. Health professions students are recruited from various schools in the area. Originally the mentors were medical students, although DFW AHEC welcomes students/individuals from all health disciplines. Though not a requirement, mentors are often minorities and many have come from backgrounds similar to those of the students with whom they are working. Whenever possible, mentors are matched to the student based on gender and race and many have graduated from high schools within the Dallas-Fort Worth area. This significantly encourages students because they are able to see successful young adults who have encountered some of the same hardships they are experiencing. All mentors are required to complete a criminal background check and attend a one-hour training course prior to being paired with a student. The mentor meets with the student for a minimum of one hour a month, although most mentors exceed this requirement. With parental permission, mentors are allowed to visit their students outside of school hours. This tends to be a great benefit as many mentors have very busy schedules.



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The Dallas-Fort Worth AHEC's Mentoring Program

John was a 6th grade student at a local middle school. While he was academically gifted, he had a hard time fitting in with the other students. As the only Vietnamese student in the school he was often bullied and teased for being different. John also occasionally acted up in class, and while maintaining near perfect academic grades, had very low conduct grades. In the 2006-2007 school year John was paired with a Vietnamese mentor. At the first meeting with his mentor, John looked at her with tears in his eyes and asked "How do you stand up for your people?" The mentor herself was moved to tears and talked to John, as well as the counselor, about ways to improve self-esteem and handle bullying. John's mentor continued to visit him throughout the school year and John continued to improve. John is now a 7th grader and is still in the mentoring program. He has not received an unsatisfactory conduct grade once this year and thrives in all aspects of middle school.

The mentoring program coordinator serves as the liaison between the school, the mentors and the students. Additionally, the coordinator meets with the students monthly to conduct a one-hour class presentation. The AHEC coordinator usually plans and conducts these meetings, although guest speakers speak several times during the school year. Class presentations consist of in-depth explorations of various health careers including using model arms to practice phlebotomy, creating carbohydrate polymers, playing *Health Career Jeopardy*, and learning suturing with pigs' feet.

Since its inception, the DFW AHEC Mentoring Program has met or exceeded all objectives each year: at least 95% of the students, mentors, teachers and parents have rated the mentorship experience as good, 100% of the students have passed all subjects, 100% of the students have maintained an acceptable level of absenteeism as defined by school policy, 90% of the mentors have met or exceeded the minimum number of school site visits, and 95% of the students have maintained conduct grades of satisfactory or better. In addition, the program has received many accolades from the schools where it has been conducted.

As many in the AHEC community can understand, tracking students to examine the long-term impact of this type of program is of utmost importance. DFW AHEC is trying to find an effective method for this longitudinal tracking. Several years ago a survey was mailed to past mentoring program participants, however, the number of returned surveys was minimal. The current plan of action is to partner with the schools in order to find a successful tracking method using student personal information. DFW AHEC continues to work on contacting past students to assess the effectiveness of the program in encouraging students to enter the health professions.

DFW AHEC looks forward to seeing many of these students working as health professionals in our AHEC region in the not-too-distant future.

Urban Challenges: Health Careers in the Big Apple

Rossmery Barzey, BS; Maxine Golub, MPH; and Patricia Jeudy, MPA

Metro AHEC provides a range of mentoring opportunities for students to learn about health careers in order to increase the diversity of the healthcare workforce.



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Maxine Golub, MPH, is Project Director of the Metropolitan Region of the New York State AHEC System, and the Senior Vice President for Planning and Development at the Institute for Family Health, New York, NY.



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The Metropolitan Area (Metro AHEC) of the New York State Area Health Education System includes three AHEC Centers: Bronx-Westchester, Brooklyn-Queens-Long Island, and Manhattan-Staten Island, and a regional office based at the Institute for Family Health. The primary goal of the Metro AHEC is to provide students with opportunities to learn about health careers in order to increase the diversity of the healthcare workforce, with a focus on those who might not otherwise choose health careers.

The students served by the programs are primarily African-American and Latino, and represent numerous immigrant groups. Roughly 40% of NYC students come from families that do not speak English at home. Only 50% of the African-American students graduate high school. Many are the first family member to graduate high school or go to college. Too many have a family member in prison, or affected by HIV/AIDS.

To address the significant programming challenges presented by the target students, the Metro AHEC provides several programs, serving approximately 150 high school students, 30 undergraduates, and 15-20 health professional students in the metropolitan area each year.

Summer Health Internship Program (SHIP)

For six weeks each summer, the Bronx-Westchester, Brooklyn-Queens-Long Island, and Manhattan-Staten Island AHECs each offer a SHIP program. High school and undergraduate level SHIP students are placed at hospitals, community health centers and health departments. Stipends are provided in order to ensure that students who need to earn funds over their summer vacation are able to attend.

Each participant is matched with a physician, nurse, public health professional, health administrator, physical therapist, social worker, dentist, pharmacist or other health professional. The students spend three to four days a week observing alongside their preceptor, and one day attending a didactic session that explores current health education and health policy issues, such as diabetes, HIV/AIDS, asthma, racial disparities in health, and the uninsured. There are also workshops on selecting a college and financing a college education. Highlights include trips to the Office of the Chief Medical Examiner to observe an autopsy, and to the famous "Bodies Exhibit."

For many, SHIP is the opportunity of a lifetime, the beginning of a journey toward a career in health care. While it is too early in these young people's careers to provide outcome data, pre- and post-tests demonstrate an increased knowledge of possible healthcare careers, and all students expressed a desire to continue their healthcare training.

Mentor Connection

The Mentor Connection Program is a unique partnership between the Manhattan Staten Island AHEC, Washington Irving High School (WIHS) and mentorship sites. Like many public schools in New York City, WIHS and its students face many challenges: 79% of the 3,200 students qualify for free and reduced priced lunches, and WIHS is, unfortunately, considered one of the most violent schools in the city.

Seven to ten high school juniors are selected by their teachers and guidance counselors each year, and receive high school credit for devoting the last two periods of their school day to the program.

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The Mentor Connection Program includes an internship, seminars, and individual academic counseling. Mentor Connection pairs each of its students with a healthcare professional preceptor/mentor, and arranges for them to work at their site for six to eight hours per week throughout the school year. Students meet as a group for a weekly seminar where they learn about an array of topics, including professional development, writing skills, college preparation, resume construction, etc. The group has visited several colleges. As a final assignment for the program, students produce a project on a community health topic and use their mentorship site as a resource. Mentor Connect has a 100% success rate. All of the students in the 2005-2006 class are currently in college, and all of the 2006-2007 class have been accepted to a college and will matriculate this fall.

Community Health Experience Program: An Urban Campus-Community Partnership

The Community Health Experience (CHE) Program is a partnership between the Metro AHECs and the New York College of Osteopathic Medicine (NYCOM). The CHE provides community-based learning opportunities for first-year medical students who are considering practice in medically underserved communities. This year, the program will expand to the newly opened Touro College of Osteopathic Medicine in Harlem.

Favorite placements include the Community Health Action of Staten Island – HIV/AIDS Projects; the Cornell Cooperative Extension Farmers Market Program; and the New York City Department of Health-East Harlem District Health Center. The CHE also includes weekly didactic sessions that cover such topics as racial disparities, cultural competency, immigrant health, and health policy. One student, Chioma Oti, told the staff, “This summer gave me an opportunity to be exposed to the day-to-day challenges and rewards of working in an underserved community.” Scott Stein added, “I learned the importance of community health organizations and their role in low-income communities.”

ECHO Free Clinic Pre-Med Summer Volunteer Program

Operated by the Institute for Family Health/Metro AHEC and medical students from

the Albert Einstein College of Medicine, the ECHO Project (Einstein Community Health Outreach) provides free primary care for people who lack health insurance and cannot afford health care. Located in the South Bronx, the project provides routine medical exams, social services, and counseling, as well as referrals to specialty care and diagnostic services. During the academic year, ECHO is staffed by medical students – about 300 per year work in the clinic. In summer, the ECHO Pre-Med Summer Volunteer Program allows 15-20 undergraduate students the opportunity to gain first-hand experience in a free clinic for the underserved.

The program is coordinated by a second-year medical student who recruits, trains, and schedules pre-medical students, who come from colleges throughout the metropolitan area. Students greet patients, register them in the Institute’s electronic practice management system, schedule appointments and provide health information on topics such as diabetes or high blood pressure, while researchers survey patients to gather valuable demographic data and to better gauge what the community needs from the clinic. Students with a second language (mainly Spanish) are encouraged to volunteer as interpreters, speaking to patients on the phone and translating during medical

“Working at the ECHO clinic allows pre-med students to unravel the mystery of what it takes to become a genuinely caring and well-rounded doctor.”
commented Kaysa Virasawmi, a senior from Mount Saint Vincent College. Tiffany Yeh, a junior from Rice University added, *“Volunteering at ECHO has given a face and a story to the public health statistics, making the issues of healthcare reform even more urgent.”*

Urban Challenges: Health Careers in the Big Apple

examinations. Lastly, students shadow clinical teams as they see patients, taking patient histories, observing physical exams, and presenting to the attending.

A current member, Anish Parikh, says "I am learning about the social, political, and economic inequalities that play an integral role in the health outcomes of the underserved."

have not yet determined their career goals. The program provides them with opportunities to develop skills and knowledge that they will bring into their future careers.

Community Health-Corps

The Community HealthCorps program is a national AmeriCorps program that promotes health care for the underserved while developing future healthcare workers. The Institute for Family Health/Metro AHEC hosts 11 members, who each volunteer approximately 1,700 hours per year to a specific project, including the following: conducting health education sessions at community health centers; working with a community-based coalition to eliminate racial disparities in health outcomes; providing health education at a school-based health center; and enrolling patients in pharmacy assistance programs.

Many HealthCorps members are recent college graduates or community members who

In conclusion, AHEC programs in the Big Apple give students a broad array of opportunities. As stated by Dr. Amarilys Cortijo, the medical director of the Free Clinic program, "These programs help students learn what it means to be a healthcare professional, about running a clinic, and about caring for the underserved. With luck, these experiences will change the career paths of more than a few future healthcare workers."

The authors would like to thank Mary J. Mitchell, MPA, Executive Director of the Manhattan-Staten Island AHEC and Edwin Martinez, Executive Director of the Bronx-Westchester AHEC for their assistance with this article.

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NEW: Hispanic & Latino Nurses Initiative

Gabrielle Kersaint, MSPH

The Brooklyn-Queens-Long Island (BQLI) AHEC, the Long Island University School of Nursing, and the Brooklyn Chapter of the National Association of Hispanic Nurses are collaborating to develop the NYC Hispanic & Latino Nurses Initiative to meet the healthcare needs of the traditionally underserved communities in New York City. The Initiative provides students with access to nursing professionals as mentors, and offers services to support their recruitment, admission, retention and graduation from a baccalaureate nursing program.

BQLI AHEC's role is to reach out to middle and high school students and their parents from 20 Brooklyn schools to introduce them to nursing as a career. Middle school students attend presentations and tours of healthcare facilities, while ten high school students will participate in a six week Nursing Summer Internship Program.

Gabrielle Kersaint, MSPH, is the executive director of the Brooklyn-Queens-Long Island AHEC.

Urban AHEC Advocates for Community Health Workers to Improve Health

Carol Wolff, MA; Dwyan Monroe, BA; and Linda N. Bocclair, MEd, MBA

The NJ AHEC system has long-recognized the value of community health workers (CHWs). Camden AHEC supports CHWs in their efforts to serve large urban underserved populations.

Across the country there are thousands of people who are making a difference in the lives of the poor, the homeless, and the uninsured of this nation. They are trusted guides and advisors. Their lives are stories of overcoming incredible odds; of compassion for others; of giving back to their communities. They are community health workers (CHWs) or patient navigators¹; they're organizing themselves, defining their careers and being supported by organizations like the Camden AHEC.

Camden AHEC was the second urban AHEC established in the nation and is the oldest surviving urban AHEC. Along with Garden AHEC and Shore AHEC, it is one of three centers comprising the NJ AHEC Program. NJ AHEC is an affiliate program of the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine (UMDNJ-SOM).

What do CHWs do?

CHWs are uniquely suited for performing AHEC work in an urban environment. While social workers and other types of outreach workers provide services in poorer communities, most are based in stationary sites with clients accessing services at those sites. CHWs are trusted members of the community they serve. They are the link that can facilitate access to services in organized health and social services agencies and communities; build individual and community capacity outreach, provide community education, and offer informal counseling, social support and advocacy. They know how to overcome obstacles to services and how to best utilize resources.

Camden AHEC CHWs are high school graduates between the ages of 25 and 40, recruited primarily through community referrals. They are Latino and African-Americans. Before coming to Camden AHEC they worked in schools, social service agencies, HMOs or stayed at home raising their families while volunteering in the community and serving on community advisory boards. A glimpse into the lives of two bilingual and bi-cultural Camden AHEC CHWs helps clarify their unique role in bridging the gap between their communities and good health care.

CHWs in Action

Michelle followed her client, Robert, a 49 year-old African-American man, from his recent emergency department admission to his discharge to a homeless center, where she worked with center staff to secure him permanent housing.

He used the hospital emergency department as his primary source of health care. He had no insurance and lost his job last year. Michelle gained Robert's trust as a result of her gentle way with clients, her knowledge and ability to navigate the healthcare and social systems in Camden and her ability to get results. Michelle works with a team of health care professionals to address high emergency department utilization in Camden. She follows Robert's progress weekly and reports problems to her team members who step in to provide support for medical services and/or referrals.

Lourdes travels throughout Camden day and night, on Camden AHEC's mobile health van, seeking clients in need of health care but unable to access the healthcare system for



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Urban AHEC Advocates for Community Health Workers to Improve Health



Community health workers Michelle Lamar and Lourdes (Lulu) Soriano plan a neighborhood outreach strategy to understand and identify the access barriers that are driving underserved populations to use emergency rooms for primary care.

preventive care. These potential clients have no homes, no phones and struggle to find food and shelter everyday. They are poor and lost in society, not by choice but by circumstance. It was 10 p.m. on a cold Wednesday night when Lourdes stepped off the van, ventured two blocks east and met Samuel, a 59 year-old Caucasian man, sleeping outside of a public works building. His wife had

died after a long battle with cancer. Home care, medications and a myriad of other expenses depleted his savings. Lourdes invited Samuel into the van where he found comfort

in warmth, food and a friendly, helpful staff. He agreed to HIV testing and health screenings, was placed in a temporary shelter and returned to Camden AHEC the next day to follow-up on services and to begin a journey toward gaining back his self-respect and independence.

Camden AHEC was the second urban AHEC established in the nation and is the oldest surviving urban AHEC.

What is Camden AHEC's History with CHWs?

Camden AHEC has always recognized the importance of listening to, engaging and partnering with people from the community to improve the health of the community. The value of community health workers in fulfilling AHEC's mission was very clear. They were trusted culturally competent members of the community.

While CHWs were gaining recognition through national organizations such as the Center for Sustainable Outreach, New Jersey continued to employ thousands of CHWs with minimal attention to the impact and needs of the emerging CHW profession. In 1999 NJ AHEC convened a group of CHWs and representatives from academic health professions schools, community health centers and the public health agencies to begin a dialogue that led to the creation of the Community Health Worker Institute (CHWI). Now in its fourth year of operation, the

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CHWI serves as the academic “umbrella” that provides state-wide coordination of the many facets of the emerging profession. Providing education, service and advocacy are the strategic initiatives of the CHWI. The 2005 Patient Navigator legislation introduced by Sen. Robert Menendez, D-NJ and supported by the CHWI, is further evidence of the increased awareness of the value added by CHWs.³

This is the first time I got to see first hand the power of a CHW in helping those in the community. Sure, you could read about it in a study, but it is far more empowering in person. I really do believe that CHWs need to be members of the health delivery team to help establish cultural linkages between the community and the healthcare providers.

-Third year UMDNJ-SOM Medical Student, February 28, 2008.

New Jersey is on its way to establishing itself as a frontrunner in the CHW movement, thanks to the commitment of thousands of CHWs and their supporters, such as the NJ AHEC, who have spent countless hours planning, organizing, teaching, advocating and believing in their ability to improve the health of their communities.

The UMDNJ-SOM, a key partner in Camden AHEC’s advocacy efforts, recognized the important role of CHWs in serving as links between underserved consumers and health services. Community Service Learning (CSL) rotations and Community Involved Primary Care (CIPC) projects, both courses at UMDNJ-SOM, introduce medical students and other health professionals to CHWs. The rotations provide the students with opportunities to interact with clients and patients while gaining a better understanding of cultural values, norms and barriers to care, as taught by the CHWs.



Lourdes Gutierrez, an outreach worker for over 15 years, works with client Victor about HIV counseling and testing.

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Communicating Effectively Across Languages and Cultures

Jihane Abou Chabke, MA; and Ghazaleh Joukar, BA

Northern Virginia AHEC implements interpreter training and provides translation services designed to prepare health professionals to more effectively serve an increasingly diverse urban population.

Imagine for a second that you are an American in a foreign country. You have only been there for a few days and one evening, out of the blue, you start experiencing shortness of breath and are sweating profusely. You urgently need to go to the emergency room for medical assistance.

Once there, the ER doctor asks you about your condition, but you cannot understand what he says. You try to explain to him what you are feeling but it is as if you are talking to a wall. Feelings of frustration, helplessness and despair overwhelm you. The two of you are just not speaking the same language.

This scenario is repeated throughout hospitals and health clinics in the Washington, DC metropolitan area on a daily basis. Failure to communicate effectively with healthcare providers due to language barriers is a growing problem in our Northern Virginia communities due to an increasingly diverse urban population.

In 1998, the Northern Virginia Area Health Education Center's (NVAHEC) board and staff conducted a survey in the region to assess the needs of healthcare providers. The survey identified emerging issues that specifically focused on poor access to health care.

The mission of the NVAHEC is to increase access to primary health care by recruiting and training interpreters and educating providers. The NVAHEC has expanded its services to include providing professional language services (via contract interpreting and contract translations), language proficiency testing, interpreter training and consultation to the healthcare and human services sectors. Additionally, NVAHEC works with health

and human services agencies to enhance training of their healthcare workforce to address emerging issues affecting urban areas, such as disaster preparedness and preceptorship. NVAHEC continues to develop programs designed to prepare health professionals to more effectively serve an increasingly diverse urban population while also exploring ways to reduce health disparities.

Population overview

NVAHEC is located in the DC metropolitan area, just 15 minutes from Washington, DC. Virginia ranks 11th in the nation in the number of foreign-born residents. According to the 2000 U.S. Census, 8% of Virginia's residents are foreign-born, compared to 68% in the Northern Virginia region. Forty-one percent of this population confirmed that they speak English "less than very well." Northern Virginia stands out as the part of the state with the largest share of the overall immigrant population.

A crucial advantage to being located in a diverse urban area is the ability to provide services to more people by recruiting interpreters in a wide variety of languages. NVAHEC has the luxury of cultural representation from all over the world. Because cultural connotations vary by region, it is necessary to consider their meaning in the context of a client's lifestyle, especially in health care. NVAHEC provides interpreters for over 40 different languages, including various regionalisms of Spanish. These interpreters are not only bilingual, but also bicultural. For this reason, NVAHEC's interpreter training program focuses heavily on cultural awareness.

NVAHEC interpreters are passionate about being "ambassadors" for language services in an



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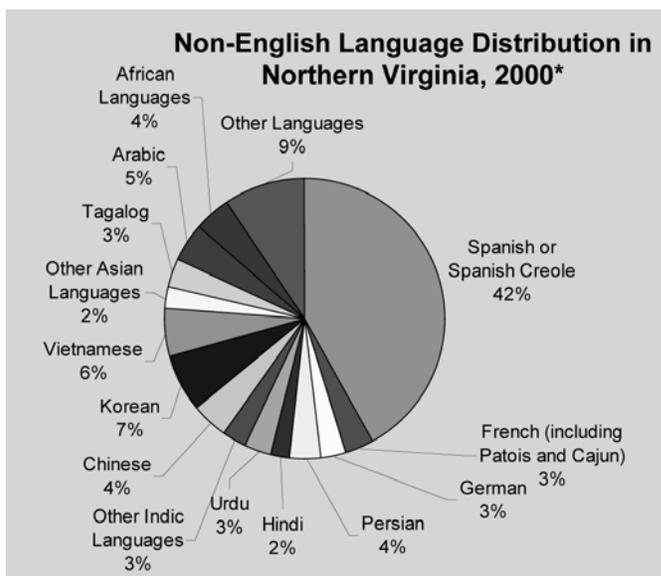


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Communicating Effectively Across Languages and Cultures

urban community. They come from a variety of professional backgrounds including non-U.S. healthcare providers, law and education. Serving as contract interpreters affords them the opportunity to acquire a broad knowledge of the U.S. federal, state, and local health and human services systems and their associated terminology. NVAHEC provides its interpreters the perfect venue to carry on with their mission of helping their communities.

a native English speaker would receive. The interpreter ensures that every word spoken during an encounter is transmitted properly and that both parties understand each other. NVAHEC clients include hospitals, health departments, clinics, and school systems, comprising a network of agencies that increasingly recognize the need for interpreting services in the healthcare setting.



Source: U.S. Census Bureau, 2000 Census of Population and Housing.

Each morning at NVAHEC the day starts with multiple phone calls and faxes to request interpreters or to make changes to previous assignments. The office scheduler is responsible for handling 30-40 contract interpreting assignments daily, giving directions to interpretation sites, and accommodating last-minute requests and cancellations. The other two staff of the language services department recruit interpreters, address feedback received from interpretation sessions, shadow new interpreters to ensure that they are performing to the best of their ability, coordinate translations and edit the newsletter.

A Day in the Life of NVAHEC

NVAHEC contract interpreters are chosen through advertising, peer recruitment and through selection of outstanding students from interpreter training classes. NVAHEC employs over 130 part-time interpreters in more than 40 languages in its "Metropolitan Language Services" division. Since 1998, NVAHEC has provided approximately 35,000 hours of interpreting services for more than 100 different agencies. More than 1,500 interpreters have completed a 40-hour interpreter training course that prepares them with the skills, techniques, ethical guidelines, and cultural information to handle any situation that may arise in an interpreting encounter. The goal of quality interpreting services is to provide a scenario in which the limited English proficient (LEP) patient receives the same service that

The two testing and training department staff members are responsible for developing new training programs and revising the testing and training materials, while also coordinating scheduled trainings. Currently, the department conducts training courses in "Interpreting in Health and Community Settings," the "Training of Trainers" for interpreters, "Introduction to the Art of Translation," and "How to Communicate Through an Interpreter." To date, more than 6,500 health and human services staff have been trained in the "How to Communicate" training. The Testing and Training Coordinator conducts language proficiency tests daily to assure that training candidates are fluent in English as well as their target language. More than 2,000 candidates have been tested. The departments work jointly to develop a monthly newsletter for interpreters, covering both healthcare

Communicating Effectively Across Languages and Cultures



The NVAHEC staff at the 10-year anniversary event.

and cultural issues. The NVAHEC is a small agency which has a huge impact on its urban service area by providing communication “bridges” for clients and healthcare providers.

Urban Challenges Facing NVAHEC

Between 1998 and 2007, NVAHEC’s language services provision has increased from 16 hours the first month to 450 hours per month. The rise in demand for NVAHEC’s services, combined with its location in a growing diverse urban area, presents both benefits and challenges to the organization.

One of the benefits is having the creativity to capitalize on the specialized skill set of interpreters and making them available, for a fee, to the health and human services community. The DC metropolitan area contains countless nonprofit agencies which compete for the

same limited resources, especially for funding. Since government and grant funds are becoming more scarce, the NVAHEC has

capitalized on marketable services that are in demand and that fill true community needs for the region. Competition and the lack of sufficient financial and human resources challenge NVAHEC’s service provision. Since NVAHEC is a small nonprofit with a small budget, it must focus on recruiting qualified staff and interpreters who are genuinely passionate about their work and their contribution to their community in lieu of receiving salaries that some DC metro-

politan area businesses can provide.

Moreover, the management team has to make an effort to always think creatively when it comes to partnership opportunities and relationships, as partnerships entail a great deal of work to ensure that the expectations of all parties are fulfilled. Nevertheless, one of NVAHEC’s great advantages over its competition is the quality and excellent services that NVAHEC provides, which has resulted in 98–100% satisfaction rate from users of the services.

NVAHEC is setting the standard for language services in the Northern Virginia region. There is a three-way sense of trust between providers, interpreters, and patients resulting in a 98 – 100% satisfaction rate. Because NVAHEC has a long-standing relationship with its clients, they trust that they will receive quality services. One of the main challenges new immigrants face is adapting to new ways of life and overcoming the cultural barriers. Receiving language services from bilingual and bicultural interpreters not only assists in their adjustment to their new environment, but also fosters a trust between them and the providers. NVAHEC has more than 10 years of experience addressing the language service needs of the healthcare community by assuring that everyone: the doctor, nurse, other support staff and the LEP person can all communicate across language and culture.

A crucial advantage to being located in a diverse urban area is the ability to provide services to more people by recruiting interpreters in a wide variety of languages. NVAHEC has the luxury of cultural representation from all over the world. Because cultural connotations vary by region, it is necessary to consider their meaning in the context of a client’s lifestyle, especially in health care.

The Emerging Healthcare Leader

Gloria Wilder, MD, MPH

Dr. Gloria Wilder provides a vision of the Social Entrepreneur as the emerging nonprofit leader who is able to secure a healthy work-life balance. Comments were solicited for this article and appear after the article.

In every society there are risk takers—those people who will leverage it all to accomplish a dream. Most often we hear examples of pure capitalist business moxie. The Microsofts, Wal-Marts and McDonalds of the world, led by individuals who step out on a limb to challenge convention in hopes of building a new industry and making great profit. Terms like “Giants of Industry” have been coined to describe this group of business leaders. We all know the horror stories that result when this type of leadership goes unchecked—such as with Enron and now the mortgage industry leaders.

What about the world of nonprofit healthcare leadership? Who are our “Giants of Industry” and how do we measure their strength? When we think of nonprofit work we tend to assume a group of leaders who are altruistic and not focused on margins and driven blindly by profits. Is this true? Or are we projecting an unfair image on an industry that drives 17% of our Gross National Product? The impact of nonprofit healthcare leadership in this nation is enormous, controlling billions of dollars in healthcare expenditure each year. Yet there is no clear path to identify and train a new set of emerging nonprofit leaders. Recognizing that a vacuum exists in the care and nurturing of nonprofit leadership, the Eugene and Agnes E. Meyer Foundation commissioned two studies to explore this critical issue. In 2006, the Foundation released *Daring to Lead* a new study based on a survey of nearly 2,000 executive directors in eight metropolitan areas throughout the U.S.; this study showed that three out of four nonprofit executive directors are likely to leave their jobs within the next five years. Reasons cited for wanting to leave their current roles included relentless fundraising pressure, a weak board of directors, low

salaries and a lack of management support. In 2008, the Meyer Foundation released a second study, *Ready to Lead?* which surveyed nearly 6,000 next generation leaders. This group of young future nonprofit leaders from the healthcare sector and beyond identified work-life balance, insufficient lifelong earning potential, lack of mentorship and overwhelming fundraising responsibilities as barriers to them seeking a more responsible position in nonprofit leadership. Do you see a theme here? According to the Urban Institute there are 850,000 publicly registered charities in the United States. We certainly all know examples of nonprofits that pay competitive wages, have professional development opportunities for their staff and support a life balance philosophy that makes taking vacations and caring for sick family members acceptable in a life of service. The unpopular truth about the life of a nonprofit leader is that it is not so different than the life of a for-profit leader. The bottom line for both is the bottom line. The truth is both nonprofit and for-profit leaders must focus on productivity, outcomes and satisfying the stakeholder. For one leader the final arbiter of satisfaction is the shareholder while the nonprofit leader's benchmarks are largely set by the funders (foundation, private donor or government agency), boards and occasionally by the client/patient or end-user of the service. Neither the for-profit nor the nonprofit leader has the ability to focus fully on the mission or the impact of service delivery. As a result, in both sectors of the health care delivery system, we are seeing poor health outcomes, increasing disparities and a lack of trust in a system that does not value their customers (patients). What is emerging out of the frustration of our broken health care delivery system and the tattered attempts at healthcare policy reform is the emergence of a new type of healthcare leader: **The Social Entrepreneur.**



Gloria Wilder, MD, MPH, is President/CEO of CORE HEALTH, and Founder of JUSTICE SPEAKS, Washington, DC.

The Emerging Healthcare Leader

The Social Entrepreneur emerges as a hybrid of the best of both the for-profit (efficiency and productivity-driven models) and the non-profit (mission driven, social focused) models. This leader blends dual training in public health and social justice with an understanding of market economics and strategies for sustaining change. It is this mixed strength that allows the social entrepreneur to reshape nonprofit health care delivery into a growth industry that allows for transformation and innovation. This leader has the courage to take on risk on behalf of the greater good. This new visionary nonprofit healthcare leader has the hunger and drive to reject the health screening and output tallies of traditional public health and instead works to develop public-private partnerships that recognize the value of healthcare markets and the ability of markets to influence health outcomes at the individual and community level. What is inherent in a leader who decides to ignore trends, follow passion and dare to challenge complacency? I believe it is a desire to produce systemic sustainable change. In addition, this

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modern pioneer recognizes that risk equals reward and therefore is no longer willing to accept a life of personal sacrifice as the requirement for pursuing a career focused on assisting those in need. The *Daring to Lead* report identified a scary reality; our current group of nonprofit healthcare leaders is aging, getting burned out, feeling

under-appreciated and have little to no succession plans within their organizations. I recently had a discussion with a very successful nonprofit executive director in Washington, DC, who runs one of the city's largest healthcare clinics. This leader is also a single mother who is uninsured, has no retirement plan and only \$15,000 worth of savings for a rainy day. At 55 years-old, she awoke one morning to realize that everything that she spent her life fighting for on behalf of her patients she had failed to secure for herself. In an effort to serve more families she

had refused pay raises, opting instead to hire more underpaid staff. In an effort to ensure she could send her child to private school she opted to forego health insurance, instead using the services within her own facility. Now awakening to the thought of retirement she is beginning to realize the path she carved for herself is the same one she had walked so often with her patients. She will eventually depend on a Social Security system that has failed the seniors in her clinic; she will carry the same Medicare card that provides them substandard care. This reality is balanced by a history of remarkable achievements and service that has included growing a clinic from a hole-in-the-wall shop to a comprehensive model of quality care and hiring, training and supporting new leaders who emerged to run healthcare organizations across the nation. All told, she is proud of the path she chose, but was it worth it? Yes. Was it necessary? No. It is not necessary to throw yourself on the sword to pursue a career in social justice. Too often people who are driven by mission assume an unhealthy level of personal sacrifice often resulting in poor care for themselves, their families and ultimately their patients. I teach medical, allied health, nursing and other students, residents and young faculty who come to me for counsel to understand the importance of self-care. The first step in helping others is recognizing that it is not selfish to nurture the strength that allows you to do so. Second, I teach them that martyrdom is selfish. I cannot tell you how many e-mails I receive from friends and colleagues who use their personal time to go on a mission or rescue trip to developing countries only to wind up needing to be rescued themselves.

Right behind the current cohort of nonprofit leaders is a new group of recent graduates, residents and junior faculty who are non-apologetic about having a life while doing the right thing. I say more power to them! It is this group that has shunned the cushy security of a tenured position in an academic institution and is instead opting to strike out on their own, creating their own businesses and providing justice in unique models that allow for a flexible lifestyle, the rewards of a decent salary and retirement benefits

The Emerging Healthcare Leader

without the constraints of a publish-or-perish mandate. While many a chairman's position is held hostage to a unilateral vision of nonprofit work, there are a group of entrepreneurial social capitalists in healthcare willing to invest their personal resources and time to drive change.

Much of the work of the last century in U.S. public health has focused on measuring the toll that healthcare disparities have taken on our citizenry. We have created offices of health disparity in each one of our major cities. At the federal level there are divisions that do nothing but document the toll of a broken health care delivery system. What

we have failed to do is to define health equity. We have failed as a nation to state unequivocally that health care is a right of all persons who reside in our borders. We have failed to define a baseline level of care that each person should expect when presenting within this

system. This series of failures has resulted in a nation where economic segregation in health care delivery has compromised our ability to compete in a global economy. Past mavericks of the healthcare industry were recognized for the pure stubbornness of their convictions. Development of the polio vaccine and creation of antiseptic techniques are just a few examples of the "no guts, no glory" mentality that drove medical pioneers. In the 21st century we have the introduction of a new breed of risk takers: the social entrepreneurs. This

adventurer invests actively in the outcome of their life's work. The community's needs and the provider's needs are in sync. In this balanced model of public health the delivery of care is one of the five major components of a healthy community. The components of a healthy community include:

- Access to quality health care.
- Access to quality public education that prepares every capable individual for gainful employment.
- Access to a clean, thriving, nonviolent, nontoxic environment.
- Access to fair economic opportunities including the ability to fairly compete for resources and to advance in socioeconomic class.
- Access to a fair and unbiased civil and criminal legal system.

These five tenets are the tenets of social justice in any society, and for those of us who chose the path of social entrepreneur they serve as the framework for our

pursuits. Change happens. Twenty-first century medicine will reflect on a group of leaders within healthcare who embarked on a new movement of social justice in health care, creating healthy communities and defining for a nation and a world a path to ending disparities and defining equity. If equality is the ultimate goal of a democratic society, then equity is the path. You must decide for yourself how this plays out in your career. For me, I am choosing to be a social entrepreneur and a physician who practices social justice for a living.

What is emerging out of the frustration of our broken health care delivery system and the tattered attempts at healthcare policy reform is the emergence of a new type of healthcare leader: The Social Entrepreneur.

Editor's note: Invited responses to this article appear on pages 36-37. Additional comments are welcome and should be submitted to editor@nationalahec.org for inclusion on the National AHEC Organization Web site.

The Emerging Healthcare Leader – invited responses to the article by Gloria Wilder



Thomas J. Bacon, PhD, is the Director of the North Carolina AHEC Program in Chapel Hill, NC, and Co-chair of the National AHEC Bulletin Editorial Board.

Dr. Wilder's call for a new form of leader for nonprofit organizations has great relevance for AHEC. In an era of scarce resources it is essential that we develop leaders at both the program and center level who understand our workforce development mission and are passionate about educating and developing a new generation of health professionals to serve our communities. At the same time they need the leadership and management skills to access new sources of support, attract and nurture talented staff, and relate effectively to both academic and community partners. It is not surprising that on the recent NAO member survey, leadership training came out as one of the top priorities. The new leadership institute being developed by NAO can play an important role in preparing AHEC leaders to guide our organizations during the coming decades.



Carol Wolff, MA, is the Executive Director of the Camden AHEC, Camden, NJ.

New healthcare leaders must move beyond the box we have been trained to occupy. We must learn to walk in the shoes of our partners. Physicians and other providers need to understand the needs, concerns and perspectives of patients. Consumers (patients) need to understand the environment and constraints of the healthcare providers. Everyone agrees the healthcare system is broken, but few have the courage to make the necessary changes. It will require a significant shift in power and few nonprofit leaders understand this dynamic. In order to address health disparity, we need to create health parity as the author describes. This means creating a shared vision for a new system that includes communities that are healthy places to live and work regardless of social-economic means.

Our current healthcare system is trapped in a model of creating special departments, offices, and initiatives to address health disparity; the same thing past leaders have done with equal opportunity, diversity, and quality improvement. Deming did not suggest we create qual-

ity improvement directors or departments, nor did Martin Luther King suggest we create equal opportunity officers for institutions and industry. In fact, by creating these named functions we create another box with boundaries and systemic change never takes place. The system remains broken.

Leadership and change require accountability and transparency. In our present broken healthcare system, who is accountable and to whom are they accountable? Who are hospitals accountable to? It is certainly not the patients they serve or the community where they exist. If they were accountable, they would naturally work with consumers, employers, providers, and public health to ensure a healthy community for all residents in their geographic area. Who is public health accountable to? Certainly not the public they are supposed to protect. They often work in isolation, seeing their role as separate from healthcare practitioners, hospitals, and private industry. Unfortunately, public health has lost credibility in this country. Who are physicians, nurse practitioners and physician assistants accountable to? Not the patient or the communities they service, they are accountable to payers and insurers. Who are employers accountable to? Although employers are the drivers of the broken system, they do not provide the leadership necessary to fix it. Could it be they are bound by profit margins and stakeholder returns? And let us not forget those we elect. To whom are they accountable when it comes to providing leadership? Certainly not the constituents who elected them but more likely those who finance their campaigns, including incredibly rich special interest lobbying groups such as pharmaceuticals.

Wilder offers us hope in the form of social entrepreneurs but I believe that the broken system requires a new kind of leader that turns the pyramid upside down, not someone who applies more Band-Aids. America's new healthcare system will require leaders with courage, compassion, knowledge, and self-interest. New leaders will come from those who use the system, not from those who provide care. It will require new partnerships, new models of care, providers who are willing to listen and to support consumer health leadership. So the leaders who will drive the changes needed in our broken system will need to be consumers – ordinary citizens who know what kind of health care they want for themselves, their families, and their communities.

The question I have is this. Is this society ready to listen to their voices? Are you? Do you have the courage to support a consumer-driven healthcare model for this country?

The Emerging Healthcare Leader

– invited responses to the article by Gloria Wilder



Kenneth L. Oakley, PhD, FACHE, is the Chief Executive Officer of two regional nonprofit organizations in Upstate Western New York: the Western New York Rural Area Health Education Center and the Lake Plains Community Care Network. Ken serves on numerous regional, statewide, and national boards including the New York State Rural Health Council and the NAO Editorial Board.

Dr. Gloria Wilder's article, "The Emerging Healthcare Leader," is a thought-provoking and timely article. As a seasoned nonprofit health and human services executive myself, and a Fellow in the American College of Health Care Executives, I was drawn to compare many of the elements suggested as social entrepreneurship to my own personal and professional life experience. There is no question that in today's environment, a successful leader, a true change agent, must be creative, innovative, and be totally prepared to embrace risk and uncertainty. Yet this same leader must also be grounded in a solid understanding of personal motivation and expectations as well as of the motivation and expectations of others, be they those we work with or those we work on behalf of.

I would suggest, and I think Dr. Wilder would agree, that a true leader is a generalist by nature, an individual capable by training and/or experience to stand back and consider the "whole" as more than just the sum of its parts. Leadership is about an almost intuitive understanding of the interrelatedness between available resources and emerging opportunities. Yet, leadership is even more about cultivating interpersonal relations. I have often felt that my own professional success has had far more to do with my early training as a Master's Degree level counselor than it ever has with my subsequent business training and acquisition of a MBA and Doctorate Degree in Management. When all is said and done, effective leadership is all about understanding and influencing people beginning and ending with one's own self.

Dr. Wilder suggests that the emerging healthcare leader, the social entrepreneur, will be successful primarily because of his/her ability to balance personal life desires with professional life expectations grounded in tenets of social justice. I could not agree more. In fact, I would even go further and say that it may not be just a "balance" of various life expectations that will permit these individuals to be successful, but rather a conscious and equitable "integration" of life expectations that will motivate and allow them to thrive in a world of continuous stress and change.



Robert J. Alpino, MIA, is the Center Director of the Eastern Virginia Area Health Education Center in southeastern Virginia. He is a member of the National AHEC Bulletin Editorial Board and is co-issue editor of this edition of the NAO Bulletin.

In her article, "The Emerging Healthcare Leader," Dr. Gloria Wilder states that the new type of healthcare leader necessary, the "Social Entrepreneur," needs to be a "hybrid of the best of both the for-profit and the nonprofit models." I could not agree more with this statement. Early in my career, a time when I was more involved in provision of direct health care services, I was fortunate to have worked with someone who served as the Vice President of Mission (yes, this was his actual title) for a Catholic hospital and healthcare delivery system. One of this person's favorite expressions was "there can be no mission without margin." That statement has always stuck with me because it impressed upon me that without the necessary business acumen, and, call it what you will, excess revenues or, dare I state it, profits, even the best-intentioned nonprofit organization and/or leader would be doomed to failure. During my career I have seen several very compassionate leaders of nonprofit organizations fail to heed the "there can be no mission without margin" adage. They failed and their organizations failed. So, I encourage you young, emerging nonprofit sector leaders to pay serious attention to Dr. Gloria's advice. Taking several accounting courses along with your epidemiology courses could be a good start...

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The National AHEC Bulletin

Autumn/Winter 2008

Call for Articles

AHECs in 2009:

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The *National AHEC Bulletin* Editorial Board is soliciting articles on new and exciting AHEC initiatives that address health workforce needs and provide support to underserved communities. Typically *Bulletin* issues focus on a specific theme; this issue will highlight a wide variety of creative programs. Your article may address any AHEC focus area: health career enticement, student training, educational services for practitioners, or enhancing local health services. In addition, articles on individual success stories and describing new evidence-based strategies utilized in your programs are welcome.

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Please refer to the *Bulletin* Submission Guidelines (Editorial Guidelines) posted on the NAO Web site:
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Please submit drafts, photos, and accompanying materials to:
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