

The
KATAHDIN
AREA HEALTH EDUCATION CENTER:
Organizing for Educational Access and Jobs in
a Rural Development Context

A Project in Community Development
presented by
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Submitted to the
Masters Program in Community and Economic Development
of New Hampshire College
in partial fulfillment of the
requirements for the degree of
Master of Science
in
Community and Economic Development

June 1988

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FORWARD

As this writer attempted to encapsulate nearly four years of a developmental process into a 20-30 page project narrative, I realized the inherent limitations of conveying many of the subtler aspects of that process in an essentially subjective summary. Therefore, I would direct the interested reader to the following appendices for a more detailed and objectified presentation of the development of the Katahdin Area Health Education Center:

1. For a clearer sense of citizen involvement in planning and governance, review Appendix C and the Regional Council portion of Appendix G,
2. For an explicit needs assessment, refer to Appendix E (particularly pages 7 through 30), and
3. For a fairly straightforward progress report as of the Spring of 1988, review Appendix F.

I also encourage the reader to review the bibliography on community development planning and health professions education in a rural context. I consider this a useful, working, evolving document and hope that readers will forward to me additional appropriate readings and resources for inclusion.

I want to express my appreciation to numerous individuals who encouraged and supported me throughout this process. They include: Wayne A. Newell, Assistant Principal at the Passamaquoddy Indian Township School; (former Governor) John Stevens, Facilities Manager of Maine Indian Education; Yvon Labbé, Executive Director of Le Centre Franco-Américain at the University of Maine; Shirl Weaver, Director of the AHEC Program of the College of Osteopathic Medicine at the University of New England (UNE); Mike Morris, Dean of the College of Arts and Sciences at UNE; Harlen Goodwin, Development Director at UNE; Claire Bolduc, Penquis Regional Coordinator at the Katahdin AHEC; Ruth Allen Smith, Administrative Assistant at the Downeast Katahdin AHEC; and my wife, Mary Dunn, and daughters, Shyla and Willow.

I view the development of the Katahdin AHEC as a natural process that merely needed catalytic guidance, support and occasional intervention. Its emphasis on prevention, cultural sensitivity, community control, and education as an integral conceptual part of the rural development process does set it apart from AHEC activities in other areas. This is due to the literally hundreds of rural Maine people who have participated in the development and continue to play an active role in the Katahdin AHEC.

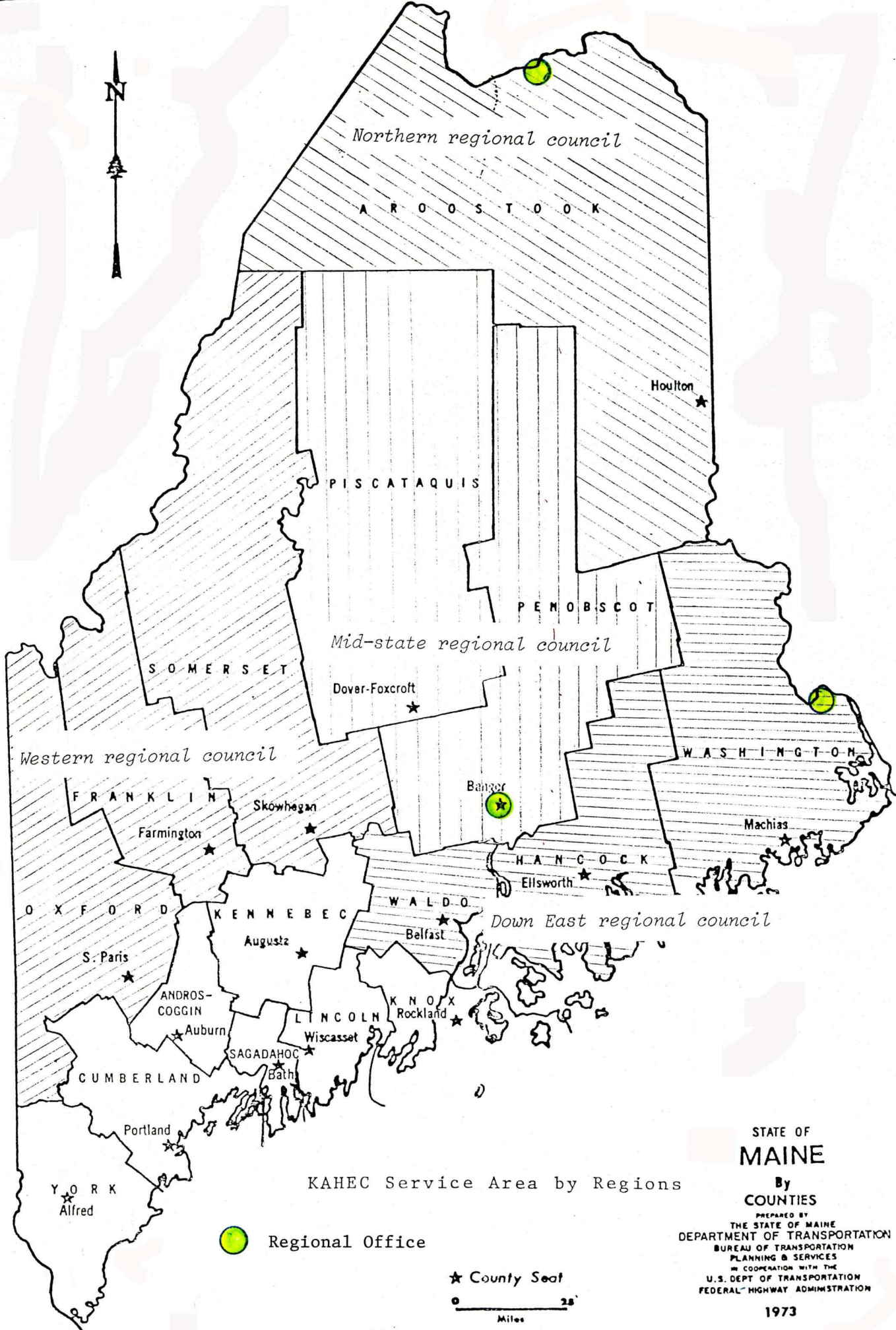
PREFACE

Problem(s):

Macro - The political economy of the health care "system" in the United States.

Micro - The lack of trained health care workers to meet the public's needs in rural eastern Maine, an area which has the lowest per capita income and among the highest unemployment rates in New England.

I should state from the start that the above-noted macroproblem is of such magnitude that individualized, project-oriented "solutions" are not likely to result in significant impact. The political economy of the U.S. health care "system" can only be changed via public education and organizing around a progressive political agenda that recognizes access to health services and medical care as a fundamental right of the citizenry, and proposes radical changes in conceptualizing and provision of educational and health services. While this writer is actively involved in promoting such a progressive political agenda, neither the described project in community development nor this project report directly addresses this necessary process of implimenting fundamental socioeconomic and political change.



KAHEC Service Area by Regions

STATE OF
MAINE

By
COUNTIES

PREPARED BY
THE STATE OF MAINE
DEPARTMENT OF TRANSPORTATION
BUREAU OF TRANSPORTATION
PLANNING & SERVICES
IN COOPERATION WITH THE
U.S. DEPT. OF TRANSPORTATION
FEDERAL HIGHWAY ADMINISTRATION

1973

★ County Seat

0 25 Miles

PROJECT NARRATIVE

This project, the Katahdin Area Health Education Center (AHEC), had its genesis in the fall of 1984. At that time, I was in my fifth year as Health Planner for the Passamaquoddy Tribe at Indian Township, Maine. I was in my second year as a member of the Board of Directors at Calais Regional Hospital, a position achieved as a result of a community-based reform effort initiated by the Eastern Maine/St. Croix Valley chapter of the Maine Peoples Alliance. I was also serving on the boards of directors of the Maine Public Health Association, the Maine Association of Planners and the Washington County Mental Health Association. These activities, combined with two decades of experience as a social worker, educator, planner and organizer in rural Maine, offered a sound basis for analyzing some of the problems and opportunities associated with the area's health status and delivery systems.

Though it focused on health and social services, my role as planner for the Passamaquoddy was a broad one. In addition to data collection and grant-writing, I had responsibilities in the areas of staff development (education) and recruitment. When I arrived in 1979, the Tribe's health services consisted of a staff of eight crammed into the back of the fire hall at Peter Dana Point village, with clinical services coordinated and referral provided by an R.N. out of an adjacent moldy trailer. By 1984, as a result of aggressive planning and resource development, the program had moved into a nine thousand square-foot wood/passive solar heated facility, and the staff increased to twenty-three "Full-Time Equivalents" (FTEs). While programmatically the emphasis remained on community outreach, education and prevention, the Tribe's capacity to provide clinical services was greatly enhanced. Unfortunately, the low educational levels of most Passamaquoddies required the Tribe to recruit "white mercenaries" with the training and appropriate licensure to work as physicians, dentists, nutritionists, sanitation/health engineers and masters-level (clinical) social workers. Negative attitudes toward "Indians" and scarceness of these professionals in the immediate area dictated a strategy of national recruiting for these health professionals. While some professionals arrived with high hopes (and, frequently, greatly distorted expectations), others arrived a bit more cynically, with substantial obligations to the National Health Service Corp (which they preferred to fulfill on the Maine

coast as opposed to Burning Rock, Arizona). Most of these white professionals did not cope well with the reality of working in a Tribal context, and a cycle of extensive recruiting, brief service, and extensive recruiting developed. The Reagan administration's targeting for destruction of the National Health Service Corps, the health professional supplier of last resort for underserved areas, compounded a gloomy outlook.

In the course of this recruitment process, I became disturbed by the resources required to bring in these providers from the outside. Considerable staff time, advertising budgets, interview (travel) costs, etc., were incurred, only to have the individuals recruited leave with their experience in a year or two.

A need I identified and task I assumed by default, was to work with each nonprofessional staff person to identify educational goals and establish an Individual Development Plan (IDP). Of the health center's staff of 23, 10 were classified as professional, 13 as nonprofessional. Of the professional staff, only the Tribal Health Director (who had an M.Ed. from Harvard) and the Human Services (mental health/substance abuse) Coordinator (who was an R.N.) were Passamaquoddy. Of the non or para-professionals, only 3 were not Native Americans. Of the 10 nonprofessional Passamaquoddies, only 3 had completed high school, with another 3 having obtained their GEDs. A process evolved of meeting with each staff person and discussing their developmental or educational goals within the context of the IDP concept, followed a few weeks later by a second meeting in which specific activities toward clear goals were established. Goals varied as widely as pursuing readings intended to enhance one's potential to pass the state's tests to become a Registered Substance Abuse Counselor, to taking remedial and prerequisite courses needed to enter dental hygiene school, to enrolling in an external degree program in environmental health and undertaking guided independent study leading to certification as a medical records technician. Even with moral and financial support, success with these IDPs was slow in coming, in part because of the psychological overlay of individual/collective failure within an educational structure designed and controlled by the oppressing culture, and in part due to other, more personal, reasons. In the process of working with these individuals, almost all of whom spoke fluent Passamaquoddy and were committed to the

improvement of reservation life, I became deeply impressed with their insight, depth of experience and general skill base. However, considerable barriers prevented these individuals from assuming positions requiring formal education and/or licensure of health/mental health professions. These included a history of racism and cultural genocide, educational systems operated in a non-Native language, poverty, geotransportational and other problems. Although the University of Maine system does waive tuition for Native Americans, and numerous Tribal members undertake coursework on a full or part-time at UMMachias (60 miles south) or UMOrono (100 miles west), those institutions' lack of a process for awarding academic credit for experiential learning meant that, for most of these adults, a four-year, full-time or eight-to-ten-year part-time (commuting) commitment was required to obtain a bachelors degree. With families, jobs and Tribal responsibilities, this posed considerable additional barriers.

In discussing these problems with Tribal Governor John Stevens and Tribal Health Director Wayne Newell, it was obvious that some measures to address these issues were important to the Tribe's goals of self-determination. In the short run, a way for adults within the Tribe to validate prior learning and to connect with nontraditional and/or external degree programs had to be explicated. In the long run, the problems that caused 57% of the 47% of Maine's Native Americans who drop out of school to drop out before the ninth grade needed to be identified and addressed. As the high school retention and completion rates improved, conscious efforts to expose youth to health and social service careers (among others) needed to be made. By doing so, more Tribal members would be employable in professional positions, thereby creating more positive role models, providing more culturally aware services, and reducing economic leakage into the surrounding non-Native population.

Not that the situation in the surrounding communities were that much better. My positions on the boards of the Calais Regional Hospital (CRH) and the Washington County Mental Health Association (WCMHA) offered some insight into recruitment and retention problems for professionals in medical and mental health settings. At CRH, a 77-bed facility, there were only six local physicians on active staff, with a consensus that a minimum of twelve were optimal to adequately meet community needs. The hospital

had lost money for two straight years and was still paying nearly \$75,000 per year for "headhunter" services and other physician recruitment costs. Over 20% of its nursing positions were vacant at any given point, another 20-25% filled by foreign nurses (Canadian, Irish, Philippino, Italian and Australian) and another 5-10% by expensive, temporary "flying nurses" from other states. All of the physicians and the great majority of other professionals in the hospital were "from away" and most of the paraprofessionals (social workers, lab techs) who were from the area lacked degrees and failed to meet tightening licensure/accreditation requirements.

The situation was as bleak in the mental health field. With no clinical social workers, psychologists or psychiatrists in private practice within seventy-five miles, the local WCMHA-supported mental health clinic was virtually the sole-source provider in the county. In its fifteen-year history the mental health center had never employed a single Maine native as a clinician. They did extensive national recruiting for professional staff, offering an "idyllic setting on the Maine coast" as a carrot. They got an occasional clinician with a N.H.S.C. service obligation. Once here and faced with marginal salaries, high food/energy costs, excessive case loads, four-month waiting lists, no continuing education opportunities, and little peer support in a idiosyncratic rural culture, these counselors tended to burn out rapidly and leave (generally within 18-24 months).

Although not as extreme as within the Passamaquoddy Tribe, the educational status of Washington County as a whole was not very positive. The county has the highest high school dropout and illiteracy rates in Maine. Institutions of post-secondary education are two: the Washington County Vocational Technical Institute in Calais (which offers only one-year certificate programs) and the University of Maine at Machias. Neither institution offered any programs in the health or mental health fields. Again, in the county with the highest unemployment in the state and the lowest per capita income in New England, quality jobs were available but local people were not being prepared to fill them.

Washington County, while extremely socioeconomically distressed, was not alone in this regard. Of Maine's sixteen counties, two (including Washington) had poverty rates of 20% or more, three had poverty rates of between 15-20% and seven had poverty rates of between 12.5-15%. The severity of distress increased in direct correlation to the distance from

the U.S. (New Hampshire) border. This phenomenon is so striking that a controversial 1982 State Planning Office economic planning document warned of:

"...the danger of accentuating the division between the two Maines': one in the south based on high wage and growing industries, and a second in the north based on low wage, (declining) mature industries and part-time employment. As this split grows more and more apparent, and as more of the State's people demand both social service and economic assistance, the potential for social conflict increases."

This noted dichotomy was not always thus. In the nineteenth and early twentieth centuries, the northern areas of Maine were quite prosperous. The region enjoyed good transportation via waterway and rail networks. Lumbering, pulp/paper, agriculture, fisheries, textiles, leather, boat building and ice harvesting were all active economic sectors. However, in the past fifty years, a significant decline has occurred. Some of this decline is due to technological change, such as the electric refrigerator, the rise of the iron/steel ships and the primacy of the automobile and associated highway systems (and decline of water and rail transport). Now, rather than being a gateway to Europe, Lubec, Maine, finds itself on the U.S.' back stoop.

Much of this local decline is enmeshed with factors on a national and/or international scale. Within the U.S., natural resource industries (agriculture, forestry, fisheries and mining) provided more than four of every ten jobs in nonmetro areas in 1940; but these industries provided fewer than one job in ten by 1980. USDA researchers Herman Bluestone and Stan Daberkow summarize much of this by noting that "By 1980 the service industries, manufacturing and construction had come to dominate economic activity in nonmetro areas, much as they do in metro areas." This decline in traditional sectors is a result of conscious public policies. Since the institutionalization within the U.S. Department of Agriculture and associated state agriculture departments and land grant university systems of the University of Chicago School of Economics prescription for agricultural production, tens of thousands of America's family farms have been lost. In some counties in Maine, 90% of small farmers have gone out of business. Lax environmental, regressive tax and other policies and laws have allowed multinational woodland owners (who control over 50% of Maine's land mass)

to operate in an extractive rather than a regenerative manner. Again, in Maine the forest status has degenerated to the point that lumber production is on the wane and pulp mills are shifting to chips rather than pulp sticks because there are fewer and fewer "real trees". Mechanized clear-cuts are so extensive, one activist woodcutter likens standing in the middle of an average clear-cut to "standing on the dusty, cratored surface of the moon." Employment in fisheries, as well as agriculture and forestry, has greatly declined in Maine over the past fifty years.

Declines in traditional manufacturing (excluding paper) has also increased in Maine. This belies the assumption that rural America is somehow outside the mainstream of modern society with a basically stable economic structure. In fact, traditional rural economies are also highly attuned to international forces. Since WWII, the strengthening of the dollar and the growing competitiveness of rapidly industrializing Third World countries have negatively impacted on U.S. industries that tend to rely on export markets or substantially compete with foreign imports. The growing worldwide recession of the past decade tends to exacerbate the situation. Four of rural America's traditional industries--manufacturing, energy, forestry and agriculture--are extremely sensitive to these global economic forces and have been additionally pressed into a declining competitive stance by the above-noted conditions. In Maine, in addition to agriculture and forest products, textiles, leather and shoe manufacturing have been particularly hard-hit.

Despite the decline of our nation's basic industries, the service portion of the U.S. economy has enjoyed a relative boom. Unfortunately, this boom has not been as beneficial in rural as in urban areas. While two-thirds of the new jobs created in the U.S. between the fourth quarter of 1979 and the fourth quarter of 1984 were in services, only one of eight of these were in nonmetro areas. However, this under-representation of rural America in the burgeoning service sector of the economy may present a very real opportunity for community and economic development.

At the 1987 Farm Foundation National Public Policy Conference in Kennebunkport, Maine, presenter Kenneth Wilkinson noted that "...a program designed expressly to promote community development is not a very good means of promoting community development. A much better way is to make community development a secondary objective of efforts to reach more visible goals,

such as job or services." Experience in Maine, in the context of minority communities or the broader rural regions, would support this thesis.

Health and associated social services fit into a concept of economic diversification and regeneration rather well. First, health services may be important in attracting both employers and community residents. One way is through the formation of "human capital". Human capital is an economic development term that views humans as productive assets; and investments in education, health care, etc. are expected to yield dividends in the form of labor creativity and/or productivity. Selected studies suggest that the availability and quality of health care services can, in fact, play an important role in this scenario. Another avenue is the potential for health services in helping communities to attract and retain job-creating businesses/industries. For example, a company may meet employee resistance if it tries to transfer key (management) employees into an area with substandard services. Scattered empirical evidence suggests such a relationship exists between these infrastructural elements and the attraction of businesses and workers. On several occasions when the "smokestack chasing" economic development efforts of the Calais community development office brought nibbles from potential business investors, the hospital administrator and one or more board members met with them.

Apart from their role in attracting business and industries, the availability of health services may be even more important in attracting community residents. The concept of people as an economic base is fundamental to CED. However, the concept assumes added dimension with the growth in "passive income" (dividends, interest, and transfer payments). Passive income accounts for one out of every three dollars in U.S. personal income, with much of this income tied to the retirement-aged population.

Retirees, like business executives, may make their location choices in part on the basis of community health services. Any growth in this "grey hair" economic base leads to additional jobs, including but not limited to health service jobs. For example, one rural (Oklahoma) study indicates that a full-time physician in a small town typically employs 3.75 persons. The study also suggests that local spending generated by a physician's practice and the practice's personnel may generate an additional 13 non-medical jobs in the local economy. Similarly, another (Pennsylvania)

study indicated that a hospital in a typical small (8,000± population) town could account--directly or indirectly--for one-fourth of all the community's jobs. As rural areas tend to display demographic reverse bell curves with high youth, low mid-adult and higher elder populations, attracting or retaining elder residents would seem a sound economic development strategy. Indeed, after eighty years of declining population, Maine's rural areas (especially the coastal counties) have turned around, with retirement-aged in-migrants playing an even more consistently significant role in population growth than the "back-to-the-landers" of the seventies.

Nationally, seven of the forty industries that are projected to have the highest rates of job growth through 1995 are health-oriented: nursing and personal care facilities, physician offices, non-physician health practitioner offices, hospitals (including state and local), dentist offices and health and allied services not otherwise classified. The opportunities for maintaining and expanding the local economy by improving the status of health services is recognized by Rich Couto's observation that

"Under the right conditions a process may occur where the leaders of health fairs and clinics become (or often already are), recognized as 'doers', the community begins to feel better about itself, providing a boost in mental health, specific skills, such as fund raising are received; and new skills that are acquired in clinic development, such as proposal writing, can be applied to additional problems like the need for improved water systems, roads and housing."

Within Washington County, the evidence would seem to support this perspective. The two hospitals in the (bi-polar) county's largest communities are those communities second or third largest employers. However, since the start of federal investment in the health care infrastructure in the early seventies, the county's six rural health centers' total employment is akin to that of the hospitals, and their political support networks of boards, staff and patients (including a sizeable number of relatively affluent and educated retirees) a factor to be recognized in any local endeavor.

It is within this context that my project, the Katahdin Area Health Education Center, began to unfold. In 1984, the Tribe's first full-time physician (with a N.H.S.C. obligation), Scott Treatman, attended a Maine

Osteopathic Association convention. There he met Dr. Martyn Richardson, the Dean of the College of Osteopathic Medicine at the University of New England (UNECOM), located five hours south in Biddeford, Maine. Dr. Treatman indicated that Dr. Richardson had expressed interest in placing a student physician at the Tribe's health center for clinical training. I was aware that some medical schools out west (particularly in Oklahoma and the Dakotas) had developed residential summer programs for Native American youth which exposed them to health careers and which offered 4-8 week courses in math and science. I suggested to Tribal Health Director Newell that UNECOM's interest might be parleyed into some similar type of program. He agreed, and a meeting was arranged with Dr. Richardson, ostensibly to discuss placing a student under Dr. Treatman's preceptorship.

The meeting was held under a fine September sky at a picnic table by Big Lake at Peter Dana Point village, Indian Township. Present for the Tribe was Tribal Governor John Stevens, Health Director Newell, Dr. Treatman and myself. Present for the University of New England (UNE) was Martyn Richardson, D.O., Academic Dean of the College of Osteopathic Medicine, Bruce Bates, D.O., Associate Dean of the College of Osteopathic Medicine, and Charles Ford, Ph.D., Dean of the College of Health Sciences. Following introductions, Dr. Richardson broached the idea of placing one or two student physicians with the Tribe. Governor Stevens indicated that such would be perfectly acceptable to the Tribe, and that hopefully such an effort would lead to the students being interested in returning to serve the Tribe or the broader community in the medically underserved St. Croix Valley, thereby strengthening the local hospital (CRH). Pleased, Dr. Richardson asked a rhetorical question, "How can UNE be helpful, in return, to the Passamaquoddies?" Governor Stevens immediately responded that, since UNE had the only educational programs in Maine to train physicians, physical therapists and occupational therapists (as well as nurses and social workers), that "you can work with us to get more Indians into and through your school." Although surprised by the promptness and relative specificity of the response, the UNE representatives reacted positively to the challenge and considerable brainstorming ensued. During this discussion, it seemed that the UNE representatives got fairly excited. Dr. Bates could relate to some issues as a native of northern Maine himself. Dr. Ford, it was revealed, was an early Peace Corps volunteer and had some understanding of Third

World issues, and Dr. Richardson was simply a positive and affirming individual. They honestly shared some of the constraints they functioned under, with UNE being a small (1,000 students), private, limited-resource institution, and its medical school being the youngest (6 years old) in the U.S. However, after considerable discussion, the meeting ended positively, if inconclusively, with Drs. Richardson and Ford pledging to "explore all avenues" for mutual cooperation between UNE and the Passamaquoddy Tribal Government at Indian Township. Nice words from good white liberals, but neither Wayne Newell or myself expected much further interaction.

We were, therefore, surprised when Dr. Richardson wrote the following month to indicate that UNECOM was exploring funding sources for programs that could develop rural clinical training opportunities while improving the health status of local populations. He suggested that the Tribe might wish to meet with UNE's Development Director, Harlen Goodwin, to review what funds might be amenable to address the issues raised in our brainstorming session at the Township. Wayne assigned me the task and I traveled south to meet with Harlen. In reviewing with him various notices in the Federal Register, one RFP virtually jumped off the page at me. This was under the Area Health Education Center (AHEC) Program of the Office of Health Professions of the U.S. Public Health Service, DHHS.

The overall goal of the AHEC Program was to increase the supply of health professionals to underserved rural and urban areas. The program grew out of a 1970-71 Carnegie Commission study which examined the national shortage of physicians and recommended a series of government initiatives to address this problem. Based on considerable research on physician recruitment and retention, the sole major identifiable predictive factor for where a physician established a practice seemed to be where s/he did clinical training. The Commission therefore urged the Public Health Service to provide technical and financial support for physician student and medical residency (clinical) training in underserved areas. Starting in 1972, the federal government did so. By 1984, these efforts had gone forward in 32 states, none of them in northern New England. The program's thrust had also changed somewhat over the intervening years. The problem of the physician shortage had metamorphosized into one of physician maldistribution, with poorer communities being the least served. Also, there was a growing awareness that more than physicians were required to provide adequate health

services. This astounding insight led to the broadening of the AHEC concept to include other health professions.

All Harlen and I had to go on was the Federal Register announcement which outlined that the AHEC Program addressed the recruitment and retention of health professionals in rural areas by: 1. Developing clinical training sites in underserved areas for students in health professions disciplines, 2. Developing continuing education opportunities for health professionals currently practicing in rural areas, and 3. Developing initiatives to support "under-represented populations" in entering the health professions. The funding had to flow into a state through a medical school, with at least 75% of the money "passing through" to an autonomous, non-profit corporation. We agreed to go for it, with only about five weeks left 'til the proposal was due.

Upon receiving the proposal guidelines, it became apparent that Maine's Native American population of around 4,500 (.41% of the state's total), only about half of whom were on or adjacent to one of the three reservations served by a Tribally-operated health center, would not likely have the "critical mass" to stand alone as an AHEC project. Other "under-represented populations" (the feds current term for racial minorities) were not well-represented in Maine. Only .29% of Maine's population is black, .46% Hispanic and .27% Asian. However, state estimates of Franco-Americans in Maine put them at about 39% of total population, of which about 38% speak French as their first language. Substantial numbers of these Francos were of Acadian stock and had inhabited the small farms of the St. John Valley at the extreme northern end of Aroostook County for over 200 years (see Appendix H for map). Others were Québécois who had settled in the state's mill towns in the past 75-100 years. Franco-Americans had also faced considerable obstacles in Maine, with considerable animosity towards their language and religion reflected in such diverse ways as the "French and Indian" wars of the 17th and 18th centuries, to being targeted by the Klu Klux Klan (who elected a Maine governor) following WWI, to being forbidden to speak their language in school well into the sixties, to the "Dumb Frenchman jokes" of the eighties. As with other minorities, the aspirations of Francos rose during the sixties and seventies, but, although they had managed to secure some funding for bilingual education programs, they were

not able to obtain recognition from the U.S. Census Bureau or other federal agencies equivalent to that granted Hispanic Americans. As the state's largest ethnic minority, it seemed appropriate to serve them as a target population within the context of an AHEC project.

So, with a general strategy and sense of constituencies in mind, I faced a damn quick job of organizing in time to crank out a proposal in thirty days. In the next week, I drew on some of the contacts I had established in two decades of community activism in Maine by meeting with and presenting the opportunities to: 1. The Maine Indian Health Consortium. This was a group that Wayne Newell, former Penobscot Nation Health Director Maynard Krieder and I had titled in 1981, and which attempted to formalize, via regular meetings and cooperative projects, the informal linkages between the Indian Health Service funded programs in Maine. Participants included the Tribal health directors and planners at Passamaquoddy Indian Township, Passamaquoddy Pleasant Point, Penobscot Indian Nation and the Houlton Band of Malicite; as well as a representative of the Central Maine Indian Association (which attempts to represent the interests of off-reservation Indians). I requested and received this group's support and commitment of participation in the AHEC planning process. 2. The Maine Ambulatory Care Coalition. This group, upon whose board of directors I sat, represented eighteen of the state's twenty-three federally-supported rural health centers (including all three Tribal centers) covering Maine's designated health manpower shortage areas. Again, support and participation was requested and pledged. 3. Action for Franco-Americans in Northern Maine. Entre to this group, a local affiliate of a New England-wide Franco group, was obtained via Claire Bolduc and Yvon Labbé, two long-time comrades in regional struggles for cultural self-determination and social change. Several small group meetings resulted in a consensus by Francos to actively participate in the ongoing planning and development process.

On the basis of this rather narrow base, I pulled together some "bare bones" data and met again with Harlen Goodwin at UNE. Following a virtual tizzy of writing, an amorphous proposal was hacked out and mailed about seventy-two hours later just under the deadline (see appendix D for initial planning proposal). We developed thirteen objectives for this proposal, of which all but the first two were (self-acknowledgedly) unrealistic. The two realistic objectives were:

1. To establish a community-based project planning and advisory committee consisting of the above-mentioned and other appropriate groups, and
2. To establish an educationally-based planning effort that would provide staff and technical assistance to this community-based committee in identifying the needs and opportunities for an AHEC project in rural Maine, and to concurrently develop, under community guidance, a model to present to the feds for implementation funding.

Activities associated with this project during 1985 were, frankly, minimal. In May, UNE was informed that they would receive an eighteen-month planning grant that would commence in July. I was assigned by the Tribe to work with UNE in developing a job description and selection process. The process dragged until Shirl Weaver, Ph.D., was hired in November. In the meantime, I was reading everything I could on AHECs and informally sharing this information through the Maine Indian Health Consortium (MIHC), the Maine Ambulatory Care Coalition (MACC) and every other forum I could find. We were essentially in a holding pattern for much of the year.

In 1986, however, the pattern and pace of activities changed dramatically. In January we held the first formal organizational meeting of the Katahdin AHEC, named for the highest mountain in Maine (from which we can see our entire target area) and the most imposing spiritual symbol for the Penobscot and Passamaquoddy peoples. Except for Dr. Weaver, the entire group consisted of the Maine Indian Health Coalition. An agreement was reached to try to have monthly meetings and to identify appropriate constituencies for additional board seats. In February, Yvon Labbé, Director of the Franco-American Resource Opportunity Group (FAROG) at the University of Maine joined the group, representing Action for Franco Americans in Northern Maine (ActFAM Nor). In March, the group was joined by Bonnie Post, Director of the MACC, and Claire Bolduc, a long-time activist in issues associated with Francos, bilingual/cultural education and occupational health. Subsequent meetings included Debbie Wheaton, a nurse educator representing the state's vocational technical system; Katherine Musgrave, a nutritionist with the University of Maine; Steve Dawson, a clinical psychologist with the region's mental health clinics; and Bery Kornreich, representing the Maine Public Health Association.

Most of these folks became active participants in the planning process.

In May, I left the position of Health Planner at Indian Township (which I had held for five years) to work full-time with Dr. Weaver as UNECOM's Field Coordinator. This move was necessitated by the common recognition that the project needed someone based in northern Maine who was familiar with the region's resources. This recognition was somewhat spurred by the planning committee's expressed need to have "one of their own" as an integral part of the planning process. Several other events also occurred that made me receptive to this change. For one, Dr. Ford became the President of UNE, an auspicious sign for the project continuing in good faith. Another was the selection as the new Dean of the (reorganized) College of Arts and Sciences of Mike Morris, who came directly from five years as Education Director for the Oklahoma Band of Cherokees. In addition to his experience with Native Americans, Mike was quite involved with the Highlander Center and his doctoral work focused on nontraditional post-secondary education. I was also able to work with these parties to maintain Maine's only M.S.W. program. This was a nonresidential (weekend) program through the University of Connecticut that had come into Maine on a ten-year National Institute of Mental Health grant that a committee I served on had initiated in 1975. With the grant expiring and the University of Maine uninterested, I urged UNE to assume the program, which they did, and which gave rise to hope that M.S.W. coursework could be extended to Washington and Aroostook counties, a long-time goal of mine.

I immediately plunged into a formal research and problem identification phase, which objectified and confirmed most of our previously-held perceptions. This formed the rationale, the guts, of our implementation proposal (see pages 13 through 30 of Appendix E which I strongly urge the reader to review). This was no small task, for since the Reagan administration halted funding for health systems agencies, no single data source existed. For example, I had to individually count and map by residence, each of Maine's eleven thousand (\pm) registered nurses just to get a distribution chart!

The planning process did not solely hang on bean-counting, however. The KAHEC organized a forum at the University of Maine in June. Titled "What the Heck's an AHEC: A Forum on the Needs and Opportunities for a

Health Education Center in Northern Maine", the forum drew over a hundred participants who were willing to spend a sunny Saturday identifying how their communities' needs could be addressed via the KAHEC (see Appendix

G). I also went on the road holding a series of generally publicized meetings in Ft. Kent, Caribou, Calais, Machias, Ellsworth, Bangor/Orono, Dover-Foxcroft and Millinocket. I spoke before seemingly innumerable "special interest" groups, such as hospital administrators, social workers, nurses associations, Franco groups, Indian Health Service, small hospital education directors, etc. I visited every post-secondary educational institution in northern Maine offering programs in the health professions. I met with boards/administrators/clinical staff of virtually every agency offering health or mental health services in Maine's northern counties, actively soliciting input data and participation in the planning process. This was basically a process of identifying constituents and offering them the opportunity to "buy into" the planning/implementation network.

Out of this emerged several threads. A consensus evolved that all programmatic activities should emphasize health education/promotion, be developed from the perspective of comprehensive (public) health care and consciously address issues of culture (ethnicity, language, political economy, etc.). Also, activities should not be medically controlled or focused.

The emerging proposal identified as its primary disciplinary tier physicians (mandated by the feds), nurses and mental health workers (social workers, psychologists and substance abuse counselors). A secondary tier included occupational therapists, physical therapists, speech/hearing therapists and "physician extenders" (physicians assistants and nurse practitioners), all disciplines in critically short supply within the initial five-county planning region, particularly outside the Bangor area (see Table 28, page 28, Appendix E).

As we learned more about the "AHEC world" we became aware that our emerging proposal was differing from other AHEC projects in several ways. First, the rule of thumb had been to have either a medical/health focus or a mental health focus, with separate processes/boards/proposals. We felt that this increased the tendency of western medicine to create an artificial dichotomy between the body and the mind/spirit, and preferred to adopt a holistic (Native) perspective. Secondly, most AHECs have

specialized staff located in a central office that handled very specific pieces of the puzzle (for example, medical residencies, clinical training supervision for occupational therapists or continuing professional education). The KAHEC opted for regional coordinators who were generalists located away from academic centers, each with her/his local advisory board. Finally, and perhaps most significantly, almost all AHEC boards were clearly dominated by physicians who perpetuated the cycle of large hospital-based programs with most of the resources going to physician training. The KAHEC designated just one board seat for a physician (per federal mandate) with a community-controlled board representing multiple constituencies (Native Americans, Franco-Americans, rural health centers, public and private vocational and academic education, mental health centers, public health and the various regions). (See Appendix B for articles of incorporation, by-laws and 501(c)3 application.)

The three major programmatic areas inherent in the AHEC concept were to be approached as follows:

1. Clinical Training.

Clinical training was to be based in Tribal and other rural health centers, small (under 60-bed) hospitals, community-based health/mental health agencies and rural private practitioners offices. The idea being that: physician students need to learn they can practice good medicine without a CAT scanner down the hall, nursing students need to know that to practice in a rural area one needs to be a good community organizer as well as clinician, and that social work or psychology students need to have a personal understanding of the cultural ecology from which they draw clients. All need to be supported in considering the potential for a professionally-rewarding and financially feasible practice in these underserved areas, as well as the options for personally satisfying lifestyle choices. Carrots utilized to draw students in included the potential to experience unique clinical settings (rural primary care, Native and Franco communities), the development of service-learning recruitment opportunities linked with loan pay-back incentives offered by local health agencies, and free housing provided by volunteer "host/ess families". Again, the themes would be community,

education/prevention, holistic and culturally appropriate care.

2. Continuing (and extended) Education.

The traditional AHEC way of doing the continuing ed piece is via one or two-day workshops and seminars. We determined to do this because it was needed to enable health practitioners to maintain licensure/registration, no one (except in Aroostook) was doing it in rural areas, and because it was an easy, acceptable way to meet the programmatic mandate. Again, the focus would be inter/multi-disciplinary, community-based, education/prevention oriented, holistic and culturally relevant.

When I say the above continuing ed piece is "easy", I mean that it easily slips into the prestructured pattern that is readily recognizable and acceptable to the feds. In actuality, a primary focus of the KAHEC in this area is "extended" education, a process whereby we act as a catalyst to make health and social service workers (particularly para-professionals) aware of and linked to a variety of nontraditional and external degree opportunities. There are two variant approaches to this activity area.

One is to actually "satellite" an academic program into an area, where the need and critical mass of learners has been identified. For example, the highest priority for KAHEC activity identified for Washington County by the Downeast Regional Council is the creation of a multiple-entry/multiple-exit coop ed Associate Degree in Nursing (ADN) program. The KAHEC staff surveyed health care institutions and the public (targeting Certified Nurses Aides and Licensed Practical Nurses) to measure the need for and interest in such a program (see Appendix H for surveys). Such a program will be satellited from Eastern Maine Vocational Technical Institute (EMVTI) in Bangor to Washington County Vocational Technical Institute (WCVTI) in Calais, with academic support forthcoming from the University of Maine at Machias. The program will be set up on a full-time basis for the first year, at the end of which participants would be eligible to take the Practical Nursing (LPN) exam. They could then leave the program, go into the second cycle of the ADN program on a half-time basis with a

cooperative ed half-time work position (at \$7.00/hr.) stretched over a two-year period, or go full-time for a second year. Those currently with their LPNs could come into the program and in one (or two half-time) year(s) also complete their ADN, at which point they are eligible to take the Registered Nurse exam. By targeting welfare recipients, disabled workers, displaced homemakers, persons with English as a second language, and lowest-level para-professionals, we can in two or three years bring into a profession with an entry-level salary of around \$22,000 (in a county with a per capita income of less than \$8,000/yr.). If operated for five years, this effort would result in a minimum of 100 new R.N.s, mostly with welfare/working class backgrounds, being prepared for existing jobs (with a gross aggregate income base of over \$2,000,000) that are currently going primarily to people from outside the region. In April of 1988, the writer was able to secure commitments of \$138,000 from federal, state and private sources to initiate the first year of this program. Similar efforts are being undertaken by the KAHEC to bring non-traditionally-structured classes for a Masters in Social Work and a Masters in Public Health into rural northern Maine.

The other approach to extended education is to make people aware of existing external degree programs in the health and social service fields, to work with them to generate Individual Development Plans and to support them in undertaking and completing an external degree. Towards this end, the KAHEC (me) is developing a brochure listing several dozen such programs (see Appendix H), is working up a "road show" to take into the community, and is establishing at each of its three regional offices an "Alternative Education Resource Center" for local citizens to utilize in developing educational plans. This writer is currently seeking specific funding to underwrite one or more "study and mutual support" groups for individuals pursuing this route to a degree.

3. Supporting Under-represented Populations in Entering Health Professions.

This programmatic element has been the most difficult to conceptualize and operationalize. The board has prioritized target

populations for this element as being: a) Native Americans, b) Franco-Americans, and c) Swamp Yankees (defined as non-Native, non-Franco working class/public assistance recipients/first-generation post-secondary ed participants/etc.). Some of the work in this area involves increasing the awareness of individuals of the desirability and possibilities of health-related careers and expanding physical access to or linkages with education and training programs. But much of the work with these minority and oppressed populations must address basic issues of cultural identity, self-esteem and aspirations, which calls for us to support leadership initiatives arising within their own communities.

With the adult populations, we are proactively establishing linkages with complementary programs such as Welfare Employment Education and Training (WEET), Displaced Homemakers Project, Displaced Worker Program, Onward, several unions, etc., with a primary intent being to make them aware of and encourage them to utilize either conventional educational programs or the KAHEC's Alternative Education Resource Centers.

However, the board has consistently felt that emphasis in this area should go towards youth, particularly the junior high and high school levels. The KAHEC was an active participant in organizing a state-wide conference at the University of Maine on Aspirations and continues to be involved in its principal follow-up activity, the Maine Aspirations Compact (an evolving effort between post-secondary ed institutions, state government and the private sector). We are working locally and state-wide with parents, educators and guidance personnel, developing health career days, health career clubs and peer groups. We are linking with Upward Bound, Talent Search and other appropriate groups.

Perhaps our most concrete manifestation of this program element is the set-aside of funds specifically to support youth leadership and development activities among Native Americans. We have provided funds to an Inter-Tribal Youth Camp that utilizes a forest retreat and experiential ed model to address issues of

of cultural identity, self-esteem, substance abuse, aspirations and service-leadership. We are supporting the Penobscot Nation's Youth Running Project which has similar goals and also addresses the prevention of obesity and Type II (juvenile onset) diabetes associated with Native People. In association with Maine Indian Education (decentralized Tribally-controlled elementary school district) we have brought the premier Native youth development worker, Mac Hall (Cherokee) into the state for a round of presentations, a projected series of follow-up activities and technical/fiscal support. We hope to draw from this experience to structure some experiential/wilderness ed and service-leadership development activities with Franco and Swamp Yankee youth during the upcoming year(s).

During the fall (October) of 1987, the Katahdin AHEC began full functional operations. In the three years since our little "blueskying" conversation around a picnic table at Passamaquoddy Indian Township, the project has taken numerous twists and turns. Many of us, particularly those of us advocating for Native and Franco communities, initially felt the AHEC concept would be more amenable to fundamental social change than has been the case. To be fair, however, it must be said that our model is much more community-controlled and oriented towards issues of culture and socioeconomic equity than other such projects (most of which are controlled by physicians/medical schools). As Saul Alinsky writes, "The basic requirement for the understanding of the politics of change is to recognize the world as it is. We must work with it on its terms if we are to change to the kind of world we would like it to be." The KAHEC is taking a liberal program and testing its limits as a change mechanism, just as another community-based group might establish a community development corporation to work within an economically exploitative system to achieve moderate social goals such as community stability or increased employment.

There have been a few glitches along the way that I, as the acknowledged prime mover of this project, did not anticipate, and, in fact, am still grappling with. One has been the peripheralization of the effort in the Tribal context due, in part, to the broadening of the KAHEC board's base/representation, and, in part, to changes in reservation administrations resulting from Tribal elections. At both Passamaquoddy reserves and at

Penobscot Nation, the Tribal health staffs were considered among the losing faction. In fact, at Penobscot, the Tribal Health Director came in second in the race for Governor and was removed (twice). Indian Township's Tribal Health Director, the most educated and experienced Native American administrator of the eighteen Tribally-controlled (federally-funded) health programs east of the Mississippi, was removed (also twice). With a less cooperative, more competitive, attitude emerging between the Maine Tribes, the Maine Indian Health Consortium is tottering, and shared programs in the areas of pharmacy, dental and environmental health services are being phased out. Current Tribal elected officials and administrators do not have a sense of ownership of the KAHEC. The KAHEC board is explicitly addressing this issue and exploring several alternatives that could insure ongoing, stable and active representation by Native peoples with direct links to Tribal governments.

Another problematic area is the inherent potential for members of the KAHEC board to both act in ways which could be perceived as self-dealing and to function from a perspective of competitiveness with other board members/organizations or even the KAHEC. The need to ensure representation from both health service providers and health professions educators in a rural area means that people sit on a board that is likely to establish coop agreements or contracts with their employing organizations, flirting with issues of conflict of interest or ethically impropriety even if they themselves refrain from voting on specific board actions. From surveying the board composition of numerous AHEC programs in other parts of the U.S., it would seem that this self-dealing "old-boy" (or old Doc) network is a marginally-explicit enabling factor in many programs. Where such representation is mandated and resource organizations limited (as in the case in underserved rural areas) it would seem this is a grey area that should be explicated and accepted.

Also, the potential for feelings of competitiveness between board members is a reality. For example, the KAHEC target area has five nursing programs, two in northern Aroostook and three in the Bangor area. Directors of all three Bangor programs (two direct competitors for students) serve on the KAHEC board. Another example is the board participation by the directors of the state ambulatory care (rural health centers) organization and the largest rural family planning/maternal care agency in the Downeast

region, both of whom seek funding for similar services. Again, recognition of this as an issue and a good-faith effort to act cooperatively on specific activities that will benefit the region as a whole is the acceptable option. A more problematic area is the potential for a board member to feel that the KAHEC itself is a competitor with his/her employing organization. There is some evidence and considerable sentiment by staff and (several) board members that at least one long-time key board member has been manipulative in the context of board dynamics, has used information gained from board participation, and has withheld information from the KAHEC board/staff, all to inappropriately benefit that individual's own agency. How this situation will be resolved and future occurrences forestalled is yet to be seen.

The only other unexpected development that has occurred was the expansion, in 1987, of our target area from our original northernmost five counties to include an adjacent four counties. The planning group strongly felt from their first formal meeting in January of '85 that they wanted to focus on the northern five counties, as our collective experience indicated that most programs serving a broad, state-wide region tended to focus on the southern, more urban areas. In December of '86, just before our operational funding proposal was due, the new Dean of the College of Osteopathic Medicine at the University of New England (remember, these monies have to flow through an in-state medical school), who had virtually no interactive history with the KAHEC, threatened to block our proposal if we didn't redefine our project to a state-wide service area. The board refused, indicating their belief that if the project went state-wide, the most needy areas would not receive an appropriately affirmative share of the resources. They stood firm on their position that they would rather not have the proposal submitted at all than to have the board process and control compromised. Suddenly, the new Dean found himself looking at a 25% indirect rate on nothing. Furthermore, he found that he did not have the normal academic hierarchy to protect him as he was unaware of the role his own University's president had in the genesis of the KAHEC. Following several meetings the KAHEC board offered a face-saving compromise by adding four counties that I had previously defined as particularly needful of AHEC-type services and which the board had already identified for potential expansion to the official KAHEC target area.

Some of these problems inevitably arise from the process of problem

identification and organizing development strategy to remediate the problem.

A key dimension of community development is the issue of "development for what?" The problems or areas to be addressed by development activities are linked to the reality base and perceptions of who defines the problem. In the case of the KAHEC, there were multiple inputs into problem definition, from Native Americans, Francos, health service providers and recipients, educators, etc. This came in the form of individual discussions, staff meetings, outreach to rural and other special populations, larger public forums, surveys, and research by board and staff. These activities reflected an emerging consensus that access to quality health services in rural areas is a critical public policy issue and that community-based activities can ameliorate many aspects of the problem while simultaneously addressing local needs for education and employment.

Another key variable in community development is the selection of organizing strategies and techniques. Within the context of the KAHEC project, several approaches to organizing were utilized, while others were avoided. The micro-problems identified did not seem to lend themselves readily to either "Alinsky-style" or "mass-based" organizing strategies within the context of the rural social ecology of the target area. Also, the conscious-raising approach seemed best limited to focusing on the mal-distribution problems of health providers and educational access/equity rather than the macro-problem of the political economy of our health care system, due in large part to the program's reliance on physicians and other health professionals to be volunteer preceptors, etc. Some aspects of the citizen participation and community control strategies were useful. Essentially, however, the primary approach utilized was that of public advocacy organizing. As explicated by Speeter, this is where

"...a small group of people select a basic issue for a ... political-geographical area, such as a region of a state... and tries to set up local groups to respond locally or state-wide to win an issue...Members often act as representatives of other local groups, and a major function of the organizing can consist of coalition-building (as opposed to grass-roots organizing)."

Although much has been written and said about the limitations or even dangers of advocacy planning, it seemed the most amenable to the task at hand, the milieu in which the planning group had to function, and the

liberal mechanisms available to ameliorate identified problematic areas.

Between October and December, the KAHEC became fully staffed. I resisted inner and external pressures to apply for the Executive Director position. This was due in part to the fact that we had strong consensus that the main office should be at the University of Maine (for strategic/continuation purposes, of which more later) which is 110 miles from my home, my distaste for administrative matters (particularly personnel supervision) and the fact that I had been working 55-hour weeks for eighteen months and needed a break.

We hired a Ph.D.-level medical anthropologist, Jim Ross, as Executive Director. Claire Bolduc, a N.H.C./CED alumni and long-time activist on Franco, bilingual/cultural ed and occupational health issues was hired as Regional Coordinator for the Penquis (Penobscot and Piscataquis counties) region. Arlene Keaton, a Franco (despite her surname) social worker and lay nun active in church-related social justice activities, elder issues and bilingual ed was hired as Regional Coordinator for Aroostook County. I was hired as Downeast (Washington and Hancock) Regional Coordinator. All four professional staff are from the county (Aroostook), our most rural area. Four support (secretarial/clerical) staff were hired, all from the local area. With the funding for our ADN program, we will be creating an additional four positions by the end of this year.

We have seventy-six (72 osteopathic, 4 allopathic) student physicians assigned to 14 precepting physicians with free housing provided by the community. We are developing four rural training sites for medical residents, two of which are associated with migrant health projects we are pro-actively developing (using for one an aging mobile clinic we begged from UNE). We have twelve student nurses going into community-based, public health training slots, who we are supporting with mileage and/or housing. We have established a model rural training program for occupational therapists utilizing two small hospitals and a mental health center. We have provided a community organizing practicum for one MSW student and have another starting in June. Also in June, we have two grad students (one in public health, one in public administration) undertaking a comprehensive manpower needs assessment.

Our continuing education workshops and seminars are getting underway.

They have included topics such as AIDS(2), substance abuse (2) and domestic violence, each drawing from 40-130 participants and all (but one) resulting in modest financial surpluses. We are actively working with our regional councils, professional groups and community-based organizations to identify high-need topics and appropriate siting/scheduling.

The KAHEC project will pump over \$450,000± into the most rural areas of Maine this year and (if our ADN project is funded) another \$650,000± next year. Yet board and staff are keenly aware of our need to be entrepreneurial. Part of our scheme in designing our board was with an eye to sustainability by constituency-building. Our decisions around office locations were similarly prompted. For example, Claire is at University College (Bangor), in part because we want to identify with that group and in part because the U.Maine system's two community colleges are developing a state-wide interactive telecommunications network. Arlene is at Northern Maine Medical Center (Ft. Kent) because we want to be centered in the Franco-Acadian community, identified with rural hospitals and linked with an innovative Robert Wood Johnson-funded rural health initiative. I am at WCVTI because we want to identify with the state's vocational system and its working-class student body, we want to satellite an ADN program between VTIs, and we want to be close to the Passamaquoddy reserves. Jim is at the main campus of the University of Maine system for multiple reasons, including the fact that we believe strategic alignment with that system offers credibility and the best potential for institutionalization. UMaine's new president, Dale Lick, once ran an AHEC-like health professions support program, and Maine has no such program. President Lick has provided us with free office space, an administrative linkage (that does not compromise our independent corporate status) within his Division of Research and Public Service and a pledge to pick up an increasing percent of salary costs (starting with 20% of our Executive Director) over the next few years. We are also aligning ourselves to provide clinical training for students who attend the University of Vermont and Tufts University medical schools under a Maine compact purchase-of-seats program that predates UNECOM. Several legislative initiatives, including one to deeply subsidize nursing education have the potential to explicitly utilize the KAHEC as a central player, with state support funds. In short, there is good reason to believe

that by the time federal funding ends five years hence, the Katahdin AHEC will remain, well-positioned to work with other elements within Maine's educational systems and rural health networks to provide clinical training opportunities for health professions students, to provide continuing and extended educational opportunities for health professionals and para-professionals in isolated areas and to support career awareness and higher aspirations among minority and working-class youth. In combination, this should bring greater educational and employment opportunities to local people while enhancing the overall health status of rural Mainiacs through a more equitable distribution of health workers. It is anticipated that quality of care will be positively enhanced as well, due in part to more provision by providers who are part of the local (working-class/minority) community, in part due to providers drawn to the area and made more sensitive to the social ecology by KAHEC-sponsored community-based clinical training experiences, and in part due to the availability of an ongoing program of workshops, seminars, preceptorships and other "continuing ed" activities. Additional, though less measurable, benefits can result from this process of community development and related increased involvement by local health service providers and communities in the education, training, recruitment and retention of health technicians and professionals.

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June, 1988

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