Blueprint for a Health Manpower Consortium: Joint College/Community Agency Efforts

San Fernando Valley's Model for a Health Services/Educational Activity

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THE REGIONAL MEDICAL PROGRAMS SERVICE of the Public Health Service was authorized in 1972 to provide the funding for the development of community-based consortia or corporations to improve the quality of health care through coordinated and innovative approaches to health manpower education. These community-based organizations are now designated as Health Services/Education Activity (HS/EA) centers. During fiscal year 1972–73, Congress assigned the National Institutes of Health's Bureau of Health Manpower Education the responsibility for the development of Area Health Education Centers (AHEC).

From the National Coordinators Conference, attended by 50 regional medical program coordinators, held in St. Louis in January 1972, a definitive list of objectives evolved from the discussions and workshops of how emerging community-oriented manpower programs could more closely relate education to the health service delivery needs of an area. Presently serving as planning guides for emerging HS/EAs, the objectives may be summarized as follows:

- To establish linkages among health care and educational institutions, as well as health agencies, and provide a means for informational input from health professionals and consumers;
- Regional planning and articulation of health manpower training programs, including continuing education, to increase the quality and cost effectiveness of manpower production and utilization;
- Task analyses designed to identify emerging health occupations and delineation of health care team functions; and
- Development of an effective consumer health education program.

Many persons are confused about the differences between the concept of Area Health Education Centers funded originally by the Bureau of Health Manpower Education (now the Bureau of Health Manpower, Health Resources Administration) and the HS/EAs. Guidelines for the development of Area Health Education Centers *(1)* are addressed to many of the same objectives as the HS/EAs. The AHEC is different, however, principally in the emphases on postgraduate medical education and remediation of manpower maldistribution problems. It is not entirely clear what the differences and relationships between HS/EA and AHEC will be, but AHEC likely will be less community oriented because of the requirement that it be university, medical-school based. The HS/EAs should provide more input regarding consumer concerns because of their broader community base.

California Regional Medical Programs has approved the development of 17 HS/EAs in the State; approximately 4 or 5 of these are still in the planning and organizational stages. At present there is only one AHEC in the State, under the direction of the University of California (San Francisco) Medical Center in coordination with the University of California, Los Angeles. Because that AHEC is directed primarily toward the need for medical education in the San Joaquin Valley region, it has developed a formal linkage with the local HS/EA in Fresno. The targest HS/EA in the country is located in the city of Santa Rosa in Sonoma County. The HS/EAs in California have demonstrated great diversity in their development, as outlined in a recent summary of their activities *(2)*.

The oldest existing consortium for health manpower training in California (and one of the oldest in the country), located in the San Fernando Valley north of Los Angeles, is the outgrowth of joint cooperation between local colleges and community organizations. The more recently developed Maryland Consortium of the Health Sciences has been described by Young *(3)*.

The San Fernando Valley encompasses a 144-square-mile area with a population of 750,000. The consortium service area was gradually extended to include Santa Monica, Venice, West Los Angeles, and Antelope Valley, with an additional half-million people. The service area includes both highly urban and rural populations, 2 major graduate institutions of higher education (California State University, Northridge, and University of California, Los Angeles), 6 community colleges (1 private, nonprofit), several

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private (for profit) short-course training institutes, 8 major hospitals, 50 smaller hospitals, and more than 100 skilled nursing care facilities. These various facilities employ more than 32,000 health care personnel.

Background and Organization

The details regarding the historical development of the San Fernando Valley Health Consortium were published in January 1972 *(4)*. The consortium emerged from the need — recognized by educators, hospital administrators, and health professionals — for better coordination of health manpower training activities in the valley. California State University, Northridge, and the executive committee of the San Fernando Valley's Regional Medical Programs organized the first series of discussions regarding the need for a formal coalition of health manpower training resources. A broadly based steering and planning committee was formed of 35 volunteers representing educational and health care institutions, as well as health personnel and health consumers. During 1 year, a preliminary structure emerged and eight major planning task forces were formed. Initial planning monies totaling $35,000 were provided by Regional Medical Programs (Area IV, University of California at Los Angeles, and Area V, University of Southern California). Also, the local hospitals donated $3,500 of planning money.

A formal set of bylaws and articles of incorporation were developed by a task force and ratified by the steering and planning committee. The consortium was incorporated as a private, nonprofit, educational corporation in September 1971. At that time, California State University at Northridge appointed a full-time college director of consortium activities, and a full-time coordinator was hired to conduct comprehensive health manpower analyses. Several part-time consultants assisted in special areas of need, such as grant development. By January 1972, a 25-member board of directors was elected. Board membership subsequently was expanded to 35 in order to encompass the more rural surrounding communities.

The consortium board of directors is required by the bylaws to have a majority of health consumer members (at least 51 percent). A health consumer is defined in the bylaws as "any person who is not or has not been engaged in the delivery of health care, health manpower training, health education or health planning." At least two of the health consumers on the board must be students. Additional representation on the board is given as equally as possible to health workers, health care delivery institutions (and agencies), and educational institutions. The initial board was elected to staggered terms to provide for annual rotation of approximately one-third of the membership. Replacements to the board are elected by vote of the consortium membership, which consists of both individuals and institutional representatives from the consortium service area. Eventually, it is planned to assess a small charge for consortium membership. Guidelines and criteria for individual and institutional membership were developed by a committee of the board of directors and are available from the authors.

In July 1972, the consortium was designated as an HS/EA through RMP, for 3 years. A full-time executive director, eight full-time staff persons, and a number of part-time paid consultants were hired.

The consortium board organized three standing committees (personnel, membership, and nominations), and seven at-large committees: Health Manpower, Medical Education, Articulation and Curriculum, Continuing Education, Licensure, Certification and Accreditation, Consumer Education, and Health Library Resources.

Summary Of Activities

The past and present activities of the consortium have related primarily to priorities identified by the various committees.

The Health Manpower Committee assisted in the design and conduct of a year-long survey of the health manpower status in the area's health care institutions *(5)*. The problems related to health manpower utilization identified in that survey have served to set consortium program priorities. An inventory of area health manpower training programs in both private and public institutions was completed and made available to all consortium institutions *(6)*. Copies of these survey and inventory documents are available from the consortium corporation at nominal cost. Both surveys have since been updated, and figures on minority employment have been collected. By monitoring both health care and training resources, the consortium hopes to avoid either a surplus or a shortage of trained manpower needed locally. Local manpower data are being provided to a statewide Regional Medical Program Committee so that it can develop a statewide planning strategy.

The Medical Education Committee identified several years ago the need for an inter-institutional medical education component directed toward a primary physician program. As the result of recent action by the California State Legislature, a feasibility study for such a medical school is being conducted in collaboration with the consortium. Additionally, the consortium is working with several hospitals and universities in the development of a proposal for an inter-institutional Family Practice Residency Program. The Medical Education Committee is also collaborating with a local hospital in development of an intensive postgraduate course for broad recertification in internal medicine.

The Curriculum Committee assisted in the design of a study of transfer of credit problems among the health manpower training programs in the various educational institutions. A 4-month study was conducted and completed in the spring of 1973 *(7)*.

This study identified a myriad of specific course transfer problems among the community college, 4-

year college, and graduate university training programs. A host of articulation recommendations were implemented in the consortium education institutions during 1974.

The Curriculum Committee is also responsible for the development of interdisciplinary and core curriculums for health manpower training. Common knowledges *(8)* and functional task inventory approaches *(9)* are also being considered. The team approach to comprehensive health care delivery and training will also be emphasized throughout the curriculum *(10)*. The initial core course will be for first-semester freshmen who are interested in exploring broad health career opportunities and related academic requirements. The course will provide this orientation along with an introduction to the health sciences and the preventive concepts of public health. The primary core course was pilot tested in September 1974. A second-level core course is presently being designed with four modules: introduction to basic medical terminology, introduction to basic science, introduction to patient care skills, and community health. Burnett *(11)* recently conducted a national survey of existing health professions core curricula and provided a good summary of advantages and related problems.

Continuing Education Committee. The consortium is particularly concerned with the goal of increasing job mobility for health manpower workers *(12)*.

Local manpower analyses made by the consortium indicated that the career mobility problem was particularly acute for entry-level workers in hospitals and skilled nursing care facilities. Through the Consortium Curriculum and Continuing Education Committees a large number of programs have been developed to enable nursing assistants and aides, orderlies, LVNs, RNs, mental health assistants, and other personnel to better their job opportunities, and at the same time to earn transferable academic credit. Whenever appropriate, continuing education curricula are directed toward interdisciplinary team function and extended roles of personnel. In the past year, the following courses have been offered for various health personnel, all self-supporting through fees or tuition:

LVN equivalency course
Critical care nursing
Rehabilitative nursing
Coping with death and dying
Training program for clinical instructors in skilled nursing care facilities
Communication and leadership for nurses
Pediatric nurse series
Implementation of the problem-oriented medical record system
Spanish language for health care personnel
Reality orientation
Review of recent developments in internal medicine (physicians)
Educational strategies for continuing medical education (directors of medical education)
Problem-oriented medical record workshop

Licensure Committee. The health career mobility dilemma is created in part by academic institutional requirements and in part by licensure and accreditation requirements. A national synopsis of allied health accreditation and certification has been published by the Bureau of Health Manpower Education *(13)*. The Consortium Licensure Committee has devoted its major efforts to identifying barriers to horizontal and vertical career mobility. That committee is now working with a statewide HS/EA Committee and State professional associations in identifying needed educational and legal reforms. It is anticipated that the 17 HS/EA organizations in the State can collectively become a professional and consumer force which can assist in bringing about substantial change in academic and licensure requirements. The committee is now collaborating with the California Nurses Association in gaining support for modification of the Nurse Practice Act.

Health careers. A survey *(14)* conducted in the northeast part of the consortium service areas indicated that blacks and other ethnic minorities are represented in the health care delivery system but primarily in low-level positions. A similar study *(15)* of the inner-city Los Angeles hospitals showed that the majority of entry-level, nonprofessional employees are blacks, Mexican-Americans, or orientals. The consortium organization provides for a minority community coordinator whose responsibility entails identification of entry problems of minority students into the allied health professions. This coordinator has established a working relationship with target junior and senior high schools in the minority community and conducts recruitment, counseling, and retention programs for minorities in health manpower training programs. Efforts are being made to increase educational opportunities for minorities in the health professions, as exemplified by a recent national survey *(16)*.

The consortium is also concerned with the evolvement of new health careers. Continued analyses of additional required allied health personnel are included in the design of health career ladders. One consortium program recently provided training for 25 family (outreach) health workers to be employed in a minority community health maintenance organization facility. The consortium collaborated with the training staff of the HMO (Northeast Valley Health Corporation) in the design of the curriculum, selection of instructors, and program evaluation.

The family health worker curriculum consisted of specially designed university courses in basic health sciences, community and public health, sociology, psychology, written and oral communication, nursing, and emergency care procedures. The students attended school full time for 7 months and received 15 units of college credit. The consortium staff worked with the HMO staff in the design of clinical health team functions and development of a programed modular system for problem-oriented medical records. The family health workers are the nucleus of the outpatient clinical team, and the consortium is responsible for followup

on-the-job evaluation and continuing education directed at career mobility. At present, 13 of the family health workers are attending school part time, taking an LVN course established through the local occupational skills center.

A Health Library Resources Committee was established to foster cooperative resource sharing among the area hospital and educational libraries. The committee additionally provides periodic continuing education programs for medical library personnel. One example is a recently offered course titled "The Organization of a Hospital Library."

The Consumer Health Education Committee was recently established to develop programs emphasizing accessibility to the full spectrum of health care. As an example, the consortium is collaborating with a large outpatient facility in the retraining of clinical team personnel for more effective management of hypertension patients. Concurrently, a patient education curriculum is being designed to teach preventive health care. It will provide the patient with a better background on the etiology of hypertension and related factors such as diet, exercise, weight control, emotional stress, and medication.

The committee is also concerned with the development of a children's health education program to be broadcast over a local cable television station. The pilot program was implemented late in 1974.

Consumer health education workshops on a variety of subjects were held throughout 1974, including one on preparing for a hospital stay.

Conclusion

The regional consortium approach to coordination of health manpower training holds the promise of economies in expenditures for education along with improved quality of manpower education. The 17 HS/EAs in California have established close communication and eventually will provide a good manpower data reference for the State. In addition, they should be able to collectively identify the most critical "barrier problems" (for example, licensure, accreditation) and, through concerted consumer efforts, get appropriate enabling legislation enacted.

The consortium approach is not without problems. These relate primarily to maintaining effective interinstitutional communication, overcoming traditionalism and institutional vested interests, as well as gaining political acceptance by the larger community. Maintaining continued consumer involvement in such a complex area is difficult and requires special consumer education programs. It is believed, however, that the consortium has the potential to better the quality and efficiency of health care delivery. This good may be achieved by raising the quality of manpower trained to work in the system, increasing career mobility, reducing manpower turnover, and by providing a mechanism whereby eduational institutions can quickly respond to the changing needs of health care delivery—such as those created by emerging HMOs or the passage of a national health insurance program.

The HS/EA experience in California should provide a good basis for evaluation of the effectiveness of the college-community consortia, since they are evolving in a variety of both rural and urban settings. If they are able to meet the needs of the local health delivery system and collectively address themselves to statewide needs, then surely a workable health manpower model shall have been established for other locales in the country.

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