‘GROWING OUR OWN’ THROUGH PARTNERSHIP WITH EDUCATIONAL INSTITUTIONS:

PUTTING THE COMMUNITY HEALTH CENTER PHILOSOPHY INTO ACTION FOR DIVERSITY[1]

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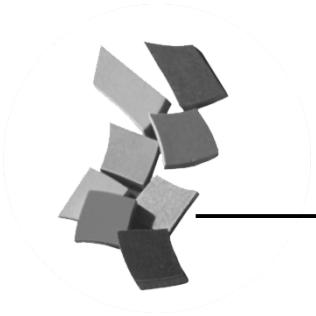


Overview

There are many qualities of community health centers (CHCs) that make them distinctive healthcare settings - one of which is their strong commitment to a "grow our own" approach to staff development. Further, it is this particular philosophy that also can enhance CHCs' success in implementing other core values related to the provision of culturally responsive healthcare. In this report, we explore strategies utilized by some CHCs to promote the development of staff who come from the same ethnic/racial groups that live within the communities they serve. These strategies have the potential to improve responsiveness by increasing the demographic match between providers and service recipients. In particular, we summarize CHC approaches to working closely with institutions of higher education both to provide current staff with avenues for advancement and to encourage diverse providers to enter the community health sector.

The arrangements we discuss are not only occasions for CHCs to foster staff development, but they also constitute unique opportunities for educational institutions. For community colleges and public universities, collaborative arrangements with CHCs represent a path toward expanding their reach and actualizing their mandate to promote the development of the regional workforce. Further, many CHCs are important training sites where college and university students can get critical hands-on experience related to a wide range of disciplines.

The Connection to Staff Diversity

It has become increasingly apparent that achieving diversity within all staffing levels in healthcare settings is critical to the provision of quality care. Despite the sophistication of the US healthcare system on many dimensions, the nation continues to grapple with troubling health disparities across ethnic/racial groups.[i, ii] Academics, advocacy groups, and policy makers alike have underscored the crucial role of culturally competent healthcare delivery in addressing these disparities,[iii, iv] and there is evidence that increasing the ethnic and racial diversity of staff at all levels is an essential part of the equation.[v, vi]

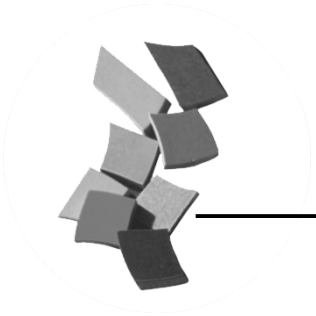
The need for an ethnically/racially diverse healthcare workforce is particularly intense in CHCs. Given their mission to provide comprehensive primary healthcare to medically underserved populations without regard to individuals' ability to pay, CHCs often serve the most economically and socially vulnerable members of society.[vii] Many low-income communities (particularly those in urban areas) tend to be home to racially and ethnically diverse individuals and families.[viii] Therefore it is not surprising that CHCs serve many US-born ethnic/racial minorities as well as many new immigrant families, and that almost one in three CHC patients nationally has limited English proficiency.[ix]

Efforts to enhance diversity within the CHC workforce are varied. One potentially powerful strategy is to cultivate diverse entry-level workers who are already employed in health centers, i.e., "grow our own" by promoting current staff. The pattern of greater diversity at the bottom of the organizational hierarchy is not uncommon across many types of organizations. [x,xi,xii, xiii] What is unique about CHCs is their strong and explicit commitment to rectify this occupational segregation and to enable motivated ethnic/racial minority staff to move into higher level positions. For many healthcare center positions (both clinical and administrative), this type of occupational mobility requires further educational preparation and, for many specialized health jobs, also involves formal certification or licensure.

Other "grow our own" approaches focus on attracting new ethnic/racial minority individuals into the CHC pipeline. Some efforts are focused on recruitment into clinical training programs while other approaches provide supports that enable current students to complete their education.[xiv, xv] Other important interventions include introducing new healthcare workers to community health through practica, internships, and residency placement as well as providing mentoring and support for diverse individuals as they make the transition into their first healthcare jobs.[xvi, xvii]

The Potential of Community Health Center-Educational Institution Partnerships

The primary focus of the project reported here has been on explicating the ways in which CHCs can forward their "grow our own" philosophy through educational partnerships in ways that also forward the goals of workforce diversification. Throughout this report, we will refer to these types of arrangements as "CHC-EDU Partnerships." Thus, our project was designed to: 1) develop an overview of approaches adopted by Massachusetts CHCs to support ongoing education of their current multi-cultural, multi-lingual workforce; 2) document the history, successes, and challenges of particularly successful educational partnerships from the perspectives of both the CHCs and the partnering educational institutions (i.e., college, technical institute, or university); 3) identify the variety of ways in which CHCs coordinate with educational institutions to bring diverse individuals into the community health center system; and 4) disseminate this information to critical stakeholders who can facilitate further adoption of such programs/partnerships across the state.



Methods

Archival Analysis

To develop a portrait of existing CHC- EDU partnerships, we first examined the websites of all CHCs in Massachusetts. For each CHC website, we conducted an in-depth search (explored all tabs, reports/newsletters) looking for information about educational opportunities, partnerships, and/or programs. The information from our website search was then cross-referenced with subsequent data gathered from our survey and interviews.

Surveys

Because the Massachusetts League of Community Health Centers (MLCHC) has 100% membership of CHCs in the Commonwealth, MLCHC sent a link to our online survey via email to all CHCs operating at the time of the study (n = 52). Executive Directors and/or Human Resource managers were asked to complete a questionnaire regarding the use of educational partnerships as a workforce development tool. We defined educational partnerships as relationships with community colleges, technical institutes, two or four year colleges, as well as the Area Health Educations Centers (AHEC). The questionnaire employed a mixed response format, with some questions being close ended (with participants checking the response(s) from a list of possible answers) and some being open ended (participants were asked to provide information in their own words). The survey queried for information regarding: 1) existing educational partnerships, 2) CHCs as sites for supervised internships or practica opportunities, 3) options for tuition support, 4) barriers to staff's educational advancement, and 5) current and needed supports for educational advancement. Several follow-up email reminders were sent to encourage additional responses. We received responses from 20 CHCs.

Interviews

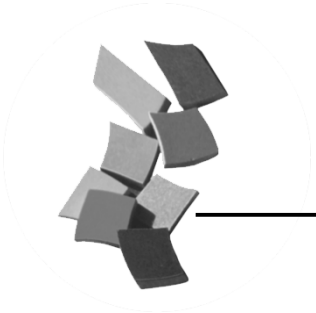
CHC representatives: We asked representatives of four CHCs to speak with us further about their participation in partnerships with educational institutions. Interview sites were selected based on the degree to which they appeared to have well-developed partnerships. We garnered this information from survey responses, our knowledge of these partnerships based on our previous work,[xviii] as well as recommendations made by the MLCHC. Given the relatively small sample, and the novel nature of each partnership, they were readily identifiable. We met with CHC Executive Directors and/or their designated representatives to gather additional information regarding the partnership, specifically: the history of how the program was initiated, the daily functioning of the program (logistical aspects), and the positive outcomes,

and challenges associated with the program. We also asked what advice the interviewees would provide to other CHCs hoping to create similar partnerships.

Educational institution representatives: In order to develop a fuller understanding of CHC- EDU partnerships, we also met with representatives of the educational institution counterparts of these partnerships. Specifically, we wanted to include their perspective on the benefits, challenges, and success factors of the partnerships.

Healthy Diversity Summit

We convened a summit in May 2013 to present our preliminary findings to a group of 15 invested stakeholders. The summit provided an opportunity to meet with representatives from CHCs, educational institutions, MLCHC, and AHEC. The goals of the summit were: 1) to present preliminary findings, 2) share potential models for increasing CHC-Educational collaboration to grow the CHC workforce, and 3) engage stakeholders to finalize the report and formulate recommendations for future action steps. The insights gleaned from this meeting have been incorporated into this final report.



CHC-EDU Partnerships

There are two primary types of CHC- EDU partnership models: 1) CHCs connect *current* staff to educational opportunities sponsored by educational institutions to enable staff to move to different and/or increasingly responsible positions, and 2) educational institutions send their students to CHCs for applied experience as part of a healthcare-related degree program. Both are critical to the development of the CHC workforce and aid in efforts to employ diverse staff. There are also a few partnerships that sponsor formal education programs that serve multiple CHCs.

A graphic overview of approaches to CHC-EDU arrangements among survey respondents is provided in Figure 1.

Partnerships to Train Current CHC Workforce

One way in which the CHC "grow our own" philosophy may be realized is through efforts to support current staff in their development of skills and credentials to grow into jobs with increasing responsibility - for positions on both the clinical and administrative sides of the organization. The CHCs we queried have adopted approaches that include helping staff with tuition costs (tuition reimbursement and/or loan repayment programs) and providing incentives for staff to take courses at local colleges. According to the survey, the most common programs include staff enrolling in existing educational programs at community colleges and universities that target relevant skills, enrolling in educational programs developed in partnership with a CHC in order to target specific training needs, and enrolling in existing educational programs that prepare staff for entry into a degree program. Less common, but still available at some of the CHCs surveyed, are programs where staff enroll in educational programs that award credits for on-the-job experience. Fewer CHCs have the option for staff to enroll in formal credited courses held on-site at the CHC. See Table 1 for an overview of the types of connections that the CHC survey participants have with educational institutions.

Of the twenty responding CHCs, 60% reported that their staff participated in the MLCHC Provider Loan Repayment Program. Fifty percent had staff members that participated in the Massachusetts Loan Repayment Program, and nearly all of the responding CHCs (85%) employed members of the National Health Services Corps (NHSC), which provides loan repayments and scholarships to students serving at NHSC designated sites. A few CHCs reported that their employees took advantage of MassHealth student loan repayment programs. Finally, three CHCs reported that some of their staff received tuition reimbursement through other avenues, which included grants, HRSA loan repayments, and private funding.

Figure 1: "Growing Our Own": CHC-EDU Approaches

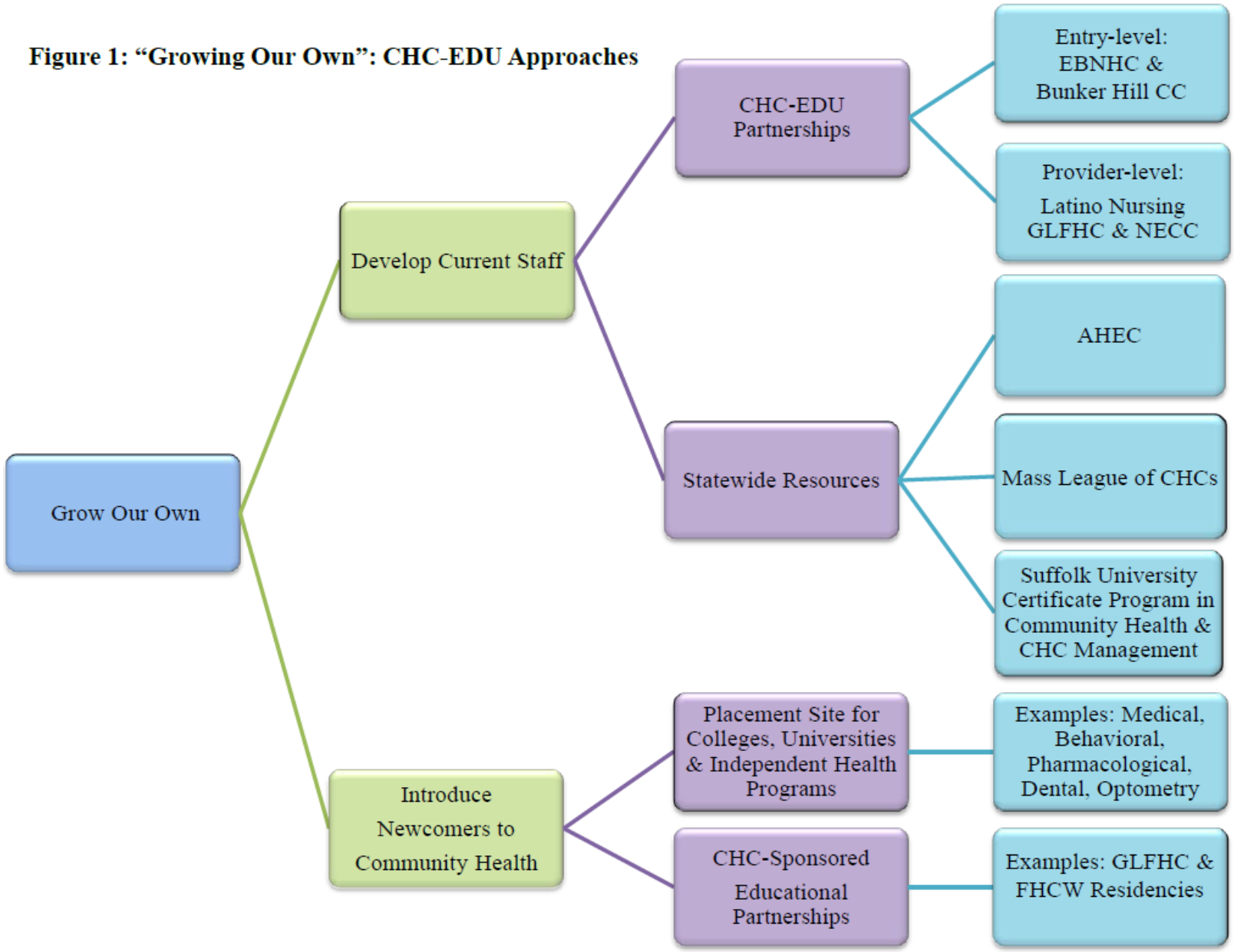


Table 1: Opportunities Available to CHC Staff through CHC-EDU Partnerships

Community Health Center	Staff Enroll in EDU Courses Held On-site	Staff Enroll in EDU Programs Developed with CHCs - Targeting Specific Needs	Staff Enroll in Existing EDU Programs	Staff Enroll in EDU Programs that Award Credit for Experience	Staff Enroll in EDU Programs that Prepare Staff for Entry into Degree Program	Staff Participate in Loan Repayment Programs
Boston Health Care for the Homeless	X	X	X			X
Brockton Neighborhood			X	X	X	X
Caring Health Center	X	X	X		X	X
CHC of Franklin						
Community Health Connections	X	X	X	X	X	X
Duffy Health Center		X	X			
East Boston Neighborhood Health	X	X	X			X
Edward M. Kennedy		X	X	X	X	X
Family Health Center of Worcester	X	X	X		X	X
Greater New Bedford	X	X	X	X	X	X
Health First Family Care Center	X	X	X	X	X	X
Holyoke Health Center			X		X	X
Joseph M Smith CHC			X			X
Lowell CHC		X	X		X	X
Lynn CHC	X	X	X	X	X	X
Mattapan CHC		X	X			X
North Shore Community Health		X	X		X	X
South Cove CHC						X
South End CHC		X	X	X	X	
Stanley Street CHC			X			X

Two CHC-EDU partnerships we highlight here are: 1) a program designed primarily to help entry-level CHC workers advance their skills and 2) a program devoted to moving more Latino/a individuals into nursing positions. We have chosen these programs as exemplars based on the degree to which they represent well-developed partnerships, with heavy involvement on behalf of both sides of the partnership, as well as based on their track record of success.

East Boston Neighborhood Health Center - Bunker Hill Community College: Developing Entry Level Staff

East Boston Neighborhood Health Center (EBNHC) has established a strong educational partnership with Bunker Hill Community College. What started out as a relatively small collaboration has now grown into an impressive partnership between the two organizations. They are one of the few CHCs in the country that has invested considerable resources into making college-level courses available on-site at a CHC training center. It should be noted that EBNHC is one of the largest CHCs in the country with a large number of employees and serving a large number of community residents.

In 2005, Bunker Hill offered its first series of courses to EBNHC employees. These were short (not full semester), non-credit courses predominately in English as Second Language (ESL) and other fundamental skills such as business writing or basic medical terminology. EBNHC encouraged employee participation by agreeing to contribute one hour of "work time" for one hour of personal time. Given the fast-paced nature of health center work, it is rarely possible for a staff position to be uncovered for even one hour per week, and back up coverage has been cited as a primary constraint for offering staff development opportunities on work time.[xix] Given the size of EBNHC (and Bunker Hill's willingness to offer courses several times per year), they were able to increase employee involvement by implementing a rotating schedule where employees could cover for one another while in class. Managers' support for flexible scheduling enabled them to accommodate the initial enrollees. In fact, our informants believed it was this positive organizational climate that increased the demand for college-credit courses.

These on-site courses provided a number of benefits to CHC employees. In addition to acquiring new skills and promoting general workforce development, they provided CHC employees with the opportunity to experience higher-education in a non-threatening way. There was no financial commitment on the part of the employee as the cost was covered by the EBNHC, and the non-credit nature of the courses made them less intimidating. Furthermore, success in these foundational courses provided employees, who had little or no experience with higher education, with the necessary confidence to try taking courses for credit.

Over time, the partnership developed such that EBNHC starting hosting additional community college courses for credit, including computer literacy, medical English, writing skills, mathematics, and medical translation. Both to enhance enrollments and to fulfill their mission to serve the broader community, EBNHC opened up these on-site courses to the broader local community. The leaders of EBNHC and Bunker Hill Community College made formal commitments to recognizing the health center site as a satellite of the community college. This

expanded audience has proved to be mutually beneficial allowing EBNHC to provide workforce development opportunities to its staff while Bunker Hill has been able to attract new students by offering accessible classes. While EBNHC acknowledges the need for more formal tracking of program participants, it is clear that increasing numbers of employees are taking advantage of this partnership. Furthermore, Bunker Hill has been able to increase enrollments by offering courses at an off-campus location.

Neither EBNHC nor Bunker Hill has formally tracked the extent to which their partnership has increased diversity in the hiring or promotion of current staff at EBNHC. However, given the overwhelmingly non-white composition of these courses, it is clear that the on-site training opportunity is reaching largely ethnic/minority individuals.

Greater Lawrence Family Health Center- Northern Essex Community College: Promoting Diversity in Nursing

Since 2004, Greater Lawrence Family Health Center (GLFHC) - in conjunction with the Merrimack Valley Area Health Education Center (MV-AHEC) - partnered primarily with Northern Essex Community College (NECC) to establish the Lawrence Latino Nursing Program. The program is designed to provide a pathway for interested Latino/as to obtain nursing degrees. The participants include mostly medical assistants currently employed at GLFHC, in addition to some recruits from the community. The ultimate goal - for all participants - is to increase the number of Latino/a RNs employed at the health center.

GLFHC, located in Lawrence, MA is home to the largest proportion of Hispanics of any Massachusetts community.[xx] GLFHC is host to one of the six AHEC regional offices in the state. There are key staff who straddle both organizations and thus, while technically separate organizations, their work often overlaps.

Sometime around 2003, Directors of both GLFHC and the regional MV-AHEC decided they needed to address the nursing shortage at GLFHC. In particular, there was a dearth of Spanish-bilingual and bicultural nurses, a necessity given the city's large Latino population. While a number of GLFHC entry level staff expressed an interest in pursuing nursing careers, many were the product of under-resourced public school systems which did not provide adequate opportunities to develop a strong foundation in math and science. Given the highly competitive nature of nursing programs, and their particular attention to such foundational courses in the admission process, it became clear that these pre-requisites were a primary "missing link." With funding from UMass Medical School as the Health Resources and Services Administration (HRSA) grantee and with support from the central office of the statewide AHEC Network, GLFHC and MV-AHEC reached out to NECC to establish the Lawrence Latino Nursing Program. The expressed intent of this partnership was to provide interested candidates with a mechanism to acquire the pre-requisites needed to apply for nursing school and to subsequently support them throughout their course work.

Prior to placement, NECC conducts a skill-gap analysis with each participant. These skill-gap analyses are critical not only for individuals to be properly placed in the educational pipeline, but they also enable the GLFHC and NECC stakeholders to work together to strategically monitor and develop appropriate courses to meet the needs of the students. Taking an average of 5 to 6 years to complete, the program is comprehensive and includes pre-requisite courses, tutoring, assistance with preparation for the nursing school entrance exam, prioritized application review for admission to NECC's nursing program, and mentoring and support until graduation. GLFHC provides a medical setting for field placements, as well as access to nursing mentors while students complete the program. Moreover, GLFHC medical assistants are offered loans with deferred payments while in school provided they remain in good academic standing. Upon graduation, participants are able to repay their loans through their continued employment at the health center.

Currently, the program enrolls approximately five to ten participants each year; approximately thirty people have completed their nursing degree since its inception. Given the specific focus of the program on increasing the number of Latino/a nurses, each individual who remains at the CHC, by definition, increases the diversity of the CHC workforce.

CHC-EDU Partnerships to Train Future CHC Workforce

While the need for continuing education for *current* CHC employees may at first glance seem more central to staff development, student placements within CHCs also serve a critical "grow our own" function. Internships and residencies provide vehicles for individuals to become introduced to the CHC environment, which is likely to increase their ability to acclimate and remain in such an environment following graduation and/or credentialing. The mission and work environment of CHCs are different from many other healthcare outpatient settings and can be particularly demanding in terms of the work with vulnerable populations. As one interviewee put it, "having people placed at a CHC before they get their degree not only can help get them committed to the mission, but also can ease them into an environment before their entire professional career is dependent on it."

The ways in which CHCs collaborate with formal educational institutions to provide training to aspiring healthcare professionals vary widely. Several CHCs host interns and practicum students in nursing, psychology, dental, and pharmaceutical placements. Some centers host interns who will work on the administrative side of the healthcare environment (e.g., program managers, evaluation specialists). At least two centers are innovative family practice residency sites; one CHC has developed its own family practice residency program in collaboration with local medical schools; and one CHC hosts the only nurse practitioner residency program in the country. These programs serve the critical role of training a new wave of professionals devoted to healthcare for low-income, vulnerable populations.

Table 2: Internships, Practicum, and Residency Sites

Community Health Center (CHC)	Internship/ Practicum Site	Residency Site	Position	Technical Program, College, or University
Boston Health Care for the Homeless	X	X	Medical Assistant	Lincoln Technical Institute
			RN	Northeastern University, Regis College
			Nurse Practitioner	MGH Institute of Health Professions
			Physician Assistant	Mass College of Pharmacy and Health Services
Brockton Neighborhood HC	X		Nurse Practitioner	Boston College, Regis College
			Dentist	Boston University
			LPN	Blue Hills Regional Technical School
			Social Work	Bridgewater State University, Boston University, Boston College, Simmons College
			Medical Assistant	Lincoln Technical Institute, Salter School, Southeastern Technical Institute
Caring Health Center	X		Nurse	American International College, Holyoke Community College, Elms College, Westfield State University
			Nurse Practitioner	Boston University, UMass Amherst
			Physician Assistant	Springfield College, Bay Path College
CHC of Franklin	X		*	*
Community Health Connection	X	X	Medical Assistants	Salter College, Mount Wachusett Community College, Lincoln Technical Institute, Everest Institute/Boston Inst/Health Training Career Inst
			Dental Assistant	Salter College, Mount Wachusett Community College
			Residents	UMass Medical
			Medical Students	UMass Medical, University of New England, New York Institute of Technology College of Osteopathic Medicine, A. T. Still University, Boston University, Pacific Northwest University Health Sciences, University of Medicine and Dentistry New Jersey
			Nursing	Atlantic Union College, Mount Wachusett Community College, Mount Wachusett Regional Vocational Technical School, Fitchburg State University
Edward M. Kennedy CHC	X	X	Pharmacist	Mass College of Pharmacy
			Dental Hygienist	Quinsigamond Community College
			RN	Worcester State University
			Medical Assistant	Salter School
			Nurse Practitioner	UMass Medical
Family Health Center of Worcester	X	X	Physician	UMass Medical
			Nurse Practitioner	Internal Program
			Dentist	Lutheran Medical Center
Greater New Bedford CHC	X	X	*	*

* Detailed information not reported on survey

Table 2: Internships, Practicum, and Residency Sites (continued)

Community Health Center (CHC)	Internship/ Practicum Site	Residency Site	Position	Technical Program, College, or University
HealthFirst Family Care Center	X		Medical Assistant	Salter, Bristol Community College, NETI
			Nurse Practitioner & Physician Assistant	Simmons College, UMass, Brown
			Dental Assistant	Diman Regional Vocational Technical High School, Health Care Training Services
			LPN	Diman Regional Vocational Technical, Bristol Community College, UMass
			Nutritionist	University of Rhode Island, University of New Hampshire
Holyoke HC	X	X	Nurse	Holyoke Community College
Joseph M. Smith CHC	*	*	Psychologist	Massachusetts School of Professional Psychology
			RN	Boston College
			Optometrist	New England Educational Institute, New England College of Optometry
			Interpreter	Bunker Hill Community College
			Dentist	Harvard School of Dental Medicine, Lutheran Medical Center
Lowell CHC	X		Nurse/NP	UMass Lowell
			Medical Assistant	Lincoln Technical Institute, Middlesex Community College, Other
			Health Education	UMass Lowell
Lynn CHC	X	X	Nurse	Simmons College, Salem State University, UMass Boston, Endicott College
			Medical Assistant	North Shore Community College
			Nurse Practitioner	Massachusetts General Hospital
			Dental Students	Tufts University, Boston University
			Medical Students	*
Mattapan CHC	X	X	Nurse Practitioner	UMass Boston
			Dentist	Harvard School of Dental Medicine
North Shore Community Health	X		RN	Salem State University
			Medical Assistants	Everest, North Shore Community College, SSU, Acton
			Nurse Practitioner	Simmons College, UMass
			Physicians	Boston University, Tufts University School of Medicine
			Billing and Coding	Everest
			Sports Therapy	Salem State University
			Dentist	Tufts University School of Dental Medicine
South Cove CHC	*	*	Dentist	Lutheran Medical Center
South End CHC	*	*	Dentist	Boston University
			RN	Boston College
			Physician	Boston Medical Center
			Optometrist	New England College of Optometry
Stanley Street Treatment & Resources Inc.	X		Physician	Brown University
			Nurse Practitioner	UMass

* Detailed information not reported on survey

Among those who participated in the survey, the vast majority (with the exception of only 2) indicated that their CHC serves as an internship/practicum site for a technical program, college, or university. It was common for these CHCs to serve as training sites for positions such as: Medical Assistants, RN, LPN, Physician Assistant, Medical Students, Residents, Nurse Practitioner, Physician, Dental Assistant, Dental Hygienist, Dentist, Social Work, Psychologist, Nutritionist, Optometrist, Interpreter, Health Education Specialist, and Billing and Coding. See summary in Table 2.

Below we highlight examples of residency and internships opportunities at the Family Health Center of Worcester, Edward M Kennedy Community Health Center, and Greater Lawrence Family Health Center.

Residency Programs at Family Health Center of Worcester

The Family Health Center of Worcester's (FHCW) has several residency programs. Their oldest, the family medicine residency, began in 1974 with UMass Medical Center, only a few years after the health center was established. They host 12 residents at any one time, each there for three years. Students now come from medical schools across the country. In partnership with the Massachusetts College of Pharmacy, they have had a pharmacy program for the last 10 years and are developing an optometry program as well. FHCW also provides a dental residency in partnership with Lutheran Medical Center in Brooklyn, NY and AHEC. The Edward M Kennedy Health Center in Worcester also participates.

Programs are developed based on current needs of the patients who frequent the health center. For example, FHCW did not have pharmacy or optometry services, thus they sought out the Massachusetts College of Pharmacy when the school opened their Worcester campus. With an established teaching track record developed through past residencies and internships, other clinical departments are developing new programs (e.g., mental health and social services department works with second year MSWs and doctoral-level psychology interns). Psychology placements are in particular demand as there are not enough internship sites across the country for the number of interested students. FHCW is able to be quite selective and recruit students with specific language abilities. Both the pharmacy and MSW programs also draw diverse student populations.

Nurse Practitioner Program at Edward M Kennedy Community Health Center

The Nurse Practitioner (NP) Program at Edward M. Kennedy Community Health Center started about five years ago. The CHC has agreements with several schools, including Regis College, UMass Medical, and Worcester State University, whereby people studying to become nurse practitioners can chose to do placements through the health center. Students in the center-sponsored NP Program also often work as RNs at the CHC while studying to become nurse practitioners. The CHC retains about 85% of the people who participate in this program; they view it as a recruitment tool and as a platform to assess participants' clinical and cultural skills.

They value recruiting students into the NP program who are bilingual and bicultural, and they believe the program and these CHC-EDU partnerships have increased the diversity of their employees.

Family Residency Program at Greater Lawrence Family Health Center

The Greater Lawrence Family Health Center's (GLFHC) Family Residency Program was started in the early 1990's to ameliorate the difficulties they were having recruiting and retaining doctors. Physician turnover was an issue of tremendous concern, and the CEO of Lawrence General Hospital (LGH) wanted to provide better primary care for the Lawrence community outside of emergency care at LGH. With commitment from the GLFHC Medical Director, along with leaders from the Massachusetts AHEC and LGH, the program was launched. AHEC led the accreditation application process, and LGH funded the program initially. Costs include compensation for precepting and salaries for residents. Currently the program is funded through the GLFHC.

The program was not explicitly created as a way to recruit for diversity. However, the faculty does place a priority on recruiting Latino/as into the program each year. The community GLFHC serves is primarily Latino/a, therefore the residency offers a full emersion curriculum promoting Spanish fluency by the end of the residents' first year. GLFHC also has a Spanish teacher on staff to assist with appointments and provide language tutoring on a long-term basis. This residency program provides GLFHC with a pool of candidates that have a history and demonstrated commitment to treating underserved populations. To date, they have graduated approximately 130 residents, up to 80% of whom have stayed within a CHC environment. GLFHC has retained 25% of these residents at their center for at least some period of time.

The Residency Program has developed a national reputation. It is very competitive, receiving approximately 600 applicants per year for only 10 slots. It is also an intensive program. Residents at GLFHC spend three years at the center (soon to be to four years), in contrast to typical CHC rotations which are often only eight weeks. The GLFHC's Residency Program is considered a model, and the US DHHS Health Resources and Services Administration (HRSA) now provides funding for CHC's to start residency programs that replicate GLFHC's program. GLFHC is advocating for language to be put into legislation for more funding for teaching-focused CHCs, residency programs, and workforce development to enhance the sustainability of their program.

CHC-EDU Supports and Partnerships that Reach Multiple CHCs

In addition to center-specific CHC-EDU partnerships, there are several workforce development opportunities available to multiple CHC employees such as through the Community Health Education Center (CHEC). In addition, there are important statewide agencies that provide training supports, such as the AHEC and MLCHC. Not only does each of these organizations provide independent trainings, they also have the capacity, legitimacy, clout, and a track record

for both fostering ongoing and brokering new relationships between CHCs and educational partners.

CHEC was established in 1993 by the Boston Public Health Commission to provide standardized training for community health workers in Massachusetts. In 1997 with a grant from the Massachusetts Department of Public Health, CHEC opened a second center in Lowell, now operating under the Lowell Community Health Center. CHEC provides education through a certificate program, health modules, seminars, and workshops. Topics cover a broad array of community health areas including cultural competency and outreach methods. They facilitate monthly network meetings and publish a newsletter where health workers can exchange information about best practices, learn about public health issues, and connect with community resources.

AHEC, is a statewide organization dedicated "to enhancing access to quality healthcare, promoting workforce development, and eliminating health disparities" through the provision of training, certification, and outreach. AHEC focuses on several areas of workforce development, including training offerings such as: medical interpreter training, cultural competency training, and various continuing education programs. While the focus of AHEC is on healthcare organizations more broadly, they work very closely with CHCs.

MLCHC has at the core of its mission to provide technical assistance and work force development opportunities to its members. MLCHC also sponsors a variety of trainings – from leadership to customer service training - for community health centers. Many of the trainings sponsored by, and hosted at, the League are executed by external consultants. While many of these trainings do not result in licensure or formal educational credits, they are a mechanism to propel workforce development particularly in administrative and managerial roles.

In addition to offering extensive independent trainings both AHEC and MLCHC have the ability and commitment to foster center-specific CHC-EDU partnerships. While there are some CHCs that are large enough to host their own in-house trainings and/or initiate CHC-EDU partnerships, for many it is costly to develop such initiatives for a handful of employees. Both AHEC and MLCHC can support CHC-EDU partnership opportunities by centralizing and consolidating workforce development efforts. An example of such a partnership is MLCHC's arrangement with Suffolk University to offer a certificate program in Community Health and Community Health Center Management that is utilized to train CHC staff from across the state.

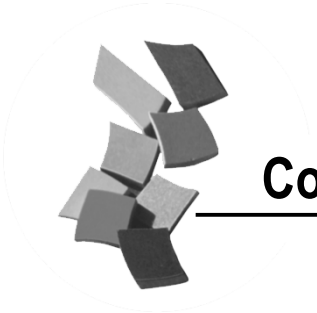
Certificate Program in Community Health and Community Health Center Management

The Suffolk University program was developed in collaboration with MLCHC and was the first of now 6 Leadership Development Institutes across the country recognized by the National Association of Community Health Centers (NACHC).[1] The Suffolk program was originally conceptualized by the President and CEO of MLCHC and the Director of the Moakley Center for

[1] http://www.nachc.com/

Public Management at Suffolk University. These leaders worked together to design a university-based program that could fill the need for a centralized curriculum for the development of CHC leaders.

Between its inception in 2001 and 2011, there have been 266 graduates. Entrance into the program is competitive, and admission requirements include currently holding managerial responsibilities at a CHC and a recommendation from the employee's CEO. The program is 25 weeks, with 5-week segments, over the course of 8 months. Classes meet one full day each week at the League offices. The program is designed to provide training in the areas of health policy, human resources, health information technology, ethical issues, finance, and marketing. These modules have been developed and improved over time with input from both CHC leadership and Suffolk Faculty. The CHC generally covers the cost of tuition. Graduates of the program are able to get up to 12 credits towards a Master's Degree at Suffolk in addition to a certificate from the Mass League. Overall, this is viewed by many as a mutually beneficial partnership: CHC workers get training and university credit toward future degree efforts, CHCs have access to quality training to build the competencies of new leaders, and Suffolk University has a gateway for potential masters students.



Common Challenges & Success Factors

The examples presented here make clear that CHC-EDU partnerships have the potential to expand opportunities for many current and aspiring community health workers. They are also potential pathways for the CHCs themselves, as these partnerships can aid organizational efforts to increase ethnic/racial diversity among healthcare providers. In what follows, we highlight some common challenges and success factors that emerged from our survey and interview data. These factors revolve around the themes of 1) leadership, 2) alignment of goals and institutional priorities, 3) programming logistics, 4) student-related issues, 5) funding, and 6) the broader context of healthcare.

Leadership support

- The importance of support from the leadership of CHC-EDU partnering entities is clear. The joining of two organizations to form a true partnership cannot be achieved without such support. Top level commitment to collaboration signals that the partnership is a *strategic* priority. Also, it is only with leadership support that possibilities open up for dedicated financial resources, without which these partnerships are unsustainable.

- While not much can happen without support from the top, the main proponent may not be the actual president or CEO. The effort still needs someone who is willing and able to become a dedicated point person. As one interviewee emphasized: "You need that person who's willing to champion [the initiative]."

Alignment of Goals & Institutional Perspectives

- One general challenge involves the alignment of perspectives of traditional healthcare settings (like hospitals) and traditional health educational training. Traditional models of healthcare are often geared toward treating acute disease and illness, and educational systems that are designed to train the healthcare workforce are often slanted towards this point of view. But CHCs are primarily geared toward prevention, wellness, and public health and, as such, require educational systems that mirror this alternative framing.

- An asset for CHC-EDU partnerships relates to the unique contexts of the community health movement and the community college mandate. CHCs and community colleges are very much aligned in their missions to serve their local communities; both are explicit about their priority to make their services accessible and relevant to the community's needs. This shared vision not only signals that their values are in sync, but it also facilitates collaboration to the extent that they share the same overarching goals. Further, because both types of institutions often serve ethnically and racially diverse communities,[xxi] the

commitment to understanding the people they serve goes hand-in-hand with a value for diversity.

- It is not enough to simply share common values at an ideological level; these partnership organizations must be willing to understand the nuances of the everyday realities of each organization in order to navigate the logistics of the partnership. As one summit participant put it, "education and health care are in different time zones." For example, while the semester schedule determines the timing of many educational institutional decisions and deadlines, it does not always dovetail with the timing of CHC needs. Similarly, the need for CHCs to cover shifts for staff while in class can constrain student attendance and potentially frustrate teachers.

- With organizations coming together with differing institutional cultures, attitudes, and ways of operating, there is plenty of opportunity for misunderstandings. Taking the time to spell out the meanings of seemingly common terms and develop a shared language is a lesson for other organizations seeking similar partnerships. One study participant said she employs a cultural competency framework to help facilitate understanding across the CHC and EDU cultures: "we didn't speak the same language… So the first thing we had to do is find a common language…. and because we are trained in cultural competency… I saw my role [as] being the cultural broker amongst these groups so that we would make sure that we knew that when we said X, everybody understood that X was X, and not Y or Z. And it wasn't that hard to do, but it really…made a difference."

Logistics of On-site Training

- Challenges surrounding what may seem like minor details can end up having significant implications. Particularly when implementing an on-site training program, challenges can arise unexpectedly about the division of CHC and EDU responsibilities - even after engaging in very careful planning. One example is computer maintenance. A grant may have made it possible for a CHC to purchase and set up multiple computers for instructional purposes, but who should be responsible for loading specialized software and for computer upkeep? Additionally, the technology-related policies of one environment (CHC) may not suit the other (EDU). For example, some instructors might like to have full access to the web to enable them to bring in interesting resources to teach core course concepts. However, websites like YouTube are restricted by some CHCs' policies.

- A parallel question can emerge around responsibility for building security and maintenance. For example, if courses are held at night at a CHC site and open to the entire community rather than just CHC employees, a security guard may be required. The CHC and EDU partners must think through and negotiate solutions to such issues - often in an ongoing way because it is often difficult to anticipate every such logistical issue before the programs begin.

Student-Related Issues

- Particularly for entry level workers, it is critical to address the variety of barriers that make accessing formal education intimidating and/or logistically difficult. Our survey revealed constraints related to personal financing of education, including the need to maintain a full time job while pursuing further education. Both the time and cost of travel to educational sites can be a barrier to participation. Family responsibilities limit workers' ability to attend class outside of work time as well as their ability to set aside time for homework. The lack of flexibility to attend college full time means that a degree program may take a very long time. This can be personally discouraging as well as a strain for workers' families or extended networks that are tapped to provide back-up support.

- It is critical that the CHC and the EDU do not define these barriers as shortcomings of the individual workers or a signal of any lack of commitment. What is striking in the partnership examples we explored is the commitment - on behalf of both the CHC and the partnering EDU - to approach the particular life constraints of the CHC participants as structural challenges rather than as personal failings. The willingness to work together to propose approaches to educational access that go outside of the traditional on-campus college model is key.

- CHC-EDU partnerships need to be attuned to the wide range of educational needs of many CHC staff. For example, entry level CHC employees, typically hired from the local community, bring with them the valuable and necessary cultural understanding of the patients they serve. However, they may not have some foundational skills that need to be fostered before considering other types of more formal credentialing or degree programs. The strategy of one CHC: "we actually started to offer classes for our employees based on what our managers felt they needed at the time, which was an English business writing type of class, medical terminology, those type of things, that would help employees either new to healthcare, that had just been hired, or, you know, needed some, just to increase their skills." Further, many specialized academic programs have minimum requirements for entry, which can feel like insurmountable obstacles to staff who have never had access to such educational opportunities. Being keenly aware of the preparatory confidence and skill building that might be needed is critical.

Funding

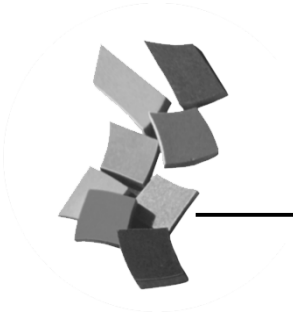
- Funding for CHC-EDU initiatives is a perennial challenge. During prosperous economic times, there has been grant funding to sponsor specialized training endeavors. Funding for training, however, is often among the first items to get eliminated when funding is tight. Sustainable funding is particularly difficult to come by. Grant-funded education programs are transient by nature, making it difficult for programs to gain traction and become a permanent part of the CHC culture. Sometimes grants can jump start important initiatives, but even then, information about short term soft money opportunities can sometimes be difficult to access.

- Renewals for grants are sometimes based on criteria that are not a good fit with CHC challenges. For example with the Lawrence Latino Nursing Program, the initial federal funding that enabled the partnership to spearhead the program was not renewed because they could not produce large numbers of nursing graduates quickly. Because the program works with participants *before* they enter in the nursing program and because many need to go part time, the program took longer to complete than would be true for full time, previously prepared students. "Other [programs] don't count the students until they're in nursing school; so the turnaround is a lot quicker. We started with people in the community. So it took us several years to even get them into the school. So we were not able to retain that funding because of the numbers."

- Tuition is costly. While there are tuition reimbursement programs and incentives available to lighten the economic burden, it appears that many individuals – and indeed entire centers - are often unaware of such programs and how to access them. In addition, any requirements for students to pay for courses upfront can be daunting, particularly when you consider that many CHC employees have a family to support. One step taken to address this issue has been to offer advanced loans, rather than structure all support as reimbursement.

Broader Healthcare Context

- CHCs that invest energy into helping current employees develop valuable healthcare-related skills, risk losing skilled employees to higher paid positions at local hospitals. Health centers have been able to hire and retain many of the graduates of the programs we have described in this report. However, bilingual, bicultural staff are in high demand and can find higher wages in local hospitals: "People who come to work as MAs are people in the neighborhood, people in the community. Now one of the disadvantages – and you probably see this in other health center too – is, they may get to be really good MAs, or even really good appointment clerks, and they get snapped up by the hospital institutions for a couple more bucks an hour."



Recommendations for New CHC-EDU Partnerships

The following recommendations are derived from our survey data and our analysis of the interviews with community health center and community college leaders. The recommendations generated by participants in the May 2013 CHC-EDU Summit are also integrated into this report.

- Establish leadership from the top
  - Identify CHC leaders who have an explicit value for education. Leaders who:
    - Fully embrace the philosophy of "grow our own"
    - Recognize the benefits of CHC-EDU partnerships for the health center
    - Promote organizational culture where education is embraced as part of the CHC mission
  - Identify EDU leaders who value connections with community-based organizations. Leaders who:
    - Value workforce development
    - Value applied experiences for students above and beyond placements required for credentialing
    - Understand the need to bridge the different cultures of healthcare and education
  - Establish commitment at the institutional level that can be sustained even when leaders change
  - Make sure the team includes a *champion/manager* who is dedicated to the partnerships and who can navigate the cultures of both organizations

- Concentrate on developing strong relationships than can bridge institutional cultures
  - Recognize and build on shared commitments to fostering CHCs as an important learning/teaching environment dedicated to serving the local community
  - Understand that the pressures and priorities of CHCs and EDUs are quite different
  - Have intentional conversations about the differences in organizational practices of the partners
  - Establish regular communication and contact; create clear mechanisms to address misunderstandings or conflicts as they emerge
  - Start with one small partnership project, honestly debrief, and grow from there

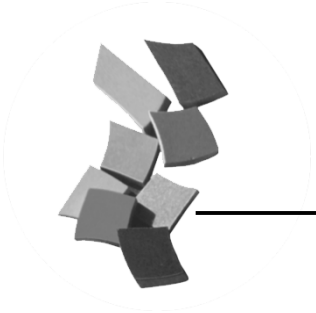
- Establish clear expectations about roles and responsibilities
  - Develop written memoranda of understanding for each partner so that expectations are clear

- Involve the leaders from each institution but also invite operational level personnel to planning teams to make sure implementation details are taken into consideration
- Have an ongoing setting where representatives of both institutions can problem solve around logistical issues and make midcourse adjustments along the way
- Establish mechanisms (& possibly an in-house team) to address barriers that might emerge within each organizations (e.g., shift coverage when people take work time for classes)

❖ Understand the wide range of issues faced by CHC staff who return to school (student - related issues)
- Include adult learners on planning committees (& ask them to help planners be aware of student-related issues)
- Provide opportunities for entry level staff to build their confidence before & during taking college courses, for example:
    - Psychological support
    - Opportunities to get their feet wet with short introductory courses
- Be attuned to the need to provide preparatory courses to ready some students for degree programs
- Recognize and address constraints on employees that emerge from life circumstances, for example:
    - Coordination with work schedules (e.g., start classes at 5:30 instead of 6:00 so they are right after work)
    - Address childcare needs
    - Transportation (e.g., provide on-site courses)
- Identify college or university structures that can support access for non-traditional, part time students
- Inform students about tuition-related supports
    - Flexible tuition payment
    - Pay back programs
    - Financial aid programs - federal as well as college-specific programs
- Adopt CHC-sponsored tuition supports where possible
    - Tuition reimbursement
    - Grants

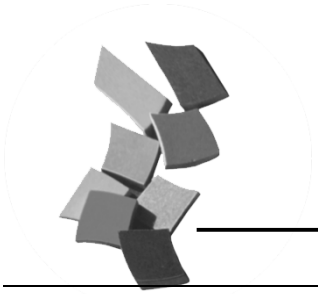
❖ Be strategic in searching for external funding
- When applying for funding, identify what the CHC has in common with funders. Appeal to the parts of the funders' mission that align with CHC priorities. Focus on the return on funders' investment
- Identify ways to leverage existing partnerships to garner funding (e.g., unique programs, hot topic areas that are receiving funding)
- Develop proposals together to strengthen submission

- Use other Resources
    - Tap into the available resources such as AHEC and the Massachusetts League of Community Health Centers



Conclusion

This investigation reveals that CHC-EDU partnerships are an innovative workforce development strategy that not only compliments the "grow our own" philosophy of many CHCs, but also has the potential to increase the diversity of the CHC workforce. Increased diversity at all levels of the organization ultimately enables CHCs to better provide culturally competent care for the communities they serve. While these partnerships are not without their challenges, it is also clear that when implemented with care, they can create tremendous opportunities for individuals, organizations, and communities. What is also clear, as echoed by our summit participants, is the need to continue the conversation between Massachusetts CHCs and institutions of higher education. CHCs, community colleges, and public universities, in particular, share priorities for enhancing the skills of members of our commonwealth. Fostering new and expanded CHC-EDU partnerships have the potential to fill a strategic need in the commonwealth's economy and health.



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