

1. Background of the Health Resources and Services Administration

The Health Resources and Services Administration (HRSA) is one of the eleven agencies of the Department of Health and Human Services. To appreciate the background of HRSA, one must start with the establishment of the U.S. Public Health Service (PHS) in 1798 when the first PHS hospitals were started. The next event significant to HRSA was the passage of the Social Security Act in 1935 that included authorization of the Maternal and Child Health Program. In 1951 President Truman appointed the Commission on the Health Needs of the Nation (the Magnuson Commission) and its report, "Building America's Health," recommended Federal aid to schools of medicine, dentistry, nursing and public health. Among other things, such funding was to remove the barriers to professional education for minority young people. In 1953 the Department of Health, Education and Welfare was established. In 1963, the Health Professions Education Assistance Act established the program of grant support for schools and students of the health professions. In 1966, the Allied Health Professions Education Subcommittee of the National Advisory Council was established to advise on allied health professions needs and resources. In 1967, the Bureau of Health Professions and Manpower Training was established and subsequently merged into the National Institutes of Health. The name was shortened to the Bureau of Health Manpower in 1970. The new bureau became one of the components of the new Public Health agency, the Health Resources Administration when this agency was formed in 1973. The director of the Bureau of Health Professions Education and Manpower when it was at the National Institutes of Health became the first Administrator of the Health Resources Administration.

In 1982, the Health Resources Administration with its emphasis on health resources and training merged with the Health Services Administration with its emphasis on health service, to form the Health Resources and Services Administration (Table 1).

HRSA's mission is to "assure that all Americans, particularly the most vulnerable, have equal access to quality health care." Its motto is "HRSA: THE ACCESS AGENCY." The current organization of HRSA is presented in the organizational chart (Figure 1). Because this study focuses on training programs that are most closely related

to the Health Resources component, the rest of the discussion will focus on this component of HRSA.

The Health Resources component has remained focused on developing the variety of health professionals needed to achieve the overall mission of quality health care, especially for the most vulnerable. The Bureau of Health Professions remains the largest component dedicated to training and most of the programs included in this study are based in the Bureau of Health Professions. The Maternal and Child Health Bureau and the HIV/AIDS Bureau have had a relatively limited history of training support.

Among many changes over the years are the increased complexity of the application process and the awarding of funding. A former Administrator of HRSA commenting on the earlier application process, stated that “The application was 4 pages, required a school to plug in enrollment data, check a couple of boxes, and sign its name. We then sent the school a check. Wouldn’t it be nice if the process were so simple today.”

HRSA’s primary responsibility remains assuring access to quality and affordable health care especially for vulnerable populations and communities. HRSA is developing a health professions workforce to assure accessible and affordable health care services. Currently, HRSA provides support for more than 80 health care programs across the nation through the Bureau of Primary Health Care, Bureau of Health Professions, Maternal and Child Health Bureau, and HIV/AIDS Bureau.

The training and education programs sponsored by the Bureau of Health Professions in concert with the states and other stakeholders are designed with specific goals in mind:

- To increase access to health care.
- To improve the quality of health care services.
- To safeguard the health and well being of the nation’s most vulnerable populations.
- To promote a health care workforce with a mix of the competencies and skills needed to deliver cost effective quality care.
- To support educational programs ability to meet the needs of vulnerable populations.

- To improve cultural diversity in the health professions; and
- To stimulate and monitor relevant systems of health profession education in responses to changing demands of the health care marketplace.

To implement these goals, HRSA employs a national training, education, and practice strategy for the health of the nation. The strategy is aimed at improving “ the health of the nation by assuring quality health care to the underserved, vulnerable and special-need populations and by promoting appropriate health profession workforce capacity and practice.” Four principles dominate the nation’s efforts to develop strategies that will provide quality health care services to medically underserved populations and serve to reflect the Mission of HRSA. These principles are health care services must be: 1) comprehensive and coordinated; 2) community based; 3) available in the clients’ communities; and 4) culturally competent.

A description of the 16 training programs under study can be founded in Appendix B.

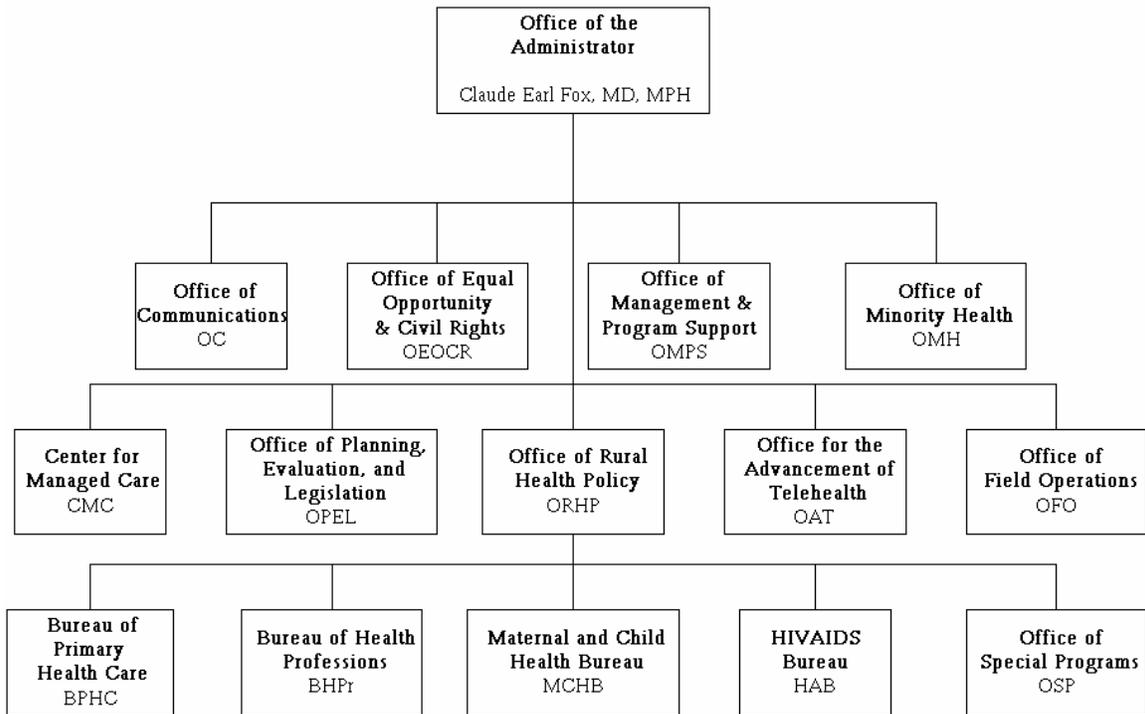
TABLE 1

Selected Highlights in the Development of HRSA

- 1798 U.S. Public Health Service Established
- 1935 Social Security Act and authorization of Maternal and Child Health Program
- 1951 Magnuson Commission on the Health Needs of the nation
- 1953 Department of Health Education and Welfare established
- 1963 Health Professions Education Assistance Act
- 1967 Bureau of Health Manpower established
- 1973 Health Resources Administration established
- 1982 Health Services Administration and Health Resources Administration merged
- 1989 Office of Rural Health established
- 1990 Ryan White AIDS legislation enacted.

FIGURE 1

Organizational Chart
Health Resources and Services Administration



2. Interviews with Key Bureau Personnel at HRSA

The interviews with bureau and division personnel were conducted individually and in small groups. The intent of the interviews was to obtain the perspectives of key bureau personnel at the policy level. The first set of questions focused on the experience of persons at this level of the Agency and there was considerable variation in experience. At one end of the spectrum was an individual who had been in the department since 1972. This individual had visited all the HBCUs and minority institutions around the country even before coming to HRSA as director of a division in 1995. At the other extreme was a division director who was relatively new to the position. The one who had the greatest depth of knowledge in that division had been in position for 18 months. Within that division, all of the experienced staff people were “ill, retired, or detailed.”

These interviewees often referred to the level of competence of the staff involved in their programs. One interviewee stated: “I have very competent people who are health professionals who know what it is like out there. We have a pretty good mix of various minority groups. We have two people who are directly from those HBCU institutions. These people are really competent, they are committed, and they are not here just because they are in the government and want to get promoted. That is the kind of people I look for.”

There was a lot of discussion about the mission of the Agency. Some explained the concept of HRSA as an access agency with access for the vulnerable and disadvantaged populations. There was the concept of services and the concept of training. These were described as the major issues at HRSA. These concepts were further refined to certain priorities including diversity, distribution of health professionals for underserved areas, and quality, with some question about the meaning of quality.

Given the mission of the Agency, there remains the problem of implementation of its mission. Another interviewee saw as the first challenge, the matter of “educating our own program staff that these are the important priorities and that they are not just rhetoric.” Another challenge was to “get our message out to the field that we really want applications from these diversified population and institutions. We are coming up with

different strategies to do that in our program, and the barrier there is that I just don't have enough staff." Adequate staffing and travel funds were reported as a major problem.

Another problem in implementation was reported to be the role of grants management and peer review. One interviewee stated, "I feel that the grants management and the peer review staffs have more authority than they need working with our programs." The support functions operate in such a way that "you have to do what they want you to do in order to get your program done the way you need to get it done."

In discussing any special consideration that was given to the Black medical schools, one interviewee indicated that there was recently more consideration given to the schools than was the case previously. Special consideration language was added this last year referring to underserved and minority populations. "So we don't talk about the schools specifically, but about the population of the schools," the interviewee said. As a result of the recent legislation, it was felt that if there was a lack of resources flowing to the schools, it was not because of a lack of attention. "I think there is a lot of attention being paid. I mean the Executive Order and all that." This interviewee felt that any failure of the schools to obtain resources was more likely due to a failure on their part to pay proper attention to the kinds of details that must be addressed in submitting an application.

Some interviewees indicated that the Agency has had difficulty tracking information needed to identify suspected changes in the level of funding and much of the work was done manually. HRSA does not currently have a fully automated system and has been undergoing a change from the NIH system. Further, one interviewee stated that organizational changes in the Agency have necessitated the transfer of some files from one bureau to another.

There was some discussion about how the Agency assesses the effectiveness of its programs in relation to its mission. One interviewee said: "We are going through an evaluation process. We have a grantee working with the National Center in Georgetown where we are evaluating all of the training portfolios. We are trying to take a long term historic look, as well as doing a lot of site visiting and surveying of current grantees to really look at what is and is not working out there. There will be suggestions for future improvements and directions. They are going to start looking and working with grantees

to recommend some performance measures to the bureau, because performance measures are now being developed but have not yet been done.”

The Application Process

The application process was a dominant issue in all discussions, often arising spontaneously. For example, one interviewee reported: “I know these schools are the ones that we should be targeting as far as medical schools are concerned, especially for African-Americans. If they are not in, we call them up but most of the time we do not have to encourage them at all. They are here in my office or talking to our folks. They are the first in line usually. It is the rest of HRSA where the problems are. These programs are designed for that type of institutions. We make sure that we have representatives from those schools in the review panels that we have. We make sure that when we have some kind of advisory group, that somebody from those schools is participating in it. We keep in touch, we give them technical assistance, and we send people down to their institutions to provide technical assistance. We make sure that they know when we have a workshop. For example, this past fall we had workshops in Atlanta and in Houston. We had one here and encouraged them to be there, and they were.” Therefore, in some cases, active solicitation exists.

Another interviewee spoke about having arguments over accepting some applications. There were 20 applications under a certain program but there were questions about whether they (the schools) had fully shown that they would achieve something. “The whole project is about achieving something, but if you go through some of the details it is not clear that they have the matching funds or whatever. My position is that they put a lot of effort into it. It may be a good project, and we want to fund the best projects we can find. I want that one reviewed. If it is approvable, approve it, with the condition that it is not going to get funded unless they show evidence that they have the matching fund.”

A major question has been the extent to which one must go to get applications from those who are eligible. It is clear that some outreach is necessary but the amount varies from program to program. One director explained that the importance of outreach was a main reason for having individual staff members who were knowledgeable and

committed. Others have explained a failure to do more on the shortage of staff. One director said: “We have program officers who may have two grant programs. They may have 200 grantees, for instance, plus all the applicants to deal with.” They offer assistance through phone calls, routine technical- assistance conference calls, and e-mail. But compared to what it might have been fifteen years ago, there is less specific kind of soliciting in getting an institution to apply.”

Apparently, the responses to the telephone conference calls have not been enthusiastically received on the part of the Black medical schools. One interviewee confirmed that the personal contacts were less than previously but added that “All the people on staff here know that if a Black medical school calls, e-mails, writes in or sends a draft, they are to give it 100%. We will go a step beyond for these schools because we know that is part of our initiative.” The interviewee added that the quality of applications has become better so that the contacts may be less pressing. One interviewee indicated that for some programs the Agency is receiving applications from schools that did not apply before. This might be due to the fact that information on programs is now available in a package form, so that while applying for one program, an applicant can learn about other programs of the Agency. There are also now more minority faculty who have attended fellowship programs and faculty development sessions that have helped to improve application writing. There was also mention that there were more applications from Meharry, Morehouse, and Drew than from Howard.

The problems of the lack of travel funds and the prohibition against using program funds for program support activities were recurrent themes with some interviewees. Likewise a number of the interviewees commented on the fact that in minority schools, many of the faculty members have heavy teaching and service responsibilities, making it more difficult to allocate time to competitive proposal development. Many young faculty members have never learned about proposal development as a part of their medical training and the schools are often without the necessary support for this purpose.

One of the problems with technical assistance relates to the segmentation of the Agency by its various programs. The idea of the Agency taking over technical assistance has great appeal to one director who has had long experience with the Agency and its

“confederacies.” Such technical assistance is appealing to this interviewee because it is a HRSA program. It is not a bureau program or HCOP technical assistance. One can obtain information from all four bureaus and the Office of Rural Health. The staff members from the Agency putting on the three-day workshops have learned a lot about HRSA in this way. This interviewee summed it by adding: “There are many areas where we could work together instead of everybody saying this is my turf, and I am not going to let any of my money go over there. We could be a lot more effective if we were working together as an Agency.” Fortunately, the current administration is strongly supportive of this approach.

The interviewers were especially interested in the impressions at this level of the response of the Black medical schools to requests for applications. One interviewee was bothered by the fact that the system is designed for the big research centers and the big medical schools rather than the smaller ones. Another felt that the content of the applications was at least average or better and that all of the applications from these schools that were approved were actually funded, indicating that they were not funded because of “entitlement” but because the applications had merit. Another interviewer indicated that a long time ago, reviewers were seen to argue about an application and finally give the money away, but that no longer happens. The schools compete. The reviewer felt that the word had gotten out that if you want funds from HRSA you must really compete. “You just cannot patch up something and send it in and expect to get funding because you are a Black medical school.” HRSA’s support of the Mentoring Program for high schools students was viewed as a successful partnership between HRSA and the schools. Interviewees spoke warmly about the mentoring program where students come to Washington and make presentations. The event is anticipated every year, and it is described as a “kind of wonderful, uplifting experience for many of the professional staff throughout the bureau.” This specialized program reflects the positive working relationship between HRSA and Black medical schools.

Another interviewee felt that the key has been better technical assistance that is offered by that bureau early and right after funding. Technical assistance is offered wherever it is needed. A team of reviewers would visit and “If they needed somebody to come in and help them set up a financial system they would recommend that. If they felt

that the clinical system was not strong enough, they would recommend that we send a clinician down to work with them as necessary.” This interviewee felt that if any of the schools received that kind of assistance they should not fail and the program should not fail. Another interviewee said, “I do not have a sense that these four schools call anymore frequently or less frequently than other schools.” There were also some negative comments about administration at the schools making it difficult for faculty who had won grants to perform. One interviewee said: “The faculty have both written the grant and they obtained the money, but being able to spend it in a timely and efficient way is another matter. They are often ham-strung by the organizational barriers to implementation.”

The Peer Review Process

The peer review process was a focus for a great deal of discussion, especially with respect to authority and the choice of peer reviewers. The area of contention was the result of centralizing the process within the Bureau of Health Professions and delegating to that office some functions that were previously managed by program staff. One interviewee described the selection process as follows, “The programs provide them a list of potential reviewers and then a list of reviewers is negotiated between the program and the peer review office.” The problem does not appear to be the centralizing of the process but that the list of reviewers who ultimately serve does not always conform to the wishes of the program staff. The interviewee said: “ I have been disturbed that there has not been the kind of distribution that I wanted to see. On a couple of reviews they said we asked four people, but the four declined.” Interviewees were asked about the selection of the chair and there was unhappiness because even if the program made a recommendation, the peer review office could overrule the selection. The interviewee felt there was not enough balance in one group selected and said: “You know what they told me? He said if you do not use this group, then you are not going to spend your money this year. Well, I am not going to cut off my nose to spite my face.” The same interviewee, however, admitted that it is very difficult and labor intensive to develop an effective review system. Another interviewee indicated that the decision to determine whether a person was really qualified to serve on the review committee should be a

program decision and not a peer review decision. The programs would like to assure that there is representation over a wide range of characteristics such as ethnicity, geography, specialty, minority status, etc. Several persons recognized that even if a chair is selected, the group dynamics might be such that the leadership of the committee may actually lie with some other member of the group. The program personnel feel trapped by the peer review system. Those who have had difficulty with the independent review process were rather frustrated. One interviewee summed it up this way: “The bottom line is that we are fairly limited now to basically identifying and giving them (the Peer Review Branch) the names of people qualified to review for these programs. They construct the panels and we have limited input.” When the interviewees were asked if they should have veto rights. The answer was “Yes, we don’t have that right now.”

The centralized system of peer review does not apply to the entire agency. Those who do their own review process comment on the benefits of the process and how much the participants gain as a result. One such interviewee said: “We have never had trouble getting reviewers. I think that there are a lot of people who want to learn the process. They love coming to Washington. Their colleagues are green with envy and want to participate. A lot of them will come and say that I wanted to do this because this helps me so much when I sit down and apply for a grant.” This interviewee suggested, “The historically Black colleges and medical schools should promote the idea of serving on those panels not for the good of the government but for the good of the university.”

Those interviewees who did not have an independent peer review office faced a different problem. Their assessment was that “Being responsible for the review process was a tremendous amount of work, everything from making hotel reservations, to calling, to filling packages.” Members of the professional staff feel that they would like some of that to be done by someone else. In fact, this unit is considering contracting out some of the work and may even decide that it is better to have a centralized office.

The Peer Review Branch

The centralized Peer Review Branch serving the Bureau of Health Professions gave its own assessment. The Branch was established four years ago to “bring efficiency, consistency, and a fair and equitable process to the order and methods used to review

applications for the various grant programs.” The Branch believes that it has brought greater objectivity to the review process. Prior to the forming of the Branch, there were forty different ways of doing business. In addition the grant reviews are summarized and mailed to the applicant in a timely manner.

The peer review process has moved from Charter committees to ad hoc committees which allows for changes in membership annually. Charter committee members were appointed for three years. Under the current process an unsatisfactory reviewer simply does not get invited back. Administratively the ad hoc committees are less burdensome to manage.

The Branch is seeking “more good reviewers who mirror the population of the United States.” At present, Hispanics and Native Americans are not adequately represented and representation from minority faculty on the review panels is below expectations. It is hard to get balanced panels and good reviewers. The Review Branch would like to have the authority to seek out, identify, and approve reviewers to serve on the panels. Currently, the Branch is dependent on the program staffs to provide and approve names of qualified reviewers to serve on the panels. The program staffs also approve the chairs of the ad hoc committees.

Funding

The interview questions around funding included such issues as set asides, long term funding, and the Executive Order. First discussing set asides, the Centers of Excellence funding includes 12 million dollars set aside for four HBCUs including Meharry Medical College. Neither Howard nor Morehouse are included. One interviewee believed this was because Howard gets federal support, and Morehouse receives state support. According to that interviewee, during the previous year, the agency required the programs to give preference to HBCUs, Hispanic Serving Institutions and Native American focus programs. The largest set of new set-aside money (two million dollars) was for AIDS Education Training Centers to subcontract with Historically Black Colleges. This set-aside was written into Congressional language. The exact allocation of these funds was yet to be decided. The total amount could be as much as 4.8 million dollars with the funds going primarily to the institutions with

medical schools. The emphasis on the program for clinical providers, minority providers and those serving minority communities was due to the interest of the Congressional Black Caucus.

In a broader sense, a funding preference for HCOP is given to those institutions that have a community linkage and include broader elements of the pipeline. One interviewee said: “The pipeline is being built. That is almost a requirement. If you are going to come in for a HCOP and you do not have that linkage you would not get the preference.” There are, in fact, those who think that too much emphasis is being placed on the professional end of the pipeline and the greater emphasis needs to be given to the lower levels.

The duration of funding is also an important issue since three years of funding is recognized to be not enough time to develop an effective and long lasting program. It was the understanding of one interviewee that three years of funding will be changed by the year 2000 to five-year rather than three-year grants. There are occasionally special initiative funds. One case was cited in which AIDS funds were made available to one school as a special initiative grant.

The question arose about funding some programs indefinitely. The general view is that the HRSA funds are intended to be a catalyst and that grantees should seek funds elsewhere for the continuation of programs. There are few exceptions to that for the HBCUs, but even among them there are a large number of schools seeking funds. In the words of one interviewee: “We have 120 or so HBCUs and most of them are undergraduate schools. We have approximately the same number of Hispanic Serving entities and about 21 Tribal Colleges. We are required to reach out to all of them by Executive Order.” This makes the assumption of entitlement quite unlikely, and the emphasis is still on competition. There was occasional reference to one of the schools with a feeling that the institution acted as if it were entitled to funding regardless of the circumstances. Some of these institutions will need funds for a long time and the issue for these schools is to demonstrate that they are not taking a handout. One interviewee said: “I think they have to state the case. The Agency sets aside \$12 million dollars for four HBCUs out of one program. That is not even a drop in the bucket. These minority schools are barely making it, and they depend on these minority programs, which offer a

very minimal amount of funding. The rest of the agency has to chip in a lot more funds.” There was also the suggestion by one interviewee that the grant funding mechanism was not the best method for the survival of these schools. This interviewee suggested that the congressional route with the schools as line items in the national budget might be one mechanism. Another approach would be to increase the budget for the Centers of Excellence and to expand the number of Black medical schools to be funded through this mechanism.

There is considerable support for the four medical schools at the highest levels of HRSA. There may be a few within HRSA who think that Morehouse is getting special treatment or that Meharry is getting a disproportionate share of money. According to one interviewee, “the vast majority of people who are working with programs do not feel that way.” They feel that the best way to address the current under-representation is to assure that these schools survive. There is special admiration for Meharry that has survived operating largely on grant funds. This is in comparison with Howard University. One interviewee, speaking of Meharry, thought “We did them a huge disservice many years ago when we gave them a loan to build that hospital. It became a terrible financial drain.” There was not a clear understanding of the financial picture for Drew and the extent to which it is dependent on funding but the assumption of this interviewee was that it was also a pretty shaky situation. This interviewee’s assessment was that “The way to stabilize these four schools is to put them all on the federal budget as national federal resources.” He was not sure about Morehouse but suspected that it was in a little better financial position. He cited the case where one senator was able to get written into the legislation an appropriation of over one million dollars for a particular institution by name. The interviewee was aware of the history of the Centers of Excellence funding and the predecessor “Distress” grants. The four designated schools compete among themselves for this set aside funding.

Interviewees were asked about the Executive Order. There was apparently not a clear understanding of the Order, but one interviewee responded: “I am critical of the efforts to respond to the Executive Order. I do not think that we begin to make the effort that we should be making to provide technical assistance. I don’t see a real effort being made to engage the minority institutions that are covered by the Executive Order. I have

even seen some resentment to involving ourselves in this Office of Minority Health project.”

Recent and Suggested Changes

There had been some rethinking within the Agency concerning funding practices, relating to relatively new leadership as well as the approach of a new cycle of funding. Perhaps there was no need for change in some circumstances because there was a sense of great accomplishment. For example, the Agency has played a significant role in the infrastructure development of family medicine at medical schools and the increased emphasis on primary care. The AHEC programs have been quite successful in establishing AHEC programs in 38 of the 50 states and these programs are structured around community needs.

There were, however, some suggested changes for the immediate future. One interviewee thought that the Agency should try to determine why some schools do not apply when they are eligible. Reference was especially made to Howard University, but that suggestion led to considering whether the problem was with the school or the agency. One interviewee said: “Some of that may fall back on us because it is not uncommon for us to be late in getting our announcements out and some of our instructions are appalling. If I had my say, I would throw out every set of instructions we have for all of our 40 or 50 programs. I would bring in some people from the schools to sit down with our staff and with somebody from general council. I would then say, okay folks, I want you to write instructions that are clear, that fall within the law, that are understandable and not more than 15 pages long.”

There have been changes in recent years but change occurs very slowly. One interviewee gave his reasons for the slow change. “It is the middle managers that usually hold things up. There is so much bureaucracy, so many regulations, and so many people have to look at things that changes occur very slowly. They are tied into the system so closely that things do not move. I know that Dr. (Earl) Fox is committed, and Tom Morford is committed. In fact, they actually forced the bureau last year to focus on small institutions, HBCUs, Hispanic Serving Institutions, and Tribal Colleges. Some of the staff argued that was going against the law. There were objections from different places

and the Agency leadership said, ‘we will handle it.’ That was courage.” But these changes occurred in only one division. “There is a belief that there are set aside funds for these institutions. We do not have to worry about them. Send them over there.” Positive remarks about leadership were also made about Dr. (Vincent) Rogers and it was suggested that since he is relatively new, the four Black medical schools should arrange to meet with him.

Is Survival of the Schools Crucial to HRSA’s Mission?

Finally, interviewers asked if it were critical for Black medical schools to survive in view of HRSA’s mission and objectives. Some wondered if these schools were necessary in view of the opportunities for competitive grants. An interviewee said: “We are all committed to a diverse work force. Whether the HBCUs are the best place to do it, I really do not know enough to give you an answer. My gut feeling is that they probably train a lot of minority students and professionals and a lot of them have gone on to the very top echelons of their career. So I guess they are doing something right and does it make sense to let them go under? It does not make a lot of sense to me. I think we ought to try to increase the potential of our programs and help them to be more successful. We should also explore the point advantage in review scoring as an incentive. We should find out if it (point advantage) was successful and why did it disappear.” Another interviewee said: “I believe that if these institutions did not exist we would have to invent them. There continues to be a need for the kind of training and preparation that these institutions provide.”

An interviewee asked if we were scheduled to meet with Dr. Rogers, and, if not why not? The question was asked because this interviewee knew that even though Dr. Rogers was new to the bureau, he had some definite ideas about the issue of diversity in the health professions and of strategies to achieve it.

3. Interviews with the Program Directors and Key Staff at HRSA

Most of the program directors and key staff had visited at least one of the four schools, although these visits might have been long ago or in connection with a different program from their present responsibilities. One of the interviewees had once been a faculty member at one of the institutions and two of them had been educated at an HBCU other than one of the four study schools. Some key personnel had been in contact with all of the schools, either through working at HRSA or at NIH. Some key personnel had worked at HRSA for many years and others were new in their positions.

The impressions documented below are based on the visits of key personnel to the four Black medical schools, involvement as a project officer of a grant at one of the schools, or peer reviewers' comments. In one case, the impressions were based on a member of the faculty of one of the schools visiting the Agency for technical assistance, and/or meeting with members of the faculty who came to the Agency to serve on a peer review panel.

Impressions of the Black Medical Schools

The general impression was that the mission of most of the schools is to train physicians to serve the medically underserved. One interviewee said: "My experience has been that when they write a credible grant they have been funded. When the grant is not well written is when they have difficulty. I conducted reviews and one of the grants was written very poorly. I saw the reviewers really put forth a concerted effort to fund that particular grant, but it was just not possible to do so. When the grants come in written fairly well, I see the reviewers really put forth an effort to support them because they are supporting HRSA's mission." Another interviewee added, "Sometimes when the application is not written as well, I think the reviewers try to see if there is a fundable portion of the application because they know that the institutions are doing a good thing."

Another interviewee's impression was that "The four schools came about because of the need to serve a medically underserved population at a time when it was difficult to enter non-minority schools. Over the years, the schools have had a tremendous impact in training a large number of minority individuals to provide health care to a very needy population in general." This interviewee reported that, "One of the

schools had a lot of problems over the years. It had recruited students who were borderline and would not be taken by other institutions and had given them the opportunity to pursue a career in medicine. The recruitment of such students impacted on the school's ranking on national test scores. That school had problems retaining good faculty because of a reluctance to be associated with a teaching institution that does not have the best (students) in the country." The interviewee concluded that "Fostering faculty development within that institution as well as perhaps combining it with other recruitment programs and trying to balance the type of students that it accepts may impact on how the institution does over time."

The same interviewee recalls that Meharry residents had to travel hundreds of miles to do their rotations, and he was hopeful that a new remedy would work out. With respect to California, the interviewee noted that the relationship between UCLA and Drew was sometimes not clear. When the proposals came in, they were sometimes downgraded because it was not clear how the funds were going to flow from the applicant to the Drew site. The outcome may depend on who submits the application." The interviewee had never visited Drew but the impressions were based on "paper that I see flowing, and the comments of peer reviewers." Another interviewee wondered about the technology at the schools. "Do they have access? How does their computer technology compare with other medical schools? I have no idea?"

Each of the schools was described as being unique. Howard was described as having a different mission from Meharry, Morehouse or Drew, but that interviewee was least familiar with Howard University. The mission of Meharry was described as "recruiting, training and graduating African-American practitioners. They do not push students to do a lot of research. Their practitioners are in primary care and they generally go to underserved areas. Their mission is not to attract the best and brightest but to enroll second- or third-tier students from disadvantaged backgrounds who are competitive. There is a sense of family. They do not have pretty shiny buildings. They do with what they have and they do very well." One interviewee added, "I was not overly impressed by some of the faculty at Meharry on one of my visits there, but that was at least ten years ago." That interviewee added, "I think one of the best things that has happened for the HBCUs is Mrs. Barbara Bush and the stand she took in support of some of the HBCUs."

Morehouse was described as tending “to attract the best and brightest African-American males to the school of medicine. The focus is still on practitioners although it is not the overall thrust that it is at Meharry. Students are encouraged to go in different directions and to fill gaps in leadership. The enrollment is smaller. One picks up a sense of family there also with personal concern for the students and a brotherhood among the students, but their equipment is a lot shinier, a lot prettier, a lot newer than Meharry’s; a lot more dollars.” There had been peer reviewers from Morehouse, but one interviewee was disappointed that one of the reviewers had not responded to offers of help in developing a proposal. This interviewee added, “ I think that people are not aware that federal employees, even though we manage the grant program, are actually here to help them with their writing, in terms of what they can and cannot do.”

One interviewee explained the situation at Drew. “ Drew is not a typical HBCU like either Meharry, Morehouse, or even Howard. The students who go there go to UCLA for the first two years. You get a different type of student and a different type of environment. You get a different sense of a student at Drew from what you get at Meharry, Morehouse, or Howard where they spend all four years. Drew has developed a very good pipeline all the way down and has worked with the community very well. At Drew, you have to be competitive to get in - you have to run with the herd, so to speak, at UCLA for the first two years, so you are in between. You have a friendly environment at Drew and even at UCLA the students do not have a label identifying them as Drew students. At UCLA, the students are encouraged to go into the research track and at Drew, during the last two years, they are encouraged more into clinical practice.” One interviewee mentioned that Drew has been funded for faculty development and it was not clear why they never applied for residency training.

One interviewee could not speak a great deal about Howard but from visits, had an impression that “Money is not really the issue there.” Another interviewee, however, was impressed by what Howard was doing and the caliber of their graduates. One interviewee had tried to get the chair of a department at Howard to be a peer reviewer but was not successful, adding, however that the chair had been helpful to the Division in other activities.

Another interviewee described that each of the schools “has a unique history” in terms of its relation to HRSA. “Howard has the tradition of Freedman’s Hospital and being among the first of the schools. Meharry brings with it the distinction of having turned out leaders in the health care field in terms of surgeon generals and and deputy surgeon generals. This school has a rather bedrock kind of existence in terms of the delivery of health care for African Americans. Morehouse has the reputation of providing primary health care workers who not only practice in the southeast area but across the country. Drew has the tradition of a close relationship with Howard - its name honors Dr. Charles R. Drew, a former faculty member from the School of Medicine at Howard. At the same time, it has a unique relationship with the multi-cultural population that surrounds the school. As the demographics of the community have changed, the demographics of Drew have changed. I have seen that from the ethnic background of the students who have come to Washington from the LAMP program. The top students from the LAMP program are selected by the faculty and staff to come here for Child Health Day and read their papers and make presentations to the staff here, and I have seen the students who have represented this change over the years.”

One interviewee had some strong comments about Howard University. This interviewee had the impression that “While they are accomplishing the things they have set out in their project, there seems to be a rather chaotic way of getting it done. They have a number of projects there and they tend not to talk to each other, so there is some redundancy and duplication of effort. There does seem to be a lack of organization and cooperation as far as I’m concerned.”

Another interviewee described Drew as fairly competitive but added, “The problem is accreditation. They’re not independently accredited as a medical school. In order to receive COE grant dollars you have to be an accredited medical school, so even if I wanted to put money there I could not. To make that exception for Drew opens everything up for someone to say, ‘How come they get special dispensation?’ I don’t think Drew wants that”.

One interviewee did not agree with the accolades given to Morehouse on their applications and concluded that it “depends on the program and those who are running that particular program and their ability to write a grant that will successfully present

itself for funding.” Another summation was that “One of the most serious deficiencies for the HBCUs is being able to write a good application. Some of the Ivy League institutions hire good grant-writers and they present outstanding applications. That serious deficiency may be due to a lack of funds, but they do not present themselves as well during the competitive review cycle.”

An Ideal Relationship Between HRSA and the Schools

The next issue discussed was an ideal relationship between HRSA and the schools. An interviewee stated: “The common goal is very clear, improving public health care. Our goal is diversity, quality, distribution and access, and those are the things that we are looking for. We would like the Black medical schools to increase their diversity, to see that the graduates are actually going to medically underserved areas, and that there is documentation of this. The percentage of graduates actually practicing in underserved areas is not currently well documented. We depend on the Black medical schools to follow up on these data in a meticulous way.” Another interviewee said: “Our emphasis is to train primary care physicians and statistics show that the Black medical schools produce the kind of physicians that we need. I would really like to see all of them funded.” Another added, “I would really like to see all of the grants that come in funded.”

One interviewee felt that the issue of access is best addressed in the AHEC program. The view also was expressed that in the geriatric education centers the matter is “Extremely comparable because a needs assessment must be done prior to funding. This assessment tells you what the need is in the community and, therefore, guides how you are going to address that need. The geriatric education centers have been in the forefront of ethno-geriatrics. They have done an excellent job as far as helping to prepare the work force to deal with diversity.”

Another interviewee saw a one-to-one correspondence between the HRSA mandate and the mission of the schools. The mission of the schools is “to provide those kinds of health care providers for populations in underserved areas.” Another view was that “it would be good to put together a program for three or five years that uses the comprehensive model that we’ve been touting over the last several months. The model

would include getting community involvement, and including schools somewhere else in the pipeline as well as the undergraduate and health professional schools. Such a program could be funded for one or two cycles and then be institutionalized within the university. If the institution had a program and found out that it was working well, they should convert it to a regular school program and make it happen within the school's own funding structure.”

The consensus of several interviewees was that site visits would contribute to an ideal relationship. One interviewee expressed the view that the schools “cannot be as effective as I feel they could be with site visits but the project officers cannot make site visits. How can you ask them to meet the criteria of the program without more detailed technical assistance? You cannot effectively do it over the phone. The Agency is more or less putting the Black medical schools on a rough curve. I think that is a serious detriment because you cannot actually see that they are meeting the criteria. If they write a good application, sure they are going to get awards. The ability to make site visits depends on the program and its management. In my estimation, to be expected to effectively administer a multimillion-dollar a year grant and not be able to site visit is basically wrong.”

Another issue that seems to affect the relationship is the ability of the school to become self-sustaining. One interviewee expressed the matter in this way: “The programs that are started, at least on the training side, should have an end-product and at some point in time they should be either self-sustaining or at least halfway self-sustaining. However, to do that, somebody will have to pay attention and put together a team. It could be as small as two people to help them (the schools) become better prepared to participate more fully in applying for and ultimately receiving grants and contracts from both the state and federal governments. I think that if HRSA is truly interested in helping them, something can be done along this line. I don't know if it is preferable to help the four of them as a group or to have special teams for each one. Certainly, the schools themselves have the brainpower to accept this kind of help from us feds. It would not be an ongoing thing. We start it today and we end in a year or two, or something like that. From my experience, part of the problem - maybe even a big part of

the problem - is not necessarily in the programs themselves but in the administration. This might tie in with what people are saying about things being in chaos.”

Several of the interviewees expressed the view that a HRSA grant should be a catalyst to promote institutional change and are concerned when there is the appearance of a legislative entitlement rather than a competitive award. One interviewee expressed it this way: “If I am going to write a grant and know I’m going to get the money anyway, I can do whatever I want to do with it. For a number of years HHS and HRSA dollars have gone to support the infrastructure of a lot of these schools, specifically Meharry (both medical and dental), to help pay faculty, provide for the library, etc. For a number of them, how many years are we going to continue to do that, and what is the message we are giving them? I can see some difference in schools where they are hungry for the money like Meharry, I’m sorry, and Morehouse where they want the money and are willing to make changes rather than assuming that they are going to get it anyway. I don’t know what we have done to the Meharrys of this world by saying you’re entitled to it anyway. Certainly, in terms of technical assistance we have sent a lot of folks down there to help them with bookkeeping and the infrastructure part of it. Part of their problem is salary and infrastructure problems, which lead to all the things that we are talking about. The core of it is having a fixed infrastructure that’s going to be there year in and year out. They lose many good faculty to more attractive offers, but many core staff members remain because of their commitment to Meharry’s mission. The point I’m trying to make is that entitlement and setting aside X number of dollars is fine for the short run. I don’t know if after 15, 20, 30 years, that continues to be a plus or not. I don’t know.” On the other hand, there were those who saw no reason why these schools should not be funded continuously. One of them said, “We have other programs that have been funded for 18 or 20 years and there would be no reason for them (the Black medical schools) not to be funded continuously.”

Another interviewee expressed it this way: “One of the criteria that we set up when we look for an institution is its ability to carry out the program that they say they are going to carry out. Do they have the infrastructure? Do they have the staff, faculty, facilities, and where-with-all to actually make the program work? As good stewards of federal funding, that becomes a serious issue for us to consider. I recently had the

opportunity to work with the HRSA team that went to a number of HBCUs to teach them about grants and contracts, and I got to travel with two of the teams. One of the things I found was that most of the people were only aware of federal funds and not the vast amount of monies that are available in places outside the federal government to help continue their programs.”

One interviewee gave a counter assessment. This interviewee indicated that one of the main criteria of the AHEC program was self-sufficiency. “You are supposed to solicit foundation, state and other money. The Black medical schools have a little more difficulty trying to solicit extra monies, but they still - at least Meharry - have been successful. They don’t receive windfalls. The relationship between Meharry and the geriatric education centers has been excellent. Howard is also involved, but there have been no applications from Morehouse or Drew.”

Some felt that an effort was being made on the part of HRSA to improve the relationship between HRSA and the schools. Reference was made to an effort to provide technical assistance to a wide variety of HBCUs.

Funding

Interviewees were asked if, over the past five years, the funding had increased, decreased or remained the same. Answers were uncertain. One interviewee said: “I think it has declined and that is probably the reason why you are looking at this now.” Another suggested that the interviewers should check contracts as well as grants to get a more complete assessment of the funding. The matter of funding brought up the issue of the quality of the applications and the nature of the review process.

One of the interviewees remarked: “In many of these applications, the need is more compelling to the reviewer than the way that the application was put together, the rationale, or what they’re planning to do. I have heard pleas from the primary reviewers and sometimes the need outweighs any of the other concerns.”

Another interviewee discussed the group dynamics of the review process using a systems approach, beginning with the application as the input and the review process as the process leading to the outcome. “We may have thought that we officially selected a chairman of the panel, but this is affected by intangibles. For example, we go around the

table and introduce ourselves, and it makes a difference if I introduce myself as a Professor from Johns Hopkins University, or whatever I do to impress you with who I am academically. It matters not only who presents a recommendation for approval, but the time of the day and the order in which the proposals are presented. It is one thing to make sure that the application accurately reflects what you are trying to do, but it is important to encourage and solicit the names of people to serve on the review panel, and that is what we did with the Black medical schools.”

Another interviewee expressed reservations about the equity of the funding in the following words: “ I do not feel that equity is applied. Even though the Executive Order is applicable agency wide, we do not operate based on it. Sensitivity to providing equity is lacking because additional funding is available through special initiatives, purchase orders and contracts and these are not equitably applied.”

Questions were asked about funding preferences. The response was “to receive the statutory funding preference the applicant must score in the top 80 percent of the approved applications. Even if they are otherwise eligible for the statutory funding preference but their score is below that, then the statutory funding preference will not come into effect.”

The Executive Order

The interviewees were asked if the Executive Order had the effect of increasing or decreasing the funding to the schools, or if there was no effect. Most were uncertain about the Executive Order of 1993 for HBCUs, as if they were not aware of it. When the matter was clarified, there were both positive and negative effects discussed. One interviewee responded this way: “If there was no Executive Order, would these schools be getting that amount of funding? My answer is probably not. It awards some money to those schools. It keeps it on the front burner. It keeps it on the conscious level. Without the Executive Order, that wouldn’t happen. People forget. But that is a difficult question. I don’t know at what point it loses its effectiveness. I don’t know.”

Another interviewee said: “I agree that they help inasmuch as it was a way of actually getting started and getting into the system. The question then becomes whether these institutions have become complacent and rely on that Executive Order to give them

money every year?” This interviewee felt that the orders resulted in an attitude of “Why should I knock myself out to even try to compete when the bottom line is whether I compete or not, I’ve got it coming.”

Another perspective was that the support was going to the wrong end of the pipeline. “There are some HBCUs that are very poor and need those dollars for infrastructure. The four medical schools are at the end of the pipeline and throw a gigantic shadow. On the other hand, you have some one hundred plus small HBCUs that have very little shadow and as a group would not have gotten OMH to let out a contract with your company to do this. The fact that these are four medical schools certainly does it. You could have gotten four small undergraduate schools at the brink of bankruptcy and they wouldn’t have gotten OMH to bring in this powerhouse to examine these programs.”

There was a sense of frustration experienced by some interviewees about the existence of the Executive Order to assist institutions that they felt were not doing enough to become self-sufficient. There was, however, another perspective on the issue. Another interviewee was frustrated because “I see that biases still exist within HRSA as to what they could do to help these schools improve and become independent.” This interviewee did not see the sense of entitlement that some others saw, and felt that it does not apply to all HRSA’s programs.

There was also another point of view. One interviewee saw it this way: “If the size of the pie remains the same, and you increase the number of slices that you are making in that pie, you haven’t done anything. You haven’t increased your commitment. You haven’t enlarged the program. All you have done is increase the probability that there will be more intra-fighting over smaller and smaller pieces of the pie.” The concern about the size and the division of the pie related to an effort to decrease attention to the HBCUs in an effort to increase funding to Hispanic Serving Institutions. One interviewee described this incident: “I saw some leadership de-emphasizing HBCUs, and shifting it. I don’t want to see that because, if it continues, the Black medical schools are going to have difficulty surviving from a HRSA standpoint.” This interviewee saw pitting one minority group against another as counterproductive. The interviewee also

was concerned that most of the assistance comes from the Division of Disadvantaged Assistance and would like to see this effort shared throughout the Agency.

Improvements Suggested for the Schools

There were several suggestions made by interviewees with respect to the schools. First among them was improving administration by having a strong Office of Sponsored Programs. One interviewee put it this way: “With people moving from one job to another, you need a strong Office of Sponsored Programs. It doesn’t matter how many people come to that office or leave, you have a central office that monitors the deadlines for the different applications and technical assistance, and so on. I think that the turnover of the staff in the programs has a lot to do with lack of continuity in the funding. It may take a new person a year or so to find out about previous funding sources.”

Another interviewee said: “It is my impression that there needs to be some mechanism set in place to assure that the faculty members are provided the kind of support they need. When a grant is received, they should have the support of the fiscal officers of the university to facilitate and not obstruct the operation. Too many times, it has been reported to me as a project officer that ‘I can’t do that. They won’t let me.’ For a variety of reasons, the principal investigator is prohibited by unstated rules that prevent things from being done. It is the institution’s grant (not the faculty member’s) and that has to be understood, but it is the faculty member who has put in the sweat, blood and tears, and late nights to get it.”

Another interviewee said that “Most of the applicants must have a grant writing office or hire consultants that are good in grant writing.” This view was shared by another interviewee who offered the following conclusion, “It is not realistic if the institution assumes that the person preparing the proposal can really assemble one of these applications alone.” This interviewee stated: “The proposals arrive in very poor shape. Their appearance is very bad. Typos. Some of these proposals are so annoying. Another thing is submitting applications they have submitted for other programs and they forget to delete inappropriate sentences when editing. It is annoying for a reviewer that has six or seven applications and they have to read them more than once. They have to score the application and then write it up. One of these applications is going to take them two or

three times longer than it takes to review an application that comes from a school that has a group of writers. Not only is it important to have a group of writers that you write with, but also you have to have a team to put the application together, including a budget individual, a program person and an evaluator.” Another reported problem is the preparation of proposals without following the instructions provided. One interviewee summed it up as follows: “It sort of pricks at our heart to know that they are doing great and wonderful things; they just need somebody to help them write. If I had a wish list, it would be that there could be some way to give them more hours in the day or take something away so they could have the time to devote to writing the applications.”

Another observation related to lack of participation in telephone technical assistance. This interviewee said: “I think one big drawback for the Black medical schools is that they do not participate in technical assistance. We have had conference calls now for two or three years. They call, if they call, two or three days before the deadline and there is very little we can do. Even a week before the deadline, it is nearly impossible to counsel anyone.” The need for more peer reviewers from the Black medical schools was generally expressed. One interviewee said, “Even if they can’t provide a lot of people, one person could take what they have learned back to the other departments.”

One additional suggestion was “The institutions should come in and meet the directors of the different divisions, or programs, so that people know who they are and what they are interested in. I think that more active participation by the institutions is important.”

Suggestions for HRSA

When asked about suggestions for improvement at HRSA, there were fewer suggestions and those more often referred to the schools rather than the Agency. One interviewee said: “I do not know what to tell you, because we make it available. If they (the schools) call back and they are not available for technical assistance at that time, but wish to schedule one-hour of technical assistance at another time, I’ll schedule it. I don’t know what other program people do, but I take all of my disapprovals and approved-but-

not-funded applicants and call or e-mail them once the application kit is available and offer my services. I don't know what else to do.”

One interviewee did indicate that the Agency is expanding the provision of technical assistance with the intent of insuring that the institutions have all the necessary information. Some of that assistance may take a different form from the present and it is hoped that it can be institutionalized and passed on to others.

Another interviewee was concerned about the level of debt that students acquire in the process of professional education and thought that there ought to be more emphasis on student scholarships. The interviewee particularly referred to the “post-bac” HCOP program at Meharry that provided a student with a \$13,000 scholarship so that the student did not have to work and could concentrate on his/her studies.

There were also some strong positive reflections. One interviewee reflected on the time spent in the Division of Disadvantaged Assistance. At that time, there was an annual Program Directors meeting. All the project directors and their assistants came together to discuss issues and concerns, not only about their grants but also about future directions. That was an opportunity for them to learn more about HRSA because there were a number of HRSA programs that participated in that meeting and it was an opportunity for HRSA to learn more about the needs of the grantees that they were serving. This interviewee thought that it would be a good approach to fostering better relationships and bringing about more awareness. Another interviewee said: “At one time, when I first came to HRSA, we would call the Black medical schools to let them know that grant applications were coming out, and that we were actually here to help them.” That was one more effort that HRSA could extend to the schools

Should These Schools survive?

Finally, interviewees were asked if they thought that these schools should survive. With only one exception, the response was that they should survive. One interviewee expressed it this way: “ I think that the philosophy of the institution is very important in molding the individual that is being trained. So, the same way that you have schools that focus on research or academic medicine, you should have institutions that focus on producing providers for medically underserved communities, or for their racial

or ethnic group. I think these four schools have been producing great numbers of minority individuals that do return to their community. That should not be expected because it is not expected of other persons. We need minority chancellors and deans. They are so under-represented in all health professions that it really does not matter where they go. They are needed. If nobody can guarantee that they will graduate the same number of minority individuals that these four schools produce, then I would say they are needed.”

Another interviewee said: “I would hate to see any of these schools close. I think they play a very big part in the education of residents, minorities in particular. I think they have a lot to offer for the future of the multi-cultural environment where we are strongly headed.”

A third interviewee added: “There is a purpose for these Black medical schools. They are in most cases training providers of health care for the very population that HRSA is mandated to serve. It is surprising that we have not been doing more. The missions of the colleges of medicine, as well as the legislation that supports our organization, talk about addressing the needs of the same people. The tides are taking care of whether it should be a futuristic Black college of medicine. Drew is a good example of the future look of Historically Black Colleges and Universities.”

There was one reservation expressed in these terms: “This is a competitive world and I think that we ought to attach something to what it means to be competitive. The weak fall out. I’m not saying that they are weak. I’m just saying that the weak fall out because of the society we live in. You have got to swim or sink. You can extend preferences or whatever you want to call it, but at some point the market is going to take over.”

4. Background of the Black Medical Schools: Mission and Commitment

More than one hundred and thirty years ago, Howard University opened in Washington, D.C. to provide access to care for African Americans, especially the underserved and newly freed slaves. Its motto was “equal rights and knowledge for all.” Its founders envisioned an institution that would educate students “without respect of race or sex.” It was the first school in Washington to admit women, and in 1872 the Howard delegation was barred from the American Medical Association because it had hired a woman to teach ophthalmology and treat eye and ear infections at its teaching hospital¹. For most of its existence, it has been one of two leading institutions training most of the Black physicians. It continues to be among the institutions training minority physicians and other health professionals with a commitment to care for the medically underserved.

Meharry Medical College has had a similar mission and commitment. The Freedmen’s Aid Society of the Methodist Episcopal Church founded it in 1876 as a division of Central Tennessee College. Its purpose was to educate freed slaves and to provide health care to the poor and underserved². For over a hundred years it has remained faithful to its mission, despite enormous challenges. It provides training in medicine and dentistry at both the undergraduate and postgraduate levels and there is postgraduate training in the basic sciences. This is the second of the two schools that have trained physicians, dentists and other health professions for more than a century with a special concern for the poor and the medically underserved. No other schools in the country can compare. These two schools were the only Black medical schools to survive the reorganization of medical education initiated by the Flexner report of 1910.

The more recent schools, Drew and Morehouse, have had similar origins and have continued the same mission and commitment. The Charles R. Drew University of Medicine & Science was founded in 1966, immediately after the disturbances in Watts, and the founding dean was a Professor of Surgery at Howard University. It is technically not an HBCU institution but is so in practice. The mission of Drew has been to train health professionals to provide care with competence and compassion to underserved populations. As in the case of the other schools, there is a commitment to diversity and, as the population around the school has become more ethnically diverse, that diversity is reflected in the institution. The school is different from the others in its development

since it chose to begin as a postgraduate medical school. This was the quickest way to impact on the health services to this community, and the school has developed as a clinical campus. A new Los Angeles County/Martin Luther King Hospital, the teaching hospital, was opened in 1972. As a result of an affiliation with the University of California, 24 students are admitted and receive the first two years of medical education at UCLA, but Drew remains a private institution. Although the affiliation of the medical education program with UCLA has created the impression that it is a part of the University of California system, the constitution of the state does not permit public funds to support a private institution. The school is known for its community relationships and it offers training programs from Head Start to specialty training in many fields of medicine. There is a state-of-the-art high school on the campus for facilitating students with a special interest in the health sciences. Drew was recently awarded the Association of American Medical Colleges' Community Service Award.

The fastest growing of the four institutions is Morehouse School of Medicine. Its mission is to recruit and train minority and other students as physicians and biomedical scientists committed to the primary health care needs of the underserved. It is a private medical school established in 1975 as The School of Medicine at Morehouse College. The charter class of twenty-four students entered a two-year basic sciences program in September 1978. In 1981 the school became the Morehouse School of Medicine. The school is now a four-year, M.D. degree granting institution, fully accredited by the Liaison Committee on Medical Education. It is the first minority school to establish a Neuroscience Institute and NASA/Space Medicine Life Sciences Research Center. Morehouse is also establishing a National Center for Primary Care³. Morehouse has distinguished itself as being, of all medical schools in the nation, the one with the highest percentage of its graduates entering primary care.

While the first two schools were established long before HRSA was conceived, the latter two schools were established with the assistance of the Health Resources Administration.

5. Interviews at the Black Medical Schools

There was an impressive list of interviewees from the four schools, including representatives from faculty, administration, and many of the programs funded by HRSA. There were interviewees who were not aware of the full extent of programs funded by HRSA. Some of the interviewees had been involved in HRSA programs for as much as twenty years and were most familiar with the HCOP and AHEC programs. One interviewee said, “I am here to learn more about the HRSA program because we have not participated in it.” Another had just received her first grant in faculty development. At the other extreme, one interviewee had the title of Director of Proposal Development and another reported that his department had successfully continued, “not just the funding for those programs but in training younger faculty to be able to write competing proposals.” There were those who were familiar with the Mentoring Program and those who had never heard about it. There were representatives from the Centers of Excellence Program, Family Medicine, Nurse Midwifery, Leadership Training, the Training of Physician Assistants, AIDS Education and Training Centers, Dentistry, Nursing, and other programs. Persons at the level of Vice President or Dean sometimes represented the administration of the institutions. There were representatives from offices of finance and from offices of grants and contracts. The group interviews were an opportunity to provide information for the study but also to exchange information.

Impressions of HRSA

The interviewees had a wide range of impressions of the Agency based on their contacts with different individuals over the years. Most of these impressions were quite positive. Few impressions were negative. One interviewee said: “HRSA has been very, very supportive. Their mission is very similar to ours and there is, I think, a natural affiliation between our institutions with regard to what they are trying to accomplish to meet the needs of underserved populations.” Another interviewee described how the Agency was “very supportive and helpful to us.” He described how the people from grants management “were determined that their grant was going to be funded, so they were on the phone to M.... almost every day telling him what to do to get it through. They went out of the way to make sure that he got that grant.” Another interviewee said:

“I have had a very cordial relationship with them (staff at HRSA). In fact, I usually ask them up front and say: ‘I believe that you are there to help me, and, therefore, if you are there to help me, I need some help from you.’ I try to call them in advance to make sure that they do that. I called my consultant and asked him if he would review a draft grant proposal for me, and he did that. I think we were in a favorable position when that was over because we were able to hear their thinking, specifically some of the downfalls and disadvantages that we should look for.”

One of the most positive statements about HRSA compared it with NIH. An interviewee said, “I think that HRSA, over the years, has done a lot with very limited resources. I think that if HRSA had NIH money, they could improve the health status of the country a lot quicker than NIH could.” The same interviewee said that, unfortunately, some of the limited resources “end up going to fund programs that would have happened anyway or that were already under way at institutions able to generate a better grant or a more impressive CV.” It was felt that until recently HRSA had not done a good job of evaluating its own programs and had depended on evaluations done by others.

On the negative side, one interviewee mentioned that the expectation that a residency program could become self-sufficient in three years was unrealistic and placed un-due pressure on the program and the school. Others indicated that it was often difficult to maintain a program at the same level of effort without the resources offered by HRSA. Another interviewee said: “In early years, my contact with that office was very positive, informative and satisfying. As time went on, there were some changes and a period of instability. The relationship was no longer as strong as a result of staff changes. We did not have the contact that we had before. My information came only from written correspondence, and a number of times when I wanted to contact the office I was not able to identify or locate my consultant.” Others confirmed that there was a change in relationship in some instances. One interviewee said, “There is not that personal touch when there is a computer.” In general the change from personal contacts to computer contacts has left a negative impression on those who have had a long relationship with the Agency. One interviewee said: “I went on the web to see if I could identify when the review process was to occur because we submitted much later this year than usual, and I could not find the information. I also tried to call, and I could not get

anyone.” Another interviewee said, “We were presented with the idea of developing a model program that could be replicable. They only gave us three years to develop this program, and in the second year we were told the program would not be funded before we even had developed the model. I thought that was a little strange.”

Another circumstance that left a negative impression was a conflict within the Agency. In this case, the school had been granted a carryover of funds from prior years. The interviewee said, even though this matter came to their attention over a year ago, “We still have not been given the right to draw those monies down, and we have contacted both sides, the administrative and the PMS side. The administrative side says: it is okay you can use the money; the PMS side is still not letting us access those funds.”

The most negative impression came from one interviewee who described the specific program as having a lack of coordination. This interviewee said: “There does not seem to be any direct person that is responsible. There have been a lot of changes in leadership over the last four or five years, which causes it to be destabilized each time someone else comes in, usually in an acting capacity. This has been very frustrating to me. We are still waiting to hear the outcome of an application for renewal of grant support. The old grant ends June 30th. We have heard nothing. I have been calling and asking what should we do? No one knows. The main program director does not know. This does not make a lot of sense.” This interviewee was ready to “put a letter in the mail to Earl Fox and to everybody else.” The interviewee concluded by adding: “Most of the people at HRSA that make decisions are very nice people. However, I think there is a lack of cultural competency, if you understand what I mean, and so that is a problem also.”

The Mission of the Schools and of HRSA

Discussions on the missions of HRSA and the schools went in two directions. Several interviewees felt that there was a close relationship between the mission of HRSA and that of the schools. Examples of those who saw a close relationship include statements such as “they kind of run on parallel tracks”, or “it sounds like a match to me, it definitely does, that is what we do.” They see the agency as being “Most accommodating of projects to assure equity in health care with a special emphasis on

vulnerable populations.” There was an opposing view that raised question about HRSA’s mission. One interviewee said, “I do not know what their articulated mission is.” There were some who sensed that HRSA might be changing its focus. This was best expressed by the view that HRSA is “now very interested in seeing how many people are coming out of the pipeline.” This meant that they were starting late in order to see quick results. This interviewee, who was seconded by another, felt that HRSA should plan to reach students earlier in the pipeline.

Another interviewee thought that HRSA tended to focus more on medicine as a profession and not give enough emphasis to dentistry and the dental needs of the medically underserved. Still another interviewee felt that HRSA was moving more towards research by requiring evidence that the funded project actually made a difference. This interviewee said: “They want this kind of information so they can use it to show that they need to invest more in this program or to change it. So, at the end of the day, it is still a research tool even though it is education.” An interviewee who represented the field of Family Medicine gave the strongest argument on the common mission with that of the schools. He said, “It was really these grants, like faculty development, that allowed us to double the size of the MD faculty to 95% minority representation. HRSA funding was really the fuel in the engine that turned that department around and created us as a leader in family medicine.”

Clarity of the Application Guidelines

There were lengthy discussions about the application guidelines. There were those who felt that the guidelines were very clear. One of the interviewees who felt this way had once hired a consultant with a great deal of experience but who had said that it was not necessary to include a certain section which was requested. The application was sent without that section, but fortunately the deadline was extended and the applicant had enough time to do it over as the program officer recommended.

One interviewee applauded the guidelines coming from the Division of Medicine. This interviewee said: “ I don’t know if it is the same across divisions that you have to develop a separate budget for each objective and for each year. It is very tedious to do, but it is a very tight application and it is easier to review. It is a very difficult process to

do in terms of writing grants, much more difficult than most applications, I think. You have to provide additional information in order to be eligible for preference, and you get special additional points for preferences. Preferences are very consistent with what we are doing in terms of training physicians for underserved areas, but it is very difficult for us to have the data. A lot of it has to do with our graduates and where they are practicing. It is an additional burden for us to be able to collect the information so that we can report it and be eligible for the preferences, but if you get a preference you are almost guaranteed funding.”

Another interviewee said: “They have been quite specific, quite detailed, but quite oriented toward outcome and impact data. They want a lot of spreadsheets so the application ended up being a lot of graphs, tables, spreadsheets and less narrative.”

One interviewee compared the HRSA guidelines with those of CDC and said, “I found them quite good, particularly since I have been dealing with RFAs from CDC which are terrible.” Another said, “The application guidelines are usually very specific. They actually make it easier for me to teach people how to write HRSA grants than to teach them how to write a research-oriented grant for a different agency.” This interviewee found that the greatest difficulty was the cycle time between release of the final version of the guidelines and the actual deadline for submission.”

There were interviewees who were quite outspoken about how confusing the application guidelines are. One interviewee said: “In this year’s HCOP application, there was a question about where dentistry fits in. The way it was laid out, it was not clear. We made an interpretation and put it in somewhere, then called somebody and they said, well, that is okay. They tried to use one common application for 35 to 40 different kinds of programs. It is like trying to mix apples and oranges. There may be some baseline information that you want from all grantees, but the ability to neatly categorize these things is not that simple. They are taking that data and putting it in the computer and trying to come out with reports that give them what they are looking for, but the application is cumbersome. They really need to go back and identify the data needed to make a good decision on an application. And after you have made a grant award, what is the data needed for comprehensive reports on what is going on in an agency. I think the two are not one and the same. I just think that a lot of time is being spent by those who

are trying to apply in an effort to figure out what is being asked for. Not only that, the automated application process is not without its problems. They put the application on the Internet and you are supposed to be able to pull it down, but there are people who would like to apply who may not have the technology in place yet to be able to do that. So it gets cumbersome.”

The recent instructions for the progress reports on the Internet were also confusing to some interviewees. Another interviewee said: “I think they need to be simplified. You have a lot of what I consider very important information in the back. I am not sure what purpose is served by not making it clear, but if you want good grants—as they say in the computer world, garbage in garbage out. Sometimes it is difficult to understand what HRSA wants. You look at it and it looks like Greek sometimes.”

Another interviewee said: “This was really very confusing as we went back and forth and read between the lines and tried to understand exactly what we should give them to make sure it is what they want. I don’t think that it has to do with a lack of comprehension, certainly not on my part, because I have written NIH grants and comparable things. This was just not clear.”

Another interviewee added: “I have been a reviewer and my first time doing it, I had to ask someone to please interpret it for me. The language itself is just so — you know, you just put it aside. You say, look, I have no understanding. It is totally not my primary language.” Despite the presence of a number of dentists, one interviewee said: “I tell you, it truly was like pulling teeth. It wasn’t easy to follow.”

Clearly, there are differences among people and among the application guidelines. One interviewee said: “I am fairly familiar with most of them. I do believe that some of the requested data is not really helpful to them and amounts to busy work. I believe in collecting data for scholarly purposes and looking at the effectiveness of programs, but I do believe that a lot of the data that is being asked for recently is really taking away from what the application should be looking for. As far as most of the applications are concerned, they are relatively clear, but I am used to them and it makes a difference if you are used to them.”

It becomes a problem to applicants when they have important data they would like to present but cannot because of page limitations. They think this is very unfair. The

complaint appeared to be especially strong with respect to the HCOP applications. There was also the view that the limitations on the length of the summary resulted in making the print so small that it antagonized reviewers right at the beginning.

One recommendation was that the collection of some of the data be an institutional responsibility rather than that of the grant applicant. This interviewee described the situation this way: “ Most of the time when I work on a grant, I’m walking out of here at 5:00 o’clock in the morning to go shower and change and come right back and start again at 8:00. I just don’t have the energy to do that anymore. When it says, ‘did not apply’, I’m just tired. Also the attitude of Washington hasn’t been that great sometimes to give us what we really need.”

There was much discussion about the importance and the reliability of the numbers now required. One interviewee summed this problem correctly when he said that new investigators do not quite realize the implications of those numbers. New investigators do not realize that if you don’t hit the mark on those funding preferences, you go to the bottom of the list.”

The Peer Review Process

Less than half of the interviewees had participated in the peer review process. The reason for non-participation was most frequently that they had not been asked, or that the notice was too short. Those who had participated had some strong comments, which were mostly positive, confirming the benefits of participation. One interviewee gave three benefits of participation. “The real advantages are that you get to see what the process entails and how a grant is actually reviewed and become able to apply that knowledge to your own grant. Another advantage is getting to know the program officers. They have been very, very helpful. They will keep an eye on things and let you know when new grants are going to be announced. You also get to see what other people are doing elsewhere in the country.” One department chairman said, “I haven’t done it much, but a member of my faculty is a regular participant on grant review panels, and she comes back with lots of pointers and tidbits that help us write our grants better. I feel sorry for people who do not have that kind of inside knowledge.” Another experienced interviewee commented on the latitude of interpretation by reviewers. “Some of the areas

where I have seen disallowance of support for a particular aspect of a program clearly said to me that this is an individual who has very little understanding of what goes on in the small university. They are doing the review in the context of their understanding of how things operate and that puts us at a tremendous disadvantage.” This interviewee further commented that there were institutional barriers to submitting a proposal to HRSA because at that institution there was a policy against submitting proposals when the indirect cost was such that it required the school to subsidize the grant. Special arrangements had to be made with the dean who was generally very accommodating with respect to the training grants.

One interviewee said that she had been called several times about submitting names of individuals but that the request was specifically for Hispanics. This interviewee suggested, “It would be beneficial if some of the MDs would participate on the peer review process for the physician assistant training programs.”

It appeared that there was no clear understanding of how one gets on a review panel. One interviewee indicated that the opportunity often arises at a late moment and then one has to find someone who is both willing and able to participate. This interviewee, however, indicated that part of the problem at the institution is helping people to understand why they need to participate. “We do not understand that in order to really obtain your fair share, you have got to participate. We have not focused as hard on getting people to participate as we need to. We need to approach it at two levels — first making sure that we get people on panels understanding the process and the timeliness of getting people nominated. Then we must have people participate who can be effective, because if they are not effective they are neither helpful to the institution nor to the panel.”

There was also a suggestion that the scoring process be reviewed and evaluated with respect to the weight given to various areas. One interviewee said, “If the real focus is on community service, then you certainly do not want to penalize those institutions who historically have done that but may not be as sophisticated in terms of the application process.” An interviewee gave one specific example of bad scoring. He said, “In scoring many of the Bureau of Health Professions grants, there are points awarded for the program’s ability to add to a diverse work force. Every time I have been

on one of the committees, the committee awards the full amount of points to whatever grant comes up first on that indicator. Typically some grants pay lip service to the work force — we tried real hard, we really want to see a diverse work force, we actually do not have a specific plan or a recruiting plan and we certainly don't have a track record, but we are doing the best we can and it is really hard. Then everybody around the table says, 'yeah, me too.' It is then my role to say, 'Excuse me, if that is 15 points, what do you get for having a program that has 95 % minority enrollment and that has been successful in achieving the kinds of numbers that will actually change the numbers in the pool rather than just reflecting the numbers in the pool?' One difficulty, stated one interviewee, is that the panels are always dominated by majority institutions, and these institutions influence the ways that grant proposals are evaluated. That influence serves actually to undermine the mission of the agency.

Another interviewee said, " There is too much credit given for good grant writing and good skills in putting together a really clean, elegant grant." And still another interviewee said: "Getting a grant is too much of an essay contest; whoever writes the best essay gets the grant. It does not speak necessarily to the need for the program or even the ability of the institution to implement the program. It really speaks to who has the best technical grant writer on their staff and how they put the proposal together." Another suggestion was that the Agency should screen out proposals that do not meet the Agency criteria rather than sending them for review. Still another suggestion related to the complicated language. This interviewee said: "I find that the average person staffing those particular units has absolutely no idea what it is like in the trenches. They have never visited, and in many cases have never been in our position. There was a time when the information we provided was valued, but I do not think that is the case anymore." Finally, one interviewee concluded, "There is an attempt, and I am going to use their words, to make it a fairer process, but I am not sure that it is really occurring."

One suggestion from one of the interviewees was that HRSA offer technical assistance grants to bring in consultants or partner with other institutions to support those schools where there are tremendous needs and they cannot pull it off on their own resources.

Funding

There were several issues with respect to funding, but the major ones were the extent of their dependence on HRSA funding, their sense of changes in the funding level, and their perceptions of how long a good program should be funded.

All interviewees indicated a very high level of dependence on the HRSA funding. Some of the interviewees were very candid. For example, they indicated that they were fully aware that the funding guidelines required that they specify how they were going to institutionalize the programs once they were developed. One interviewee said: “Much of what we said was a fairy story. We have institutionalized them to some extent, but we were very dependent on this funding to get the programs up and going. Once the funding was over, even though a program was continued to some extent, it was not at the same level as it was when we had the funding.” Another interviewee said, “We have to show that we’ll be self-sufficient, but it ends up being smoke and mirrors.” Another added, “and they know it when they review it too.”

Most interviewees recognize that they have become dependent on the funds to supplement what they are doing, but they feel it can be justified because “for us HRSA is such a close match in terms of their focus on primary care in underserved communities.” Even though there were claims of complete dependence, there was evidence of an institution picking up the costs of continuing a program. In the case cited, HCOP had pulled back at least 30% of the funding because they wanted institutions to support at least that much, and the institution picked up the difference. At the same time, there was evidence that three programs were terminated because there was no more funding. One interviewee expressed it this way: “We are a three-legged stool now, as we do also have some clinical money and some other sources of money. At least we are not a one legged stool anymore. Still, if you kick one leg out of a three-legged stool, you’re on the floor and could be hurt very badly by even one of these revenue streams being knocked out.”

Howard University is a special case and is mentioned here by name only because it is unique in the respect of being an item in the Federal budget. On this basis, there is a general impression that this institution should not be dependent on HRSA funding. Howard showed that it supports the HCOP funded program at a level of 35 to 40 percent, and, when HRSA funding was not available, the programs were continued at a reduced

level. One interviewee at Howard said, “If you look at the Howard federal support, it constitutes about 40 per cent of our operational budget. At one point in time it constituted maybe as much as 80 per cent, so over the years it has been significantly decreased. I think there are a lot of people who feel that because Howard gets a big federal check that it is easier for us. In some ways and in some areas it may be so, but in other ways and other areas it is not. We live with the threat that at some point that support could go away, and then what do we do? In fact, in 1994, Congress basically had decided to zero us out of the budget. We had to go in and make a strong case to be put back in. We have been able to kind of maintain it since, but, in 1986, the Heritage Foundation did a study and said that Howard should to become independent at the earliest possible time in the most efficient manner. For 12 years, we have been pursuing that, but it is not easy. The tuition and fees cannot carry the cost of what it takes to run this institution. We don’t have a problem filling our professional programs. Our problem is the mix and these programs assure the right mix.”

When asked how long any of the institutions would be dependent on HRSA programs, it was clear that it would be a long time. One interviewee said: “To be honest, I would think it is going to take quite some time before we are in a position to say that we are independent. I think a large part is due to the product that we have produced, namely individuals who will serve in underserved areas. There is no independent wealth among our graduates. They are trying to make it, bearing in mind that many are graduating from medical school with over a hundred thousand dollars in debt.”

Interviewees were told that we had the actual numbers but wanted to know if they sensed either an increase or decrease in the actual funding over the past several years, and if they were aware of the Executive Order. There was no awareness of the Executive Order and no one was particularly aware of an increase in funding. At best it was considered level and at worst an absolute decrease. One interviewee said: “My funding level is so low that it almost doesn’t even deserve to be called a program. It is very minimal. We’ve seen a constant decrease in the amount of money even when we write new proposals. The budgets have been whittled down in a way that changes the whole program. It changes your scope of work, what you propose to do.” At Howard University, one interviewee felt that Howard does not receive the same level of support

for some activities as other people who don't have a federal subsidy. "People look at Howard University and say we got \$210 million in the last budget year, but they don't acknowledge that Johns Hopkins received more than \$700 million in federal funds in the same budget year. That wasn't a direct appropriation, but it still represents federal support far greater than the amount received by Howard. But nobody looks at that. Because we have a line item, we get looked at differently than others."

Asking how long the respondents felt that a good program should be funded by HRSA triggered one of the most controversial issues about the funding. All agreed that the three-year cycle was too short and would favor a five-year cycle instead. Some would be satisfied if a second five-year cycle were possible following a satisfactory first cycle. At this point, there was divergence. Some felt that a good program should be funded as long as the need existed. This was best expressed as follows, "If a program is successful, cost-effective, and is addressing all of the initiatives, and the results are positive, as long as the need is demonstrated, it should be funded." This view was strongly opposed by a few who argued that long-term funding of a program prevents HRSA from moving in new directions. "Somebody continues to get funding, means that other people do not have an opportunity." Those who did not agree with this view felt that the institutions should have strong development offices that would help in raising the necessary funds for programs to continue and not leave the responsibility entirely on the faculty. Others felt that the Agency should at least help the schools identify alternate funding for programs that were considered crucial. Interviewees who were opposed to continuous funding felt that it was actually harmful to the institution because it allows poor, small organizations to be defined by the government funding. "I think that happens when the government tells your program to meet these standards and we'll fund you." There were others who felt that the universities did not create the major problems in the provision of health care and they should not be fully responsible for solving them.

An Ideal Relationship

Interviewees were asked what they would consider an ideal relationship between HRSA and their institutions. One suggestion was that HRSA be more realistic in the expectations of self-sufficiency. The current situation sets the stage for failure on both

sides. “I think that looking at some of these programs more realistically would be a significant step in the right direction.”

Drew has the special problem of not being eligible to apply directly because it does not offer all four years of medical training, but carries out its medical education program jointly with UCLA. For Drew, an ideal relationship would be the ability to apply directly rather than through an intermediary. The situation varies with the program and sometimes the institution thinks that it cannot apply directly while HRSA staff thinks that Drew can apply directly as a “designated health professions school.”

The relationship would improve if there were someone at the institutional level who could satisfactorily resolve these problems and not leave it to the faculty member preparing an application. This view was advocated, not only at Drew, but also at other sites. “It seems that we would benefit from having someone at the institutional level who is the contact point person for a lot of this to help the different people in the different programs.” There was consensus on the need for greater coordination at the institutional level. A similar suggestion was made with respect to HRSA. “They may want to think of restructuring an opportunity that would cut across some of their different bureaus in contracting directly with the institution. It would really coordinate activities across the institution, allowing us to meet both their mission and ours.” Another interviewee felt that HRSA should have a project officer who is very well acquainted with several of the Black medical schools and have that project officer be the primary contact at HRSA.

Another suggestion was for a closer relationship with certain schools. One interviewee said, “I do think that staff at HRSA have recognized over the years that there are some institutions that are a whole lot closer to their mission than others, and that are a whole lot closer to being good institutional partners for doing the mission of HRSA. At that level I would really encourage a much tighter relationship in planning and developing programs and funding streams, and figuring out how to do the mission as real partners rather than a grantor-grantee relationship.”

Another suggestion related to broader representation on the review committees. One interviewee said, “The dynamics of the review committees, and the desire for consensus mean that if you are the only one from an HBCU, you only get a certain number of objections. There is not a formal limited number, but the dynamics of the

group are such that you can't be fussing at everybody about everything, and you have to pick your issues. I think more representation would allow individuals not to feel so isolated when they have to speak on issues, and also to be more a part of the consensus rather than the minority opinion or the voice crying in the wilderness.”

Interviewees recognized that HRSA is under-funded considering the importance of its mission, and the level of funds that would be needed to support that mission. They felt that if HRSA were more adequately funded, they could more adequately support schools that need the assistance, including the minority schools.

Another suggestion was that funds be made available through a block grant that would cover all HRSA programs. HRSA would give the schools “x” number of dollars and specify that those funds be spent in accordance with HRSA’s mission, and the institution’s mission. “So, it is not RFA-driven, but mission-driven.” This suggestion was quickly challenged on the grounds that it would still be necessary to spell out the criteria that the school should use. The response was that “When you get block grants on a state level, you don’t just get a blank check. You have certain things you must do that address that responsibility.” When asked how long the interviewee would expect the block grant to continue, the answer was “as long as HRSA continues.”

Other ideas included a kind of mentoring relationship with the schools, and facilitating linkages between the minority schools and other institutions that are very successful in getting their grants funded. Another suggestion was a greater use of cooperative agreements. An underlying theme was that HRSA should invest not only the money but also the health resources that exist at HRSA, using such arrangements as those authorized under the Intergovernmental Personnel Act (IPA) Mobility Program.

The Competitiveness of Proposals from the Black Medical Schools

Interviewees were told that applications from the Black medical schools were often judged to be less competitive than proposals from the majority institutions. Some immediately challenged the assumption, on the basis that they had served on several review committees and had seen proposals from majority institutions that were of poor quality. “It is true in some cases and not true in others.”

Some argued that much depends on how one defines competitive. For example, “If you are defining competitive as winning an essay contest, I think it is probably accurate that some of the grants we have sent in were not up to that standard. I would say that some of their grants are very poorly competitive in their ability to do the mission because they exhibit to me a very superficial understanding of issues of health and poverty and minority communities and how you develop relationships with community members and so forth. If you sent one of their grants to a committee of people in our group we would say it doesn’t pass the first test, it is not competitive.” Then there is the issue of the halo effect. One interviewee said. “I have some concern that we start out with a strike or two against us when the reviewer sees that the application is from a minority institution. There is a built-in assumption that it will be a weaker application than one submitted from Harvard or Hopkins.”

On the other hand, there were interviewees who argued that there were proposals from minority institutions that were very weak. The major reason contributing to this weakness was an inadequate infrastructure. “ I think it is reflective of the infrastructure that exists with the submitting institutions. Historically, there has not been the support for Black colleges and universities to build them to the point that there is the infrastructure required to make them competitive.” Often the necessary data are not readily available. The Offices of Grants and Contracts are not well staffed and are not as helpful as they are at other places. Apparently, the most help that an applicant receives is in generating the budget pages. Data on the percentage of trainees now serving underserved areas are not readily available. Faculty that we interviewed generally disagreed with representatives from the Offices of Grants and Contracts on the effectiveness of the Office. Generally those offices thought they were offering more support than the faculty felt they were receiving. For example, one officer, who was acknowledged by some at the institution to be the most helpful person to faculty, indicated that a support team consisting of an epidemiologist and statistician were also available to assist in grant development. Another interviewee from the same institution indicated that these people were usually occupied elsewhere and not available. If available, the requesting department had to pay for the time of this special group. Still another interviewee said, “That office has not seen its role primarily as being one of

customer service or as a support center.” Another member of the group of interviewees stated that when it is Friday and the grant has to be out, these offices stop what they are doing and make sure that things are signed.’ Some interviewees suggested having another office, others suggested strengthening the present offices. Still others said, “We should use the talent of the people who, remarkably given this environment, have successfully obtained grants to suggest improvements to the structure of the institution’s Office of Grants and Contracts.” Some of the interviewees had had the opportunity to see several top-notch grant assistance offices at other institutions. They regretted that “Anyone sitting around this table that has put out a grant probably did it on their own time, working day and night on top of their other clinical responsibilities. It takes an extraordinary effort and you can only live like that so long before you burn out.” Another interviewee said, “It is not that I think that the people are inadequate. I think their resources, including time, are not adequate to the creation and presentation of well-developed and well-planned programs.” HRSA sometimes invites persons to a workshop, but often the faculty members do not have the time or the money to respond. Further, the invitation often arrives too late to allow enough time for proper presentation, especially if it must be done in addition to other routine responsibilities. Making matters worse, the school often is not supportive. One interviewee said, “The institution also needs to be more user friendly. When you apply for a grant, you don’t need to be slapped because you applied. We need encouragement, not the opposite.”

One interviewee felt that the emphasis is often placed on the wrong place, even if one hypothetically conceded applications from majority institutions might be more competitive. “The real points for being competitive are that we are not thrown off by our lesser volume of data, or more rudimentary presentation of data. Those in themselves are not what makes a good, operating and effective grant.”

Special Consideration for Black Medical Schools’ Proposals

Most interviewees felt that proposals from the Black medical schools deserved special consideration. There was some skepticism about the preferences. “They (the federal government) create preferences where they have these small pots, so you end up misdirected because you are looking at the small minority pot and they have this huge pot

over here for the majority institutions. Here, we are scrambling and fighting for smaller amounts of money. I saw this happen in AHEC. I saw it happen in HCOP where they just have this little pot and the pot keeps shrinking and shrinking and they keep adding more and more players. It gets to be ridiculous. This is a problem with preferences and set-asides. It's a game that I think gets played on us.”

The main reasons for assuming that these proposals deserve special consideration was expressed by one interviewee in this way: “If we are doing the work that they are asking all the schools to do and we are the only ones doing it, yes, we should be provided special consideration. Our results are what they are using for staying in existence as far as the program is concerned.” Another interviewee put it this way: “The whole mission statement, the whole charter of these schools was right down the line of the purposes outlined by Congress. So, therefore, within that track record, and in that background statement from these particular schools, a score, if you were to call it a preference score or a better score, is solicited just by the background of those institutions in carrying out the legislative purposes.”

This, however, was not considered special consideration but rather a matter of fairness. “I do not see it so much as an issue of special consideration, but that we get a fair assessment for what we do. I think you need to have more people that have experience, more people from our institutions serving on these review panels, that have some experience working with disadvantaged groups in order for us to get a fair shake.”

There remains a strong feeling among interviewees that these schools are not getting their fair share. One interviewee saw it this way. “You know, if I read a grant, I am going to try to find what the person is really trying to say. I do not go along with the fact that they are very verbose or that they obviously have a professional writer. I try to find some merit in it. But I have to tell you the attitude sometimes is if you are not from the right school, you are just not going to get a lot of money. Somebody is looking to see how much money is coming in. Because you already received a little money, what are you asking for some more money for? You know you already got enough. You know, I have heard that myself on these reviews, and it is a little discouraging. I think there should be something set aside.” One interviewee felt that rather than receiving special consideration, in their particular program, it was just the reverse. This interviewee said,

“This is just my feeling. I think there was a direct intent on HRSA’s part to see to it that we received less money.”

Two additional issues were raised. There was a question as to whether preferences were awarded for the right things. There was the argument that both minority and majority schools should receive preference but based on outcomes rather than process. One interviewee said, “With all the numbers on the tables that we now have to fill out for these grants, we still do not look at outcomes. We look at process. We look at the number of students or residents who participated in a particular rotation. We do not look at the percentage of graduates who provide care to under-served and under-represented minorities. We do not look at the percentage of graduates who enter primary care professions.”

Another interviewee added the second issue relating to the composition of the review committee. His view was, “It doesn’t matter how you write the criteria, if nine out of ten people on the grant committee are from large majority institutions and seven out of ten are from a certain cultural background. Under those circumstances it seems to them that I am being unfair if I say they just don’t get it. In fact, their unfair advantage is that everything is being filtered through their perspective.”

Technical Assistance from HRSA

Opinions about HRSA’s technical assistance varied widely, depending on the program and both HRSA and medical school interviewees. At the positive end was a statement by one interviewee, “They (HRSA staff) have been pretty cooperative and understanding and have assisted us adequately in response to our technical assistance requests.”

Another interviewee said, “The level of technical assistance offered by HRSA, once you are funded, has declined dramatically over the years.” There were also statements like this: “Over the last six years the technical assistance seems to have waned. There have been questions and a lack of clarity within HRSA’s administrative structure,. They’re not always on the same page in terms of what they are doing. As a result they’re not able to always give us the type of technical assistance that might be most helpful.”

Another interviewee had a different explanation. This interviewee thought that the problem was that HRSA was evolving and as a result, “There’s nothing that you can really grab onto.” The grids were cited as a good example. “They’re very complicated. It seems HRSA staff is casting about for information without thinking through the validity or purpose of the requested information.” In the words of another, “Sometimes they know in their minds what they want, but it has not necessarily been articulated to us in a way that we can key into and provide them exactly what they want.”

A major irritant relates to tracking. “A person may delay entering into practice for many years after receipt of the M.D. degree. Tracking is expensive but not allowed in the program budget. It is, therefore, considered similar to an un-funded mandate and grossly unfair.”

Errors in notices of award are another problem. The problem is not the error, but achieving a satisfactory and timely resolution so as to not hamper program operations. In one case, the school was given the wrong tax ID number and could not draw down on the money. “This stuff was unheard of years ago - it now happens frequently.”

The adequacy of short-term technical assistance was another concern. An interviewee expressed, “If you are really going to provide quality technical assistance to an entity, a day may not be adequate. There ought to be some process in which there is a continuous interaction so that you come in and have an initial visit, an initial discussion, and then you have some feedback back, time for reflection, and additional discussions.” This interviewee had high praise for one project officer who offered that kind of assistance. It was said: “You really need a project officer who understands who they’re trying to give technical assistance to. I know it makes a difference because we had one that did and that person made it a point, when the opportunity arose to travel, to ask to come here. That individual said: ‘The only way I’m going to understand your operation is to actually come down, spend some time with you, ask questions, visit a center, get the lay of the land. Then when we’re on the phone, what I’m saying will be relevant and helpful to you.’ You need that kind of a person. You’re then comfortable saying whatever it is you have to say and that person is also comfortable telling you whatever it is they feel they need to tell you. Unfortunately, shortly after we developed a good relationship with that person, she was reassigned.”

One interviewee concluded, “I don’t think that the existing staff has the ability to provide the level of technical assistance that may be required.” The interviewee then offered a suggestion that HRSA create a funding mechanism for development grants that has criteria dramatically weighted toward the need and the potential, rather than the track record and the existing infrastructure.

Should Graduates of Black Medical Schools Bear a Greater Burden?

If time permitted, we asked some of the interviewees whether graduates of Black medical schools should be expected to bear a greater burden for the medically underserved. One response was: “I don’t think that they should be expected to, although in reality I think they do because they are committed over the training process to that population. As such, they are committed on a much higher level and likely dedicated towards doing that (serving the medically underserved).”

One problem is that even though students may be admitted partially on their desire to serve the medically underserved, and this may be a part of the mission of the school, there is no foolproof method of assessing that commitment on the part of the entering student. Those who think that students should be expected to bear a heavier burden make this assumption on the basis of the school’s mission. They see this expectation as central to the institution’s mission. But there are other variables, such as the GPA and the MCAT, and there may be no correlation among these variables and the level of commitment of an individual to serve the underserved. That level of commitment cannot be quantified in the same objective manner as test scores. Even if an individual enters the school based on the impressive level of commitment expressed in their admission statements, which includes serving the medically underserved, that individual may be lost in the course of training.

On the other hand, there were interviewees who felt that the expectation for graduates of Black medical schools to uniformly serve the medically underserved is unreasonable, and conflicts with the economic realities of medical training in America and the heavy burden of debt that many students acquire in the process. They also felt that the burden of caring for the medically underserved should not be placed entirely upon minorities, but should be everyone’s responsibility. At the same time it was

recognized that the nature of a graduate's practice is influenced by the economics of medicine, and the long-established racism that affects much of American society. These interviewees were concerned that the assumption that minorities serve only minorities carries with it a measure of racism undesirable in America.

Interviewees were also asked how they track performance of graduates serving the medically underserved. Most take into consideration only the location of the primary practice. They were then asked if they would exclude persons whose primary practice was in a middle-income area but volunteered or practiced part-time in a medically underserved area. At that point, consideration was directed to a questionnaire used by some of the schools (Appendix D). The questionnaire elicited, among other parameters, the patient mix, including privately insured, Medicaid and other categories. The intent was to see the extent to which the complexity of the problem was addressed by interviewees. Another aspect was whether interviewees would prefer that 10% of a class dedicated 100% of their time to the medically underserved or 100% of the class dedicated at least 10% of their time. The majority favored the latter option. In the end, there were those who felt that the choice is an individual matter for graduates. However, if a graduate entered medical school using this commitment in order to be admitted, they should be held to it as a matter of integrity. On the other hand, some interviewees felt that the responsibility of caring for the medically underserved is a national responsibility. Whether or not Black medical schools should be expected to share a heavier burden than others, they actually do. Further, their students are urged to do so throughout their training. This urging is grounded in the historical context of the schools' missions.

Another view was that the predominately white medical schools should bear a much greater responsibility than they do at present. This interviewee said, "They are actively running away from their responsibilities to meet the needs of the medically underserved." Another interviewee supported this view, "They should not be rewarded, through increased funding, for doing less in addressing the true medical needs of the country."

Blackness, Diversity, and the Medically Underserved

Interviewees were asked to express their views as to whether the schools should emphasize blackness, diversity or the medically underserved. The intent was to see what priority would be attached to each. Some interviewees began by insisting, “The emphasis should be maintained on blackness.” One interviewee said: “I agree that we should maintain our emphasis (on blackness). That does not say that we could not support diversity, but I don’t think we can be all things to all people.” It is difficult to separate blackness from the medically underserved population “because a large percentage of the Black population has been underserved.” Another interviewee added: “There should be some predominance. If this school was founded on the premise that it needs to predominantly address the medical issues of Black people or African Americans, then that is where we should predominantly focus. But at the same time we must serve other underserved populations as well.” Another view was that the black medical schools “historically have conveyed this special sense of mission to the underserved population and will continue to do so because, absent that, they are just another medical school.”

There was no difficulty linking blackness with being medically underserved but there had to be further probing with respect to diversity. All the representatives from the schools believed that the Black medical schools are currently more diverse than other schools in general. One interviewee said, “As a percentage of our student body and of our patients served, we are more diversified than the majority institutions.” Interviewees were, therefore, asked to try to put these elements in some kind of ranking. While some felt that the correct order was historically Black, underserved and diversity, others did not agree. For example one interviewee said: “I have a problem putting them in some kind of rank order. I don’t think there is (a rank order) because I don’t think there is any conflict in a Black medical school embracing diversity. We have a diverse community. I don’t think that at all challenges the historical nature of the school - that it arose from the cries of Black folks. That needs to be a part of what we do, but at the same time, it doesn’t mean that you can’t embrace all people, both in terms of your faculty and your students. Diversity is an important thing for all of us, not just for Black folks but also for the whole nation. I think it is important that we have African-American institutions today. I would

welcome the emergence of Hispanic institutions because we need diversity in our institutions. And the diversity has to be reflected institutionally as well as individually.”

There was another view on diversity and the majority institutions. The interviewee said: “The majority institutions do not realize the extent to which they have incorporated cultural dimensions of the white-Anglo experience, even as they may have hired people from lots of different ethnic backgrounds. They have hired them into a majority culture. They preserve that culture of individualism - almost cutthroat competitiveness - between students, between faculty members, and so forth that is normal in a majority institution, but would be inappropriate and destructive here. I think diversity has a good ring to it, but it has the hidden danger to a minority institution of favoring majority culture. If you try to force diversity with lots of different cultures, you may have to use majority culture as the common ground on which everyone meets, and you lose the ability then to nurture minority culture and values.”

6. The Executive Order 12876: Funding of the Black Medical Schools

The White House Initiative on Historically Black Colleges and Universities was established in 1980 by Executive Order of President Carter and has continued with each succeeding president. The primary purpose of the initiative was to strengthen the capacity of Historically Black Colleges and Universities (HBCUs) to provide a quality education and to increase their opportunities to participate in and benefit from federal programs.

President Clinton signed Executive Order 12876 on November 1, 1993. Section 4 of that order reads as follows:

“To carry out the purposes of this order, each executive department and each agency designated by the Secretary shall, consistent with applicable law, enter into appropriate grants, contracts, or cooperative agreements with historically Black colleges and universities. The head of each agency subject to this order shall establish an annual goal for the amount of funds to be awarded in grants, contracts and cooperative agreements to historically Black colleges and universities. Consistent with the funds available to the agency, the goal shall be an amount above the actual amount of such awards from the previous fiscal year and shall represent a substantial effort to increase the amounts available to historically Black colleges and universities for grants, contracts and cooperative agreements. In order to facilitate the attainment of the goals established by this section, the head of each agency subject to this order shall provide technical assistance and information to historically Black colleges and universities regarding the program activities of the agency and the preparation of applications or proposals for grants, contracts, or cooperative agreements.”⁴

There are now other Executive Orders relating to Hispanic Serving Institutions and Tribal Colleges. One of the purposes of this study was to examine the impact of the Executive Order on the funding of training for health professionals at the Black medical schools.

HRSA Data on Funding

Data on the funding to the Black medical schools for the period FY 91 to FY 98 was provided by HRSA. The data for the Bureau of Health Professions from FY 91 to FY 93 came from an NIH file. The data for FY 94 to FY 98 came from HRSA worksheets. The data for the Maternal and Child Health Bureau, and for the HIV/AIDS Bureau came from additional files. The data is given in Table 2 and does not include Centers of Excellence funds to Meharry, a legislatively mandated set-aside for four schools including Meharry. The data indicates a decline from FY 94 with a gradual but not full recovery in FY98. The same trend appears when the funds awarded to the Black medical schools are compared with the total funds to all medical schools for the same programs. The trend line for all medical schools shows a general steady increase. No doubt there are some inaccuracies in the data, but the trend is clearly not consistent with the Executive Order and was recognized by persons interviewed within HRSA.

Reconciliation of Funding Data from HRSA and the Schools

It seemed prudent to reconcile the HRSA data on funds awarded by HRSA with the funds received by the schools for the same programs. Tables 3 to 6 present data from the schools individually and Table 7 shows the summary data for all schools. Figure 2 illustrates by line graph funding by schools from 1995 through 1999.

Howard University School of Medicine (Table 3)

Howard has for several years received fewer funds than the other schools and the decline in funding has been quite significant during the last two years. It was also the most difficult to reconcile and the data presented reflect data drawn more from HRSA records than data that could be retrieved from Howard files. At HRSA, there is no lack of interest in Howard and interviewees at HRSA repeatedly stated that they could not understand why Howard did not apply. It appears that Howard is interested in applying, but that the knowledge of HRSA programs is not widely disseminated within the university. It is not unreasonable to expect that this study will itself stimulate greater interest in applying.

Meharry Medical College (Table 4)

This table shows the data with and without the Centers of Excellence set-aside for Meharry. It was easier to reconcile HRSA funding with Meharry records than with any other school. The decline in funding in recent years was due to smaller HCOP awards, the reduction in AHEC funding as the institution progressed from being a Basic Core AHEC to a Model State-supported AHEC and the failure to apply for certain funds related to Family Medicine.

Charles R. Drew University of Medicine & Science (Table 5)

The decline in funding for Drew was related to the Centers of Excellence funding. The original application for this funding was submitted jointly with UCLA because Drew students receive the first two years of medical education through UCLA. That funding expired and Drew has been trying to arrange funding independently as a “designated health professions school.” Other program funding declines relate to a reduction in HCOP funds and in funds for Family Medicine. In this respect, it was similar to Meharry.

Morehouse School of Medicine (Table 6)

The only school that did not show a decline was Morehouse. It did not suffer a reduction in HCOP funding and competed successfully for competitive COE funding for the five years under consideration. It also reported funding from the Partnership for Health Professions Education Project, a program not reported by other schools. Even without that program, there was a steady increase in funding over the years. The only decline was in funding for Graduate Training in Family Medicine, which was more than offset by the progress in funding for Faculty Development and the Centers of Excellence grants.

Summarized Data for all Schools (Table 7)

This table shows comparisons excluding the COE set-aside funds unavailable to schools other than Meharry. Additional COE funds are more widely available and are shown for the other schools, when received. The summary table shows a declining trend from FY95 to FY98 with an increase in FY99. Morehouse clearly leads all other schools in successfully receiving HRSA funds over the five-year period and did not participate in the overall decline. This poses a major question as to why Morehouse succeeded in

increasing its funding while others failed. One might use the reasons given by the schools but they do not seem fully explanatory. For example, why should Howard University lack information about the programs at HRSA when the information is so readily available? Why do some schools participate more in the review process than others? The reduction in funding from the HCOP program could be due to decreased funds at HRSA, but why did the funds drop at other schools and not at Morehouse? The reduced funds for Family Medicine are explained either by schools not applying, or by having carry-over funds from the previous year. But why do some schools not apply in some years? The answers are not complex. It is sometimes due to a turnover of staff at the institution; and when the preparation of proposals is a solo effort, the loss of that one person may mean a vacuum in expertise. Carry-over funds may result from a failure of the program to make efficient use of its funds, in part due to administrative barriers at the institution, which result in an inability to perform. In some cases a failure to apply is due to an inability to process the required statistics that now form a critical part of the application and the progress report. These are all problems at the school level and are symptoms of more fundamental problems. However, such failures at the schools adversely affect HRSA's ability to carry out its mission. The interdependence of HRSA and the schools is not recognized to the extent that it should be and is one of the underlying problems that must be addressed. These and other issues are addressed in the next section.

Table 2
Summary of HRSA Training Funds by Bureau and Year for All Medical Schools and Black Medical Schools

*Excludes COE funds for Meharry

		FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98
BMS	BHPr	\$ 3,520,990	\$ 3,475,107	\$ 3,944,527	\$ 4,669,470	\$ 4,879,681	\$ 3,185,545	\$ 4,436,329	\$ 4,827,119
BMS	MCHB	-	-	-	\$ 999,965	\$ 794,619	\$ 791,192	\$ 763,012	\$ 760,955
BMS	HIV/AIDS	\$ 434,341	\$ 550,000	\$ 540,051	\$ 528,000	-	-	-	-
BMS Totals		\$ 3,955,331	\$ 4,025,107	\$ 4,484,578	\$ 6,197,435	\$ 5,674,300	\$ 3,976,737	\$ 5,199,341	\$ 5,588,074
Total									
Total	BHPR	\$ 82,358,581	\$ 85,266,270	\$ 84,277,326	\$ 92,103,845	\$ 91,017,326	\$ 88,876,149	\$102,708,897	\$ 100,900,488
Total	MCHB	-	-	-	\$ 36,869,450	\$ 36,626,729	\$ 37,599,689	\$ 43,038,259	\$ 40,991,556
Total	HIV/AIDS	\$ 16,519,749	\$ 16,519,835	\$ 16,403,838	\$ 16,064,661	\$ 15,974,719	\$ 13,773,707	\$ 16,188,846	-
Training Totals		\$ 98,878,330	\$101,786,105	\$100,681,164	\$145,037,956	\$ 143,618,774	\$ 140,249,545	\$161,936,002	\$ 141,892,044
% BMS	BHPR	4.3%	4.1%	4.7%	5.1%	5.4%	3.6%	4.3%	4.8%
% BMS	MCHB	-	-	-	2.6%	2.2%	2.1%	1.8%	1.9%
% BMS	HIV/AIDS	2.6%	3.3%	3.3%	3.3%	0.0%	0.0%	0.0%	-
% BMS	Totals	4.0%	4.0%	4.5%	4.3%	4.0%	2.8%	3.2%	3.9%

Sources

1. 1991 to 1993 BHPR data comes from NIH file of 05/20/99
2. 1994 to 1998 BHPR data comes from HRSA work sheets provided 07/07/99
3. HIV/AIDS data for 1991 to 1998 comes from electronic file provided 05/21/99
4. MCHB data comes from electronic file provided 05/21/99

Table 3

**Funding by Program and by Year for the
School of Medicine/Howard University**

	FY 95	FY 96	FY 97	FY 98	FY 99	TOTALS
AHEC	\$ 158,400	0	0	0	0	\$ 158,400
HCOP (Post-Bac.)	0	\$ 167,981	0	0	0	\$ 167,981
HCOP	\$ 681,594	\$ 686,682	\$ 520,511	\$520,511	\$520,511	\$ 2,929,809
HCOP	0	0	\$ 442,244	0	0	\$ 442,244
HCOP	0	0	\$ 446,948	0	0	\$ 446,948
Adv. Education/ Gen Dentistry	0	0	\$ 73,251	0	0	\$ 73,251
Adv. Education/ Gen. Dentistry	0	0	\$ 60,588	0	0	\$ 60,588
AETC	\$ 528,000	\$ 30,000	\$ 51,339	0	0	\$ 609,339
AETC	0	0	\$ 25,000	0	\$ 25,000	\$ 50,000
Peds. Residency Training	\$ 225,690	\$ 221,395	\$ 11,012	0	\$166,076	\$ 624,173
Interdisciplinary leadership MCH	\$ 138,889	\$ 99,572	\$ 101,570	\$100,000	\$100,000	\$ 540,031
Residency Training/Community	0	0	\$ 168,276	\$166,593	0	\$ 334,869
Physician Assistant Program	0	\$ 299,012	\$ 288,536	\$168,119	\$169,120	\$ 924,787
TOTALS	\$ 1,732,573	\$1,504,642	\$ 2,189,275	\$955,223	\$980,707	\$ 7,362,420

Source: Financial records of HRSA and Black Medical Schools

Table 4
**Funding by Program and by Year for the
Meharry Medical College**

	FY95	FY96	FY97	FY98	FY99	TOTAL
Centers of Excellence (Med)	\$ 5,778,636	\$ 5,809,796	\$ 5,697,968	\$ 4,860,000	\$ 4,760,000	\$ 26,906,400
Centers of Excellence (Den)	\$ 1,700,000	\$ 1,698,040	\$ 1,698,040	\$ 1,770,000	\$ 1,770,000	\$ 8,636,080
Health Careers (Pre-Bac.)	\$ 601,406	\$ 601,406		\$ 173,951	\$ 244,149	\$ 1,620,912
Health Careers (Post-Bac.)			\$ 302,102	\$ 305,764	\$ 309,536	\$ 917,402
Health Careers (SDAP)	\$ 177,695	\$ 177,695	\$ 201,544	\$ 203,130	\$ 204,779	\$ 964,843
AHEC	\$ 351,293	\$ 342,193	\$ 88,873	\$ 159,212	\$ 148,646	\$ 1,090,217
Faculty Development	\$ 99,274	\$ 40,000	\$ 112,944	\$ 97,056	\$ 131,900	\$ 481,174
Dept. of Family Medicine	\$ 109,627	\$ 74,246	\$ 75,533			\$ 259,406
Pre-doc. Family Medicine	\$ 129,600	\$ 124,200				\$ 253,800
Grad. Training Family Medicine	\$ 122,040	\$ 122,040				\$ 244,080
OB-Gyn. Train.-Fam. Med.	\$ 174,090	\$ 173,670	\$ 164,882	\$ 163,233	\$ 162,727	\$ 838,602
General Dentistry	\$ 97,844		\$ 75,569	\$ 60,569	\$ 60,569	\$ 294,551
Geriatric Education		\$ 158,760	\$ 158,760	\$ 158,760	\$ 162,000	\$ 638,280
Res. Training Prev. Med.		\$ 112,587	\$ 115,094	\$ 119,593	\$ 84,852	\$ 432,126
Rural Training	\$ 282,250	\$ 264,542	\$ 246,905	\$ 191,533	\$ 191,533	\$ 1,176,763
Health Admin. Traineeships	\$ 35,279	\$ 34,716	\$ 32,333		\$ 8,872	\$ 111,200
Totals	\$ 9,659,034	\$ 9,733,891	\$ 8,970,547	\$ 8,262,801	\$ 8,239,563	\$ 44,865,836
Legislative COE Set-aside	\$ 7,478,636	\$ 7,507,836	\$ 7,396,008	\$ 6,630,000	\$ 6,530,000	\$ 35,542,480
Difference	\$ 2,180,398	\$ 2,226,055	\$ 1,574,539	\$ 1,632,801	\$ 1,709,563	\$ 9,323,356

Source: Financial records of HRSA and Medical Schools

Table 5
Funding by Program and by Year for the
Charles R. Drew University of Medicine & Science

	FY95	FY96	FY97	FY98	FY99	TOTAL
Centers of Excellence (UCLA)	\$ 205,300	\$ 205,300	\$ -			\$ 410,600
Health Careers Oppor. Program	\$ 184,513	\$ 192,716	\$ 154,382	\$ 159,362	\$ 166,113	\$ 857,086
Health Careers Oppor. Program	\$ 184,513	\$ 183,888	\$ -	\$ 231,443	\$ 239,330	\$ 839,174
Health Careers Oppor. Program	\$ 144,804	\$ 155,173	\$ -	\$ -	\$ -	\$ 299,977
Area Health Educ. Centers	\$ 38,904	\$ 29,466	\$ 29,466	\$ 51,590	\$ 59,496	\$ 208,922
Health Educ. Training Centers	\$ 318,162	\$ -	\$ 197,371	\$ 160,253	\$ 197,034	\$ 872,820
MCH Training (Nurse Midwife)	\$ 40,965	\$ 31,941	\$ -	\$ 15,603	\$ 5,998	\$ 94,507
AIDS Educ. and Training Center	\$ 158,725	\$ 155,757	\$ 123,120	\$ 156,829	\$ 213,887	\$ 808,318
Graduate Training in Fam. Med.	\$ 297,800	\$ 139,228	\$ -	\$ -	\$ 137,519	\$ 574,547
Department of Fam. Medicine	\$ 189,463	\$ 155,000	\$ 108,000	\$ 180,926	\$ 155,655	\$ 789,044
MCH Adoles. Training Prog.	\$ 239,568	\$ 212,999	\$ 168,276	\$ 166,593	\$ 166,076	\$ 953,512
Physician Assistant Training	\$ 138,889	\$ 130,509	\$ 125,508	\$ 164,893	\$ 156,448	\$ 716,247
TOTALS	\$ 2,141,606	\$ 1,591,977	\$ 906,123	\$ 1,287,492	\$ 1,497,556	\$ 7,424,754

Source: Financial records of HRSA and Medical Schools

Table 6
Funding by Program and by Year for the
Morehouse School of Medicine

	FY 95	FY 96	FY 97	FY 98	FY 99	TOTAL
Centers of Excellence	\$ 576,681	\$ 500,004	\$ 675,000	\$ 500,000	\$ 800,000	\$ 3,051,685
Health Careers Oppor. Program	\$ 257,092	\$ 257,092	\$ 257,092	\$ 252,669	\$ 257,607	\$ 1,281,552
Area Health Education Centers	\$ 158,400	\$ 155,577	\$ 177,745	\$ 318,422	\$ 297,287	\$ 1,107,431
Health Education Training Ctrs.	\$ 277,516	\$ 344,770	\$ 311,112	\$ 373,122	\$ 391,407	\$ 1,697,927
Dept. of Family Medicine	\$ -	\$ -	\$ 287,376	\$ 274,873	\$ 281,454	\$ 843,703
Predoc. Training in Fam. Med.	\$ -	\$ -	\$ -	\$ -	\$ 186,211	\$ 186,211
Grad. Training in Fam. Med.	\$ 59,925	\$ 42,811	\$ -	\$ -	\$ -	\$ 102,736
Fac. Dev. in Fam. Medicine	\$ 312,200	\$ 310,498	\$ -	\$ 187,151	\$ 187,637	\$ 997,486
Residency Training in Prev. Med.	\$ 188,460	\$ 190,258	\$ 207,858	\$ 216,428	\$ 212,155	\$ 1,015,159
Partners for Health Prof. Ed. Proj.	\$ -	\$ -	\$ 500,000	\$ 500,000	\$ 500,270	\$ 1,500,270
Rural Interdiscip. Training	\$ 180,017	\$ 178,252	\$ 81,271	\$ 211,218	\$ 222,914	\$ 873,672
Totals	\$ 2,010,291	\$ 1,979,262	\$ 2,497,454	\$2,833,883	\$3,336,942	\$12,657,832

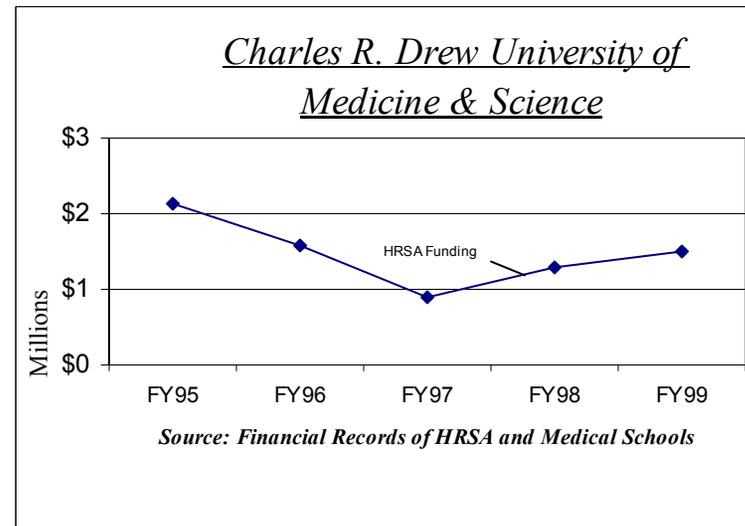
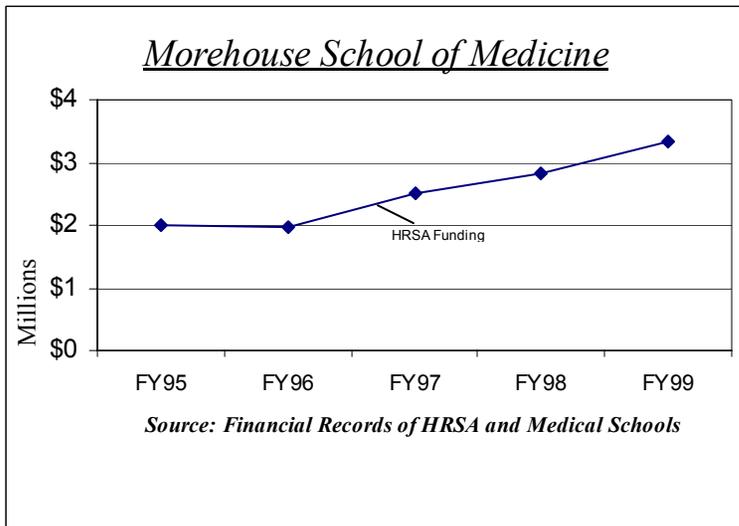
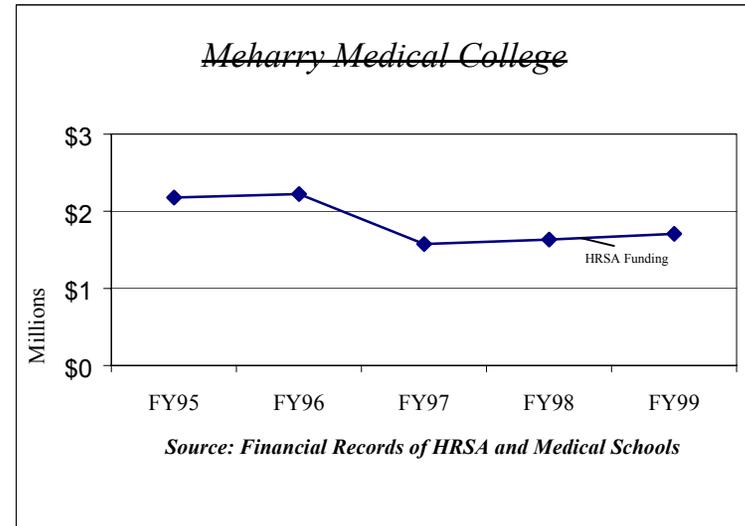
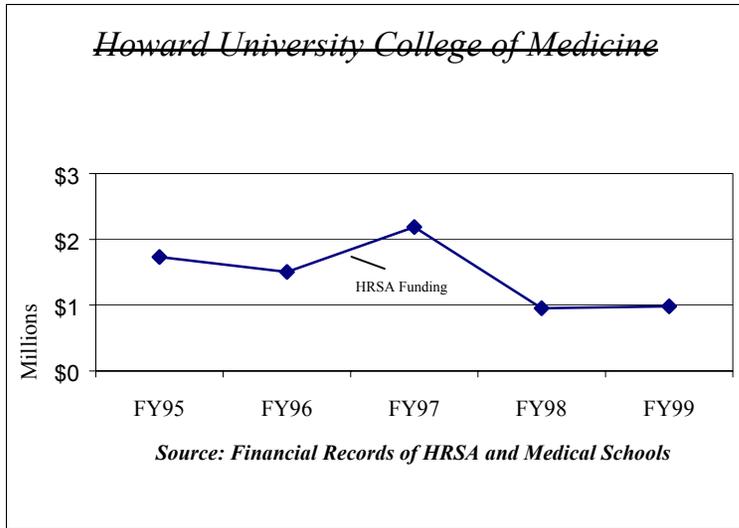
Source: Financial records of HRSA and Medical Schools

Table 7
Total Training Funds Awarded to
Black Medical Schools from FY 95 to FY 99

	FY 95	FY 96	FY 97	FY 98	FY 99	TOTAL
Howard University College of Medicine	\$ 1,732,573	\$ 1,504,642	\$ 2,189,275	\$ 955,223	\$ 980,707	\$ 7,362,420
Meharry Medical College	\$ 2,180,398	\$ 2,226,055	\$ 1,574,539	\$ 1,632,801	\$ 1,709,563	\$ 9,323,356
Charles R. Drew University of Medicine and Science	\$ 2,141,606	\$ 1,591,977	\$ 906,123	\$ 1,287,492	\$ 1,497,556	\$ 7,424,754
Morehouse School of Medicine	\$ 2,010,291	\$ 1,979,262	\$ 2,497,454	\$ 2,833,883	\$ 3,336,942	\$ 12,657,832
TOTAL	\$ 8,064,868	\$ 7,301,936	\$ 7,167,391	\$ 6,709,399	\$ 7,524,768	\$ 36,768,362

Source: Financial Records of HRSA and Medical Schools

Figure 2:
A Comparison of Training Funds Awarded to Schools
From FY95-FY99



7. HRSA and the Black Medical Schools: A Shared Mission and Commitment

Discussion of Major Issues

The funding data for recent years confirm a decline that is in the process of recovery, but the decline is seen in only three of the four schools. Morehouse has shown a steady increase over the same period. The most likely reason for the success of Morehouse appears to be stable and outstanding institutional leadership and careful selection of competent and committed faculty and staff. At the other schools, the decline appears to be related to a failure to appreciate the range of programs offered by HRSA, failure to apply, or failure to submit a winning application. Some programs have had difficulty dealing with the required statistics. Although these problems existed at the schools in varying degrees, they also reflect problems at HRSA. The decline is not what would have been expected based on the Executive Order.

Some interviewees at HRSA believe that the major problem at the schools is related to their inability to prepare competitive proposals. The schools confirm that the preparation of proposals is often a solo effort and must be done in addition to a heavy clinical workload. Also, the importance attached to the increased amount of statistical data required is not understood by some faculty and is sometimes a deterrent to applying. The review process is a troubling matter in the Bureau of Health Professions and at the schools, but for entirely different reasons. Some staff at HRSA seem to think that these schools are looking for a handout, while the schools ask only for a fair review based on HRSA objectives. The faculty at the schools reported that the review process is inherently biased in favor of majority institutions and this results in the process being an essay contest with the winner being the one with the best essay.

Additional issues include the number of years for which an institution should be funded is an issue with some at HRSA, but not with others. Further, the preferences are not well understood by HRSA staff or the schools, and are rather complex. In addition, competence and turnover of HRSA staff have an impact on the relationship with the schools. Competence and turnover at the schools have an impact on the quality of the applications. HRSA technical assistance has declined in recent years, reportedly due to the heavy workload and the limitations on travel. Agency technical assistance, as

opposed to program technical assistance, is being tried and appears promising. Also, the schools believe that HRSA is inadequately funded to carry out its mission. Finally, information technology has not advanced to the level expected either at HRSA or at the schools and performance objectives are now being developed at HRSA. These issues are discussed in the following section.

Findings and Recommendations

Clarifying and Implementing the Mission

The factors that initially appear to be the causes for the decline in funding are in fact symptoms of a more fundamental problem at HRSA and at the schools. But one must first examine the missions of HRSA and of the schools — the reasons for their existence. The mission of HRSA arose in the same way that the missions of most organizations arise — to address an existing need. Unlike other developed nations, the United States does not have a mechanism for assuring the provision of adequate health care for all of its citizens, and as a result, millions of Americans are medically underserved. HRSA's mission is to address this need. That is the mission of the agency as a whole. In addition to the mission of the agency, each component has its own special mission, and the mission of HRSA can be achieved only if the missions of the components are understood and implemented. The services that HRSA seeks to assure will not be provided unless the health resources are available to provide them. That specific need leads to the mission of the component of HRSA that is involved in training. The health resources component of HRSA does not provide training but it supports institutions that provide this training. It does not appear to be clear to all that HRSA's real training mission is the support of training institutions. Too many people see their main role to be that of processing applications. HRSA's dependency on medical schools requires that it maintain a close relationship with the schools that provide training, and an even closer relationship with those schools that have been strongly committed to this mission for many years.

This concept of close collaboration is recognized at the highest levels, but not throughout the organization. During the visit to Morehouse as a part of this study, a letter

arrived from the Administrator to Dr. Daniel Blumenthal with the following opening paragraph:

“The Health Resources and Services Administration (HRSA) is the health care access arm of the U.S. Department of Health and Human Services. HRSA has an uncompromising commitment to its mission of increasing access to primary and preventive care and improving overall health outcomes for underserved and vulnerable populations. At HRSA, we recognize that achieving this mission is only possible through increased collaboration with stakeholders, like you, also seeking to improve the public health, particularly the health of the most vulnerable.”⁵

If this concept were to be institutionalized within the HRSA and the schools, it would do more than any other single item to enhance the effectiveness of HRSA. HRSA and the schools could move together to accomplish the enormous tasks that remain until a better system of health care is developed. It would replace the feeling of some HRSA staff that these schools are only looking for a handout, and some staff would see that their work is far more than the processing of applications. The HBCUs deserve special consideration because of the Executive Order. In addition, any school created with a mission similar to that of the Black medical schools, and remains committed to that mission, also deserves a very close working relationship with HRSA. There are not many in this category. Therefore, the Black medical schools have a different problem. There is general recognition at the minority schools of the need to train health professionals to have a special concern for the underserved, but there is not always a full commitment to the mission.

Recommendation 1: It should be clearly understood within HRSA and by the training institutions that HRSA’s training mission is to support those institutions that are truly committed to training professionals who will address the needs of the medically underserved.

The HRSA interviewee was correct in saying, “If these schools did not exist, they would have to be created.” The schools did not create the problem; they are a large part of the solution. There are many ways of building this supportive relationship, such as having school representatives participate in planning and evaluation efforts, more visits by HRSA staff to the institutions, periodic consultations with the school officials, etc. The impression from the interviews is that HRSA staff members are so overworked with

the processing of proposals and the monitoring of projects that they do not have time for relationships except by e-mail or telephone conferences. Perhaps, there is a greater emphasis on pursuing efficiency than on effectiveness. Staffs of both HRSA and the schools repeatedly noted the diminution in their present relationships compared to the past. Despite that change, many members of the HRSA staff were mentioned as being especially helpful. The challenge will be to increase that number so that it becomes a part of the agency culture.

The relationships cannot be one sided. The schools will also have to make a greater effort to sustain a close relationship. The foundation for that improvement is the high regard for HRSA as evidenced by general remarks in the Black medical school interviews. Some faculty saw the agency as doing more for the health of the American people than any other government agency and would like to see its funding increased. Action by the schools toward improving the relationship that would be especially appreciated by HRSA is a more active response to requests for participation in the review process and other HRSA activities. Such action, although time consuming, has substantial rewards for the schools and the individuals, and they should be willing to participate in other ways as the relationship increases.

Recommendation 2: The schools should volunteer to be helpful to HRSA in any way possible even if it requires additional time and effort beyond their heavy responsibilities.

The Operating Model

If the system at HRSA is fair and the schools are truly committed to their mission, then there should be less concern about funding. Unfortunately, the health resources component of HRSA had its origins at NIH and continues to operate on the NIH model. The emphasis-on-research model, appropriate for NIH, is not necessarily an appropriate model for HRSA. It has an entirely different mission. NIH places its emphasis on investigator-initiated research, and measures results such as the number of scientific articles appearing in peer-reviewed journals. Nor is a foundation model appropriate for HRSA. A more appropriate model for HRSA would be an investment model.

It should be clearly understood that HRSA invests in institutions that are producing results that support its mission.. And the more successful the institution is in

achieving those results, the more likely it would be funded. In the investment model, the individual principal investigator is less important than the institution as a whole, and innovation in method is less critical than a solid record of institutional performance.

The investment model makes it clear that one should not expect charity, as in a foundation model, but should reasonably expect fairness. A beautifully crafted proposal from a majority institution without a record of performance should not be weighed more heavily than a less elegant proposal from an institution with a strong record of performance. This model is relevant for all institutions. Correctly implemented, it is less likely that minority institutions would feel that the level of funding is too heavily based on an essay contest. It requires a review process that is based strongly on performance and evidence of a strong commitment toward HRSA's mission on the part of the schools.

Recommendation 3: HRSA should change from the NIH model of operation to an investment model and it should fund on the basis of performance that is more closely in accord with its mission.

Results Oriented Objectives

Emphasis on collaboration does not eliminate the need for results-oriented objectives and performance measures. The investment model absolutely requires knowing whether targets are or are not met. Interviewees at HRSA indicated that HRSA is in the process of developing performance measures. Interviewees at the schools indicated that the objectives required in the proposals are process-oriented rather than results-oriented. HRSA and the schools both need to have clearly defined objectives that are results-oriented and measurable. Some objectives may appear to be entirely qualitative and immeasurable but may in fact lead to outcomes that are measurable. For example, the difference in funding at Morehouse is attributed to leadership and commitment. In this context, leadership refers to the commitment to a great cause and the ability to persuade others to make that cause their own. Commitment refers to the willingness to do over and beyond what is normally expected. These qualitative characteristics can lead to measurable outcomes. Leadership occurs at all levels in an institution. It may be the president, dean, department chairman, or program director. The higher the level of leadership, the greater will be the measurable impact. Changes in leadership at various levels may have negative or positive results within HRSA or the

schools. Some of the decline and subsequent recovery in funding could be due to leadership changes at HRSA or at the schools.

The precise objectives of HRSA and the schools, though possibly different, should converge at some point. HRSA has national objectives, and the schools need to have similar objectives, though not necessarily national in scope.

A clear definition of results-oriented objectives should precede attempts to develop more performance measures. A correspondence between objectives and results will provide a measure of effectiveness, and the summation of the effectiveness of school programs will result in the effectiveness of the national effort. The objectives set by the schools will be influenced by the objectives set by the agency. However, there is a need for both collaboration and independence. Collaboration in setting the national objectives is a natural consequence of a true partnership, and enhances the results. Indeed, if the same results are assessed using independent measurements, then the findings are more reliable. Both levels should collaborate in the setting of objectives, but achieve those objectives independently.

Accurate definitions can be a major problem. For example, HRSA is concerned about medically underserved areas of the country, but there should be a uniform definition of a medically underserved area and consensus on who should make the definition. If the definition depends on local notice, an underserved area could easily be neglected because there is not the interest or the priority at the local level to make the identification. For example, the need for a hospital in the Watts area was consistently ignored until the riots occurred in 1965. Those who are experts in population medicine can often be helpful in conducting community assessment and diagnosis to determine the need for health services. While public health officials are now capable of developing sophisticated, measurable outcomes, dynamic change in the health and economics of the country may require new definitions of the medically underserved. It is not simply a function of geographic location, or health insurance or family income. HRSA is the agency of the federal government that must provide guidance in this matter.

Although the training components of HRSA are especially concerned about resource allocation, meeting the needs of the medically underserved must include consideration not only of the resources but also the needs of the population involved.

Satisfactorily meeting the needs of the population involved may require a certain mix of health professionals. The training institutions must respond to this need, not only for treatment services but also for prevention. HRSA and the schools must collaborate on these issues to obtain the best results. However, it must be recognized that this is not the only responsibility of the medical schools.

The older schools, Howard and Meharry, have led the way in assessing the impact of their training on the medically underserved. The Meharry survey (Appendix D) is a good example, albeit it could be improved. The primary location of the physician's office is not a complete measure of physician commitment to the medically underserved. The patient mix may be a more useful indicator of that commitment. Physicians who allocate a portion of their time to the medically underserved should not be ignored. Even though the patient numbers may be the same, it may be better for society if 100% of graduates allocated 10% of their time to the medically underserved than if 10% of the graduates allocated 100% of their time. One must also decide who should be counted as graduates: the number completing the MD degree, in the case of medicine; or the number of primary care residents who complete their training; or both. These important questions require consensus, since the level of training often occurs at different institutions. Another issue is whether concern for the medically underserved should be limited to "the primary care specialties," or made the concern of all graduates of an institution?

Mission, Commitment, and Outcomes

The rewards of working at HRSA come, not from processing applications, but from seeing results. Those who have been involved in watching the developments in Family Medicine, for example, take pride in seeing the results across the country. Knowing that HRSA was a strong partner in this effort gives a sense of personal pride. Those that have benefited from funding for the Physician Assistant program at the Black medical schools are grateful for the assistance from HRSA. The Black medical schools, too, take pride in seeing the success that has come to their graduates and the benefits to the community. The reward from having results-oriented objectives is the satisfaction that derives from achieving measurable outcomes and participating in the process. The task of affording access to the medically underserved in America is enormous and it helps

to know that real progress is being made. HRSA and the schools share this burden and must work together in setting the objectives and measuring the outcomes.

Recommendation 4: HRSA and the Black medical schools should collaborate in defining results-oriented and measurable objectives for the nation and for the schools.

The Specialty Versus the Team Approach

The organizational structure of HRSA is very much like that of the medical schools with its specialized departments. At a medical school, faculty in one department may not know what is occurring in another department. This is especially true in postgraduate training, where each specialty board accredits its own program. The segmentation of HRSA is clearly a function of the legislative process, and its mandate to respond to the special issues identified by Congress. A major difference, however, is that patient care often requires special medical interests to work as a team. The medical center must both respect the obligations of the specific disciplines and facilitate team management in the interest of the quality of patient care.

In the course of interviews at the schools, it was clear that many members of the faculty did not appreciate the full extent of HRSA's programs. Merely putting a list on the Internet does not achieve the desired end. One activity at HRSA promises to be more effective in this regard—the agency technical assistance teams. These combined agency activities appear to be helpful to both HRSA and the schools in conveying a better understanding of HRSA and its role in addressing the needs of the medically underserved. The agency technical assistance teams should be continued.

Experts in organizational theory no longer consider the bureaucratic structure of organizations to be the ideal even though an organization may be structured in such a way as to increase productivity and maximize efficiency. Instead, these experts encourage different metaphors such as viewing organizations as organisms or as brains. The matrix organization combines the functional or departmental structure found in a bureaucracy with a project-team structure. It is difficult to change the structure of an organization from a purely departmental structure to a matrix structure. Those who have tried it in an academic institution have not always been successful. Morgan writes:

“ Matrix and other team-based organizations tend to be driven by meetings that, at times, can be very time consuming, but, when working effectively, can be very productive.”⁶

A matrix organization may not be the best organizational structure for HRSA, but greater emphasis on team activities could have benefits both for HRSA and the schools.

At the schools, there is also a need for more team activities, especially as it relates to HRSA programs, beginning with the project application and continuing through implementation. Presently, preparing a HRSA application is almost always a solo effort, and puts an enormous strain on the preparer, undoubtedly already under a heavy workload. There is more of a solo effort for training grants than for research grants. A team approach to proposal writing could result in higher quality proposals. It is not unusual for an institution to have more than one HRSA grant but in separate components, such as medicine and dentistry, or medicine and allied health. These components may operate without any collaboration.

Another opportunity for team activities at HRSA could be to have the same project officer for the same schools, but covering several programs. A HRSA project officer would thereby be familiar with the operation of several programs and with a group of schools. There are ample opportunities for joint HRSA and school teams working together on several activities. Team interaction could result in greater productivity and personal satisfaction for those involved. Some may argue that preserving the financial integrity of the programs would inhibit more team activities; but team activity may be achieved concurrent with full accounting for the allocation of financial resources. Another possibility for a team approach is for HRSA to support HRSA centers, similar to research centers, that draw from diverse disciplines within the school.

Opportunities abound for joint HRSA and school teams working together on several activities. One of the HRSA interviewees suggested such a working group for reviewing the guidelines. Participants could be drawn from those schools demonstrating the greatest commitment to the mission of HRSA. Such participants could learn more about HRSA and could also be added to the list of peer reviewers. Joint activities are beneficial for HRSA and the schools.

Complaints were heard at the schools about the preparation of proposals being largely a solo effort. The schools' Offices of Grants and Contracts believed that they

were more helpful than the faculty found them to be, especially with respect to proposal writing. The Offices of Finance were reported usually to be helpful only in checking the budget. Training grants sometimes receive less assistance from school resources than research grants and may be less understood by the general faculty. The allowable indirect cost is lower than that of other grants and may have a lower priority in the institution than grants that allow the full indirect cost. On the other hand, there was one model cited at Morehouse that appears to offer a solution to the problem. Several members of one department were trained in the preparation of proposals. If a similar strategy were adopted and enhanced by the schools, the writing of proposals could become more of a team effort and the input from the Office of Grants and Contracts and the Office of Finance could then be even more valuable. This investment would seem to be a valuable one for all schools. A team approach cannot help but leverage HRSA's technical assistance. An added advantage is that the loss of one faculty member does not set back a department if the knowledge has become part of institutional memory.

Recommendation 5: Schools should develop institutional teams competent in high quality proposal preparation rather than depending on the solo efforts of individuals for grant submission.

Recommendation 6: HRSA and the Black medical schools should seriously consider exploring greater team activities within and among their organizations. Greater collaboration among schools with similar missions should also be encouraged.

Management by Information

The investment model recommended to HRSA benefits from rapid access to pertinent information. During the latter part of the twentieth century, the United States moved rapidly into the information age. It became possible to have instant information. This revolution has had a great impact on the management of business and education. In business, those organizations with access to information technology have a great advantage over those who do not. Virtual organizations use information technology to eliminate the barriers associated with time and space and to coordinate activities around the world. With the advent of inexpensive microcomputers able to process large volumes of information rapidly, each component of an organization has its own source of information and access to information that was formerly limited to a few at the highest

levels. Distance learning made it possible to democratize education and allow workers to pursue degrees without full-time attendance at a university. Not all the changes have been positive but they have occurred so rapidly and have been so widespread that it has been impossible to stop them.

Some of the same changes are occurring in government offices, as the government seeks to increase productivity and decrease costs. Some of these changes are occurring at HRSA, and have been used in the area of technical assistance. For example, communication with grantees is now conducted by e-mail and program information is posted on the Internet. However, it is generally felt that there has been a decline in the quality of HRSA technical assistance. This view was expressed by long-term employees of HRSA and by faculty members at the schools who had long-term relationships with HRSA. Information technology should be used to increase productivity, but not at the expense of relationships, especially for those organizations that depend largely on their relationships. Information technology can make the organizations more productive in certain aspects while at the same time affording time for cultivating better relationships.

It is not clear to what extent information technology has influenced management in general at HRSA. Its greatest benefit to the organization in this respect would be to make information rapidly available for management to determine whether the objectives of the organization were being achieved, and to take corrective action when this is not occurring. Because the objectives of the training component have not been satisfactorily defined in measurable terms, it is less likely that management is benefiting as it should by the availability of information technology. Obtaining the information for this project on funding took longer than would ordinarily be expected if the agency were operating with a fully automated information system. This was in part due to the fact that more data was initially requested than was necessary, such as individual information on all medical schools funded by HRSA, and because some of the data was not actually at HRSA but at NIH. The financial component is, however, only one component of a well-designed information system for the agency.

It appears that HRSA does not have critical data on the extent to which its training program activities are influencing the amount of care accessible to the medically underserved. This may be the reason that it places a burden on the applicant to complete

statistical data as a part of the application process or progress report. Most grant applications, public or private, focus on the nature of the problem to be addressed, the method by which it will be addressed, the competence of the applicant to do what needs to be done and the cost. The non-HRSA program progress reports focus on the extent to which the proposed plan was completed and the results obtained. By comparison, the HRSA applications and progress reports require a great deal of statistics that are not always available to the applicant, and the usefulness of providing the data is not always apparent. Results tend to be less than satisfactory when information systems fail to obtain adequate input from the end-users. This lesson was learned early in the reporting system of the neighborhood health centers. At the same time, HRSA needs to have its own system of national data collection that will allow it to monitor the extent to which defined objectives are being met, specifically with regard to meeting the health needs of the medically underserved.

The Black medical schools may be only slightly better users of information technology. The information technology under which the four schools prepare and manage grants is not currently state-of-the-art. However, with the exception of Howard, the four schools were able to submit their financial information more rapidly than the agency. A few medical schools in the country make excellent use of information technology for managing the institution and it makes a significant difference in their ability to use and to gain resources. Clear definitions of objectives, in measurable terms, at each organizational level and the organization as a whole, integrated into appropriate information systems, results in an enormous advantage. This alone may well account for the differences noted between the majority and the minority schools.

An institutional information system has many components. The most critical component from the perspective of the schools and of HRSA concerns the data required by many of the HRSA applications. This information is very important to both HRSA and the schools. Some interviewees at HRSA expressed the opinion that solid evidence did not exist to support the claim that minorities were more likely to practice in underserved areas. Interviewees at the schools unequivocally believed that minorities did gravitate toward practicing in underserved areas. Indeed, a classic paper on the subject published by a faculty member at Drew showed that minorities were twice as likely to do

so as majority physicians.⁷ If HRSA program staff is uncertain about this information, then it is also uncertain about the effectiveness of its programs. HRSA needs reliable independent information on which to base its programs and should not entirely depend on statements in grant applications. The schools should continue to conduct their own surveys but HRSA should also have national information to support its programs. Schools funded by HRSA could join with HRSA in designing a reporting system that would provide all parties pertinent information without making it a large part of the grant application. More of the application could then be allocated to a discussion of the method that the schools plan to use in implementing the project, while adhering to the prescribed page limits of the application. One alternative is to have the statistical data submitted by the school, such as by its Office of Grants and Contracts, prior to the submission of an application by a principal investigator. The National Cancer Institute, in its Cancer Support Program, routinely requires the submission of certain data prior to the submission of a grant application. One advantage of having the school submit the statistical data, rather than the program director, is that it becomes significantly more important to the school and brings, to the school as a whole, a greater awareness of HRSA.

Recommendation 7: HRSA and HRSA-funded schools should together design an information system that would provide information for evaluation of school performance without inclusion of this data in the grant application and the progress report. Statistical data needed by HRSA should be submitted by the schools, rather than a principal investigator, and should be submitted prior to the HRSA grant applications.

Focus on the Institution Rather than on the Grant Application

HRSA adoption of an investment model for program operations would focus greater attention on the institution than on the grant application. Wise investors focus on the operations of strong companies rather than on the stock prices of the companies. If a school possesses both strong leadership and a strong commitment to the mission of HRSA, grant applications can easily be improved. On the other hand, HRSA makes a short-term, and therefore bad, investment when a departmental application is strong but the institutional commitment to HRSA's mission is weak. This is true whether the

institution is a majority or a minority institution. HRSA should seriously encourage a stronger focus on institutions firmly committed to HRSA's mission and award institutional grants, allowing the institutions to meld their HRSA programs together in ways that optimally meet the objectives of HRSA and their own commitment to HRSA's mission. Grants should even include some support for a key person at the institution who would be the principal liaison with HRSA and HRSA programs. Having such an investment model would result in a broader understanding of HRSA and its programs.

Greater team activity could be also fostered at the school level if HRSA made institutional rather than departmental grants. Many students come to medical school with the intent of making a commitment to the medically underserved upon graduation but are discouraged from doing so during the years of clinical training. The stronger an institution's commitment to addressing the medical needs of the medically underserved the more likely their students will also possess the same commitment upon graduation, thereby advancing HRSA's mission.

Recommendation 8: HRSA should increase its focus on the schools by making institutional grants, wherever possible, and encourage coordination of HRSA programs at an institution.

Modifying the Peer Review Process

Within HRSA, the peer review process is perceived in different ways depending on who has responsibility. The process is centralized within the Bureau of Health Professions but not centralized within the Maternal and Child Health Bureau. Program staff within the Bureau of Health Professions expressed concern that they no longer control the process. Program staff within the Bureau of Maternal and Child Health expressed concern about having to do non-professional work associated with having the responsibility for the peer review process. Staff of the Peer Review Branch in the Bureau of Health Professions are satisfied that the centralization of the process has added efficiency and quality to the process, and they are probably right.

The HRSA interviewees generally agreed on a need for greater representation on peer review panels on the part of the minority institutions. Of the interviewees at the schools, those who had participated in the peer review process were generally pleased to

have had the opportunity to do so, and agreed that such participation is an excellent learning experience. Those who had not participated in a peer review indicated that they had not been asked and further did not know how to obtain an invitation. A thorough review of the material submitted for this study indicated that Morehouse seemed to have participated more often than the other schools. (The data provided did not include information on Drew.) In one department at Morehouse, the chairman had not participated but a representative from that department who had participated would routinely share important information from that participation with the department chair. It is a mistake on the part of the schools to have someone participate in a HRSA peer review panel and not share their learning experiences with other members of the faculty.

Interviewees, who had served as peer reviewers, stated that they noticed that members of peer review panels often failed to understand what it is like to be at a minority institution. They keenly experienced a sense of being a minority or being from a minority school when serving on peer review panels. They felt that while they could place a valid point of view on the table, they were always in the numerical minority and relatively powerless to influence the process or outcomes. The discouraging aspect of this is the fact that even if there were more minorities participating in general, the minorities would always be a numerical minority on any committee. The matter is made worse by the feeling of some of the interviewed faculty that HRSA does not evaluate proposals in a manner consistent with its objectives. They are convinced that if the evaluations were more consistent with HRSA objectives, the fact that minorities always comprise a numerical minority on a committee would not be such a problem. Lacking an emphasis on consistency with HRSA objectives, the application process becomes an essay contest and those who write the best essay win. They argue strongly that the applications submitted by minority institutions are as competitive as any, or more so, if one takes the HRSA objectives into consideration. This point of view deserves very serious consideration. If there is to be a dominant view on a peer review committee, it should be based on the level of commitment to the HRSA's mission; and there should be a way of assuring that this view predominates.

Recommendation 9: The scoring for the review process should be reevaluated to ensure that proposals are judged more rigorously on the basis of HRSA's stated mission and objectives.

Adding Meaning to Preferences

Questions to the HRSA staff and the faculty from the Black medical schools about preferences resulted in vague answers, indicating that the procedures for preferences are not generally understood. This is not surprising when one considers the complexity of the process and the number of preferences that exist. A discussion of preferences by program is included in the appendix. Clearly the preference process should not be part of the peer review procedure and the peer review panels should not be concerned about this. However, the procedure by which a grant applicant obtains preference should be clearly stated. It is not clear at present. Funding should be assured if the approval rating is satisfactory and the preference accurately determined.

Recommendation 10: The requirements and conditions necessary for preference should be clearly defined by HRSA's administration, clearly stated to all applicants, and separated from the peer review process.

Technical Assistance and Self-Assistance

Personnel at HRSA and faculty who have had a long relationship with HRSA agree that the technical assistance has deteriorated over the years. There is still a great deal of technical assistance but the quality of that assistance has changed due to the inability to make site visits and have direct personal relationships as was more common in the past. The reason usually given for this is the shortage of staff and the limitations on travel. These relationships may be critical to assuring the success of HRSA's mission. Perhaps these close relationships can be rekindled, and HRSA productivity increased, without dramatically affecting HRSA staff or budget constraints.

Agency technical assistance, as opposed to the program-by-program assistance, offers some real possibilities and should be continued. It could be enhanced by directing it towards institutions with several HRSA programs and particularly to institutions with a faculty member who represents HRSA programs throughout the campus. Further, the model of departmental teams at the schools collaborating on applications institutionalizes what has been learned, and as a by-product decreases the reliance on potentially mobile

individual faculty members. Both of these approaches have been discussed above. There remains the need for institutionalizing relationships both at the HRSA level and that of the schools.

Schools can be clustered according to their commitment to HRSA's mission or according to geography to assure maximum use and successful technical assistance. Strong relationships can be established and maintained by having the same contacts on both sides. HRSA should also consider clustering its grants at institutions whenever possible, which would result in a smaller number of grants and grantees. Arrangements of this kind could diminish the workload at HRSA and at the institutions and allow more time for maintaining relationships.

Travel by HRSA staff, however, remains essential. Persons who have not worked in a university setting, and especially in a minority institution, do not really understand the situation on the basis of reading proposals. The HBCUs feel that persons who have not visited the applying HBCU do not truly understand the HBCU's efforts and that this failure to understand is unfair to the HBCUs. The team arrangement and the establishment of long-term relationships can decrease, but not altogether eliminate, the need for travel. HRSA should find a way to allow appropriate travel both by the agency and by the grantee.

Recommendation 11: Agency technical assistance, clustering, and long-term linkages should be used to minimize the workload and increase productivity without sacrificing relationships. There will still be a need for site visits to understand the schools and the circumstances under which they operate.

Recommendation 12: The Black medical schools should institutionalize self-assistance and develop local expertise in the operation of all HRSA grants administered, regardless of department or division of the institution. School experts should be encouraged to visit HRSA for the purpose of developing a mutual understanding of each other's missions, objectives, responsibilities and duties.

The Duration of Funding

The most striking observation with respect to funding is that HRSA's funding is not in any way proportionate to the task that it has to perform. A serious attempt to address the problem of access for the medically underserved of the country would

certainly require additional funding, even if the funding were leveraged, as it presently is by the schools.

With respect to the Black medical schools, there is no observable impact of the Executive Order. With the proportion of minorities in the country increasing, and the number of Executive Orders increasing without increased funds, there is a risk of increasing conflict among minority groups rather than a concerted effort to solve the national problem. There is a strong emphasis on self-sufficiency among the staff at HRSA that is sometimes counter-productive. HRSA does not recognize the success that minority schools have had in training persons committed to meeting the needs of the medically underserved. It is difficult to understand why HRSA should try to place the full financial burden of training persons for the medically underserved on schools that are fully dedicated to this mission and are leveraging HRSA investments by producing results that are twice as great as majority institutions. As an example, the awards to Morehouse for these programs amount to only 3% of its annual budget. It is difficult to understand why anyone should resent supporting such an important effort at a level of 3%. These schools are not looking for a handout. The oldest schools have been giving all they had, and more, to this cause even before the establishment of HRSA. The younger ones are doing the same. There should be less talk about self-sufficiency and more recognition of those contributions. There are those at HRSA who recognize the contributions that these schools have been making and see a better solution as finding a stable base of funding. One proposal was to make these schools a line item in the federal budget. Wise investors abandon their investments only when they have to do so or find better investments. The minority schools are good investments, and funding should be assured as long as they continue to fulfill their mission and HRSA has the funds.

HRSA operates within the limits of legislative authority. Schools should not expect it to do what it is not authorized to do. HRSA and the schools both work in the public interest, and as such deserve full legislative support. The interviews at the schools indicate that they fully recognize the need for HRSA to be more adequately funded to do the task it is assigned. The schools have confidence that, under the present circumstances, HRSA can do more than any other agency to meet the present challenge.

Recommendation 13: HRSA should fully recognize the contributions of the Black medical schools, and, rather than urging them to assume the full responsibility for training the needed health professionals, should support efforts to assure their continued funding, as long as they remain faithful to their mission.

Sharpening the Focus on Minority and Highly Committed Institutions

When funding goals are reviewed and monitored within the agency, someone familiar with these institutions should be present to participate and make suggestions to assure that the goals are met. This requirement will help to realize the goals of the Executive Orders, including the goals for Hispanic Serving Institutions and Tribal Colleges. It is important to sharpen the focus on those institutions, minority or not, that are most highly committed to HRSA's mission. In addition to this criterion, the Executive Orders should result in a sharper focus on minority institutions or institutions with large percentages of minority students and faculty.

Recommendation 14: There should be in the Office of the Administrator an individual closely tied to program operations and planning who can participate in policy decisions with respect to minority schools and other schools that are strongly committed to the mission of the agency.

Conclusions

The ideal solution for both HRSA and the Black medical schools depends on leadership that is able to institutionalize a commitment to serving the needs of the medically underserved. Because the missions of HRSA and the schools are complementary, a close working relationship between the agency and the schools is critical and that relationship should be strongest for those institutions that are most committed to HRSA's mission. Working together, and using the investment model, should result in greater funding for HRSA and more stable funding for those institutions that are most committed to serving the medically underserved as judged by meeting measurable outcomes and clearly defined objectives.

ENDNOTES

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Appendix A

Categories of Participants by Bureau, Program, and Schools

Health Resources and Services Administration

Twenty persons were interviewed at HRSA, drawn from a list provided by the Office of Minority Health:

- The Bureau of Health Professions
- The Maternal and Child Health Bureau
- The HIV/AIDS Bureau

Interviewees were primarily from The Bureau of Health Professions and its components:

- The Division of Disadvantaged Assistance
- The Division of Medicine
- The Division of Associated Dental and Public Health Professions
- The Grants Management Branch
- The Peer Review Branch

Key Personnel were interviewed from the following training programs:

1. Health Careers Opportunity Program
2. Area Health Education Centers
3. Geriatric Education Centers
4. Rural Interdisciplinary Training
5. Nurse Midwifery
6. Interdepartmental Adolescent Training
7. AIDS Education and Training Centers
8. Physician Assistant Training
9. Faculty Development in Family Medicine
10. Faculty Development in General Internal Medicine and Pediatrics
11. Establishment of Departments of Family Medicine
12. Graduate Training in General Internal Medicine and Pediatrics
13. Graduate Training in Family Medicine
14. Preventive Medicine and Dentistry
15. Centers of Excellence
16. Health Education Training Centers

The Four Black Medical Schools

Fifty-three persons were interviewed from the medical schools. The interviewees included:

- Deans (Medicine, Dentistry and Allied Health)
- Chairs and department representatives (Family Medicine, Community Health and Preventive Medicine, Obstetrics and Gynecology, Pediatrics, Internal Medicine, Dentistry, Medical Education, Allied Health and Nursing).
- Directors and representatives from the Offices of Grants and Contracts
- Vice President for Sponsored Research, Offices of Sponsored Programs, and Office of Research Support Services.
- Representatives from MS/PH programs and Health Administration
- Vice Presidents and Special Assistant to the Vice President

Appendix B

Description of Training Programs Under Study

The list of programs included in this study is specified by the contract and does not reflect the total range of programs provided by HRSA. The descriptions of each program are provided to demonstrate the range of training programs available to the Schools for participation. The distribution of the programs by Bureau, and Division of the Bureau, is given in Table 1.

Centers of Excellence

This program assists eligible schools in supporting programs of excellence in health profession education for underrepresented minority faculty and students. The goal of this program is to increase the number of underrepresented minority individuals that enter the educational pipeline for health profession careers. The program is designed to facilitate the establishment of new programs, the strengthening of existing programs and/or expansion of programs that enhance the academic performance of underrepresented minority students. Funding is provided to improve the school's capacity to increase the number of underrepresented minority faculty, and to increase training on minority health issues including research and service delivery through community based facilities.

Health Careers Opportunity Programs (HCOP)

The Health Careers Opportunity Program was established in 1973 “to correct inequities in access to health careers by removing the cultural, educational, and other discriminatory barriers that historically discouraged

minorities from pursuing health careers.” The Bureau funds projects to increase the number of individuals from disadvantaged backgrounds that enter into and complete their health or allied health profession education. These programs facilitate the entry of individuals from disadvantaged backgrounds to such schools and provide preliminary education to individuals from disadvantaged backgrounds so that they can successfully complete training. The grantee is required to use the funds awarded to develop a large competitive applicant pool through linkages with institutions of higher education, local school districts, and other community-based entities. The grantee is also expected to establish an educational pipeline for health professions careers.

Area Health Education Centers (AHECs)

Viewed as one of the Bureau’s most successful initiatives, the Area Health Education Centers (AHECs) program was established in 1972. AHECs address the problems of distribution of health professionals and access to care through educational interventions providing clinical experiences in areas remote from the academic institution. Approximately two thirds of the Nation’s medical schools are linked to AHECs. This program was established to improve the supply and distribution of health care professionals, with an emphasis on primary care, through community/academic partnerships. AHECs are collaborative partnerships that address current health work force needs in a region of a state, or an entire state.

Health Education and Training Centers (HETCs)

This program provides funds to help schools improve the distribution, supply, quality and efficiency of health services personnel providing care to medically underserved populations in the State of Florida, States on the U.S.-Mexico border, and other urban/rural areas of the United States. The program encourages health promotion and disease prevention through public education in border and non-border areas.

Establishment of Departments of Family Medicine

This program awards grants to establish, maintain or improve academic administrative units that provide clinical instruction in family medicine. The program provides funds to plan and develop pre-doctoral education, faculty development, and graduate medical education programs in family medicine. It provides support for academic and clinical activities relevant to the field of family medicine and provides funds to strengthen institutional structures responsible for planning, coordinating and evaluating undergraduate and graduate training in family medicine.

Pre-doctoral Training in Family Medicine

The program is designed to promote pre-doctoral training in allopathic and osteopathic family medicine. The program assists schools in meeting the costs of planning, developing and operating or participating in pre-doctoral training programs in family medicine. The intent of this program is to encourage graduates to seek residency training in family medicine and to encourage entry

into a family medicine career. The program provides funding for curriculum development, clerkships, preceptorships, and/or student assistantships.

Graduate Training in Family Medicine

The program is designed to assist with the training of physicians in family medicine. The program provides support to plan, develop and operate graduate medical education programs in the field of family medicine. Qualified schools include accredited schools of medicine, osteopathic medicine, public, private nonprofit hospitals and/or other public or private nonprofit entities.

Faculty Development in Family Medicine

This program is designed to provide funds to increase the supply of physician faculty available to teach in family medicine programs and to enhance the pedagogical skills of faculty teaching in family medicine programs. The program provides funds to public and private nonprofit hospitals, schools of medicine and health education institutions that serve to increase the supply of faculty of family medicine programs.

Faculty Development in General Internal Medicine/General Pediatrics

This program is designed to increase the supply of physician faculty available to teach in general internal medicine or general pediatrics programs. In addition, the program has a component that provides funding for the enhancement of pedagogical skills of faculty teaching in general internal medicine or general pediatrics programs. The program provides funds public and private nonprofit, hospitals, schools of medicine and health education institutions that serve to

increase the supply of program faculty of general internal medicine or general pediatric programs.

Residency Training in General Internal Medicine/General Pediatrics

The program is designed to assist with the promotion of graduate training in general internal medicine and/or general pediatrics. The program provides support to graduate training programs that emphasize continuity, ambulatory, preventive and psychosocial aspects of the practice of medicine. The program assists schools with meeting the costs of projects to plan, develop and operate approved residency programs that emphasize the training of residents for the practice of general internal medicine or general pediatrics.

Physician Assistant Training

This program assists schools to meet the costs of projects to plan, develop and operate or maintain programs for the training of physician assistants and for the training of individuals who will teach in those programs. The program requires that applicant schools develop and use methods designed to encourage graduates of the program to work in health professional shortage areas. Eligible programs include physician assistant programs accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission of Allied Health Education Programs.

Residency Training in Preventive Medicine

The program provides grants to accredited schools of allopathic and osteopathic medicine, and public health, to help promote graduate medical education in preventive medicine. The program also provides funding to advance

the cause of health promotion and disease prevention. Funding is provided for three-years to assist schools with the planning and development of new residency training programs. Funding is also provided for maintaining and/or improving existing residency programs and for financial assistance to trainees.

Geriatric Education Centers (GECs)

This program is designed to strengthen multidisciplinary training of health professionals in the diagnosis, treatment, and prevention of disease and other health concerns of the elderly. The program provides grants to accredited health professions schools, physician assistant programs, and schools of allied health, to assist with costs related to improving training in geriatrics, including residencies, traineeships, or fellowships. The program also provides support for geriatric treatment curricula, faculty training on geriatrics, and continuing education on geriatric care. The program also provides students with clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

Primary Care Dentistry

This program supports postdoctoral general dentistry residency training programs that have a proven record of producing diverse graduates who are more likely to practice in underserved areas.

Rural Interdisciplinary Training Initiative

The program funds interdisciplinary training projects designed to use new and innovative methods to train health care practitioners to provide services in rural areas. The program encourages and prepares health care professionals to

enter into and/or remain in practice in rural America. Projects funded under this program demonstrate and evaluate innovative interdisciplinary methods and models designed to provide access to cost-effective comprehensive health care to individuals residing in rural areas.

Maternal and Child Health Training (MCH)

The program serves to increase the leadership of MCH professionals, and to facilitate the implementation and updating of new information, research and technology related to maternal and child health. The program also provides support for short-term, non-degree workshops, and meetings on maternal and child health. MCH also supports the development of curricula, guidelines, standards, and educational tools designed to assure quality health care for the maternal and child populations. An additional program offered by MCH to the schools, is its Continuing Education and Collaboration in Pediatric and Child Psychology program. It fosters continuing education in pediatrics and child psychology and promotes the development of programs that are designed to address practice challenges faced by community practitioners. The emphasis of this collaboration is on the psychosocial-development aspects of child health.

AIDS Education and Training Center Programs (AETC)

This program provides funding to nonprofit entities and schools for projects related to HIV/AIDS diagnosis, treatment, and prevention. The purpose of the AETC is to improve the care of people living with HIV/AIDS by supporting clinical consultation, education, and training for clinicians serving this population. This is accomplished through the training of health personnel, including

practitioners in programs funded under the Ryan White CARE Act and other community providers. The program includes a national network of 15 centers that conduct targeted, multi-disciplinary education and training programs for health care providers. These centers are designed to increase the number of health care providers who can diagnose, treat, and manage care for individuals with HIV/AIDS. These programs fall within the new Bureau of HIV/AIDS.

Summary of HRSA Training Programs by Bureau and Division

PROGRAM	BUREAU	DIVISION
Centers of Excellence	Health Professions	Disadvantaged Assistance
Health Careers Opportunity Program	Health Professions	Disadvantaged Assistance
Area Health Education Centers	Health Professions	Medicine
Health Education Training Centers	Health Professions	Medicine
Establishment of Departments of Family Medicine	Health Professions	Medicine
Pre-doctoral Training in Family Medicine	Health Professions	Medicine
Geriatrics Education Centers	Health Professions	Medicine
Faculty Development in Family Medicine	Health Professions	Medicine
Faculty Development in Pediatrics and General Internal Medicine	Health Professions	Medicine
Residency Training in Pediatrics and General Internal Medicine	Health Professions	Medicine
Physician Assistant Training	Health Professions	Medicine
Residency Training/Preventive Medicine	Health Professions	Allied Health/Dentistry Public Health
Geriatric Education Centers	Health Professions	Allied Health/Dentistry Public Health
Faculty Development in General Internal Medicine/Dentistry	Health Professions	Allied Health/Dentistry Public Health
Rural Interdisciplinary Training	Health Professions	Allied Health/Dentistry Public Health
Maternal and Child Health Training	Maternal and Child Health	Research Training and Education
AIDS Education and Training Centers	HIV/AIDS	Training and Technical Assistance

Appendix C

BHPR-Funding Factors: Description of Preferences by Program

Appendix D

Alumni Physicians Questionnaire: Meharry Medical College