Promoting "Rural" with Residency Programs

NOSORH recently asked SORHs in states with rural residency programs to share information about any work they do to promote "rural" within residency programs – anything they do to provide outreach promote the visibility and value of rural practices, etc., as well as any partners with them on those efforts. The following is a summary of responses that NOSORH has received to date:

Alabama

The Alabama Office of Primary Care and Rural Health (OPCRH) conducts many activities to support rural residency programs.

1. **Annual Physicians of Alabama Opportunity Fair** – OPCRH partners with the Alabama Hospital Association, the Alabama Academy of Family Physicians, Alabama schools of medicine and others to host this opportunity fair for primary care physicians. Rural residency programs and hospitals/clinics in communities with 22,500 people or less are invited.
2. **Rural Health Career Planning Guide** – OPCRH created and distributes this resource to junior high students in Alabama.
3. OPCRH collaborates with the West Alabama Rural Medical Care Alliance, the Alabama Rural Health Association, the Rural Medical Scholars Program and the Family Practice Rural Health Board (FPRHB) on various initiatives. Virtually all FPRHB grant/contract awards focus on training family practitioners in rural environments.
4. **Alabama Family Medicine Council** – OCPRH serves on this committee of family practice residency programs located throughout the state.
5. OPCRH facilitated a conference call with the Alabama Chamber of Commerce Education Program Director and Envision 2020 regarding health profession high schools and pipeline programs.
6. OPCRH is facilitating meetings between the Alabama Department of Education Health Science Advisory Council, Alabama family medicine residency directors and the Health Occupations Students of America to establish linkages between family residency programs and junior high and high school science/health occupation programs.
7. OPCRH is working with the dental school and Medicaid Oral Health Coalition to link pipeline efforts with the primary care residency programs, with the primary focus being to develop an AHEC-like program in Alabama.
8. **Crucial Conversation on Recruitment and Retentions of Healthcare Professionals Mini-Conference** – OPCRH was instrumental in coordinating this mini-conference focused on creating a recruitment and retention pipeline and creating recruitable community programs. Nurse practitioner program directors and family practice and internal medicine residency directors were the primary participants in this conference.
9. OPCRH shares information about the National Health Service Corps Loan Repayment Program and the Alabama State Loan Repayment Program with all Alabama residency programs in order boost interest for practicing in rural Alabama.
10. **Physician Placements** – Three four primary care physician placements coordinated by OPCRH in the past year were in rural areas.

Alaska

Alaska's Family Medicine Residency Program was set up with a primarily rural focus. The program, based in Anchorage with a rural retention site in Bethel, has a good record of retention placement in the state.

There is also a group working on developing a psychiatry residency for rural communities

Georgia

The Georgia Office of Rural Health partners with AHEC and hospital associations to promote rural residencies; it also partners with the Georgina Medical Education Board to promote recruitment programs and for using 3RNet.

Iowa

Iowa conducts a variety of activities and partnership projects to support and fund rural residency training tracks:

- Technical assistance— Host recruitment and retention workshops (See the following newsletter article):

A Rural Provider Returns to Iowa…
Thanks to Loan Repayment Support from Health Care Organizations
By: Erin Drinnin, MSW, Primary Care Recruitment and Retention Endeavor (PRIMECARRE)

Mary Ann Zakutney knows rural – she was born in a small mining town of 600 people and learned about the value of love and support from neighbors and the feeling of a strong community. She has lived and worked throughout the U.S. and the world, including American Samoa. She has also lived among the tribes of Borneo and Malaysia studying cultures, farming practices and family dynamics. Dr. Zakutney's first encounter with Fairfield, Iowa was in 1980 and again in 1983 when she taught nursing at the University of Iowa and worked as a family nurse practitioner.

Although Dr. Zakutney left Fairfield years ago to further her education, she leapt at the chance to return to practice as a family physician and bring her mother to reside with her in the community. "My experience in other countries as well as other cities have drawn me back to the more basic traditions of a community that has a strong relationship with the land and neighbors." She has incurred a significant amount of education loans and the opportunity for loan repayment was a significant incentive for accepting the position with Jefferson County Health Center.

Thanks to a partnership between the Iowa Department of Public Health (IDPH) and several private organizations, including Des Moines University, Mercy Medical Center – Des Moines, Iowa Health System, and the University of Iowa Health Care, IDPH was able to secure the dollar-for-dollar match needed for approximately $75,000 in federal funds toward loan repayment. These additional funds, which are being distributed through the loan repayment program, known as PRIMECARRE, are supporting health care providers like Dr. Zakutney who make a commitment to work in underserved areas in Iowa.

Dr. Zakutney is excited about her new job and residence, and hopes to become engaged in all facets of the community. "My commitment to this community is based on my respect for the people and their work. The diversity of the community in age, background, work, and cultural experiences is the right setting for my involvement as a family physician." In addition, Dr. Zakutney plans to educate new physicians and nurse practitioners about the benefits of living and working in rural areas and hopes to recruit them to rural Iowa.
Dr. Zakutney's story highlights the draw of rural communities, and the great opportunities that exist when the right connection happens with an experienced and compassionate health care provider. The IDPH would also like to take the opportunity to thank our partners on this project; their contributions are helping us improve access to primary care services for Iowans living in rural and underserved areas, and they made Dr. Zakutney's story possible!

- Outreach - Feature/promote rural family practice providers who were awarded SLRP (2) (see article in newsletter – "Bureau of Health Care Access Hosts IA R&R Workshop"):

On December 1, the Iowa Health Workforce Center and the Primary Care Office held a one-day recruitment and retention workshop for health professional recruiters from around the state of Iowa. This was the second event focused on recruitment and retention and provided information on key retention factors, tools for developing and implementing retention plans, and best practices in Iowa related to recruitment and retention.
The event included an update from the department regarding loan repayment, the Conrad 30 program, and the department's new Direct Care Workforce Initiative. Steve Shotwell from the Michigan Center for Rural Health, whose visit was made possible by the National Organization of State Offices of Rural Health (NOSORH), presented on his organization's physician retention study. The findings highlighted many "practice factors," such as professional satisfaction with practice, competent medical support staff, and communication and support of hospital administration as the major factors influencing retention among physicians in Michigan. Steve also shared the tool developed by the Michigan Center for Rural Health to assist non-profit and rural providers in developing and implementing retention plans. Dr. David Schmitz and Dr. Ed Baker from the Idaho Center for Health Policy joined the workshop via web-conferencing to present on their validated tool for improving rural communities' recruitment and retention practices. Known as the Community Apgar Project, Dr. Schmitz and Dr. Baker "assess" communities' abilities to recruit and retain family physicians based on five areas: geographic, economic, scope of practice, medical support, and hospital and community support. The presentation provided background information regarding the research and details about the process utilized with communities (a series of site visits and interviews) to develop a targeted plan for improving recruitment and retention practices.

- Policy - Recently worked closely with the IA Center for Rural Health & Primary Care Advisory Committee to send a memo to the UI to support rural track training (see attachment):

Dear Drs. Mason, Rothman and Robillard:
This letter advocates for increased attention to the rural health workforce shortages on behalf of the 43 percent of Iowa's population living in rural areas. The Center for Rural Health & Primary Care Advisory Committee's role as state stakeholders is to advise the Center for Rural Health and Primary Care (CRHPC). The CRHPC was created by the Iowa Legislature in 1994. The advisory committee was convened to act as a source of direction and guidance to the State Office of Rural Health staff in coordinating and collaborating with all Iowa agencies concerned with rural issues. (Further information on the CRHPC can be seen in the 2010 annual report at the following web site: http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/2010_rhpc_annualreport.pd)

Our committee includes governor-appointed representatives a broad spectrum of rural health stakeholders. The following web site lists the legislation authorizing the CRHPC, and the stakeholder categories that are to make up the Center (http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/rural_health_primary_care_code.pdf)

Currently, 54 Iowa counties are fully or partially designated as Federal Primary Care Health Professional Shortage Areas (HPSAs), 62 counties are entirely or partially designated as dental HPSAs, and all but 9 counties in Iowa are designated as mental health HPSAs. A decreasing dental provider enrollment trend in Medicaid participation worsens existing access difficulties, particularly for the very young and old.

A recent informal survey of rural Iowa stakeholders ranked health workforce recruitment, retention, education, and training as the highest priority facing rural healthcare in Iowa, and over 60 percent of the respondents cited the increase of rural tracks at medical and nursing schools as programs to assist in alleviating the rural health care workforce shortage. These interventions are also suggested as ways to help meet current needs and to address the increasing need for successful implementation of the Patient Protection and Affordable Care Act.

While various programs exist to recruit health professionals to shortage areas, there is a clear need to produce more clinicians who are ready, properly trained, and willing to practice in rural and underserved areas. Therefore, we request that the University of Iowa consider two strategies to support residents of Iowa.

First, include rural track programs in health care professions training at the University. Rural track programs provide clinicians with the background that supports and predicts their probability of seeking practice opportunities in rural areas. Numerous studies have shown there are several critical factors that predict whether or not health care students will practice in rural areas, including (among others) : 1) Students who come from rural/farm settings, 2) at least part of clinical training occurs in settings serving rural and underserved populations, and 3) training in primary care medicine/nursing. Fifty percent of our rural population is involved in agriculture. Production Agriculture is the most hazardous industry in the state. Although about 10% of the total persons employed in the state are in farming, they account for approximately 30% of all occupational fatalities. Rural track program development should include agricultural health and safety, occupational medical program training, and rural tracks in behavioral health fields such as psychology, counseling, and social work.

Second, admit students from rural backgrounds to medical programs. Research shows that the clinicians who grew up in rural areas are those who are most likely to return to practice in rural areas. Design admissions criteria so that preference is given to qualified students from rural Iowa.

According to the Association of Academic Health Centers (Moskowitz, 2007), “Institutions of higher education, from community colleges to academic health centers, play an indispensable role in nearly all aspects of health workforce development.” As a major producer of health and medical clinicians in Iowa, the University of Iowa is key to assuring that rural and underserved Iowans receive access to health care.

Recently the Congressional Committee on Appropriations passed the FY 2011 Year Long Funding Act. It provides $170.27 billion for health, human services and education including funding to decrease shortages of primary care practitioners and other providers through the health professions training programs. Rural Physician Training Grants were included in the Affordable Care Act.

On Thursday, February 10th, our committee will host a legislative breakfast in Room 116 at the Capitol. We will share the attached list of priorities for rural Iowans. We invite you to join us, beginning at 7:00 AM, as we share these priorities with legislators.

Thank you for your dedication and educational service to Iowans.

Sincerely,

Dr. Laine Dvorak, Chairperson

Iowa Center for Rural Health and Primary Care Advisory Committee

- Promote – Facilitated Dr. Larry Severidt as speaker at Region C Meeting. He spoke about the medical residency program and the success with rural placement

This is a good site! The family medicine residency maps are great
http://www.graham-center.org/online/graham/home/tools-resources/maps/local/ia.html

Missouri

The Missouri Office of Rural Health collaborates with the Missouri Primary Care Association (MCPA) on recruitment efforts. MCPA does make visits to the Missouri Family Medicine Residency programs that allow them to visit. The organization has been able to make great relationships and connections with several of those programs and continues to work with others to strengthen their relationship.

The partners have also been invited to attend and present information to some of the Family Medicine Interest Groups in the Missouri medical schools. They also do several exhibits and participate in the groups' career fairs, Hospital Days and conferences.

North Dakota

In the past, the North Dakota Center for Rural Health hosted an opportunity for students and residents to visit with rural communities. The event, called POND, was successful for about seven years; but, given the small number of residents in North Dakota and the fact that third-year residents had already usually committed, the numbers in attendance were small in the later years. CRH tried to revive POND by having a fair at another residency program on the west side of the state, but it was poorly attended.

Another idea being considered after attending a few CareerMD fairs out-of-state is to bring a similar event to ND. Because of ND's sparse resident population, it's hard to have a large career fair for just residents; so CRH is working with CareerMD to possibly expand their scope and invite PAs, NPs, nurses, PTs, OTs, etc. The idea is that healthcare delivery is a team effort, so career fairs shouldn't be insular to residents or other types of training programs.

CRH does residency visits promoting rural opportunities and loan repayment. It also hosts a community "meet and greet" for first- and second-year medical students that gives rural administrators a chance to meet with students attending UND.

As far as rural tracks, Minot is currently sending residents to Garrison; Bismarck has rotations in Fort Yates. The AHEC has been trying to figure out how to help residency programs set up rural rotations; it has also explored the subject of the one-two rural residency tracks program. Funding has apparently changed, which was always an issue in sending residents out of the clinics.

In terms of preceptors, much much more could and should be done in this area. The medical school does not pay preceptors. After the SEARCH rotation, certificates are given to the preceptors. Other SEARCH programs are starting to do awards. As far as preceptor education, the director of our family and community medicine program shares tips with them every time he meets with them.

Oregon

Oregon has one rural residency training program in Oregon – the Cascades East Family Medicine program in Klamath Falls, which is affiliated with Oregon Health & Science University (where the Oregon Office of Rural Health is located). While most of the collaboration between the residency program and OHSU is done through the AHEC, ORH does some things to support interest in rural among the medical, dental, NP and PA students. The Office sponsors some student scholarships to its annual Rural Health Conference; it hosts an annual "student BBQ" which brings together students, preceptors, clinics and hospitals; it used to pay travel expenses for dental students to do optional rural clinical rotations (until being told it was an inappropriate use of Flex funds); it publicized a blog done by one of the med students while on her rural clinical rotation; it has a seat on the advisory committee of the OHSU School of Nursing's Doctor of Nursing Practice (DNP) rural training track and is helping to find NP preceptors/sites (for as long as nine months); it speaks about rural practice, when invited, to classes of dental, medical and NP students.

South Dakota

South Dakota offers Rural Residency Programs in Family Medicine and Psychiatry through its AHEC Program Office at several sites: Rapid, Winner, Gregory, Parkston, Sisseton, Madison, Yankton, Redfield, and Sioux Falls. The Family Medicine rotations last four weeks; the Psychiatry rotations are one or two times per week for four weeks.

The South Dakota Office of Rural Health coordinates a "Community at a Glance" program with the Family Practice residencies in South Dakota. The program takes place over the lunch hour and all residency students are required to attend. A community leader/hospital administrator spends about 15 minutes showcasing their community and highlighting the job opportunities that are available. The remaining time is spent with the physician giving a case study on a topic of their choice.

The following text is from a handout that also describes the program:

Community at a Glance
A program presented by the Office of Rural Health to showcase individual rural South Dakota communities for the Residency Programs of the state.

An excellent source of potential candidates for practicing medicine in rural South Dakota communities is the people in training who will be seeking their first positions. It is generally felt that this group is the easiest to recruit. There are relatively few physicians and other health professionals who wish to relocate at any time.

Communities that are going to be successful in their recruitment efforts need to recognize the long-term value in establishing a continuum of contact with health professions students. Communities establishing these communication links with students often improve their ability to recruit the students when they complete their training.

The Office of Rural Health, in conjunction with the USD School of Medicine, has developed the Community at a Glance Program to provide communities an opportunity to present their individual practice opportunities in an uninterrupted scenario to the candidates currently in training. This scenario provides a rural community the chance to show off its community pride/spirit and showcase its practice opportunity leaders, which will allow for a better understanding by the candidate of the physical environment of the practice and a realistic appraisal of future opportunities.

- **Communities will showcase their practice opportunities for a Residency Program**
- **No other activities or programs will be held during the exclusive presentation**
- **Office of Rural Health will:**
- **Facilitate a planning session for each community visit**
- **Provide technical assistance**
- **Coordinate community visitation**
- **Communities will:**
- **Attend planning session**
- **Include a physician presentation to residents**
- **Send team to showcase community/practice opportunity**
- **Provide evening meal for residents and significant others**
- **Provide display and promotional materials for visitation**
- **Create display materials for off-site medical school locations**

Vermont

The following information was provided by the AHEC program office at the University of Vermont and Vermont's Family Medicine residency program:

- The University of Vermont, in partnership with Fletcher Allen Health Care, has the mission of being a national model for the delivery of high-quality academic health care for a rural region. The family medicine residency training, based in Milton, Vermont, provides residents with an immersion experience in a rural community (despite being located in a Metropolitan Statistical Area). The residency's work includes community outreach and projects in the local schools and community center.
- In addition, the AHEC supports two months of "Vermont Community Rotations" which – through partnerships with many rural practice sites including community health centers – enable residents to practice in more remote environments in the state. Part of their work at these sites involves community assessments.
- The residency program has a listserv of more than 100 participating family physicians that is utilized as a best practice communication tool. Latest research findings are distributed to practicing physicians on this network. This is something that could be improved and expanded perhaps with new media.
- The UVM OPC and AHEC use their federally funded SEARCH grant to enable rural rotations for the dental residency program. These residents are hosted at the CHCB site and each does clinical time at The Health Center in Plainfield. These are called AHEC/SEARCH rotations. There are barriers (financial and others) to hospital-based residency programs sending residents to off-

site/non owned sites (e.g.,rural rotations) because of how CMS pays/reimburses hospitals for the residents and the rules associated. The financial disincentives must change.

- I also believe that our AHEC program helps residents locate local housing, may provide stipends for housing and gasoline during their rotations, and may helping residents connect socially in the local area.