



National Organization of
State Offices of Rural Health

Toolkit for Recruitment and Retention of Primary Care Physicians in Rural Areas

DRAFT
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**FAMILY MEDICINE RESIDENCY
OF IDAHO**

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I. INTRODUCTION

A. The Role of the State Office of Rural Health in Recruitment and Retention

State Offices of Rural Health (SORHs) are funded by the [Federal Office of Rural Health Policy](#) (FORHP) to conduct three core activities: coordination, information dissemination and technical assistance. The work to support recruitment and retention can be accomplished and be part of these core functions. SORH should plan their recruitment and retention activities as part of these core activities based upon their capacity and the needs of their rural communities and partners.

In planning and conducting the coordination and collaboration activities SORH serve as conveners of partners such as the Primary Care Office (PCO), the Primary Care Association or hospital associations to bring coordinate efforts to support community needs for recruitment and retention. SORH may take the lead as the 3RNet member in their state with direct responsibility for uploading of opportunities and a point of first contact for referral to recruiting organizations. Alternatively, SORH may fund the 3RNet membership but designate or contract for another organization to maintain a vibrant state presence on the [3RNet website](#). For more information on 3RNet, see page 20 of this toolkit.

Data collection and information dissemination activities for recruitment and retention can also be wide ranging. SORH should make every effort to disseminate information available from FORHP and other grantees to rural stakeholders in their states. Examples of this information include studies from the rural health research centers, telehealth resource centers, pertinent reports from the [National Advisory Committee on Rural Health and Human Services](#) and information from the [Rural Assistance Center](#). SORH should also act as the “eyes and ears” for FORHP, other federal agencies and state partners to identify emerging trends or issues which potentially impact the recruitment and retention of primary care physicians. Some states provide simple fact sheets or web resources and write newsletter articles or share examples of good work of rural communities on recruitment and retention. Other data collection and information dissemination activities could include working closely to identify gaps in data or other information which could potentially impact shortage designations, disseminating information about shortage designation activities, collecting or disseminating information about the economic impact of primary care providers in the state or collecting data about rural recruitment and retention needs and efforts of rural providers.

Providing technical assistance activities for recruitment and retention is a great opportunity for SORH to meet community needs in their states. Some SORH provide direct recruitment services for rural communities including candidate sourcing, referral of candidates and support of communities’ efforts for screening and signing primary care physician contracts. Other SORH contract with a state partner or non-profit organization to conduct these activities. SORH technical assistance can include one to one in person technical assistance to provide support for medical staffing plans, development of a community recruitment committee, working with a clinic to understand [National Health Service Corps](#) (NHSC) opportunities. SORH can fund or conduct Community APGAR studies to assess community recruitment readiness and identify obstacles for recruitment of primary care physicians. Some SORH implement broad scale state or federally funded loan repayment programs, obstetric malpractice supplements, or scholarship

“grow your own” programs. Simpler examples of technical assistance activities may include conference sessions on best practices for recruitment and retention, providing toolkits about recruitment and retention or simply providing technical assistance on how to use 3RNet resources.

B. The Need for Recruitment and Retention in Rural Areas

There is a critical need for primary care physicians in rural areas. As stated in an NRHA policy brief, the shortage of primary care physicians was, is and always will be the major obstacle that people living in rural America face when trying to get adequate health care services. Numerous strategies are being employed to help address this issue (NHSC, Conrad 30, 3RNet, etc.), but a national shortage of almost 30,000 PCPs will remain in 2015. Further, the availability of private health insurance and expansion of Medicaid under the ACA will certainly increase that need/demand.

Recruitment and retention of physicians in rural areas is a major challenge in the United States health care system.^[1-3] There are numerous federal, state and other resources, as outlined in this toolkit, developed in an effort to alleviate these workforce shortages in rural areas to help with recruiting and retaining physicians in rural and underserved areas. Rural physician shortages will continue to increase with health care reform expansion of insurance coverage to roughly 30 million additional individuals. The longevity of physician commitment in rural areas is lacking even with the current resources available. According to a [fact sheet](#) produced by the Association of American Medical Colleges (AAMC), there is a projected shortage of more than 45,000 primary care physicians over the next decade, which will have a profound impact on rural underserved areas as “20% of Americans live in rural or inner-city locations [that] are designated as health professional shortage areas.”^[6] The AAMC also offers a [report](#) on physician shortages in the United States categorized by states.

Various challenges contribute to rural physician workforce shortages and are important as a point of focus for change due to several evident workforce issues such as obtaining health care equity in rural areas, imbalance of health care professionals, varying residency programs in regards to Primary Care sub-specialty, physician salary differences compared to urban areas, physician lifestyle choices, and older physicians’ retirement, to name a few.^[7-10] Health care organizations spend countless hours and resources on recruiting physicians to rural areas in order to deliver equitable care and address some of these workforce challenges. An array of difficulties arise when trying to recruit and retain rural physicians due to the rural living environment including spousal satisfaction, educational opportunities for children, demanding schedule with lack of physician coverage, lower salaries, scope of practice issues, lack of shopping, and other challenges.^[4,10,11] Recent studies have demonstrated that recruiting individuals with a rural background and upbringing help with retention of physicians in these areas.^[4-5]

This toolkit is intended to serve as a guide for SORHs to assist rural communities with recruitment and retention efforts.

II. FEDERAL RESOURCES

A. Health Resources and Services Administration

The [Health Resources and Services Administration](#) (HRSA) is a federal agency within the [Department of Health and Human Services](#) (HHS). HRSA is dedicated entirely to improving the health care system for those in underserved areas, targeting individuals who are “uninsured, isolated or medically vulnerable.” Using various specialized bureaus and offices, the organization utilizes its budget to supply grants and support for designated areas of need throughout the country. Several of the grants and programs outlined in this toolkit are funded at least partially by HRSA.^[12] Within HRSA, there are several departments and programs that are particularly relevant to the efforts of recruiting and retaining primary care physicians in rural areas.

1. Federal Office of Rural Health Policy (FORHP)

The Federal Office of Rural Health Policy (FORHP) is the most important federal agency partner of the 50 State Offices of Rural Health for most topic areas including recruitment and retention. FORHP was created by the Social Security Act and is devoted to creating, assessing and monitoring policy measures at the federal level in regards to how they will affect the health of those in rural areas throughout the country. FORHP administers multiple grant programs totaling over \$160 million a year that provide vital funds to hospitals, clinics and health centers in underserved areas throughout the country.^[17]

Grants provided by FORHP directly targeted to address provider shortages in rural areas include three new funding opportunities: Rural Network Allied Health Training Program (Allied Health Training); Rural Outreach Benefits Counseling Program (Benefits Counseling); and Rural Health Care Coordination Network Partnership Program (Care Coordination). For more information on these grant programs, review the [webinar recording](#). Rural Health Outreach grants and Network Development grants can be used to help retention physicians. FORHP also supports recruitment and retention resources such as [3RNet](#) and the [National Center for Rural Health Works](#).

FORHP provides funding for the [Rural Training Track \(RTT\) Technical Assistance Program](#), which is a three-year national demonstration program that began in September 2010. More information on RTT and the [Train Rural](#) web portal see page 19 of this toolkit.

Another FORHP initiative, the [National Advisory Committee on Health and Human Services](#) (NACHHS) compiles extensive recommendations for the Secretary of HHS. Particularly useful are the [2010 Recommendations](#) to The Secretary and the [compendium of recommendations](#) maintained by the NACHHS. These recommendations provide a comprehensive view of both past and current initiatives to increase the quantity and quality of the Nation’s rural primary care providers.

Questions and other information regarding current policy issues in relation to rural health and recruitment and retention can be directed to the appropriate [staff member](#) of FORHP. ^[18]

2. The Bureau of Primary Health Care (BPHC)

The [Bureau of Primary Health Care](#) (BPHC) works in conjunction with Federally Qualified and Community Health Centers (FQHCs and CHCs) to provide health care services and increase access to care for individuals in rural and urban underserved areas. Many of these centers qualify as HPSAs and can use financial incentives such as NHSC Loan Repayment Programs or Scholarships for recruiting physicians. States or facilities interested in applying for [Health Center or Look-Alike status](#) can impact their recruitment and retention efforts by increasing the number of health centers in their respective areas.^[16]

3. The Bureau of Health Workforce (BHW)

The Bureau of Clinician Recruitment and Service merged with the Bureau of Health Professions to become the [Bureau of Health Workforce](#) on June 3, 2014. BHW focuses on workforce initiatives aimed at recruiting qualified health professionals to meet the demands of the Nation's current and future health care needs. BHW offers [scholarship and loan repayment opportunities](#) for primary care and allied health professionals, especially for students from racial or ethnic minorities, disadvantaged backgrounds and underserved areas of the country.^[15] Other programs under the direction of BHW include the National Health Service Corps, and Faculty Loan Repayment Program. BHW manages the designation of Health Professional Shortage Areas and Medically Underserved Areas/Populations, which determine eligibility for Federal programs including the Health Center Program, Rural Health Clinic Program, Medicare HPSA Bonus Payment and the Exchange Visitor and Conrad State 30 programs.

a. The National Health Service Corps

[The National Health Service Corps](#) (NHSC) is a federally funded section of HHS that provides scholarships and loan repayments to providers who commit to and/or deliver health care in federally designated HPSAs. The NHSC offers four main programs to assist with both the recruitment and retention of physicians in rural areas.^[19] These programs are: NHSC Loan Repayment Program, NHSC State Loan Repayment Program, Students to Service Loan Repayment Program and NHSC Scholarship Program.

- i. [The NHSC Loan Repayment Program](#) (LRP) is offered to physicians currently practicing in an approved HPSA site. Loan repayment amounts vary from \$20-\$30k annually for each year served full-time, requiring a commitment of at least two years. Qualified applicants include licensed physicians who are currently employed at an NHSC-approved HPSA site and who have unpaid, qualifying student loans.^[20]
- ii. [The NHSC State Loan Repayment Program](#) (SLRP) is a joint federal and state effort to assist in the recruitment of trained physicians to rural areas.^[32] SLRP was authorized in 1987 and has continued to be a valuable state resource since its inception.^[33] Repayment funds are dually allotted from HRSA and from state

legislatures; federal allotments are made based upon state need, coverage area, and grant application information. Federal and state funds, equally contributed, are used to pay specified and varying amounts of student loan debt for approved primary care providers practicing in HPSAs.^[34]

States are responsible for and in control of both the federal funding and state match amounts given to participants. State match funds can be specifically appropriated or taken from existing programs; NHSC states that match funding can come from existing loan repayment and education funds or from a variety of donation sources, however cannot be from other federal funds or in-kind contributions. States are strictly required to match the federally funded amount at a minimum of 100 percent or more.^[34]

A variety of resources are available for states inquiring about SLRP, including a program overview, grantee information, state by state contact info and specific information provided by currently participating states.

- iii. [*The NHSC Students to Service Loan Repayment Program*](#) (S2S LRP) offers an opportunity to roughly 100 fourth year medical students each year who are committed to serving HPSAs of greatest need throughout the country, determined as areas with an HPSA score of 14 or above. Reimbursement for students begins during their first year of residency and is paid annually for four years to total \$120,000 in exchange for a three-year service commitment following residency training. Following the three-year service obligation, a continuation contract can be made, allowing additional service in exchange for further loan repayment funding. These contracts are made annually and are dependent upon site eligibility status and remaining individual provider loan status. Sites which have HPSA scores of 14 or higher are most likely to benefit from recruiting these students as scores below 14 do not constitute ‘high need’ status and do not qualify for this program.^[21] Tools available to recruit S2S LRP students can be found below in the NHSC Jobs Center section.
- iv. [*The NHSC Scholarship Program*](#) provides scholarship funds to medical students who commit to practice primary care in a designated HPSA after successful completion of medical school and a primary care residency. Students who receive the NHSC Scholarship are required to serve in one of several specified sites for a time of one service year per scholarship year with a minimum of two years of service.^[22]
- v. [*The NHSC Jobs Center*](#) aims to support all types of HPSAs - rural and otherwise. NHSC S2S LRP recipients and NHSC Scholarship recipients described above may utilize this site to find a potential employer that fits both their personal and contractual needs. After becoming an NHSC-approved site, qualified facilities can post and manage job openings in an effort to recruit qualified physicians who are in alignment with the organization’s mission to deliver health care to the underserved in rural areas.

b. Area Health Education Centers (AHEC)

The [Area Health Education Centers](#) (AHEC) program was developed by Congress in 1971 to recruit, train and retain a health professions workforce committed to underserved populations. The AHEC program helps bring the resources of academic medicine to address local community health needs. Today, 56 AHEC programs with more than 235 centers operate in almost every state and the District of Columbia. AHECs have a three-pronged mission of: 1. recruiting young adults into the pipeline of health professional education, 2. directing current health professional students or practitioners to communities of need, and 3. improving the health of underserved areas.

AHECs offer [educational programs](#) to encourage students in primary and secondary schools to pursue health care careers including: in-school classes, seminars, workshops and shadowing opportunities. The intent of these programs is not to attract just any student interested in health care; since AHECs are often located in underserved or rural areas, they aim to draw students who were raised in these areas in hopes they will return to these areas upon completion of their professional training.^[25] The educational efforts of AHECs are among the pipeline recruitment strategies that aim to reduce the severity of the physician shortage that currently exists and is projected to worsen.^[26]

AHEC sites serve as locations where medical students and residents can complete clerkships and rotations that introduce them to the life and practice in rural areas.^[27] Clerkships range in time and structure, including some lasting only a week and others lasting nearly a year.^[28] These clinical exposure programs are twofold in nature, providing additional practitioners to supply care in underserved areas while also attempting to capture the interest of young aspiring clinicians in hopes that they will return to these underserved areas as fully-licensed physicians when their training is complete.

AHECs are also active in promoting health education to both the public and health professional populations. Educational opportunities include mini-med schools, case-awareness seminars on a variety of public health topics and resources for local teachers and parents to use in educating the youth in the area.^[29] In addition, some AHECs also provide educational support in the form of organizing or providing CEU opportunities, preceptorship arrangements, and interprofessional development classes to enhance the skills and abilities of local practitioners.^[30]

AHECs present a unique opportunity for states to address recruitment and retention efforts from a variety of angles, including pipeline and direct recruitment along with efforts to retain the current health professionals in the AHEC area while improving the overall health of the communities they serve.

III. State Resources

A. SORH Structure and Sample Programs

Recruiting and retaining physicians in rural areas is a difficult, daunting task. To add to the complexity, the efforts of a State Office of Rural Health are largely dictated by their organization structure. Three structures currently exist, including University-Based Offices, State Government-Based Offices, and Non-Profit Offices. Oregon, South Carolina, and Idaho, each representing their own organizational structure, agreed to discuss their recruitment and retention efforts, which are outlined here, as a method of supporting other offices around the country.

1. University-Based SORH: Oregon

The [Oregon Office of Rural Health](#) (OORH) is a University-Based office, operating in coordination with [Oregon Health and Science University](#) (OHSU). An interview with the office's Communications Director and Recruitment Specialist yielded highly valuable information in regards to their successes, challenges and recommendations regarding recruiting physicians to the numerous rural areas of Oregon. 3RNet was the office's most valuable resource, and was used in combination with regional meetings, student and resident interactions, and financial incentives to attract physicians that fit particularly well to communities in need.

OORH is the main state contact for 3RNet, charging a flat fee to participating sites in exchange for helping to connect particularly well-fitting candidates to available positions. The office strives to recruit for the long-term, and makes a significant effort to ensure that they seek out candidates who have a sincere interest in practicing in rural Oregon or the Pacific Northwest. These efforts help to avoid hiring physicians who are only interested in committing to practice until their particular incentives expire. Retention is valued to be just as important as recruitment, and this selective recruitment philosophy is, in turn, one of the office's largest retention efforts. Following OORH's involvement with connecting candidates with potential employers, the office maintains continued communication with both parties to ensure that the match is successful long after employment has begun.

Collaborative efforts have proven to be extremely valuable to OORH in addressing the physician workforce needs of the state as a whole. As such, the office participates in routine regional and statewide meetings to promote collaboration and teamwork, emphasizing that recruiting physicians to the rural areas of each respective region is not a competitive, but rather a joint effort that, when done well, benefits all involved. Though the process of developing and materializing these relationships and this philosophy has been long, the team feels that it has been highly beneficial in making recruitment a joint effort between numerous sites and regions. In addition, these meetings provide the opportunity for OORH to coordinate with the Primary Care Association, the Primary Care Office and AHEC. The meetings also allow all parties involved to collectively discuss and prepare for upcoming needs in terms of future funding, legislation and workforce changes to help health care providers and facilities to determine future capacities and needs due to unknown changes in health care reform.

Three primary care residencies in the state of Oregon serve as focal points for recruiting new

physicians to Oregon's rural areas, particularly those residencies, which require or offer rural training tracks or rotations. Namely, the [OHSU Family Medicine Residency](#), the [Cascade East Family Medicine Center](#), and the [Providence Portland Internal Medicine Residency](#), which graduate roughly 50 residents in a given year, provide fertile grounds for OORH's recruitment efforts. OORH recruiting specialists have very specific intentions of maintaining direct contact and interaction with the residents themselves. The office is also dedicated to tracking their home-state medical students during their ventures to residencies all throughout the country in hopes that constant contact will encourage these students to return to the state when their training is complete. Graduating residents and medical students alike are reminded of the opportunities afforded them if they choose to practice in Oregon's rural areas. Unique practice experiences combined with financial incentives such as tax credits, loan forgiveness, and loan repayments have proven successful in connecting these young physicians with the multitude of opportunities available to them in Oregon. Though out of the control of OORH, the [Oregon AHEC](#) operates a program that identifies and tracks young students from middle school, high school, and undergraduate education to assist and encourage through the process of pursuing a career in medicine. As described here, OORH takes pride in ensuring that their students are in the forefront of their effort to recruit physicians to rural areas of the state. From junior high to residency and fellowship, these efforts provide a high yield pipeline to recruit students back to their Oregon roots.

OORH maintains constant awareness of the funding opportunities that are available to assist with recruiting physicians. Currently, a \$5000 tax credit is offered to physicians practicing in rural areas and seeing 15% Medicare, 20% Medicaid. The efficiency of this program, however, has been debated. A recent survey to physicians utilizing this tax credit resulted in a high number of participants reporting they would consider leaving the area if the tax credit were discontinued. The validity of these responses is left to debate, but the tax credit remains as one of many incentives for physicians to practice in rural Oregon. Along with the tax credit, the Office utilizes the NHSC's State Loan Repayment program and Loan Repayment Program as well as an independent State Loan Forgiveness program among others. Of particular interest is the Medicaid Federal-Facility Match Program, which is similar to SLRP except that the facility, rather than the state, matches federal grant contributions. This program currently benefits 13 physicians in rural areas throughout the state in exchange for a three-year commitment to continue practice. The program is currently at a potential turning point as the Oregon Legislature will debate a proposed allotment of \$4 million from the state government in August, 2013.

With only ten full time employees, the OORH has done a phenomenal job of successfully recruiting primary care physicians to rural areas. Their partnership with OHSU has strengthened their efforts, providing flexibility and support in their efforts meet the needs of rural communities. OORH has used this advantage and relationship particularly well to leverage their use of 3RNet, regional meetings, and resident contact in recruiting physicians. This is a fantastic model of successful recruitment and retention by a University-Based State Office of Rural Health.

2. Non-Profit SORH: South Carolina

[South Carolina Office of Rural Health](#) (SCORH) is a non-profit SORH, maintaining close relationships with the Primary Care Office (PCO), the AHEC, and Primary Care Association (PCA) to collectively address issues of recruitment and retention in the numerous rural areas of the state. The Office has an extensive support team for all aspects of rural health, but only one employee dedicated solely to recruitment and retention. Despite limited personnel, the Office greatly impacts the many facilities seeking their assistance and leads the state in progressive programs designed to help alleviate the primary care shortages throughout rural areas. South Carolina's seven primary care residencies serve as a focal point for recruiting physicians while loan repayment and rural practice bonuses provide the incentives necessary to draw these residents to areas of need. South Carolina's 'Residency to Practice' program helps to prepare and educate physicians to effectively deliver health care not only as practitioners, but also to acquire the necessary skills of practice management and other business practices for independent physicians in private clinics. Many educational efforts are made by SCORH to ensure the highest level of recruiting competency as possible, while a retention grant allows the Office to assess and promote successful actions for retaining physicians after recruitment. In the past, a Locum Tenens program, Rural Scholars Program, and SEARCH program provided additional support for the Office's recruitment efforts. In all, SCORH has successfully developed a robust approach to recruiting and retaining physicians in rural areas. Many of the efforts highlighted here are recommended to other states as highly successful opportunities to reduce physician shortages in rural areas.

SCORH provides services to many facilities through paid annual memberships. These memberships help to fund many of the services that SCORH is able to offer, and entitles the member facility to a number of resources to aid in their recruitment and retention efforts. First and foremost, SCORH serves as the 3RNet point of contact for the state. Thus, each member is granted access to 3RNet for posting available positions and utilizing the recruitment resources offered therein. In addition, members are invited to utilize all educational resources that SCORH offers, including recruitment training, webinars, and technical assistance. One webinar series was devoted entirely to educating facilities on how to develop recruitment and retention programs that assist with selecting high-quality candidates who are likely to provide long-term service. Another webinar will help facilities take advantage of the opportunities to hire foreign medical graduates, while another will help them to understand legislative changes in regards to the physicians assistants and their scope of practice. These educational efforts are examples of how SCORH maintains contact and provides continuous support to their member facilities.

The seven primary care residencies throughout the state serve as a focal point for the SCORH's recruitment efforts. Frequent meetings and constant contact directly with residents allows the Office to build relationships, promote opportunities, and educate residents on the importance of delivering health care in the physician shortages in rural areas of South Carolina. The Residency to Practice program has allowed SCORH to assist with preparing these residents to manage practices in rural areas, providing management, administrative and policy training specific to experiences in rural areas. While many residents are eager to participate in the opportunities available through NHSC, there is no SLRP available and it has been found

that many sites within the state have a hard time qualifying for the standard loan repayment or scholarship programs because of HPSA score or payment scale issues. Because of this, South Carolina has partnered with HHS and developed a Rural Physicians Incentive Bonus that has proven to be extremely successful in recruiting physicians.

The [Rural Physicians Incentive Grant](#) serves as a recruitment tool to those facilities or areas that may not qualify for benefits through NHSC, though all rural areas can use the program. The program offers 20 grant awards per year in amounts that vary from \$40,000-\$70,000 depending on the facility's HPSA score in exchange for a three-year commitment to practice. The funds are dually allotted from HHS and from the state, allowing a high number of awards while maintaining affordability for South Carolina. Since its inception in the 1980's, the program has shown that nearly 75% of physicians who receive these benefits choose to remain in practice within that county even after their bonus program has expired.

Since 2009, the SCORH has assisted the PCO and PCA with improving retention efforts statewide by identifying aspects of the practice that promote or hinder retention and longevity. This grant program has allowed SCORH to study facilities that are using the Rural Physicians Incentive Bonus as a recruitment tool. In doing so, recipients would be interviewed to determine what factors were helping to encourage them to stay in the area and what factors were discouraging them from the area. In addition, the program allowed SCORH to identify physician traits and characteristics that were predictive of long-term commitment. Over the course of this grant, it has been determined that physicians who were raised in a community, had a long-term interest in medicine and showed evidence of a 'volunteering spirit' were highly likely to remain in the area for a long period of time, especially when these individuals were well supported by their administration and appreciated by their communities and facilities.

Fortunately, South Carolina received funding for this retention study; however, a lack of funding has led to the demise of many programs that were previously utilized as recruitment tools by SCORH. The SEARCH program was previously used by South Carolina to allow medical students and residents to engage in rural rotations throughout the state. A Rural Scholars Program was used to get high school and undergraduate students interested in pursuing medical professions with intentions to practice in rural areas. Lastly, a locum tenens program utilized a nurse practitioner to supply clinical support to facilities around the state, allowing them to more efficiently recruit candidates while a nurse practitioner offered interim clinical assistance.

3. Government-Based SORH: Idaho

The [Idaho State Office of Rural Health and Primary Care](#) (SORH-PCO) is a Government-Based office housed in the Idaho Department of Health and Welfare. Located within the Department headquarters, the SORH-PCO has access to data and information regarding the health care workforce, shortages, and needs of Idaho communities and the state as a whole. The SORH-PCO uses 3RNet, repayment programs, grant opportunities, workforce studies, and educational seminars to increase awareness of the need for providers in rural areas. In addition, the Office organizes statewide gatherings to empower facilities around the state to

improve recruitment and retention strategies to help combat physician shortages.

As Idaho's point of contact for 3RNet, the office provides free assistance to facilities on creating, posting and managing vacant positions. This is not a revenue-driven service, which allows for optimal utilization by facilities throughout the state, and is one of the many advantages that SORH-PCO experiences as a result of being government-based.

The SORH-PCO is heavily involved with NHSC and helps Idaho facilities through the process of becoming NHSC-Approved, allowing the site to qualify for students fulfilling NHSC scholarship requirements while giving current and future providers the opportunities to recruit and retain providers using NHSC loan repayment incentives. Though commonly involved with NHSC; however, Idaho does not currently participate in the federal SLRP, and has come up with two different grant and loan repayment programs to help compensate for this deficit.

The [Rural Physician Incentive Program](#) (RPIP) is a loan repayment benefit that is offered to primary care physicians who commit to practice in areas of rural Idaho for a minimum of four years. Four awards are offered each year, totaling \$50,000 (\$12.5k/year). Funds are allocated from fees assessed to students of the WWAMI and WICHE programs as part of their medical school costs at the University of Washington and the University of Utah. Although RPIP is not exclusive to graduates of these schools, they are given preferential acceptance since they have personally paid into the benefit fund.

The Rural Health Care Access Program (RHCAP) is a state grant program that aims to provide financial support to facilities in order to increase access to care for Idaho residents. While the fund utilization parameters for this grant are quite broad, facilities most often cite recruitment and retention efforts as the reason for requesting the grant. Once granted, facilities can use the funds for recruiting fees, hired recruiters, loan repayment offers, sign-on bonuses, relocation assistance, community development projects and a multitude of other efforts that help to increase access in a variety of ways.

The SORH-PCO operates with only four full time employees and consequently makes a significant effort to educate and empower the health care providers and facilities throughout the state to aid in the recruitment and retention efforts in order to be as efficient and successful as possible. Aspects of this educational effort include seminars and workshops that the SORH-PCO puts on periodically in various areas of Idaho. The Office hosted a workshop that was entirely focused on educating facility leaders about what needs to be done to create a 'retaining' facility. Included in this workshop was a complete 'Retention Toolkit', which addressed many aspects of retention and highlighted that the most commonly cited reasons that providers choose to remain in one location include recognition of their good works and dedication as well as high quality, motivational leadership throughout the organization.

The most unique aspect of the SORH-PCO's recruitment and retention efforts is the 'Meet The Residents' event that is put on each year as an opportunity for facility recruiters, administrators, or providers to simply meet and mingle with the residents of Idaho's one internal medicine and two family medicine residencies. Facilities pay a very nominal charge of \$45 to reserve a table and dinner for their representatives, who then attend the event to

discuss current and future employment opportunities with the residents. This event is an extremely effective, convenient and enjoyable way to expose residents to potential employers and facilities to potential employees. ‘Meet The Residents’ night is highly anticipated each year and continues to be a very successful event year after year. States interested in a low-stakes, high yield method of connecting residents with opportunities should consider implementing this program in their respective areas.

B. Other State Programs

1. The Washington, Wyoming, Alaska, Montana, Idaho Regional Medical Education Program (WWAMI)

[The Washington, Wyoming, Alaska, Montana, Idaho Regional Medical Education Program](#) (WWAMI) is a program initiated in the 1970’s to help alleviate difficulties in training and recruiting physicians to rural areas in the above states. Each WWAMI state does not have a medical school and contracts the University of Washington School of Medicine (UWSOM) to allow a set number of students from these states to attend UWSOM at tuition equal to a Washington resident while Idaho pays the difference in out-of-state and in-state tuition.^[36]

First year students train at existing state universities in the basic-science courses and then travel to the Seattle campus of UWSOM to receive training from academic focused physicians in the advanced sciences. Following the second year advanced science classes physicians select their required clerkships that are located across all of the WWAMI states with certain states even creating rural “tracks” that focus all of those clerkships in one state, concentrating in rural areas. Additional programs are offered through the WWAMI program to emphasize rural health care such as the WRITE program which gives third-year medical students a chance to experience rural medicine and [The Rural/Underserved Opportunities Program](#) (R/UOP) which gives first year medical students the chance to work side-by-side a rural physician.

By providing undergraduate medical education in states that do not have a formal medical school, retention of physicians has increased. 47.8% of medical school graduates return to the state in which they attended their undergraduate medical training and this increases to 66.6% when they attend both graduate and undergraduate medical education in the same state.^[37]

Of particular interest to rural areas are initiatives such as the [Targeted Rural and Underserved Track](#) (TRUST) of the WWAMI program at the University of Washington School of Medicine- the highest ranked rural health program in the country.^[38-39] This new program at the University of Washington School of Medicine intends to recruit students who have a background in and desire to serve rural and underserved areas of their respective state. TRUST is designed in a unique fashion, which involves a continuous connection between the student, UWSOM and a specific community within the student’s home state. In addition, TRUST students follow the curricular path of all WWAMI students, completing their first year of school in their home state’s university training site and the second year at the main UWSOM campus in Seattle, Washington. In the third and fourth years of the program, students engage in clerkships and clinical rotations, many of which are within their home state, giving them a first-hand view of the opportunities available and troubles within the areas where

they hope to practice. As an added benefit, students participating in the TRUST program are only required to a portion of the full costs of the UWSOM program, as a majority of the fees for each student are subsidized by their home state legislature.

While this program is still new, admitting its first group of students in the matriculating class of 2008, it is anticipated to be a highly successful tactic in the effort to manage physician shortages in rural areas of the Northwest. As a state-subsidized program, the TRUST initiative and other similar programs such as WRITE and RUOP present unique opportunities for states to increase pipeline recruitment efforts that are guaranteed to produce physicians with rural backgrounds, training and career focus.

2. Rural Physician Incentive Program

The Rural Physician Incentive Program (RPIP) is a loan repayment benefit that is offered to primary care physicians who commit to practice in areas of rural [Idaho](#) or [Montana](#) for a minimum of four years. The maximum repayment benefit is \$50,000 in Idaho and \$100,000 in Montana. Funds are allocated from fees assessed to students of the WWAMI and Western Interstate Commission on Higher Education programs as part of their medical school costs at the University of Washington and the University of Utah. Although the RPIP is not exclusive to graduates of these schools, they are given preferential acceptance since they have personally paid into the benefit fund. Other states with interstate compacts for medical education such as the WICHE could potentially use this strong recruitment tool to provide incentives for primary care physicians practicing in rural areas.

3. Health Access Incentive Program

The Health Access Incentive Program is an initiative by the Tennessee Department of Health (TDOH) to recruit primary care providers to practice in rural and underserved areas of the state. Since its inception in 1989, over 200 providers have been recruited to practice primary care in 71 counties. Funds for qualified providers are allotted from the annual [Health Access Plan](#) fund. The [Health Access Incentive Program](#) offers three grant options to appeal to a variety of providers and needs. The Practice Incentive Grant (pg. 10) is offered to primary care and dental practitioners in Health Resource Shortage Areas (HRSAs) to support their respective facilities with operations or recruitment. The Locum Tenens Grant (pg. 11) is offered to health care providers in solo-practice within an HRSA to assist with the costs of utilizing locum tenens physicians. For recipients of either the Practice Incentive Grant or an incentive from NHSC, the Extended Term Incentive Program (pg. 11) is a grant that can be utilized to assist with practice maintenance costs. This program provides funds into an interest-bearing account which accrues monthly for the life of the extended term agreement. As opposed to the former two grants, which focus on recruitment of physicians and increased access to care, this grant is directly intended to promote retention of the practicing physician by rewarding long-term service. These incentive grants are some of the many efforts taken by the TDOH to recruit and retain physicians in the rural and urban areas of highest need. States interested in learning more about the Tennessee Health Access Incentive Program are encouraged to contact TDOH, division of the Health Access Plan.^[40-41]

4. Community Match Rural Physician Recruitment Program

The [Community Match Rural Physician Recruitment Program](#) is an effort by the state of Arkansas to encourage physicians to form relationships with and commit to practice in rural communities. When a physician-community relationship has been made and intent to practice is mutually agreed upon, the pair can apply for the Community Match grant. If granted, this program provides the physician with \$10,000 per year paid by the state and \$10,000 per year paid by the community for a duration of four years, totaling a grant sum of \$80,000 over four years. As a unique program that encourages state and community collaboration, states are highly encouraged to consider developing similar programs as an efficient and effective method of recruiting, and, equally as important, retaining, primary care physicians in rural areas.

5. Minnesota's Web Based and e-Resources

The [Minnesota Office of Rural Health and Primary Care](#) (ORHPC) offers robust resources for recruitment and retention information and *serves as a comprehensive source for health care workforce data, analysis, shortage information, and financial and technical assistance for health professionals*. The Workforce Analysis Program gathers workforce information, analyzes workforce trends and distributes findings to policymakers, educators, professionals and employers.

ORHPC produces a monthly newsletter with information regarding workforce initiatives, loans, grants, policies, and other issues that pertain to health care providers or facilities in rural areas. States can subscribe to this newsletter or view [a sample](#) to obtain more information.

The National Rural Recruitment and Retention Network (3RNet) and the National Rural Health Resource Center, working in partnership with the Minnesota Office of Rural Health and Primary Care and its state counterparts in Wisconsin and Indiana, developed the multi-part [toolkit](#) to support health care recruitment and retention efforts, particularly in rural and underserved areas.

IV. Additional Resources

A. Professional Organizations

Professional organizations such as the [American Medical Association](#), [American Academy of Family Practice](#), [American Congress of Obstetricians and Gynecologists](#) and [Society of General Internal Medicine](#) provide a wealth of information regarding recruitment and retention of their respective specialized physicians in rural areas. Often funding or performing research on issues regarding efforts to combat the rural physician shortage, these organizations are able to offer a great deal of up-to-date information that can be useful for states striving to seize recruitment and retention opportunities. Utilizing newsletters, websites, national or regional conferences and other resources offered by these organizations, states can ensure that they are receiving the latest and most applicable information to assist with recruiting and retaining physicians in rural areas. Considering the ease of access and potential impact, these types of professional organizations are considered a first-choice effort to improve recruitment efforts for rural areas.

B. Rural Tracks and Rural Training Tracks

Medical schools are largely funded by government educational subsidies and research. In general, they have a responsibility to serve the public in high demand areas. However, the majority of rural physicians are trained in a minority of medical institutions throughout the country.^[42] To assuage this disparity, some states and medical education centers have adopted programs to prepare physicians for rural practice; these are collectively known as either Rural Tracks or Rural Training Tracks (RTT). These programs are offered for both undergraduate and graduate medical education, and vary in their scope of practice and organizational accreditation.

Rural Tracks

Rural Track programs are used in both undergraduate and graduate medical education to provide students and residents with opportunities to experience both life and practice in a rural setting. Some undergraduate institutions will reserve a certain number of their available matriculation seats for students selected to use the rural track programs. For example, The [University of Kentucky Rural Physician Leadership Program](#) reserves seats for 10 rural track students each year, whose rotation curricula differ from non-rural track students in the amount and type of rural clerkships required during the third and fourth years of their medical education. These students attend their clinical rotations in heavily rural areas, giving them the knowledge and experience needed to become excellent rural physicians.

Some graduate organizations also offer this type of rural track as a method of increasing residents' experience in rural medicine. This is generally accomplished in a fashion similar to undergraduate rural tracks; residents are given the opportunity to participate in rotations in rural areas to fulfill elective or mandatory curriculum requirements. These rotations are available for all residents of the program; no separate application or acceptance process is needed and the residency does not need to apply for multiple accreditations.

Rural Training Tracks

A similar but entirely separate training program offered by some residencies is the [Rural Training Track](#) program. This type of program allows residents to complete most or all of their graduate medical education in a rural setting, thereby increasing their experience and providing optimal training in rural medicine. Many organizations, such as the [Family Medicine Residency of Idaho](#), offer programs with a “1+2” structure that includes one year of residency in an urban area followed by two years in a more rural area, both organizations being separate, fully accredited programs. This training method offers residents a dynamic, diverse educational experience that captures the best opportunities available in both areas of practice.^[43] Rural Training Tracks have been highly successful in fulfilling their mission of combatting physician shortages in rural areas. Currently, these programs produce two to three times the proportion of graduates entering rural practice and a high proportion, who serve in shortage areas and in safety-net facilities. This success has been highly recognized, leading graduate organizations throughout the country to increase the size and number of Rural Training Tracks offered.

C. Train Rural Website

One of the most difficult aspects of convincing physicians to practice in a rural environment is to dispel the negative ideas of rural practice. Young medical students often think of rural medicine as poor quality training with a reduced scope of practice in an isolated environment. [Train Rural](#) is a website devoted to dispelling those ideas and proving that training for a rural environment is just as prestigious and rewarding as training for an urban environment.

Funded by the Office of Rural Health Policy, Train Rural provides information on the Nation’s various Rural Training Tracks and rural focused residency programs. Additionally, Train Rural tries to redefine the image of rural medicine by providing information on living in rural environments and interviews with current rural residents. Train Rural takes a different approach than most to rural recruitment and retention. In addition to offering incentives like many programs do, they are attempting to redefine rural medicine in the eyes of new medical students.

D. Tax Credits

A small number of states have elected to provide physicians working in a rural, medically underserved area a \$5,000 tax credit for differing periods of time. [Alabama](#) started their program in 1994 and offer the credit for up to five years while New Mexico started theirs in 2006 and as of yet have no maximum time period allowance.

Increased funding for rural physicians usually aids in increasing the number of practicing physicians in an area; however, the efficacy of the tax credit program is debatable. Recent legislature in Alabama aims to increase their program from the current \$5,000 per year to \$8,000 per year for up to eight years. Oregon on the other hand is debating reducing the

scope and amount of the program.

E. J-1 Visa Waivers or National Interest Waivers

Currently, Foreign Medical Graduates (FMGs) who want to do Graduate Medical Education (GME) in the US can enter on either a J1 (training) or H1B (work) visa. Those who choose the J1 visa can stay in the US after training if they agree to practice for 3 years in an underserved area and get a waiver. Most of that is handled by State Primary Care Offices (PCOs) through the Conrad 30 J1 Visa Waiver program. Those who enter on the H1B visa can simply stay in the US if they find employment, and there is no service obligation. Currently, about 3,000 FMGs enter GME in the US every year, almost all in primary care. About half are on a H1B Visa and the other half are J1s.

Foreign physicians trained in the United States are given a [J-1 visa](#), which is a non-immigrant visa that allows them to remain in the country during medical school training. Following completion of the program, foreign physicians must return to their home country for a [minimum of 2 years](#), after which they are able to seek dual intent visas for re-entry into the United States.

The [Conrad 30 J-1 Visa Waiver Program](#) was created to help alleviate shortages of qualified physicians in underserved areas. This program allows J-1 visa physicians to waive the 2-year home residence requirement in exchange for practicing in a Health Professional Shortage Area (HPSA). Each state is allowed to waive up to 30 physicians in exchange for their commitments to the underserved. States have their own applications and guidelines regarding compensation and length of service. The Conrad 30 Program is a method of bringing experienced, trained physicians to medically underserved areas as loan repayments or service bonuses are not required.

F. Community APGAR Program

The [Community Apgar Program](#) (CAP) was developed by researchers, educators and clinicians at Boise State University and the Family Medicine Residency of Idaho to help organize community factors for action of improving the recruitment and retention of physicians to rural and underserved communities.^[44-45] The CAP is a two year program utilizing site visit interviews of rural physicians and hospital administrators to assess both modifiable and non-modifiable factors identified as most important in aiding the recruitment and retention of family physicians. CAP provides specific information for Critical Access Hospitals (CAHs) and Community Health Centers (CHCs) utilizing the [Community Apgar Questionnaire](#) (CAQ). The CAQ is a validated tool utilizing [50 factors in five classes](#) to aid in rural community self-evaluation to obtain a real-time assessment of assets and capabilities in recruiting and retaining physicians. Several states are participating in CAH CAP including Idaho, Wyoming, North Dakota, Wisconsin and Alaska. CHC CAP includes Idaho and Maine, while both of these programs have numerous states interested in participating. CAP provides a new approach to the old problem of physician recruitment, self-empowering for the community as opposed to needing to hire a “headhunter”, developing and participating in the ‘best practices’ across community networks, participating in a national database sharing trends and patterns to

identify opportunities to improve workforce challenges, and going beyond physician recruitment to community improvement.

G. 3RNet ‘Best Practices’ for Recruitment and Retention

The [National Rural Recruitment and Retention Network](#) (3RNet) is a non-profit organization that has created a valuable resource for health care organizations to recruit health care providers to rural and underserved areas. They accomplish this by helping determine an individual’s needs and wants, matching them to an organization that will best suit their mutual interests. Retention is a priority for the 3RNet organization, focusing on what is best for the health care provider and the health care organization to most efficiently place the health care provider and organization appropriately. A priority for this organization is to be a valuable avenue for resources and provide industry benchmark information sharing best practices in the industry.

H. Other ‘Best Practices’ Resources

The [National Rural Health Association](#) promotes several policies and positions advocating nationally. A recent policy brief defines the issues and principles of health care workforce recruitment and retention. A valuable resource offered by the [National Association of Community Health Centers](#) is a [best practice guide](#) for recruitment and retention of clinicians.

The State of California, Office of Statewide Health Planning and Development and the National Rural Health Association published a [compendium of rural best practice models](#) with the intent to strengthen rural health care technology, training and workforce development.

The [Medical Group Management Association](#) (MGMA) has numerous [resources](#) regarding physician recruitment and retention including physician compensation average information by specialty, including industry benchmarks comparisons, and seven steps for successful physician recruitment to help increase the likelihood of recruiting physicians to practice in underserved areas.

According to a recent physician retention survey, conducted by the American Medical Group Association (AMA) and Cejka Search results indicate an increase in physician turnover. They outlined [six ways to decrease physician turnover](#). There are numerous consulting groups to help with recruiting and placing physicians with health care systems such as [Coker Group](#), [Cejka Search](#), [National Association of Physician Recruiters](#) (NAPR), and [Merritt Hawkins](#).

I. Western Interstate Commission for Higher Education

The [Western Interstate Commission for Higher Education](#) (WICHE) was created in the 1950’s to establish a centralized location for western states to share resources amongst their various higher education systems. Currently, membership includes 15 states as well as the Pacific Island U.S. territories. WICHE has numerous departments, programs, and resources to assist member states with maximizing residents’ access to higher education. One of the most

important programs in the WICHE compact is the [Professional Student Exchange Program \(PSEP\)](#).

PSEP allows for resident students of member states to enroll in certain out-of-state institutions for select professions if the resident state does not offer those positions at their universities. Included in this exchange program are 10 separate health care professions listed [here](#). Currently only four states participate in the PSEP for medical school with Montana and Wyoming sending students for allopathic medicine and Arizona, Montana, Washington, and Wyoming sending students for Osteopathic Medicine. The [WICHE website](#) includes information on the various initiatives, resources, and pertinent news as well as information on how member states can participate in the various programs that WICHE offers.

J. Rural Community Recruiting

It is no secret that recruiting a physician to practice in a rural area is more than just filling a vacancy. In most cases, it's filling a void in the community as oftentimes a well-respected physician has either retired or left the area where there have been strong relationships built over time. As such, not just any physician can fill the position as most health care facilities are searching for an individual that will be able to provide excellent health care as well as a physician that will fit into the tight-knit community. Similarly, a perfectly ideal professional opportunity that is housed in an undesirable community, be it socially, geographically, or otherwise, will not be able to attract the kind of physician that is so desperately needed. It is, therefore, not only the job of the facility, but rather the community as a whole, to become a recruiting agent that is enticing to the physicians (and other community members, for that matter) that the area needs.

The West Virginia Department of Health Division of Rural Health recognized the important role of the community in recruiting physicians many years ago and in 1998 helped to begin the Recruitable Community Program. This program was an effort to provide communities with a top to bottom recruitability makeover, starting with a 'first impression' facelift followed by community education and technical assistance. A community's recruitability was assessed multifactorially, taking into account the location, economy, education system, overall presentation and much more. In the end, items that were identified as needing improvement were addressed with the community to provide opportunity to improve the overall recruitability of the area.^[46] Many areas and organizations make similar efforts to ensure optimal chances of recruiting physicians, especially those who visit the area for an interview. Cherie Taylor, CEO of Northern Rockies Medical Center in Montana, reports that the most important part of interviewing a physician is a 'personal touch.'^[47] She attempts to emphasize this personal touch by inviting spouses and families to interviews, hosting group gatherings with home-cooked meals, and involving the family in other community events during their stay. In addition, she ensures transparency and blatant honesty in all aspects of the interviewing process, allowing the provider to understand exactly what is in store should they choose to accept the position. The most recent effort to identify methods of improving recruitability for rural communities is the Community Apgar program addressed above, which has been a very valuable resource in determining how to create a community that fosters recruitment of physicians.

K. Rural Health Scholars Programs

In an effort to address the shortage of pre-professional students who are interested in practicing in rural areas, some states, universities, AHECs, SORHs, and medical schools have created rural health scholars programs. Some of these programs target high school students, including the program offered by The University of Alabama and University of Colorado, while others target [undergraduate](#) or [medical students](#). The State Offices of Rural Health in both [North Dakota](#) and [South Dakota](#) also support great examples of rural health scholars programs.

The overarching goal of Rural Health Scholars Programs is “to increase the number of students likely to practice primary care in rural, underserved areas.”^[35] To accomplish this, students are recruited that have been raised in rural areas and are interested in returning to those areas as health professionals. Program structures vary immensely, ranging from non-credit summer camps to fully functioning medical school degree tracks; the type of program used depends on the sponsoring organization and its goals. A recent study showed that students who engaged in the Rural Health Scholars Programs at the University of North Carolina and East Carolina University were significantly more likely to match into family medicine or primary care residencies than their peers, even those peers who had similar career interests.^[35] The efficacy of this program speaks to the opportunity available for states to direct recruitment and retention efforts at students of various ages. States and universities alike can take advantage of this type of program to increase the number of young adults from rural areas who develop an interest in returning home as health professionals. The flexibility and variability allowed by this type of program provides incredible customization to accommodate each state’s particular budget, needs and goals.

L. Student and Resident Experience and Rotations in Community Health (SEARCH)

[*Student and Resident Experience and Rotations in Community Health \(SEARCH\) Program*](#) is one of many programs created with the intent of increasing medical student and resident exposure to medical practice in rural community settings. Originally, this program was funded through both NHSC and the participating state, with operational responsibilities relying solely on the state. NHSC has discontinued their involvement in the program, but many state programs have continued to function independently, refer to Appendix A, Resources by State Spreadsheet for a list of states continuing the program.

Funds allocated by states for the SEARCH program are utilized to increase the opportunity for medical students or residents to complete clerkships or rotations in specified community health and rural practice settings throughout the state. These opportunities focus on attracting students interested in primary care medical specialties including family practice, internal medicine, obstetrics, psychiatry and other related disciplines. Specific participant qualifications and program operations differ from state to state. States that are not currently participating are encouraged to investigate this program as a potential tool for recruiting students and residents to rural areas. While this program has been discontinued, some SEARCH projects are still offering health professions students and residents clinical rotations on multidisciplinary health care teams in underserved communities and many states are considering attempts to have similar programs replacing the loss of SEARCH.