

# Survey of Academic Health Centers Educating Future Health Providers to Serve Rural Populations



Produced by Workforce Council of Virginia's State Rural Health Plan  
Spring 2011

## Introduction

In 2007, stakeholders developed Virginia's State Rural Health Plan, which is a strategic plan with the goal of strengthening the health care infrastructure in rural Virginia. Four Councils have been tasked with implementing the recommendations contained in this plan. The Workforce Council is tasked with examining available resources and issues in order to make recommendations for improving the healthcare workforce in rural Virginia.

One of the recommendations given to the Council was to, "Engage academic health and medical institutions in dialogue about alternative solutions and strategies to improving the healthcare workforce in rural areas (such as required rural rotations and rural-related curriculum)." In order to successfully engage in a dialogue with these academic institutions, the Council felt it needed to better understand the current state of educating future health providers to serve rural populations. This survey was developed to learn about how academic institutions address issues related to serving rural populations in the classroom and in the field, what keeps them from being able to adequately train and educate those wanting to work in a rural area, and ways to improve the systems that support education and clinical training.

## Methodology

One hundred and nine academic health programs and residency programs were surveyed in February and March of 2011. Following IRB approval, the questions were placed in a Survey Monkey web survey and emailed to the following potential respondents:

- 16 Nursing programs
- 20 Community College Nursing programs
- 8 Nurse Practitioner programs
- 4 Physician Assistant programs
- 4 Pharmacy programs
- 7 Public Health programs
- 6 Medical Schools (5 VA, 1 TN)
- 12 Residency programs
- 5 Directors of Graduate Medical Education
- 13 Counselor Education programs
- 5 Clinical Psychology programs
- 3 Counseling Psychology programs
- 4 Social Work programs
- 2 Marriage and Family Therapy programs

A key informant interview process was developed and piloted with a few respondents. No new results were forthcoming through this further process and thus the interview process was abandoned. No results from that process are included in this report.

A total of 48 programs responded to the survey (44% response rate). Nursing schools (n=26) were the top responders. Nurse Practitioner programs (9), Physician residencies programs (7), Medical schools (6), and Physician Assistant

programs (6) were the next largest responders. The remaining programs were Counselor Education (3), Counseling Psychology (2), Pharmacy (1), Public Health (1), Clinical Psychology (1), Social Work (1), and Marriage and Family Therapy (1). Some respondents answered for more than one program, thus the number of responses for NP and PA programs was larger than reported sample size.

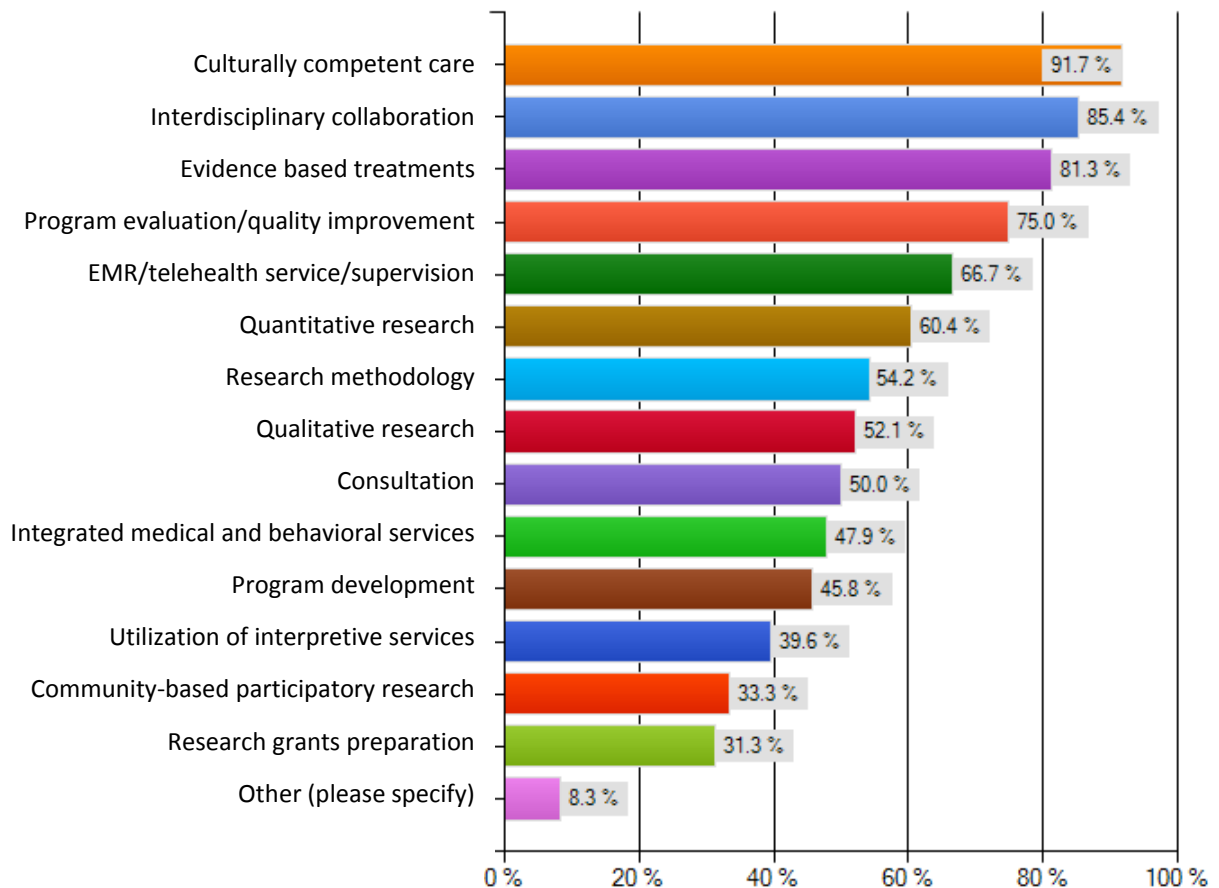
**Key Findings**

**Educating to Serve a Rural Population**

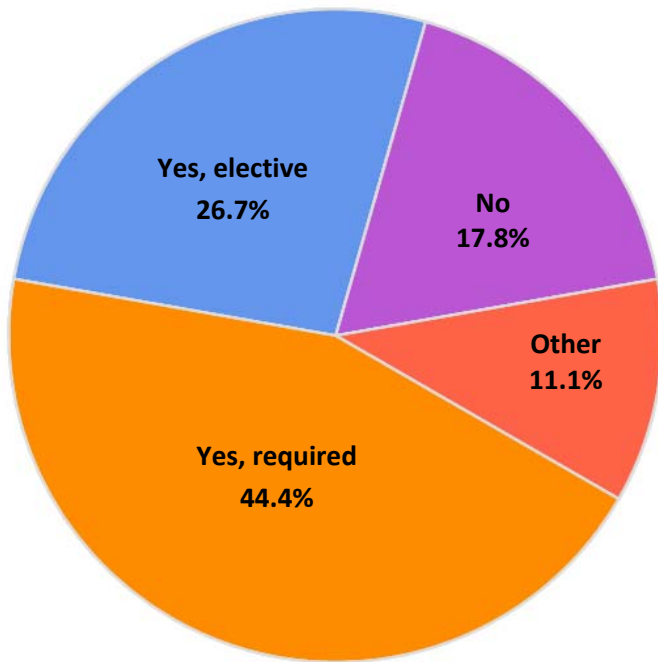
Of the reporting programs, 75.6% report that they actively recruit students from rural areas (n=45). Programs (and universities and colleges) use career and health fairs as the major way to recruit students: high school fairs (54.5%), undergraduate career fairs (54.5%), and hospital health fairs (45.5%) (n=33). Additional modes for recruitment are faculty presentations to undergraduate audiences (45.5%), mailings to potential students (30.3%), and advertisements in professional journals (24.2%). Loan repayment for a commitment to working in a rural area, scholarships, and loan reduction are less frequently used modes for recruitment.

Programs were also asked about specific content areas in their curriculum. The frequency and content areas are listed in Chart 1 below.

**Chart 1: Does your curriculum have formal coursework/content in the following areas (check all that apply)?(N=48)**



The majority of programs require their students to have rotations or placements to educate them about working in rural populations. Chart 2 below gives additional responses as to what programs require or provide for their students to practice in a rural area.

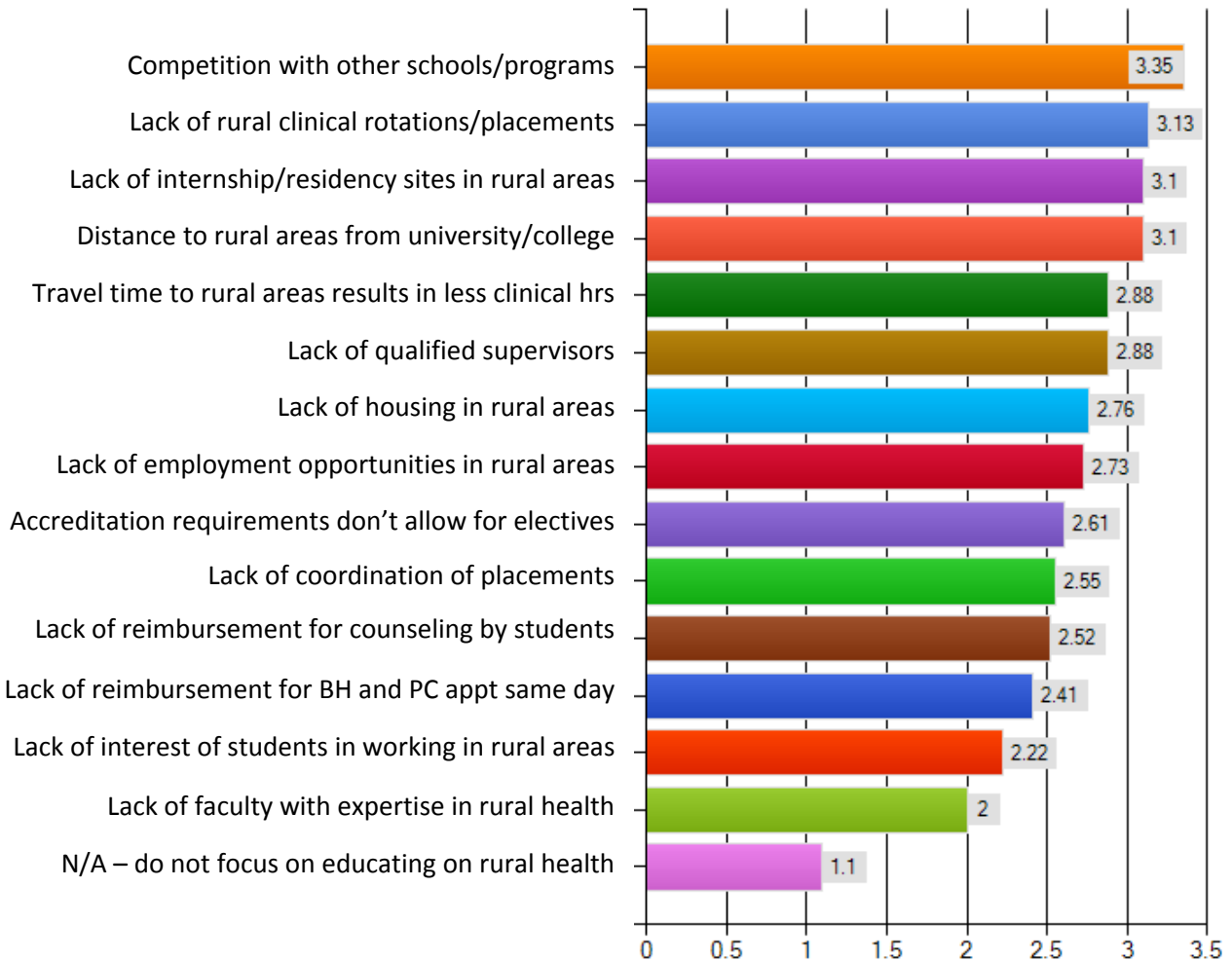


**Chart 2: Do your students have clinical rotations/placements designed to educate them about working with rural populations? (N=45)**

Community agencies that are most frequently used for clinical rotations and placements (n=44) are hospital based services for either adults (81.8%) or pediatric patients (68.2%). Behavioral health training occurs most frequently in inpatient behavioral health facilities (72.7%), adult/geriatric behavioral health programs (50%) and community based behavioral health clinics (e.g. Community Service Boards) (47.7%). Free or charitable clinics (63.6%) are used more frequently than Federally Qualified Health Centers (47.7%) or Rural Health Clinics (45.5%). Private primary care practices (50%), Women’s Health Clinics (45.5%), and university based clinics (45.5%) are also used.

There are significant barriers that prevent programs from being able to educate future health care workers on rural populations. Chart 3 below demonstrates these barriers.

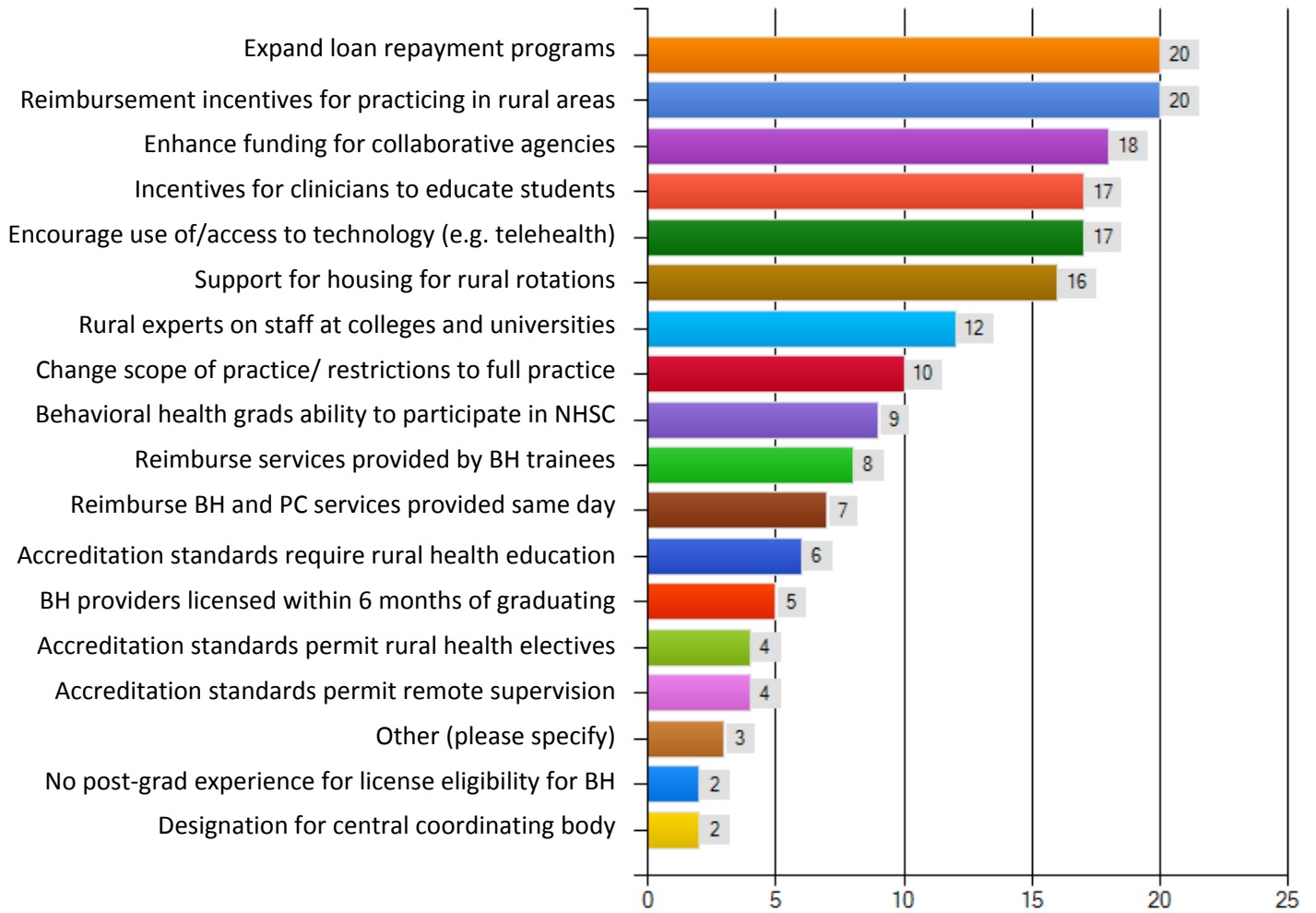
**Chart 3: If your program includes educating future health care providers to serve rural populations, please rank the following barriers from 1-4 with 4 being most challenging and 1 being least challenging (N=36).**



Programs have taken actions to overcome some of the barriers identified above (n=31). The most common action has been to integrate content related to providing integrated behavioral and primary care services for rural populations in required courses (64.5%). Utilizing adjunct faculty with expertise in serving rural populations to teach courses and/or supervise clinical rotations/placements is another way to overcome barriers (32.2%). An under-used resource is utilizing remote supervision of students through telehealth (19.4%).

Chart 4 contains suggestions for policy changes that are needed to overcome barriers to educating future health providers to serve rural populations.

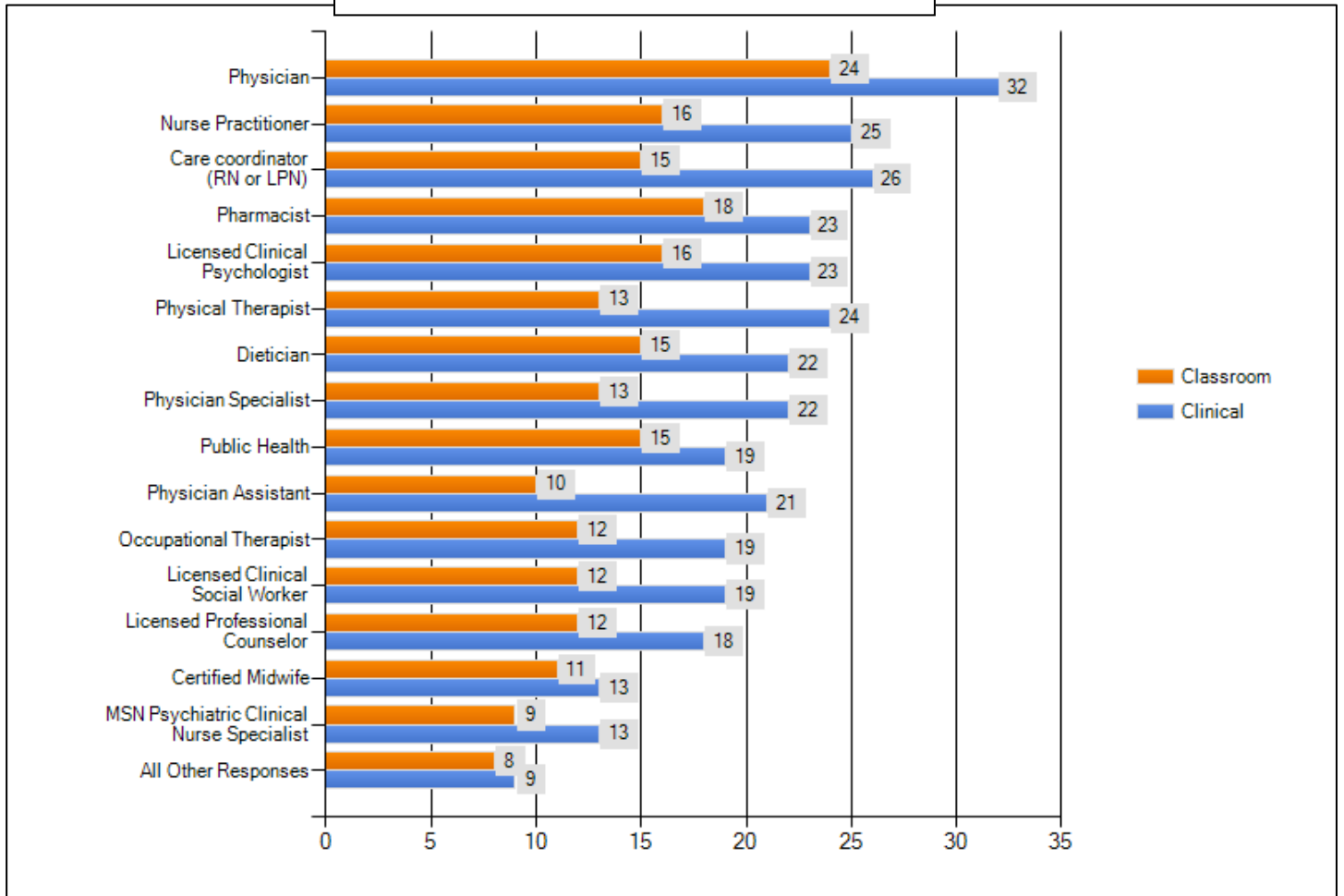
**Chart 4: Are there policy changes that need to occur to overcome barriers to educating future health providers to serve rural populations? Check all that apply. (N=30)**



## Multidisciplinary Team Approach

Of those responding, 87.5% report that their programs provide opportunities for students/residents to learn/work in multi-disciplinary teams (n=48). A list of the different disciplines that programs offer for training in the classroom or within a clinical setting is listed below in Chart 5.

**Chart 5: If you provide opportunities to work in multidisciplinary team, check whether working with the following disciplines is taught in the classroom and/or clinical setting (check all that apply)? (N=39)**

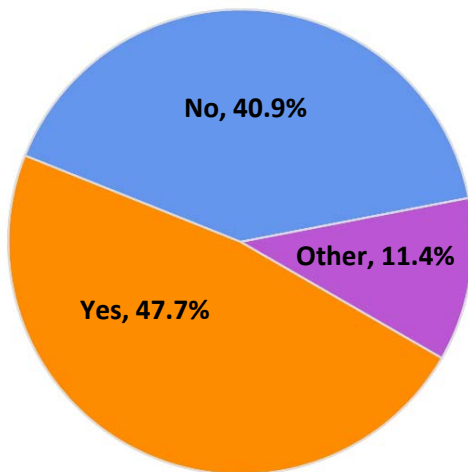


## Patient Centered Medical Home Model

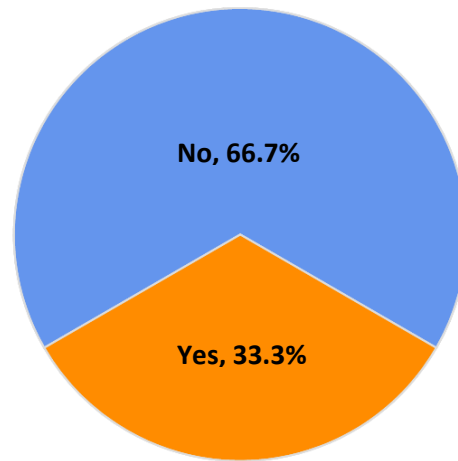
The majority of responding programs provide opportunities for students to learn about the principles of a patient centered medical home. Those in the other category report that they will soon be incorporating this into their programs.

Of those programs that do allow students to learn about the principles, only 1/3 allow their students the ability to train within National Committee for Quality Assurance (NCQA) Certified Patient-Centered Medical Homes.

**Chart 6: Does your program provide opportunities for students to learn about the principles of the patient-centered medical home? (N=44)**

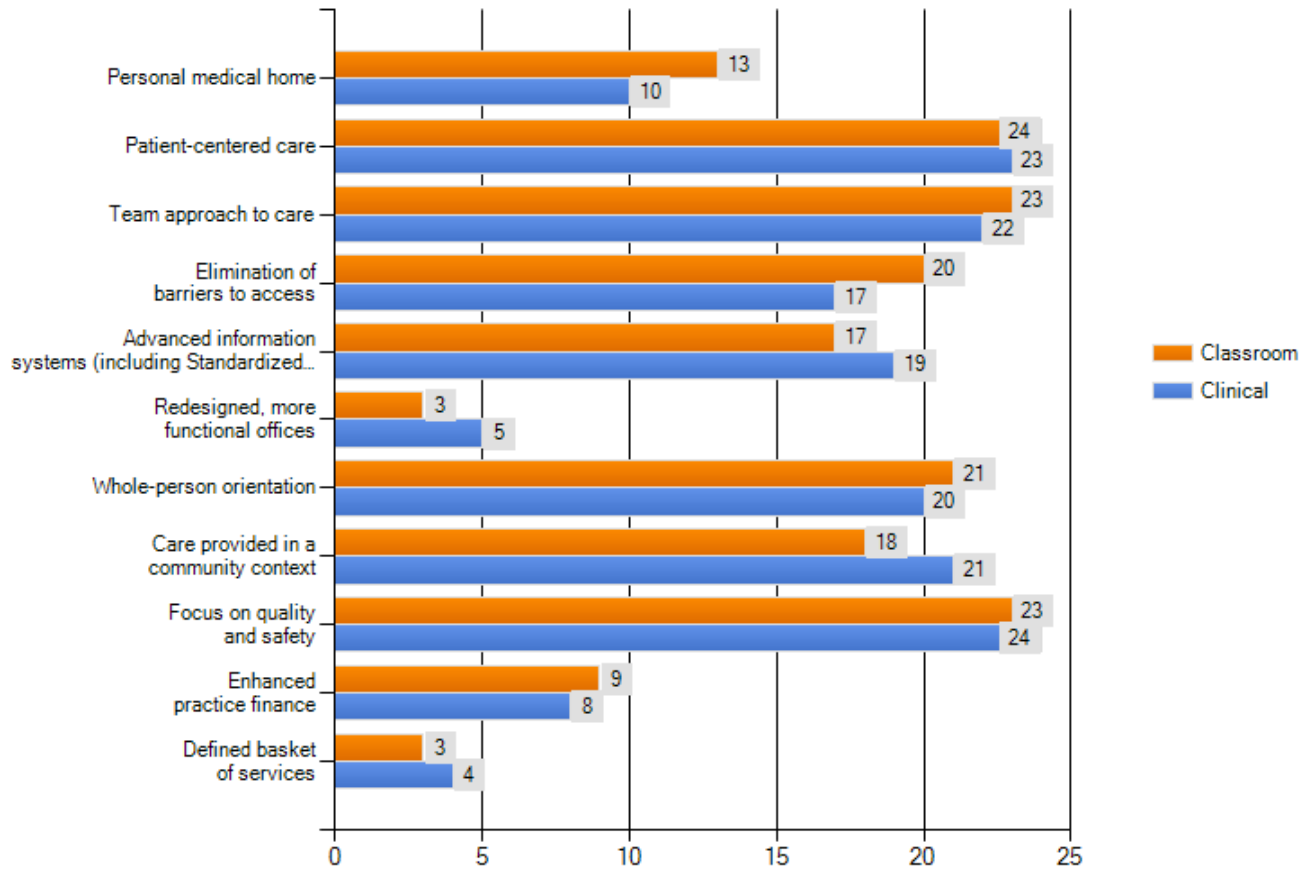


**Chart 7: Do your students have the opportunity for training within a National Committee for Quality Assurance (NCQA) Certified Patient-Centered Medical Home? (N=24)**



Of the 47.7% of programs that provide opportunities to learn about the principles of patient-centered medical homes, only 3 of the 11 key elements as defined by the Future of Family Medicine Report (Martin, JC et al. Ann. Fam. Med., 2004) are taught by the majority of programs in the classroom or in a clinical setting. These 3 elements are: patient-centered care, team approach to care, and focus on quality and safety. Elimination of barriers to access care, advanced information systems, whole-person care, and care provided in a community context are less often addressed in the classroom or in clinical settings. Chart 8 provides additional information on these key elements.

**Chart 8: If you provide opportunities to learn about patient-centered medical homes, check which of the 11 key elements [as defined by the Future of Family Medicine Report (Martin, JC et al. Ann. Fam. Med., 2004)] are taught in the classroom and/or clinical setting (check all that apply)? (N=25)**



### Integrated Behavioral Health and Primary Care

Of the responding programs, 47.5% of them have curriculum content related to integrated medical and behavioral health services (n=48).

Education on diagnosing and treating common mental health problems that present in a primary care setting (n=42) mostly occurs through clinical rotations/residencies with clinicians who have expertise in recognizing and treating mental health conditions (66.7%). Individual courses related to the integration of primary care and behavioral health services is another common way to provide this education (64.3%). Respondents also state that content integrated into courses with other foci is another way to provide this education (52.4%).

## **Recommendations**

### ***Curriculum Suggestions***

- Add how to work with interpreters under cultural competency.
- Additional focus on grant writing, program development, and community participation research.
- Enhanced education on utilizing telemedicine.

### ***Interdisciplinary Learning Opportunities***

- Practicum experience with different disciplines is strong. Match those opportunities by concentrating on this in the classroom as well.

### ***Practicing and Educating in Rural Areas***

- There is a strong need for a central coordinating body to identify and monitor residencies and placements throughout the state. AHECs are poised to assist with this role.
- Suggest that Search Program funding from the National Health Service Corps be explored for potential funds to assist students/residents in financing rural training
- Need for additional funding for all disciplines, not just medical residencies.
- Whereas there are a good number of rotations and placements, they need continued and enhanced attention. Needs for preceptors require particular attention.
- Identify ways to provide greater equity of preceptor payments
- Additional coordination with rural agencies to serve as placements for students and employee graduates.
- Federally Qualified Health Centers, Free Clinics, and Rural Health Centers should be considered more often as potential training sites in rural areas.
- Increase the use of telemedicine in training and supervision.
- Expand loan repayment programs for those employed in rural areas.
- Reimbursement incentives for practicing in a rural area.
- Increase funding to agencies that support and coordinate clinical placements.

### ***Patient Centered Medical Homes***

- Despite 33.3% of respondents indicating that their students had an opportunity to train in a NCQA certified facility, the Rural Workforce Council believes this number should be higher and encourage programs and residencies to find more certified facilities that will take students.

### ***Integration of Behavioral and Primary Care***

- Additional needs for integration of behavioral health and primary care in clinical training.

## **Summary**

The survey findings confirmed that most academic educational programs offer opportunities for students to learn about caring for rural populations, working within a multidisciplinary environment, and integrating behavioral health and primary care. However, the lack of rural clinical sites and coordination of available sites severely limits opportunities to educate future health professionals about serving rural populations and, hopefully, recruiting them for future positions in rural agencies.