

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



Executive Summary

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 a goal of strengthening 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 rural populations in the classroom and in clinical training, barriers to educating students and residents wanting to work in a rural area, and ways to improve education of future health professionals.

Methodology

One hundred and nine academic health programs and residency programs were surveyed in February and March of 2011. 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 residency 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). Programs top three content areas in their curriculum are culturally competent care (91.7%), multidisciplinary or interdisciplinary collaboration/team-based practice (85.4%), and evidence based medicine/empirically supported treatments (81.3%).

The majority of programs require their students to have rotations or placements to educate them about working with rural populations (44.4%) (n=45). An additional 26.7% offer education on an elective basis.

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%). Free or charitable clinics (63.6%) are used more frequently than Federally Qualified Health Centers (47.7%) or Rural Health Clinics (45.5%).

There are significant barriers that prevent programs from being able to educate future health care workers on rural populations (n=36). The top barriers include competition with other schools or programs, lack of rural clinical rotations or placements, and lack of internship/fellowship/residence/preceptor sites for working with rural populations, and distance of university or college from rural locations makes clinical rotations/placements less appealing.

Programs have engaged in 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%).

Policy changes that are needed to overcome barriers to educating future health providers to serve rural populations were also offered (n=30). Expanding federal and state loan repayment programs, reimbursement incentives for practicing in rural areas, enhanced funding for agencies that support and coordinate clinical placements, and encourage use of/access to technology at rural placements (distance learning, telemedicine) were the top suggestions.

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). The top disciplines that programs offer for training in the classroom or within a clinical setting are (N=39) are physician, nurse practitioner, care coordinator (LPN, RN), pharmacist, licensed clinical psychologist, and physical therapist.

Patient Centered Medical Home Model

The majority (47.7%) of programs provide opportunities for students to learn about the principles of a patient centered medical home (N=44). Most of the other programs report that they will soon be incorporating this into their curricula. Of those programs that do allow students to learn about the principles, only 1/3 provide their students the ability to train within National Committee for Quality Assurance (NCQA) Certified Patient-Centered Medical Homes (N=24).

Of the 47.7% of programs (N=25) 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 to 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.

Integrated Behavioral Health and Primary Care

Of the responding programs, 47.5% 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 stated 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 participatory 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.