WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Preliminary Performance Review

Rural Health Advisory Panel

Rural Rotations of Health Sciences Students Through RHEP Increase Healthcare Available to Rural Populations; However, RHEP's Achievements with Regard to Recruitment are not Sufficient to Address all the Health Professions Shortage Needs in the State

January 2006
PE 05-24-367

JOINT COMMITTEE ON GOVERNMENT OPERATIONS

Senate

Edwin J. Bowman
Chair

Billy Wayne Bailey, Jr.
Vice Chair

Walt Helmick

Donna J. Boley

Sarah M. Minear

Citizen Members

Dwight Calhoun

John Canfield

James Willison

W. Joseph McCoy

(Vacancy)

House Of Delegates

J.D. Beane
Chair

Timothy R. Ennis
Vice Chair

Joe Talbott

Craig P. Blair

Otis Leggett

Scott G. Varner, Ex Officio Non-Voting Member

OFFICE OF THE LEGISLATIVE AUDITOR

Aaron Allred
Legislative Auditor

John Sylvia
Director

Brian Armentrout
Research Manager

Noah Browning
Research Analyst

Performance Evaluation and Research Division
Building 1, Room W-314
State Capitol Complex
Charleston, West Virginia 25305
(304) 347-4890

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

January 9, 2006

The Honorable Edwin J. Bowman
State Senate
129 West Circle Drive
Weirton, West Virginia 26062

The Honorable J.D. Beane
House of Delegates
Building 1, Room E-213
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0470

Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Preliminary Performance Review of the *Rural Health Advisory Panel*, which will be presented to the Joint Committee on Government Operations on Monday, January 9, 2006. The issue covered herein is "Rural Rotations of Health Sciences Students Through RHEP Increase Healthcare Available to Rural Populations; However, RHEP's Achievements with Regard to Recruitment are not Sufficient to Address all the Health Professions Shortage Needs in the State."

We transmitted a draft copy of the report to the Rural Health Advisory Panel on December 19, 2005. We held an exit conference with the Panel on December 23, 2005. We received the agency response on December 29, 2005.

Let me know if you have any questions.

Sincerely,

John Sylvia

JS/wsc

Joint Committee on Government and Finance

Contents

List Of Tables

List of Figures

List Of Appendices

Executive Summary

Issue 1: Rural Rotations of Health Sciences Students Through RHEP Increase Healthcare Available To Rural Populations; However, RHEP's Achievements With Regard To Recruitment Are Not Sufficient To Address All The Health Professions Shortage Needs In The State.

If the survey results are projected onto the entire population of students who have completed a rotation, then RHEP is directly responsible for recruiting 1% of all students, while 7% of students entered rural practice of their own accord.

The Rural Health Advisory Panel (RHAP) is charged with the recruitment and retention of health professionals in rural areas. The primary means of recruitment are rural rotations, which are organized through the Rural Health Educational Partnerships (RHEP). The rural rotations provide a variable boost in healthcare availability in rural areas. However, the achievements RHEP has had with regard to recruitment are not sufficient to address all the health professions shortage needs in the state. According to a 2005 RHEP survey of rural practitioners, 8% of all health professionals in rural practice would not be in rural practice if it had not been for the RHEP experience, while 57% of rural health professionals surveyed stated that they were committed to rural practice prior to their rural rotation. However, if the survey results are projected onto the entire population of students who have completed a rotation, then RHEP is directly responsible for recruiting 1% of all students, while 7% of students entered rural practice of their own accord. **Given that RHEP provides needed, variable healthcare services to rural populations, the Legislative Auditor recommends that RHEP be continued. However, since RHEP's achievements with regard to recruitment are not sufficient to address all the health professions shortage needs in the state, RHEP should explore alternatives to improve recruitment.**

Recommendation

1. *The Legislative Auditor recommends that RHEP should be continued. However, since RHEP's achievements with regard to recruitment are not sufficient to address all the health professions shortage needs in the state, RHEP should explore alternatives to improve recruitment.*

Review Objective, Scope and Methodology

This Preliminary Performance Review of the Rural Health Advisory Panel is required and authorized by the West Virginia Sunset Law, Chapter 4, Article 10 of the West Virginia Code.

Objective

The objective of this report is to determine RHEP's level of success with regard to the recruitment and retention of health professionals in rural areas.

Scope

This report used information from academic years 1999 through 2004. Some historical information is included for informational purposes.

Methodology

The Legislative Auditor used the responses to the 2005 Rural Practitioner Survey as provided by RHEP for an indication of recruitment achievements. Additionally, the Legislative Auditor used a 2003 report from the Government Accountability Office for the purposes of verifying an increase in physician numbers. The Legislative Auditor also used data provided by RHEP (total number of students having completed a rotation, actual survey response numbers) for calculating the percentage of all students who have completed a rural rotation and entered rural practice, who were directly influenced by RHEP. For comparison purposes, the Legislative Auditor also calculated what percentage of all students who completed a rural rotation chose rural practice of their own accord. Every aspect of this evaluation complied with Generally Accepted Government Auditing Standards (GAGAS).

Issue 1

Rural Rotations of Health Sciences Students Through RHEP Increase Healthcare Available To Rural Populations; However, RHEP's Achievements With Regard To Recruitment Are Not Sufficient To Address All The Health Professions Shortage Needs In The State.

Issue Summary

According to West Virginia Code §18B-16-2, RHEP's main goal is the recruitment and retention of healthcare professionals in rural areas. Rural health rotations required of health sciences student are the primary means of recruitment for RHEP. Since 1999, RHEP has experienced an increase in the number of student weeks, faculty, and training sites. This in turn has increased the healthcare services available in rural areas. However, the rural rotations required of students last a maximum of three months, and as a result, services provided by students are a variable boost in healthcare availability. It is the long term effect on recruitment and retention of healthcare professionals that is unclear.

According to a 2005 RHEP survey 1% of all students who have participated in an RHEP rotation over the last ten years would not be in rural practice if it had not been for the RHEP experience.

According to a 2005 RHEP survey of rural practitioners, 8% of all health professionals in rural practice would not be in rural practice if it had not been for the RHEP experience. This corresponds to 1% of all students who have participated in an RHEP rotation over the last ten years. Furthermore, according to the survey, the majority of rural health professionals were committed to rural practice prior to their RHEP rotation. Reinforcing these facts is the 2004 Health Sciences and Rural Health Report Card published by the Higher Education Policy Commission. According to the report, the percentage of West Virginia medical school graduates entering rural practice averaged 10% from 1992 to 1999. It appears that there will always be a core group of health professionals entering rural practice despite RHEP and the required rural rotation. Therefore, RHEP should research other methods of recruitment of rural physicians, such increased loan repayment or practice assistance. **Given that RHEP provides needed, variable healthcare services to rural populations, the Legislative Auditor recommends that RHEP be continued. However, since RHEP's achievements with regard to recruitment are not sufficient to address all the health professions shortage needs in the state, RHEP should explore alternatives to improve recruitment.**

RHEP provides needed healthcare services to rural populations.

Background

In 1991, the Legislature passed the Rural Health Initiative Act which created the Rural Health Advisory Panel in order to increase rural healthcare resources and to recruit and retain health professionals in rural areas. The West Virginia Code lists 15 goals for the Panel, seven of which focus on recruitment and retention of health professionals. The primary means of recruitment is through Rural Health Educational Partnership (RHEP) rotations. RHEP's budget is approximately $2.4 million, and is used to provide healthcare services and support services in rural areas. Additionally, the program is compulsory for all West Virginia health sciences students in public universities, making it the only mandatory rural rotation program in the nation. Although other rural states' medical schools offer rural tracks and community rotations, those programs are strictly voluntary.

The program is compulsory for all West Virginia health sciences students in public universities, making it the only mandatory rural rotation program in the nation.

RHEP Rotations Increase Rural Healthcare Availability

From the 1999-2000 academic year to the 2003-2004 academic year, the number of field faculty increased 35%, along with the number of training sites (see Table 1). A direct effect of these increases is that more areas are available for student rotations, which in turn increases the healthcare services available to the rural populations. For example, from 2003 to 2004, clinical dental procedures provided to rural populations by RHEP students increased by 38% and had a value of nearly $1 million in free healthcare. In addition, as of July 2005, RHEP implemented a new policy encouraging students to conduct rotation in the most rural areas of the state. Should this program have the desired effect, then the most rural populations in the state will receive a boost in available healthcare. **Furthermore, should RHEP cease to exist, the healthcare services provided by the student rotations would either be reduced or no longer exist. However, RHEP rotations last a maximum of three months, and as a result, services provided by students are a variable boost in healthcare availability.**

From 2003 to 2004, clinical dental procedures provided to rural populations by RHEP students increased by 38% and had a value of nearly $1 million in free healthcare.

Table 1 Student Weeks, Field Faculty, and Training Sites By Academic Year			
Academic Year	**Student Weeks**	**Field Faculty**	**Training Sites**
1999-2000	5,508	473	295
2000-2001	5,836	498	295
2001-2002	6,359	594	318
2002-2003	6,705	610	328
2003-2004	6,726	640	367
Source: Data for this table were provided by RHEP.			

RHEP Students Provide Variety of Services

RHEP serves as the vehicle for the Coronary Artery Risk Detection in Appalachian Communities Project (CARDIAC), a cholesterol screening program for 5th grade students designed to detect persons who may be susceptible to chronic diseases, such as diabetes and heart disease.

RHEP rotations provide a multitude of services to rural populations. In 2004, RHEP provided over 70,000 community contacts. The contacts range from sports physicals to oral hygiene. Furthermore, RHEP serves as the vehicle for the Coronary Artery Risk Detection in Appalachian Communities Project (CARDIAC) by providing supplies and manpower. CARDIAC is a cholesterol screening program for 5th grade students designed to detect persons who may be susceptible to chronic diseases, such as diabetes and heart disease. This program is nationally recognized by the National Rural Health Association and the American Public Health Association. CARDIAC began in 1997 and expanded in FY 2003 to 40 counties and again in FY 2005 to 54 counties. Since its inception, CARDIAC has screened over 30,000 children. **Given that West Virginia ranks second in the nation in the prevalence of diabetes and fifth in the nation in heart disease deaths, the Legislative Auditor commends RHEP for its efforts in the prevention of disease in West Virginia.**

Increase In The Number of Rural Physicians

The number of rural physicians from 1995 to 2005 increased by 228 (20%). Additionally, the number of whole county Health Professional Shortage Areas (HPSAs) dropped from 22 in 1995 to 16 in 2005.

According to both the Government Accountability Office (GAO) and RHEP, there has been an increase in the number of rural physicians in West Virginia. According to the GAO, West Virginia averaged 156 physicians per 100,000 people in rual areas in 1991. By 2001, the rate increased to 186 physicians per 100,000 people. Furthermore, RHEP also provided data that indicated the number of rural physicians from 1995 to 2005 increased by 228. Additionally, the number of whole county Health Professional Shortage Areas (HPSAs) has dropped from 22 in 1995 to 16 in 2005. Given

that a HPSA designation is based on a physician-to-population ratio, and that the population has remained relatively stable, the drop in whole county HPSAs indicates an increase in physicians. However, the role RHEP played in this increase is unclear since the increase in physicians could be attributed to the normal increase in the number of medical school graduates (see Figure 1), and the growth rate of rural physicians is similar to the growth rate prior to the existence of RHEP.

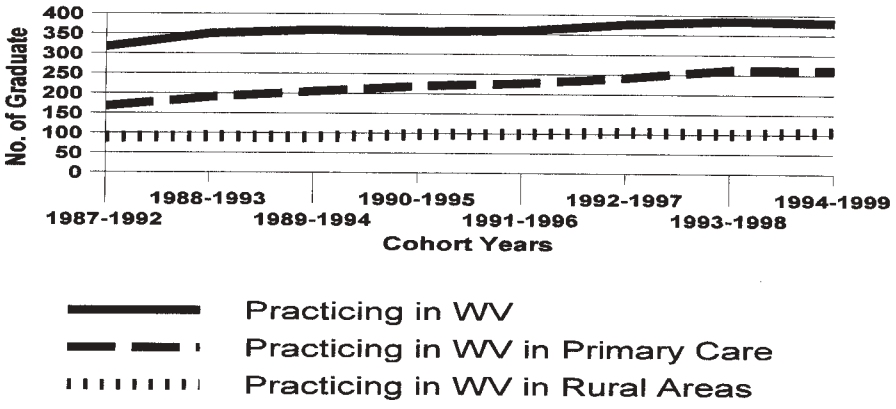
RHEP's Achievements with Regard to Recruitment are not Sufficient to Address All the Health Professions Shortage Needs in the State

The number of graduates in primary care fields increased by 56% from 1992 to 1999. However, it appears that RHEP has not been able to take advantage of the large growth in primary care graduates. During the same time frame, the number of primary care graduates entering rural practice increased 20%.

According to West Virginia Code §18B-16-4, eight of RHEP's sixteen goals focus on the recruitment and retention of healthcare professionals in rural areas. However, RHEP's achievements in this area are not sufficient to address all the health professions shortage needs in the state. As Figure 1 indicates, the number of graduates in primary care fields increased by 56% from 1992 to 1999. However, during the same time frame, the number of primary care graduates entering rural practice increased 20%. It should be noted that only graduates from 1997 through 1999 would have been influenced by RHEP through either voluntary rotations, which began in 1994, or mandatory rotations, which began in 1996. As the graph demonstrates, there is a need for programs that can influence medical graduates to choose rural practice. However, it appears that RHEP has not been able to take advantage of the large growth in primary care graduates. Furthermore, Figure 1 indicates that a core group of individuals chose rural practice before RHEP came into existence in 1994, and that the lack of an increase above the normal growth of rural physicians indicates RHEP's influence is not sufficient to address all the health professions shortage needs in the state.

Figure 1

West Virginia Medical School Graduates



Source: 2004 Health Sciences and Rural Health Report Card

RHEP is responsible for recruiting approximately 1%, or 56, of all students who completed a clinical rotation, graduated, and entered practice in rural areas over a ten year period.

In 2005, RHEP conducted a survey of rural rotation graduates known to be in rural practice in West Virginia. According to the survey, 53% of graduates in rural practice were committed to rural practice before they began their health professions program (see Table 2). Furthermore, 8% of rural practitioners stated that they would not be in rural practice if they had not had the RHEP experience. It should be noted that only those graduates in rural practice were surveyed. According to RHEP, approximate 8,000 individuals have completed an RHEP rotation. Therefore, the Legislative Auditor estimates that approximately 5,000 individuals have graduated and began practice. **Based upon the estimate of those in practice, RHEP is responsible for recruiting approximately 1%, or 56, of all students who completed a clinical rotation, graduated, and entered practice in rural areas over a ten year period.**

Table 2
Factors Determining Practice Location Decisions

RHEP Survey Response	Percentage Surveyed Responding with Response	Response Percentage Projected on the Total Number of All Students Who Participated in a RHEP Rotation
I was committed to rural practice before I began my health professions program.	53%	7%
I would not be in rural practice today if I had not had the RHEP experience.	8%	1%

Source: 2005 RHEP Survey of Rural Health Professionals; PERD Calculations

Approximately 7% of all students who have completed a clinical rotation, graduated, and entered rural practice, planned to go into rural practice prior to doing the RHEP rotation.

Also, approximately 7% of all students who have completed a clinical rotation, graduated, and entered rural practice, planned to go into rural practice prior to doing the RHEP rotation. According to the survey, of the respondents, the majority (65%) chose rural practice to be near family (see Table 3). Respondents also chose rural practice because they were familiar with the chosen community (63%). Given that every factor cannot be captured, conclusions from surveys should be cautiously understood, however, the 2005 RHEP survey indicates that individuals choose rural practice due to familiarity with the area rather than recruitment efforts. **Given that the majority of individuals who choose to practice in rural areas are from a rural area or have familial reasons, RHEP should consider increasing recruitment efforts in rural high-schools.**

Table 3
Factors Affecting Choice of Rural Practice

Rural Practice Influences	Not An Influence	Some Influence	Major Influence
Rural areas have a great need for dedicated professionals.	7%	36%	**57%**
I feel that I can make a difference in a rural area.	5%	32%	**62%**
I have/had a financial incentive that obligated me to rural practice in an under-served area.	**64%**	23%	14%
I wanted to practice near family.	15%	20%	**65%**
I was familiar with my chosen rural community.	15%	22%	**63%**
My first rural practice community actively recruited me.	**60%**	20%	21%

Source: 2005 RHEP Survey

RHEP Should Research Other Recruitment Options

Although it is clear that RHEP provides needed services to rural populations, it is unclear if RHEP rotations aid in the recruitment of physicians to rural populations. Therefore, the possibility exists that RHEP should research other methods of recruitment. For example, RHEP may choose to research tuition reimbursement and its effectiveness. The January 2004 report by the Performance Evaluation and Research Division identified that West Virginia's financial incentive awards to practitioners who work in rural areas are less than most surrounding states. As of the writing of this report, the loan repayment amount has not been changed, and West Virginia either repays less than surrounding states or equal to surrounding states (see Table 4). Other possibilities include researching options other than loan repayment that could be offered to physicians who choose a rural practice site (i.e. staffing assistance, equipment assistance). **Therefore, given that RHEP provides needed, variable healthcare services to rural populations, the Legislative Auditor recommends that RHEP be continued. However, since RHEP's achievements with regard to recruitment are not sufficient to address all the health professions shortage needs in the state, RHEP should explore alternatives to improve recruitment.**

Table 4
Comparison of Selected Loan Repayment Programs

Loan Repayment Program	Contract Amount	Extension Amount
West Virginia	Up to $40,000 for 2 years of service	Up to $25,000 per year for up to 2 more years
Ohio	Up to $40,000 for 2 years of service	$20,000 per year up to 2 more years
Virginia	Up to $50,000 for 2 years of service	Up to $85,000 for 3 years, $120,000 for 4 years
Kentucky	Up to $70,000 for 2 years of service	None
National Health Service Corps	$50,000 for 2 years plus 39% to cover income taxes	$25,000 per year for up to 2 more years, plus 39% to cover income taxes

Source: Data for this table were provided by the American Academy of Family Physicians.

RHEP Aids In Retention Of Rural Health Providers

Lastly, RHEP is also intended to help retain healthcare professionals in rural areas. According to the 2005 survey, RHEP may aid in the retention of rural health professionals. For example, 73% of physicians responded that teaching for RHEP as a preceptor helps them stay in their current profession. Furthermore, rural practitioners receive the following benefits as preceptors:

- Access to RHEP facilities for Learning Resource Centers for internet searches, books, patient education materials, staff support, for interlibrary loans, loans of lap-top computers, digital cameras, AV and other equipment.

73% of physicians responded that teaching for RHEP as a preceptor helps them stay in their current profession.

- Dental field faculty have received equipment to accommodate student training, including dental chairs, intra-oral cameras, and hand instruments.

- Field faculty receive Continuing Medical Education (CME) credits when precepting residents. Some of the WVRHEP sites cover CME costs for rural physicians and some schools cover these fees for the preceptors who hold adjunct appointments with their respective departments.

It appears, given the equipment and educational benefits received by preceptors, that RHEP aids in the retention of rural health professionals.

Conclusion

RHEP was intended to recruit and retain rural healthcare professionals. Although there has been an increase in the number of physicians in rural areas, it is unclear if this is a result of RHEP's efforts. A 2005 survey of rural health professionals indicated that most individuals were committed to rural practice before beginning their health studies programs. Additionally, the survey also indicated that 8% of rural healthcare providers would not be in rural practice without the RHEP experience. That corresponds to 1% of all students who participated in an RHEP rotation. Given that the survey indicates that rotations are not an effective method of recruitment, RHEP should research alternatives.

Although RHEP's effectiveness in the recruitment of health professionals is unclear, RHEP does provide healthcare to the rural populations of the state such as providing free dental care or staffing the states' CARDIAC

project.. Should RHEP cease to exist, the student rotations may cease altogether, thus reducing healthcare services for rural populations of the state. **Therefore, given that RHEP provides needed, variable healthcare services to rural populations, the Legislative Auditor recommends that RHEP be continued. However, since RHEP's achievements with regard to recruitment are not sufficient to address all the health professions shortage needs in the state, RHEP should explore alternatives to improve recruitment.**

Recommendation

1. *The Legislative Auditor recommends that RHEP should be continued. However, since RHEP's achievements with regard to recruitment are not sufficient to address all the health professions shortage needs in the state, RHEP should explore alternatives to improve recruitment.*

Appendix A: Transmittal Letter

WEST VIRGINIA LEGISLATURE
Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

December 19, 2005

Hilda R. Heady, Associate Vice President for Rural Health
Office of Rural Health
Robert C. Byrd Health Sciences Center at West Virginia University
P.0. Box 9003
Morgantown, WV 26506-9003

Dear Ms. Heady:

This is to transmit a draft copy of the Preliminary Performance Review of the Rural Health Advisory Panel. This report is scheduled to be presented during the January 8th interim meeting of the Joint Committee on Government Operations. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committee may have.

If you would like to schedule an exit conference to discuss any concerns you may have with the report, please notify us between December 20th and December 23rd. We need your written response by noon on Wednesday, December 28th, 2005 in order for it to be included in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, January 5th, 2006 to make arrangements.

We request that your personnel not disclose the report to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

John Sylvia

John Sylvia

Appendix B: Agency Response

December 28, 2005

Mr. John Sylvia
Legislative Auditor
West Virginia Legislature
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610

Dear Mr. Sylvia:

This is to transmit our agency response to the draft copy of your Preliminary Performance Review of the Rural Health Advisory Panel which we received on December 22, 2005. I am confirming that representatives from our agency will be present for the presentation of the report to the Joint Committee on Government Operations at the interim session on January 8, 2006.

We are pleased to receive your report and concur with the major points in the report with some exceptions. The attached document contains the specifics of our disagreements.

1. **We disagree with the assumptions presented regarding Figure 1**
   a. The report recognizes that these data go only up to 1999 and medical students who completed required rotations would not be in this data set by 1999 (rural rotations were not required until 1996 and there is at least a 3 year lag time for medical students to complete their residency).
   b. Figure 1 makes the assumption that there are no reasons to think that there would have been a decline in rural physicians during this time period when there were significant rural cost reimbursement and malpractice insurance issues and a decline in the rural versus urban population.

   We agree that community based training activities as completed under the RHEP program are not sufficient to address all the health professions shortage needs of the state, however RHEP should be considered a pro-active strategy that might help to address the impact of the challenges to recruitment and retention in the long term. Further, as an educational strategy, the partners in the RHEP program have always agreed that community based training should be combined with other strategies to address this chronic problem. The RHI Panel and the RHEP program welcome the recommendation in the report to research other alternatives. This we believe could improve the recruitment and retention efforts of not only RHEP but other state agencies with the same legislative responsibility and mission as well.

2. The PERD report fails to address the full impact and influence of the rural rotation and experience on practice decision.

The PERD report only mentions that the 8% of all health professionals in rural practice corresponds to 1% of all students who have participated in an RHEP over the last ten years. These 8% only represent the students who agreed with the very strong statement, *I would **not** be in rural practice today if I had not had the RHEP experience.* It does not recognize that 58% of respondents stated that *their commitment to rural practice was strengthened by their RHEP experiences.* The 2005 rural practitioner survey indicates that rural rotations influence trainees through the provision of experiences that would not be available if it were not for the rural rotations. Fifty eight percent of all practitioners and 52% of physicians said that their commitment to rural practice was strengthened by their RHEP experience. For example, 57% surveyed stated that *rural areas having a great need for dedicated professionals* was a major influence on their decision to practice in a rural area. Sixty two percent (62%) felt that their belief that *they could make a difference in a rural area* was also a major influence in their decision. These two

areas of influence cannot be taught in the traditional didactic health sciences curriculum.

During the presentation on January 8, we will be presenting information to the committee that will focus on the outcomes of the program since 1999. Thank you for your consideration.

Sincerely,

Hilda R. Heady, Executive Director
WV Rural Health Education Partnerships/Area Health Education Centers

Cc: Dr. Bruce Flack
Mr. Dennis McCutcheon

Agency Response to PERD Preliminary Draft Report of 12-22-05
West Virginia Rural Heath Education Partnerships
State Rural Health Advisory Panel
12-28-05

Issue 1: Rural Rotations of Health Sciences Students Through RHEP Increase Healthcare Available To Rural Populations; However, RHEP's Achievements With Regard To Recruitment Are Not Sufficient To Address All The Health Professions Shortage Needs In The State.

Page 4 paragraph below Figure 1:

1 **RHEP disagrees with the assumptions upon which the calculations are based to determine the 1% statistic and the use of Figure 1 to minimize the impact of RHEP.** Based on the assumptions used by PERD and upon the estimate of those RHEP graduates who are currently in rural practice or who have spent time in rural practice and moved on, RHEP is definitely responsible for recruiting at least 1% (93/8,000), or 93 health professionals (9% x 1031 total number RHEP grads ever in rural practice). However the report fails to emphasize the number who strengthened their commitment to rural practice (7% (598/8,000) or 598 health professionals: 58% x 1031 total number RHEP grads ever in rural practice). Very few health professionals, or people in any profession, can attribute a career decision to any one event. Most professionals are not inclined to enter careers in rural areas and therefore, most would not give any one reason as **the one**, special reason for their decision to practice or locate in a rural community. RHEP's greatest success has been in influencing those who firm up their commitment to rural practice among all the reasons that influence their practice and career decisions. RHEP does this by providing a real-life health care experience as a health professional in a rural setting, helping to counteract the many subtle and not-so-subtle anti-rural influences of the more urban, academic health care experience.

2 **The growth rate of rural physicians is greater since the inception of RHEP.** Between 1992 and 1999, medical school graduates entering rural practice averaged 10%. In 1996, the requirement that health professions students spend three months in rural, clinical rotations went into effect. The medical students under this requirement finished their residency no earlier than1999. Since 1999, there has been an annual increase of 13.4% of newly-graduated medical residents choosing rural practice. The graph (Figure 1) in the PERD preliminary report only covers medical school graduates from 1987-1999. The influence of RHEP on physicians in rural practice would not be evident until 1999.

2 While it is true that the majority (68%) of rural physicians surveyed said that they were committed to rural practice before they began their health profession program, there were 32% who were NOT committed to rural practice before they began their health profession program and 52% who said that their commitment to rural practice was strengthened by their RHEP experience and another 8% who said that they would not be in rural practice today if they had not had the RHEP experience. Also, those who said they were already committed to rural practice still included significant numbers (more than half) who cited components of the RHEP experience as valuable in preparation for rural practice.

3 A bare majority (57%) of ALL health professions said that they were committed to rural practice before they began their health profession program and an almost equal percentage (58%) said that their commitment to rural practice was strengthened by their RHEP experience and another 9% who said that they would not be in rural practice today if they had not had the RHEP experience. Those who stated they were influenced by RHEP also consistently (usually more than 2/3 for any on component) cited RHEP components as important in preparation for rural practice.

4 **RHEP has identified at least 1031 RHEP graduates in practice in a rural setting since our first R & R list was constructed in 1999.** Our annual Recruitment and Retention list does not represent 100% of all RHEP graduates who have chosen rural practice. While some national researchers make the assumption that all graduates with either a home or work address are working in rural areas, we only allow people on our R & R list who we have personally verified as working in a rural setting. It is very difficult to track health professionals, especially those in the fields of nursing, pharmacy and dental hygiene. Hospital personnel departments, traditionally, will not verify if a person is working or not at their facility. So, the 643 health

professionals who were surveyed represent, without a doubt, an undercount of the number of RHEP graduates in rural areas.

5 63% of respondents said that familiarity with the chosen rural community, which could have been gained or enhanced by the RHEP experience, was a major influence. The PERD Preliminary Draft assumes that this familiarity is only attributed to being a native of that area and not due to the familiarity gained through their RHEP rotation. It is notable that there was not as strong a statistical association between being already committed to rural practice and wanting to practice near family. For the group who stated a prior rural commitment, wanting to practice near family was not as strongly associated as was familiarity with the community.

2. The PERD report fails to address the influence of the rural rotation curriculum and experience on practice decision.

1 The 2005 rural practitioner survey indicates that rural rotations provide influences that trainees might not otherwise experience if it were not for the rural rotations. Fifty eight percent of all practitioners and 52% of physicians said that their commitment to rural practice was strengthened by their RHEP experience. We do not believe that RHEP alone was responsible for their decisions, but we do believe that it is correct to assume that RHEP served as a catalyst for their decisions, as evidenced by the value placed on RHEP components. As stated above, the majority of these practitioners who were influenced by RHEP cited RHEP components as important in preparing for rural practice, with as many as 70% citing any one component. We believe that these figures may also favorably impact on retention to rural practice. Other important factors such as, 57% surveyed stating that rural areas have a great need for dedicated professionals was a major influence on their decision to practice in a rural area, or 62% stating their belief that they could make a difference in a rural area are two areas of influence that cannot be taught in the traditional didactic health sciences curriculum.

2 RHEP clearly recognizes that there are many strategies to achieve recruitment and retention of health professionals in rural underserved areas and that no one strategy will succeed alone. Any educational strategy alone cannot achieve desired results in addressing health professions shortages. Rural communities must also address social and economic issues that deter the recruitment of all professionals to locate in these areas. This is why RHEP has partnered with other organizations to improve the recruitment environment of rural communities and the financial incentive programs in the state to combine rural rotations with financial incentives. RHEP respects the recommendation by the Legislative Auditor that RHEP should research other recruitment strategies.

3 Given our experience to date and our research it is clear that RHEP experiences help to develop a level of comfort with rural practice. RHEP is very willing to work with the state's health sciences programs to increase the enrollment and retention of students from rural areas and, together with the schools, research similar programs in other states. **Major areas for investigation may be:**

- **selective and targeted admissions of students from rural areas,**
- **the utility of a selective rural track, and**
- **the role of the rural community in training and recruitment and retention.**

For example, the Physician Shortage Area Program at Thomas Jefferson University under the supervision of Dr. Howard Rabinowitz requires a percentage of all admissions to the school be residents of rural areas and these students are trained in a rural track. Also, according to Dr. Robert Bowman at the University of Nebraska, who has done extensive work in comparing schools' production of rural practitioners; rural experiences are key to the preparation for practice with the rural underserved. One of the strategies that has worked in the US for Family Practice choice and distribution of physicians is moving the training location to a less urban location, a place where the foreign born and urban born students who prefer the most urban locations for training and for practice will not go. This is the success of decentralized training, such as the program at Duluth, Minnesota and the Upper Peninsula of Michigan which include required rural preceptorships (rotations), and admissions tracks involving rural colleges. Basically, the students who are less likely to choose FP avoid these locations.
(Bowman http://www.unmc.edu/Community/ruralmeded/precept.htm)

The RHEP experience has taught us all that rural communities and their leaders have a strong role in the training and recruitment and retention of health care providers in the underserved rural areas of the state. RHEP looks forward to continuing to work with the Legislature, health sciences programs, and rural communities, to improve all efforts to recruit and retain our best and brightest for practice in rural areas of our state.