COMPENDIUM OF BEST PRACTICES/MODELS THAT WORK IN RURAL WORKFORCE DEVELOPMENT

National Rural Health Association

NATIONAL RURAL HEALTH ASSOCIATION

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A document developed by the National Rural Task Force

PREFACE

The National Rural Task Force developed a document that can be used in a prescriptive manner by federal agencies, states and local health and health-related agencies for setting priorities for rural workforce development.

This document is envisioned to be "living" and dynamic, designed for ongoing use and modification by various entities. Opportunities for change are built into the document, allowing it to serve as an evolving national rural workforce development compendium.

The National Rural Task Force's efforts are going to be helpful as Congress looks at what programs are working and how to build on them. With the compendium, we are beginning to compile a lot of these programs and provide Congress with anecdotal information.

STATE: ALASKA

Program: Community Health Aide/Community Health Practitioner Program

Contact information: Victorie Heart,
Alaska Native Tribal Health Consortium,
4000 Ambassador Drive, Room 419,
Anchorage, Alaska 99508, vheart@anmc.org

Program web site:
www.akchap.org/GeneralInfo.cfm

Program overview: The Community Health Aide (CHA) Program was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality and high rate of injuries in rural Alaska. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and the native tribal health organizations has facilitated improved health status in rural Alaska.

The CHA Program now consists of a network of more than 550 Community Health Aides/Practitioners (CHAPs) in more than 170 rural Alaska villages. CHAPs work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual,* which outlines assessment and treatment protocols. There is an established referral relationship, which includes mid-level providers, physicians, regional hospitals and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians and dentists make visits to villages to see clients in collaboration with the CHAPs.

The Alaska Area Native Health Service has the responsibility for provision of medical and health-related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Native Health Care System. The village-based CHAPs are a vital link in the delivery system.

Community Health Aides are selected by their communities to receive training. Training centers are located in Anchorage, Bethel, Nome and Sitka. There are four sessions of CHA training; each lasts three to four weeks. Between sessions, the CHAs work in their clinics completing a skills list and practicum. Completion of the four session training curriculum and successful completion of a clinical skills preceptorship and examination, qualify the CHA as a Community Health Practitioner (CHP). CHAPs at any level of training may obtain certification by the Community Health Aide Program Certification Board. The Community Health Aide Program model is currently being used as a template to develop programs in the areas of dental care, behavioral health and elder care.

STATE: ALASKA

Program: Dental Health Aide/Dental Therapist Program

Contact information: Victorie Heart,
Alaska Native Tribal Health Consortium,
4000 Ambassador Drive, Room 419,
Anchorage, Alaska 99508, vheart@anmc.org

Program web site: www.anthc.org/cs/chs/dhs/upload/New%20approach_6-15-06_sos5.0-2.pdf

Program overview: Beginning in 2003, Alaska native tribal health organizations and the Community Health Aide Program Certification Board, a federal agency, developed a new solution to addressing rural Alaskans' dental needs: the Alaska Dental Health Aide (DHA) Initiative. The initiative is part of the Community Health Aide/Practitioner Program (CHAP), which was developed by the Indian Health Service in cooperation with Alaska tribes in the 1950s to address critical health problems in rural Alaska.

Today, more than 550 indigenous mid-level medical providers work in small community clinics providing emergency, clinical and preventive services under the general supervision of physicians at regional hospitals. The CHAP Dental Health Aide Initiative is based on this medical model, which is internationally viewed as a successful system for providing health care across great distances.

There are several levels of DHA, ranging from primary DHAs, who provide exclusively preventive services, to Dental Health Aide Therapists (DHATs), who are trained to do cleaning, fillings and uncomplicated extractions, in addition to a wide range of preventive services. All work is done under the general supervision of dentists at regional hospitals. Training for primary DHAs is provided in Alaska. DHATs are enrolled in a two-year program at the Otago University School of Dentistry in New Zealand because there is not mid-level dental practitioner training in the United States. (See updated information in article below.)

To be certified, all DHAs must meet qualifications set by the Federal Community Health Aide Program Certification Board, which is made up of experienced federal, state and tribal health professionals. Continuing education is required annually, and a skills evaluation is required every two years for re-certification.

By Shannon O'Hara
news@thedaily.washington.edu

Imagine living in a place where there is no dentist or dental program.

- Alaska natives have tooth decay rate 2.5 times the national average.
- More than one-third of children miss school because of tooth-related issues.
- There are seven students enrolled in the program.

The Kellogg and Rasmuson Foundations gave grants to help fund the training portion of the program. The Paul G. Allen Foundation helped to fund the curriculum portion.

Even if someone has severe dental health problems, there is nowhere to go except for the one time a year a dentist may come to your village. This is the problem many native Alaskans are facing. The University of Washington (UW) is helping to solve this issue through a program training dental therapists to work in remote areas.

"This is the first dental therapy program in the United States," said Ruth Ballweg, director for MEDEX Northwest, a physician assistant program closely involved with the Alaska initiative.

The UW was a logical choice, said Ron Nagel, the dental consultant for the Alaska Native Tribal Health

Consortium. The state of Alaska already has a reciprocal agreement with the university for training physicians and physician assistants.

This program is designed to last two years. The first year will be composed of lectures from various professors, and the second year will be at a regional medical center where students will be involved in internships overseen by professional dentists.

"The UW will provide lectures for the first year," Ballweg said.

Professors will be from a variety of dental and medical backgrounds.

Martha Somerman, UW School of Dentistry dean, said the university will be "involved for a year to create a very strong preventative program."

After completing the program, graduates will be placed in villages in the hopes of improving the oral health care in the area.

Although 40 countries already have a program similar to this in place, the idea is controversial in the United States. The discrepancy lies in what a dental therapist is or is not allowed to do.

"They will provide basic dental health services, especially for children, such as basic dental health care and dental procedures," Ballweg said.

According to the Alaska Native Tribal Consortium web site, therapists are trained to do cleaning, filings and uncomplicated extractions. All the work they do is under the supervision of a professional dentist at the regional hospital.

There are 11 dental therapists practicing in Alaska. These therapists had to go to New Zealand to receive their training.

However, upon returning to their native Alaska, the American Dental Association sued the therapists in hopes of blocking their procedures. Even amid the controversy, the UW plans to continue with involvement in the program.

A primary goal of the program is to "train dental therapists to provide services in rural Alaska," Nagel said. "Access to oral health care is an issue. The poor and underserved have difficulty getting oral health care."

Somerman agreed.

"Some areas have gained a better handle on oral health care, but dental health is not considered or recognized as important except for children," she said. "In the future the focus [will be] on the preventative side."

STATE: ARIZONA

Program: A.T. Still University, Doctor of Osteopathic Medicine, Mesa, Arizona

Contact information: Tom McWilliams, DO, FACOFP, Associate Dean of BioClinical Sciences School of Osteopathic Medicine in Arizona, 5850 E. Still Circle, Mesa, Arizona 85206 480-219-6053, tmcwilliams@atsu.edu

Program web site: www.atsu.edu/soma/programs/osteopathic_medicine/index.htm

Purpose: Train physicians in a rural medically underserved area to promote practice site locations in these areas.

Program overview: This newest medical school at A.T. Still University (ATSU) was initiated at the request of the National Association of Community Health Centers (NACHC). Community health centers (CHCs) are independent organizations that serve as the nation's high quality health care safety net. CHCs provide comprehensive coordinated primary care services through 5,000 clinics in the United States and its territories. These centers anticipate a need for an additional 14,000 physicians by 2020 and are partnering with ATSU to identify, educate and train high quality, community-minded physicians.

Leaders in medical education joined ATSU and NACHC in the design of a modern curriculum and learning facilitation model for the new school. This clinical presentation educational model follows an innovative path built around a core of dedicated faculty who design learning modules, facilitate module discussions and who work with renown visiting faculty. The modules present a calibrated series of medical problems that are resolved by small learning teams.

These teams are identified in the application process and begin learning together during the first year at ATSU's new campus in Mesa, Arizona. The second, third and fourth years of learning will take place in meeting rooms and facilities of 10 regional campuses located at some of the nation's premier community health centers. All students will be matched to one of these CHCs as part of their acceptance to the medical school.

STATE: MONTANA

Program: Montana Primary Care Association

Contact information: Paula Block, RN, Clinical Coordinator and Montana Collaborative Coordinator, Montana Primary Care Association, 900 N Montana, B3, Helena, Montana 59601, 406-442-2750, pblock@mtpca.org or Marge Levine at mlevine@mtpca.org

Efforts: One community health center has an on-site family practice residency program. What physicians they do not hire post-graduation are recruited heavily and often successfully by other Montana health centers. This program could be doubled or tripled to meet the needs in the state. It is very successful.

WWAMI program is a partnership between the University of Washington Medicine and the states of Wyoming, Alaska, Montana and Idaho. The purpose is to provide medical education across the region or in states that do not have a medical education program. Training rotations occur across these states. Each state designates a specific number of slots and a system (usually state funds) to cover tuition. It appears to be a successful program because 61 percent of the students stay in the region, and 42 percent pursue primary care. The challenge is that many students do not return to Montana. There is not a requirement that they must return to the state that funded their tuition. One CHC executive director reported that the current soon-to-graduate WWAMI class does not contain any doctors that are entering the specialty of family practice. They are glad to have this program, but it could be more successful.

The SEARCH program has been very helpful by enabling medical and dental providers to come to health centers in Montana for training rotations. The best way to attract future providers is an exposure or relationship to the state. Now there is a huge barrier, as funding has been cut for the SEARCH program.

The Montana Rural Physician Incentive Program, nicknamed "Mr. PIP," was established by the state legislature in 1991 to provide student loan coverage to physicians practicing in rural and medically underserved areas. The trust is funded by fees assessed on all Montana medical students participating in the WICHE and WWAMI programs. Most centers have been able to use NHSC programs, so they have not used this program much. This next legislative year, the Montana Dental Association is going to pursue a similar program for dentists.

Challenges:

- No medical or dental school in the state.
- Aging and shrinking population of dentists.
- Sparse populations over great distances in the eastern and northern parts of the state.
- Lack of robust funding from state legislature.
- More competition nationally and regionally for family practice providers.

STATE: NEW MEXICO

Program: Dental Recruitment

Contact information: Kim Kinsey, Program Manager, NM DOH, Office of Primary Care/ Rural Health, 300 San Mateo, NE Suite 900, Albuquerque, New Mexico 87108, 505-841-5871

Purpose: To recruit dentists to practice in underserved areas of New Mexico.

Program overview: New Mexico does not have a dental school and has experienced the decline in the number of dentists that has occurred elsewhere in the country. Historically dentists have been trained at out-of-state dental schools frequently at schools where dental parents, relatives and mentors were trained. Retirements and relocations accompanied with limited replacement dentists have led to disproportionate distribution in the state with many concentrated in larger cities in private practice. This dilemma called for long-term solutions. New Mexico has developed strategies, which have improved the critical need for dentists and improved the outlook for future practitioners.

New Mexico has struggled to recruit dentists from out of state for health safety net providers, particularly at community-based primary care centers. Moderate success has been made utilizing the National Health Service Corps (NHSC) resources for the community health centers. Barriers and hurdles have included the State Dental Board with restrictive requirements and a strong private practice model. Career advisement was limited to sponsorship by practicing dentists and limited financial aid for students.

Efforts have been in place to address many of the historical and emerging barriers including:

Temporary license: In 1999, a Temporary License for Dentists was created to replace the Public Health License. This license was aimed specifically to permit dentists to practice at federally funded community health centers. The Public Health License was established prior to 1970 specifically to address those dentists recruited to NHSC sites at community health centers. These were dentists trained at out-of-state schools and recruited to work in community health centers who faced a hostile Dental Board with many restrictions to becoming licensed. The license was temporary but allowed NHSC dentists see patients, who did not have resources to pay or were on Medicaid. This strategy remains in place. The New Mexico Department of Health Oral Health Program and the Primary Care Office coordinate on recommendations for dentists applying under this category.

Licensing by credentialing: In 1995, a new category was created to expand license options for dentists. This process recognized licenses from other states and permitted dentists to relocate to New Mexico without having to retake examinations (except for jurisprudence). This has made recruitment easier for community health centers and private practices.

Recruitment of dentists beyond those obligated under the NHSC programs has been challenging. Even with the NHSC programs there has been declining resources for scholarships. NHSC loan repayment has and continues to be a popular and successful option that brings dentists from outside of the state and, with the temporary license, fills many vacancies. However, a decrease in federal funding and increased demand in the state required new strategies.

Western Interstate Commission on Higher Education (WICHE) program: This program has been in existence since the 1950s and permits westerns states to have students trained for professions without schools or training programs in their state. The program pays for the difference between in-state and out-of-state tuition rates at schools in states that have agreed to terms of this program. Until the late 1990s, students were under no obligation to return to the state and would often practice elsewhere. The 2000 New Mexico legislature saw this drain on state resources and enacted a service obligation portion to the funding for WICHE support. The obligation requires students who receive support to return to the state or repay the amount of support. This has supplemented the dentist pipeline as WICHE support was and is important for students to be trained as dentists and not pay higher tuition rates. The return rate for New Mexico students has increased to 94

percent. The WICHE program is administered by the Higher Education Department, which also administers the Health Professional Loan Repayment Program and other financial aid programs at the state's various institutions.

Oral Health Councils: Approximately 10 years ago a group of volunteers established an Oral Health Council to meet and discuss many of issues identified as challenges, barriers and hurdles. Upon his election, Gov. Richardson established an Oral Health Committee with many of the same members who had served on the volunteer council. Both councils provide an opportunity for policy discussion and direction for many of the improvements listed below.

Dental residency program: A Dental residency program was created at the University of New Mexico Health Sciences Center Division of Dental Services. A one-year postdoctoral Advanced Education in General Dentistry Residency was established that admits five residents each year for a period of two years. This program will expand to seven residents this year, and last year four of the five residents became licensed and will practice in state in safety net practices.

NM Health Service Corps (NMHSC): The 2004 New Mexico legislature passed supplemental funding and expanded the NMHSC located in the Department of Health to include dentists and dental hygienists. This expanded the program to specifically support dentists in training with a stipend during their training and obligated them for a minimum of two years in an underserved area. This augmented the pipeline of dentists particularly for health centers as NHSC resources diminished. Funding was also provided to NM Health Resources, the statewide clearinghouse for recruitment and retention, to conduct outreach activities at out-of-state dental schools where New Mexico students were in attendance particularly under the WICHE program. Obligations under both programs could be satisfied by returning to the state and practicing, especially in underserved areas.

Pre-dental clubs: This effort was started in 2003 at the University of New Mexico and is now at three other state institutions. The clubs were established to provide information to students in college about a career in dentistry and the educational requirements for admittance in to dental schools. Previously, New Mexicans were applying but were being turned away for lack of an academic background in the sciences and an appropriate grade point average. The clubs provide a meeting place for students who have a common interest in dentistry as a career, provide a mentor who offers advice to improve dental school acceptance and disseminate information about financing a dental education. The situation has improved and a greater percentage of students are meeting the requirements.

New Mexico Rural Health Practitioner Tax Credit Program: This program was enacted in 2007 by the New Mexico legislature to be administered between the New Mexico Department of Health and the New Mexico Taxation and Revenue Department. The program specified health care practitioners including dentists to be eligible to receive up to $5,000 in state income tax credit for their practice in rural New Mexico. Dental hygienists are eligible for up to $3,000 in state income tax credit. Eligible practitioners are certified by the Department of Health and are issued a certificate to accompany the practitioner's income tax return. Balances in the credit can be carried over into the next tax cycle.

Summary: These activities have involved the participation of multiple individuals and organizations that have resulted in a network/design/pipeline to meet many of the dental needs in the state. As problems/barriers are identified, strategies are developed which are unique given the absence of a dental school.

NM has been able to identify and develop multiple strategies to meet many of the critical needs for dental care in the state over a sustained period of time.

Special appropriations from the New Mexico legislature made to the New Mexico Health Service Corps, Higher Education Department for the WICHE program and the University of New Mexico Health Sciences Center for the dental residency program.

STATE: NEW MEXICO

Program: Hidalgo Medical Services

Contact information: 530 DeMoss St., Lordsburg, New Mexico 88045, 575-542-8384 x40, calfero@hmsnm.org

Program web site: www.HMSNM.org

Purpose: To create a comprehensive frontier-based, community-driven primary care health professional training program in southwestern New Mexico that supports the mission of Hidalgo Medical Services (HMS).

Program overview: HMS is a 13-year-old organization with roots in a frontier county that was without health care services for 10 years prior to HMS opening its doors. From the beginning, the community board of directors understood it would need to take a more creative approach to sustaining service delivery than traditional private sector or publicly supported placement models. Incorporated into early mission and vision statements of HMS was that it would become a national model of sustainable frontier health services through community development and by establishing HMS as a training site for health professionals, thereby forever changing the perceptions of both the community and historical avoidance behavior of health professionals and their institutions.

HMS was founded with the assistance of the University of New Mexico (UNM) Health Sciences Center Rural Outreach program and funding from the New Mexico Department of Health, Office of Rural Health and Primary Care. The first providers were graduate residents of the UNM Family and Community Department and the distance FNP program at the UNM College of Nursing. The first full-time physician was a medical school graduate of UNM and of the 1+2 UNM/Las Cruces FP residency program. The first dentists at HMS were flown from Albuquerque weekly to the community (330 miles) through the UNM dental program. This history of collaboration and linkage with the state's only medical school and residency program has been key to the development of HMS as the leader in providing training of health professionals in rural and frontier New Mexico.

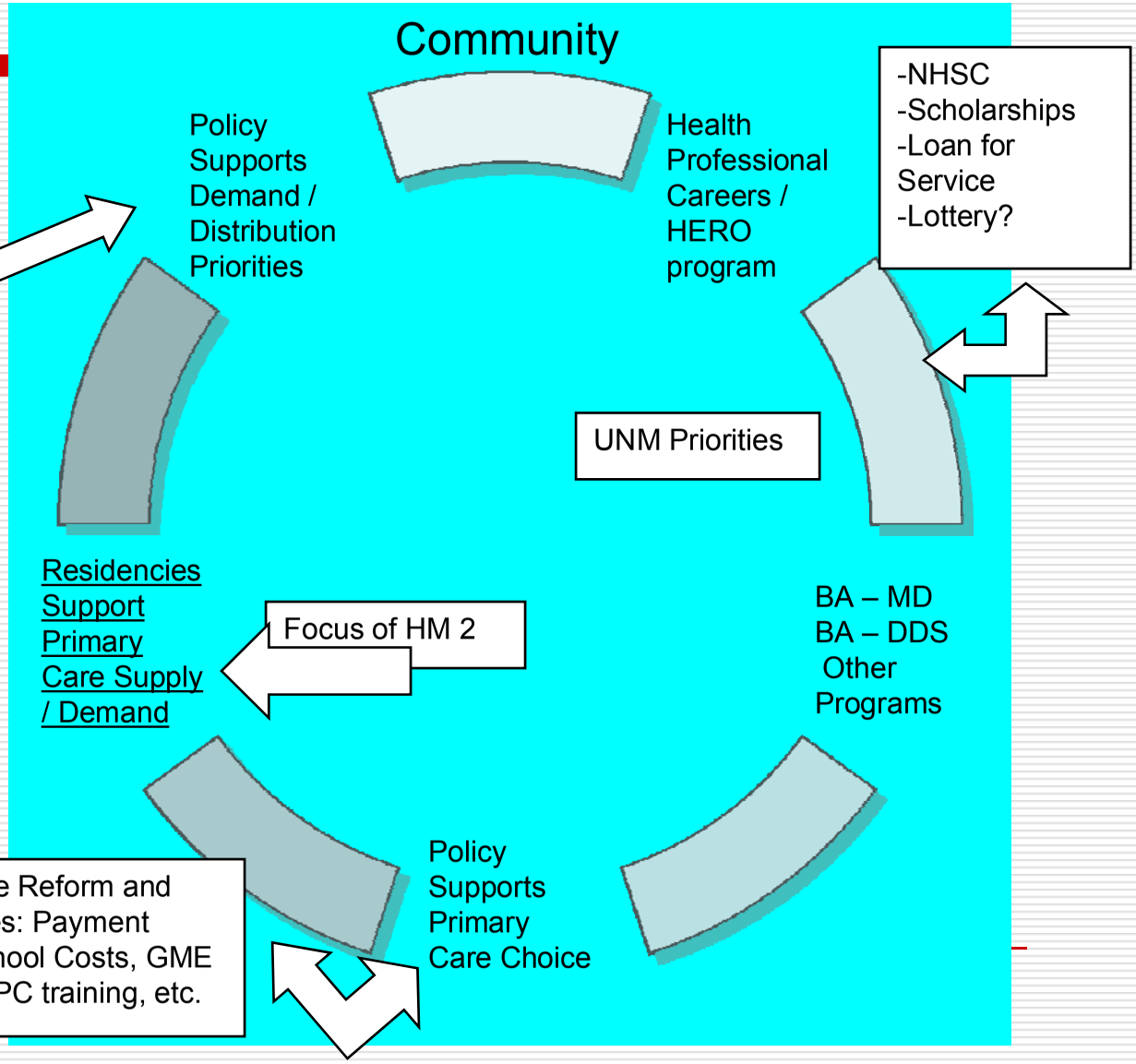
The persistent vision of HMS as a "model" has been reflected in many ways. The most dramatic way might be the development of medical and dental student and resident rotations in this remote part of the southwest.

Currently, HMS supports the following training efforts;

- 10 one-month second-year pediatric resident rotations from the UNM Department of Pediatrics. HMS is the only non-Albuquerque pediatric resident rotation site. HMS reimburses UNM per resident month in order to ensure UNM has the resources necessary to place residents.
- Six one-month family practice rotations with Memorial Medical Center in Las Cruces, a free-standing residency program
- Three one-month family medicine residents with UNM Department of Family and Community Medicine
- Six one-month dental student rotations with A.T. Still University in Mesa, Arizona
- One six-month psychiatry rotation with UNM Rural Psychiatry program
- Three to six one-month dental resident rotations with UNM
- One to three dental student rotations with Howard University, Washington, D.C.
- Two to three PA student rotations with UNM

Funding: $100,000 state appropriation to reimburse for UNM Peds/FP/Dental resident time; HMS operations; UNM psychiatry, MMC Family Residents, and A.T. Still dental student programs support of resident and student salaries and stipends. $1.7 state legislative and federal grant appropriation to construct a medical/dental training facility in Silver City. County and City resources complete financing of the project.

The Components of a Pipeline to Improve Supply and Distribution of Primary Care Physicians / Dentists and Other Health Professionals



Loan Repayment, Shortage Definitions, Loan for Service, Tax Incentives, Health Center Financing

Focus of Health Care Reform and other Policy Initiatives: Payment System, Medical School Costs, GME issues encouraging PC training, etc.

HIDALGO MEDICAL SERVICES

STATE: SOUTH CAROLINA

Program: South Carolina Rural Interdisciplinary Program of Training (SCRIPT)

Contact information: Kim Stephens, M.S.Ed., Health Professions Student Coordinator 843-782-5052 x. 106, stephensk@lcahec.com

Program web site: www.lcahec.com/script.html

Purpose: Train health professions students in interdisciplinary teams in a rural area to promote their selecting rural practice sites.

Four Rural Interdisciplinary Practicums will be offered during 2008. The SCRIPT program is sponsored by South Carolina Area Health Education Consortium (AHEC).

SCRIPT is designed to:

- Immerse students in rural health care.
- Provide experience in rural health care settings.
- Acquaint students with rural lifestyle.
- Convey knowledge and appreciation for a variety of health professions disciplines.

Opportunities to:

- Train in a rural clinical practice.
- Be part of an interdisciplinary team.
- Collaborate in a community-focused health promotion activity.
- Network with rural health professionals.
- Earn $850 stipend plus a limited amount of travel money: housing provided.
- Earn academic credit toward degree requirements.

Participating Universities.

Medical University of South Carolina, South Carolina State University, University of South Carolina, Clemson University, Francis Marion University, Winthrop University

Statewide Clinical Site Locations.

Clinical site placements are provided in 18 South Carolina counties for students from 6 universities and 13 health professions disciplines.

- Lowcountry region of South Carolina *Calhoun, Orangeburg, Barnwell, Bamberg, Allendale, Colleton, Hampton and Jasper.*
- Mid-Carolina region of South Carolina *Union, Chester, Lancaster and Fairfield.*
- Pee Dee region of South Carolina *Rural Florence, Sumter and Clarendon.*
- Upstate region of South Carolina *Oconee, Pickens and Anderson.*

Eligible Health Professions Disciplines.

Dental Medicine, Health Administration (graduate) Medicine, Nurse Midwifery, Nursing (graduate/ undergraduate), Occupational Therapy, Speech and Language, Pathology, Pharmacy, Physical Therapy Physician Assistant, Public Health (graduate) Social Work, Nutrition, Other Health Professions Students as Appropriate

Academic Credit.

To participate in the South Carolina Rural Interdisciplinary Program of Training, students must register with a university for academic credit.

All students will do the following....

A Typical Five Week Rural Experience

- Complete a web-based orientation activities
- Live in a rural community
- Attend a 4-day Rural Health Workshop (beginning May 12th or May 19th)
- Experience 16 days (9 hrs./day) of clinical practice and/or field work
- Participate in an Interdisciplinary team, community-focused health promotion activity
- Attend three "Fabulous Fridays"-field trips and interdisciplinary conferences
- Earn up to 5 semester credit hours

State: WEST VIRGINIA

Program: Rural Health Education Partnerships/AHEC

Contact information: Hilda R. Heady, MSW, Associate Vice President for Rural Health, Executive Director, WVRHEP, WV AHEC Program Director, West Virginia University Health Sciences Center, P.O. Box 9003, Room 1006 HSS, One Medical Center Drive, Morgantown, West Virginia 26506-9003, 304-293-4996, hheady@hsc.wvu.edu

Program web sites:
www.wvrhep.org, www.wvahec.org

Purpose: To increase the retention of West Virginia trained health professionals in rural underserved areas of the state.

Program overview: West Virginia is fortunate to have a robust partnership for educating health professionals in rural and underserved areas in all 55 counties, and higher education is a cornerstone in this partnership with local rural community leaders, business, health care providers and state agencies. This partnership is a health careers pipeline designed to increase the number of West Virginia-trained health professionals in practice in rural underserved communities and includes the Health Sciences Technology Academy (HSTA), the Health Careers Opportunity Program, the West Virginia Rural Health Education Partnerships/Area Health Education Centers.

To date, 967 health professionals trained through this partnership are in practice in rural underserved communities; 264 of these are physicians representing a 200 percent increase over the past nine years. Beginning in 1994, HSTA covers 26 counties and is recruiting minority and disadvantaged students into health careers. Ninety-eight percent of HSTA program completers enter college vs. 56 percent for all West Virginia, and 60 percent are health career majors vs. 17 percent for all West Virginia. A total of 836 HSTA program completers are currently in college, and 56 have gone on to graduate or professional school. From the original cohort of students, 10 are currently in medical school in the state.

Effectiveness:

- 1,000 health professionals recruited to rural areas over the past 12 years includes: physicians, midlevel providers, dentists, pharmacists, nurses, dental hygienists, physical and occupational therapists, social workers, psychologists
- 200 percent increase of rural physicians over the past 9 years
- Elimination of eight full county HPSAs from 1995 to 2005
- Evidence-based change in attitudes of students toward practice in rural communities
- Increased retention of providers who trained in program and later served as preceptors
- Increased commitment to carry low-income patients in practices by physicians and dentists

Funding: State appropriations for 75 percent; federal funds via Title VIII AHEC funds for 25 percent

APPENDIX A

Input from Primary Care Association (PCA) Workforce Survey

How do you plan to spend the one-time supplemental Bureau of Primary Health Care PCA funding that you will receive 4/1/08? (Reflects input from 36 PCAs.)

Plans	#	%
Recruitment supplies, web site, tools, video, exhibit materials	17	47%
Targeted T/TA to members on recruitment, retention, other workforce issues/Regional Summit	13	36%
To be determined	11	31%
Building/strengthening strategic partnerships/work with training programs to identify collaborations between health centers and training programs	11	31%
Hiring a recruiter/workforce staff, expanding recruitment function/coordinate joint purchasing of recruitment	6	17%
Assess health care workforce needs and develop action plan	3	8%
Workforce summit/statewide recruitment fair	2	6%
Collaborate with SHD on grants and loan repayments for physicians serving underserved areas	1	3%
Scholarship for allied health professionals	1	3%
Building awareness of workforce issues at the policy levels/limited license dentistry proposal	1	3%
Online career placement	1	3%
Continue supervisory/management training program	1	3%
Continue work on master's program	1	3%
Extend the SEARCH program	1	3%
MGMA membership for all health centers	1	3%
Re-certification of providers for state board requirements	1	3%
Preceptorships for medical students, interns and residents	1	3%
Gaining an AHEC	1	3%
Expanding dental carve-out model	1	3%
Development of health care-sponsored family practice and general dentistry residency programs	1	3%
Develop referral process for universities, colleges, etc.	1	3%
Youth Health Services Corp	1	3%
Adding credentialing as a member service	1	3%

Other specifics from the Learning Team:

Branding and marketing

- Initiate branding campaign to increase awareness and understanding of PCAs and community health centers (CHCs) through the use of in-house marketing specialists and/or marketing consultants.
- Develop or update marketing materials; including brochures, banners, display boards, video, DVD, infomercials.
- For retention efforts, send care packages to clinical residents at CHCs.

Program development

- Establish CHC-based residency programs and rotations, particularly at rural CHCs.
- Organize and strengthen pipeline programs.
- Develop mentorship programs between current clinicians and residents and new hires.
- SEARCH support
- Study best practices for recruitment at CHCs; share findings with CHCs.

Personnel and staffing

- Hire an additional staff person and/or compensate time for staff person to coordinate workforce efforts.
- Pay for PCA staff time to survey CHCs about clinical and non-clinical staff recruitment and retention statuses.
- Establish a board-level workforce committee.

Information technology

- Coordinate a joint purchasing pool among multiple PCAs to lease/purchase a national workforce provider database for recruitment.
- Develop a list of collaborations between CHC residency programs and health professions schools.

Training and education

Topics:

- Strategies for recruitment and retention of clinical and non-clinical staff
- Professional development of CHC staff including front desk, managers, clinicians
- Core competencies and best practices
- Specific PCA services available to CHCs

Methods:

- Recruit CHC clinicians to speak at conferences/fairs
- Present at recruitment conferences/fairs
- Host breakfast for clinical students at PCA annual conference
- Create PCA hosted web site or manual that provides information about candidate placement recommendations for CHCs, J1 Visas, National Health Service Corp, state loan repayment programs, applying for HPSA/MUA status
- Present at camp for high school students interested in health care careers

Partner and collaborate with…

- CHC clinical and non-clinical staff to identify workforce needs, challenges and opportunities
- Current and tenured CHC clinicians who are interested in supporting marketing, training or mentorship opportunities
- Health professions schools to establish rotation and residency programs
- Local businesses and organizations outside the health care industry to increase public awareness of CHCs and the PCA
- Regional workforce collaboratives
- AHEC

Best practices:

Has your PCA developed innovative/best practices in workforce that we may share with other PCAs? Please list or describe.

Best practices	#	%
AmeriCorps and the Medically Underserved in Utah program (AMUU)	1	3%
PCA developed and supported learning teams/learning	3	9%
Distance learning	1	3%
Salary and benefits survey	1	3%
Enhanced reimbursements for physicians practicing in underserved communities	1	3%
Ambulatory care training	1	3%
Loan repayment	1	3%
Physician practice support	2	6%
Scholarship program for Allied Health professionals	1	3%
Establishment of Workforce Committee	1	3%
Partnerships with private foundations	1	3%
CHC competencies and best practices	2	6%
Partnership between the IL, AZ, MS and VA PCAs and financial support from BPHC, a guide for best practices titled, "Recruitment and Retention of Clinicians for Community and Migrant Health Centers" developed in 2005. IPHCA makes the document available to any entity that requests it and has presented the model to at least one other PCA	3	9%
Participation in a task force on the workforce shortage	1	3%
Medicaid carve-out for medical students	1	3%
PRIMO scholar and community development program	1	3%
Health professional placement services program with state DHSS	1	3%
Fellowship program with university for executives	1	3%
Partnership with Department of Labor	1	3%
Contracts and free-standing program for loan repayment	1	3%
Committee structure to involve HC medical leadership and develop champions	1	3%
The South Dakota SEARCH program has partnered with the SD DOH in offering a Dental Externship program aimed at attracting SD dental students attending dental schools in surrounding states (Minnesota, Iowa and Nebraska). SEARCH continues to look for new partnering opportunities and is currently working on collaborations with the University of SD Dental Hygiene Program. Again, coordinate with the N. Dakota SEARCH program to bring students into the HCs across ND.	1	3%
In forming the NCHRC, the concept was that HCs across Region X would benefit if their membership organizations were working in collaboration on their behalf rather than in competition. The philosophy is "one for all and all for one." In this collaboration, the PCA partners have a shared sourcing plan and budget, candidate pool and technology and have joint protocols on working with candidates and HCs.	3	9%
Recruitment video and database which is attached to web portal.	1	3%

APPENDIX B

U.S. Department of Health & Human Services
Health Resources and Services Administration

HRSA NEWS ROOM
http://newsroom.hrsa.gov

FOR IMMEDIATE RELEASE

Monday, September 15, 2008

CONTACT: HRSA PRESS OFFICE
301-443-3376

HRSA Awards $750,000 to Create Health Workforce Information Center

The Health Resources and Services Administration today awarded $750,000 to the University of North Dakota to establish a Health Workforce Information Center as a "single point of entry" for health workforce information.

"The nation's health care system faces major challenges as a result of workforce shortages and technological advances," says HRSA Administrator Elizabeth Duke. "In response, HRSA will support the university's 'one-stop shop' for health professionals, employers, government agencies, researchers, policymakers and anyone who needs up-to-date information on health workforce topics and trends."

The new center's Web site and electronic mailing lists will provide information on:

- health workforce programs and funding sources;
- workforce data, research and policy;
- educational opportunities and models;
- best practices; and
- related news and events.

In addition, center information specialists will offer free customized assistance.

The health workforce includes practitioners in medicine, nursing, dentistry, pharmacy, mental health, allied health, other trained health care providers and the staff that supports them.

HRSA's Bureau of Health Professions awarded the 2008 fiscal year cooperative agreement to UND under the Health Professions Partnership Act of 1998.

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The Health Resources and Services Administration (HRSA), part of the U. S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. For more information, visit www.hrsa.gov.

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