



RURAL WORKFORCE

Recruiting Local People to Fill Health Care Needs

by Candi Helseth

Frontier and rural health care providers looking for innovative ways to solve increasing workforce shortages are sometimes finding that help is as near as their own backyards: by recruiting and training local people to be health care professionals in their communities.

In Nevada, the Rural Family Medicine Consortium proposed what it termed “an aggressive rural community partnership” to recruit and retain health professionals for rural and frontier communities. In Alaska, the board of directors at a critical access frontier hospital picked up the bill for hospital employees to become registered nurses. In rural Maryland, a coalition paid all expenses for local residents to become dental hygienists if they would agree to return to the area to practice.



Dr. Christine Alarcon, left, and assistant Lisa Windsor treat a three-year-old patient at the Cambridge Dental Clinic, the only dental clinic for low-income children in Dorchester County, Maryland.

Communities like these that look within their ranks to fill health care professional needs are the most likely to succeed, according to Dr. Robert Bowman, past chairman of the Rural Medical Educators Group of the [National Rural Health Association](#) and Director of Rural Health Education and Research for the [Department of Family Medicine at Nebraska Medical Center](#) in Omaha.

“Rural areas should be recruiting people that grew up in their state,” said Bowman, who has done extensive research on provider shortages. “Physicians, physician assistants, family nurse practitioners—we’ve found that these professionals who are working in underserved areas are more likely to also have been born in lower income and rural areas. And physicians who grew up in rural areas are most likely to return to that area.”

Recognizing the need to supply their own practitioners, the University of Nevada began a pilot program to develop more training opportunities in the state, said Caroline Ford, assistant dean at the University of Nevada School of Medicine and director of the [Nevada Office of Rural Health](#).

"We decided to look at how we could influence rural training opportunities for our medical students and simultaneously initiate educational and treatment programs in rural communities," Ford said.

The Rural Family Medicine Consortium—a partnership between the University of Nevada School of Medicine, a community-based hospital and a hospital-affiliated network—developed a medical student rotation program to introduce students to rural practice and, at the same time, provide more services to those communities. Fallon, a community of 13,000 about 63 miles from Reno, was selected for the first site. In 2006, the University began requiring students to do medical rotations in Fallon. By the time the program is in its third year, four residents will always be serving rotations at Fallon, Ford said.

In addition to seeing patients, medical residents provide outreach care such as prenatal exams, wellness education and chronic disease management programs. One of the most innovative aspects of the program is its attempt to also address specific health concerns. A cluster of people, primarily children in an agricultural region near Fallon, have an abnormally high rate of certain cancers. Fallon's medical residents are developing an occupational health and environmental program focused on needs of this cancer cluster.

"And as they (medical residents) see these patients, they are screening them more carefully for cancer risks than in other clinical situations," Ford said. "They're also providing cancer prevention and education outreach."

Ford said Fallon was selected for the first site because of the University's longstanding training relationship with the community. When the program is well underway, it will be evaluated and may be replicated in other rural areas of the state.

With assistance from the Nevada State Legislature, solutions are also being sought for the lack of obstetrics services in rural areas. Because the cost of malpractice insurance outweighs the number of obstetrics patients that rural family medicine physicians see, many of these physicians have dropped obstetrics, Ford said. The Nevada State Legislature has appropriated \$150,000 a year to assist with insurance premiums for family medicine/obstetrics practitioners, which is available in a pool for qualifying rural physicians. The physicians must agree to certain terms, such as not denying access. The University also offers what Ford termed "mini-residency training" to help practitioners delivering babies maintain their skill levels.

Registered nurses are also in short supply nationwide. Weary of investing extensive funds in nurse recruitment programs, the board of directors at [Petersburg Medical Center](#) in Petersburg, Alaska, partnered with a college nursing program to train interested hospital employees as registered nurses.

Four students, handpicked by the board,

completed the majority of their course work through a distance-learning program offered by Weber State University of Ogden, Utah. Then, a nurse instructor at the hospital oversaw the clinical portion of their education. The board borrowed money from the hospital's foundation to fund \$10,000 a year in educational expenses for each student.

For Angela Menish, it was a dream come true. Menish graduated from high school in Petersburg, married a fisherman and was working at Petersburg Medical Center as a certified nursing assistant. "I wanted to go into nursing and I'd even looked into nursing school, but I didn't want to move," she said. "Having to be away from home so much would have really been a burden, for my family and financially. It was so convenient to be able to do it from here."



Many in the community turned out when (from left) Elizabeth Hart, Angela Menish and Yvette Boggs graduated as registered nurses through a scholarship program established by Petersburg Medical Center. At the podium is clinical instructor Martha Smith, also a Petersburg employee.

Hospital administrator John Bringhurst said the hospital spent less money educating the nurses, who have all been working there for the last two years, than they would have spent on recruiting and training in that same time period.

Located on an island accessible only by boat or airplane, Petersburg Medical Center is a 27-bed acute and long-term care facility designated as a critical access hospital in frontier Alaska. Bringhurst said nurses they recruited from out of state came for what he terms the "Alaskan experience," but they generally stayed less than two years. Consequently, retention had become even more difficult than recruitment.

Oral health care is another arena where rural areas experience major shortages. Dorchester, Worcester and Somerset counties on Maryland's Eastern Shore are federally classified as areas with health care access and economic disparities. For several years, a dental hygienist shortage contributed to lack of access to oral health care, said Jacob Frego, executive director of the [Eastern Shore Area Health Education Center](#) in Maryland.

No dental training programs are located on Maryland's Eastern Shore, and there are only three statewide. A coalition of community resources concluded there were insufficient resources to develop their own program, so they negotiated a deal with Alleghany College in western Maryland to reserve two spots for Eastern Shore students in its dental hygiene program.

The Tri-County Council and the Three Lower Counties Community Health Center, a federally qualified health center, provided costs for student housing, tuition, books, labs and other fees, a total of about \$13,000 a year. Students were

required to commit to practicing at least two years on the Eastern Shore.

"This was a stopgap measure implemented to get some dental hygienists into this area as quickly as possible," Frego said. "Seven students were funded. Four have graduated and are working on the lower shore. Three are in the pipeline. Since that time, the University (University of Maryland Dental School) has stepped up to the plate and established a dental hygiene program with 10 slots per year for students enrolled in the community college programs."

The University's program, begun last year, allows students to train at a local community college for their first two years. They complete the last two years by participating in a distance-learning program offered by the university; they are required periodically to go to the campus. They complete clinicals locally.

Legislative support has also improved Maryland's oral health care situation. The Maryland State Legislature approved a law that goes into effect in October allowing hygienists to apply fluoride varnish in public health settings without a prescription or dentist's order.

"This law really contributes to a definite improvement in the public health service structure," Frego said. "The other area we addressed was getting services to children. There was no clinic or dentist in Dorchester County providing services to Medicaid children."

He credits a Health Resources and Services Administration (HRSA) grant for the seed money that established CROC (Children's Regional Oral Health Consortium). CROC is improving dental health care for children in low-income families through a variety of means, such as public oral health education, enhancement of inpatient hospital services and establishment of dental clinics.

"The HRSA grant helped us get an operational clinic to meet children's needs," Frego said. "Since last October, 663 children have been through Dorchester Clinic, and 91 percent of them were Medicaid patients. In that same time span, 28 children had dental surgery at Dorchester General Hospital. The majority of them were four and under. The grant stipulations are being fulfilled, and we've been able to provide a valuable service for children."

To learn more about these communities and their successes, contact Ford at 775-784-4841, Bringhurst at 907-772-4291 or Frego at 410-221-2600.

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