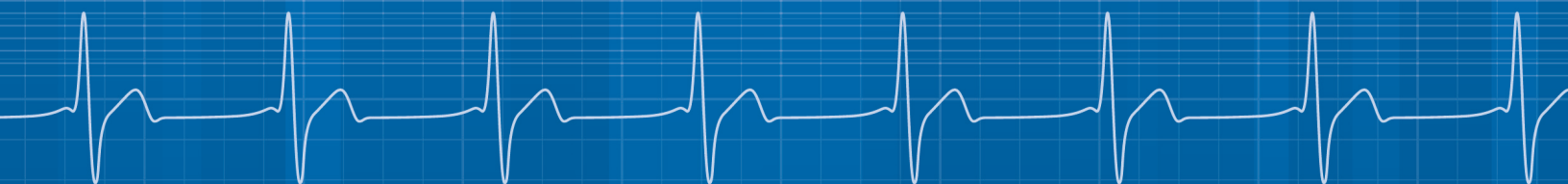




Rural Community Health Centers

Building Creative Partnerships to Meet the Workforce Challenge



National Rural Health Association



National Rural Health Association

RURAL COMMUNITY HEALTH CENTERS
BUILDING CREATIVE PARTNERSHIPS TO
MEET THE WORKFORCE CHALLENGE

A report from the National Rural Task Force

Invitational Leadership Meeting
July 10-11, 2008
Crystal City, Virginia

Meeting Summary

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Executive Summary

The National Rural Task Force (NRTF) includes executive leaders from Community Health Centers (CHCs), state Primary Care Associations (PCA), state government Primary Care Offices (PCOs), the National Rural Health Association (NRHA), the National Association of Community Health Centers (NACHC), the Bureau of Primary Health Care (BPHC) and several national rural health experts.

This meeting summary documents the second annual meeting of the National Rural Task Force held in July 2008.

Background

The National Rural Health Association is dedicated to assuring access to high quality health care in all rural and frontier communities of the United States. In an effort to support this goal, in 2007 the NRHA established a multi-disciplinary National Rural Task Force. Membership on the task force includes executive leaders from CHCs, state PCAs, state government PCOs, the NRHA, the NACHC, the BPHC and several national rural health experts.

For the first time, a broad, geographically diverse, cross-disciplinary group was established to support and strengthen rural and frontier Community Health Centers. The purpose of the task force follows:

To help rural communities move toward the improvement and expansion of access to health care:

- build partnerships with other organizations
- expand and improve access to culturally competent, quality health care
- ensure that services are available to rural and frontier patients including primary care, preventive and enabling services.

The first step in the development of the National Rural Task Force was an initial meeting in 2007 in Arlington, Virginia. At that meeting, the task force discussed the many challenges facing rural Community Health Centers and set goals for the work going forward.

This meeting summary documents the second annual meeting of the National Rural Task Force in July 2008. The agenda of the meeting is Attachment A and the list of participants is Attachment B.

The meeting was based on a strong foundation built on a full year of work by the NRTF. The work included goal setting, six conference calls, including several with distinguished experts presenting, planning for this meeting and selecting leadership. Marilyn Kasmar, executive director of the Alaska Primary Care Association was elected chair, and Michael Samuels, professor at the University of Kentucky, School of Medicine was elected co-chair.

Members of the NRTF prioritized the topic of “workforce” for the 2007-08 year, as well as the theme of the 2008 meeting. Members made it clear that they wanted a product, a policy statement, as an outcome, a document that would establish priorities resulting in improvements in education, training, recruitment and retention for rural and frontier CHCs.

Day 1: July 10, 2008

1. Welcome, Introductions

Mike Samuels, NRTF Co-Chair

Samuels opened the meeting and greeted the group. He spoke of his vision for the meeting and his hope the focus on workforce development and recruitment would emphasize the ultimate goal of enhancing the sustainability of primary care. He outlined a second, long-term goal of thinking about new models of health care provision that will better fit the conditions and needs of rural areas.

Alan Morgan, NRHA CEO

Morgan thanked the task force members for their first year of work and stated how pleased he was to attend the meeting. He reiterated the importance of workforce development for rural America and said he looked forward to the goals and priorities the task force would set.

LaVerne Greene,
Bureau of Primary Health Care, HRSA

Although Greene would not be able to stay for both days of the meeting, she said she looked forward to receiving information and suggestions to take back to HRSA.

Carol Miller, Facilitator

Miller emphasized the need to develop solutions and ensure the solutions proposed respect the heterogeneous needs of rural America. The group will decide whether or not to emphasize federal policy changes that work down, or emphasize local changes that then push federal policy changes – or both. Ultimately, for legislative purposes, a concise, solution-based, agenda to present to policy makers is needed.

Members' Goals for the Meeting

Members introduced themselves and identified their goals for the meeting.

- Mike Samuels – Develop a new model for rural health care delivery.
- Angel Goodwin – Find creative and efficient ways to compile and disseminate best-practices information.

- Wagih Michael – Frustrated by having the same discussion for the last 30 years and hopes we can begin to resolve some persistent issues.
- LaVerne Greene – The Bureau can better partner with health centers to meet their needs.
- Laura Rowen – Help to give a national voice to the agenda and needs of health centers and safety net providers, and to help ensure that their issues are considered in relevant legislative issues.
- Charlie Alfero – Focus on how to improve and expand positive changes that have happened. Remove the federal cap on primary care residencies and other prohibitive federal policies. Change funding formulas so they better address the circumstance of rural and underserved providers. Remove the two funding incentives of the number of people seen and “over-care.” New models need to keep rural in mind. Reimbursement is outcome based; the assessment is not quantitative, but qualitative.
- Patricia Tarango – Create programs that allow people to stay in their communities to receive care. Providers should be culturally competent. Gain more best-practices information. Organize workforce concerns by component and prioritize. More provider and public health department collaboration. Learn more about how to effectively use health information technology.
- John Sawyer – Ensure out of this comes clear policy requests that are solutions-based and politically viable. Take advantage of opportunity for reform in the upcoming years. Develop clearly outlined plans and policy changes that can be advocated effectively. Ensure workforce development and primary care sustainability are incorporated into universal coverage proposals.
- Carol Miller – Publicize the cause of rural primary care and have solid legislative proposals. Let's make rural primary care sexy. Find way to overcome swings in budget cycles.
- Greg Dent – Make sure that we don't ignore medical specialties, which are needed as well as primary care. Learn better advocacy skills.
- Alan Morgan – Develop a clear role for HRSA involvement and advocacy.
- Katherine Cummings – Take an asset building

approach to developing new models for care in rural areas and assess positive things we can build on. Not only identify the problems but the specific barriers so solutions can be more precise and effective.

- Sharon Ericson – Need new models. Reimbursement and incentive programs should be focused towards a larger group of health care professionals, not just doctors. Focus on changing health care education to better meet rural needs.
- Rosemary McKenzie – Need for consensus and solutions-based proposals.
- Amy Elizondo – Understand how NRHA can be useful to help advocate the proposals that come out of this meeting.
- Marilyn Kasmar – Approach problems and collaboration by being progressive and diverse.

As the group raised their goals, themes were placed on a flip chart and follows:

- Need a new model
- Creative collaboration, leverage resources
 - Urban – rural
 - BHP – FQHC
- Has been progress
- Remove cap on primary care residencies
- Volume or intensity
- Border issues – tribal
- Public health collaboration
- Access not coverage
- Solutions
- Distilled to two pages
- Cross barriers
- Reimbursement incentives to specialty: NPs/PAs not just MDs
 - Practice acts
- It “theocracy”

2. Keynote Presentation: *A Dreamer’s Vision for the Future of Primary Care Workforce: Making it a Reality*

Speaker: Candice Chen, M.D., M.P.H.,

Medical Education Futures Study,

George Washington University

(See Attachment C for presentation slides.)

Candice Chen, co-principal investigator for the George Washington University Medical Education Futures Study (MEFS) was the keynote speaker for the meeting. The goal of MEFS is to highlight the social mission of medical education during the current period of medical school expansion and potential major health care reform. Chen works on this project with Fitzhugh Mullan, former director of the National Health Service Corps and HRSA Bureau of Health Professions, and a diverse interdisciplinary national advisory board guides their work.

Chen’s presentation provided the task force with a good foundation for its discussion and the development of recommendations. The first slide, “A Look Back” showed a table of various key reports, legislative attempts to fix medical education and the diffusion of physicians around the country. Beginning with the Flexner Report in 1910, a roller coaster of policy has followed. What has now become the cyclical, up-and-down nature of medical education and indeed the identity of the profession of medicine in the United States began and is still underway after nearly 100 years.

Other data in the presentation showed trends in numbers of physicians over the past 50 years. Successful rural education and community-based medical school programs were also identified. The final part of the presentation provided information on the effects of financing on the workforce supply.

Despite discouraging historical data, the presentation ended on a very positive note. One of the slides, “Stars are Aligning,” listed five important factors:

- Medical school expansion
- Reports
- Public awareness
- New legislation
- New administration

The final slide illustrated five policy targets:

- Title VII
- National Health Service Corps
- GME funding
- State funding
- Market changes: Medicare reimbursement and medical home initiatives

The presentation was followed by a discussion led by Chen. The first question asked if she had been encouraged to go into family practice when she was in medical school. Her response was that medical students are “pliable,” and schools are creating formal mechanisms to expose students to rural and underserved primary care. Evidence-based research indicates these experiences can have a big role in channeling people into rural and underserved primary care.

Chen and the group discussed the impact of lifestyle decisions on the type of practice, as well as location of practice. As rural providers and advocates for rural communities, members of the task force are seeking health professionals with a commitment to serving the underserved, including those in remote locations.

Michael emphasized the importance for better preparation and training in the lifestyle and practice issues related to rural practice. He suggested programs like the National Health Service Corps must make very clear the reality and expectations that health providers, particularly physicians, will face as employees of rural community health centers.

Alfero finds physician extenders straight out of school need additional training for rural practice before they can be truly independent. This affects the productivity of staff physicians and more experienced physician extenders because they are training and not able to rely on the new provider as a fully productive member of the health care team.

The next question raised the current level of patient/family expectation for both regular care as well as extraordinary measures now a part of end of life care. Chen stated people must be educated to understand often they really don’t need all the specialized care that is pushed on them or recommended.

3. Discussion of HRSA Projects

Invitations had been extended to HRSA Administrator Elizabeth Duke, the Bureau of Health Professions and the Bureau of Clinician Recruitment and Service, but due to scheduling conflicts, none of these could have a representative at the task force meeting. So the task force discussed HRSA programs from the perspectives of CHCs and the states.

The discussion ranged widely and included consideration of the “medical home” concept. There was consensus about the patient care benefits implicit in this type of practice, but it is not clear if it will

resolve workforce needs and improve recruitment and retention.

The group identified numerous ways medical schools and faculty discourage students from primary care. Although there are financial incentives for the provision of more intense, sub-specialty care, the reasons for steering students toward specialization are multiple and not primarily financial. Faculty may also believe the most talented students are “too smart” for primary care practice, and they therefore mentor and encourage students towards the same specialty as theirs.

This is a change – and loss – from the late 1970s and 1980s when family medicine emerged as a specialty of its own. In those days, top students were recruited into family medicine because of the prestige of providing a full range of services to all ages of patients. There was also acknowledgement of the benefits of treating the whole person as a member of a family or care-giving group rather than as an isolated diagnosis, such as the “diabetic in room 3.”

Members were reminded there is a need for specialty care and the importance for faculty to identify and recruit students with an aptitude for specialty care so those needs can also be met.

The group had several recommendations for HRSA:

- Expand the definition of training programs to allow for more diverse programs that better meet the needs of specific communities and providers.
- Help providers build their organizational capacity to support the training of residents. Many do not have the staff or funding to meet residency training program requirements.
- HRSA and the Bureau must change the focus on productivity and encounters. Centers must be encouraged to participate in training without being punished for reduced or too-low productivity.
- Expand the number of residency slots by removing the cap.

There was a discussion of whether or not there is a need to change or increase the definition of primary care or safety net providers for the NHSC. Sawyer cautioned the benefits as well as pitfalls of expanding the types of eligible providers. Currently there is a pilot program for chiropractors in the NHSC. Some members would like to recognize geriatricians as primary care providers and allow CHC staff to see patients at nursing homes or other residential settings.

It was the consensus of the group that until the NHSC is greatly expanded, it must focus on its core mission of primary care. The Corps is significantly under-funded and not fulfilling its mission to eliminate health profession shortage areas. At some time if the Corps is tripled in size and has met the primary care needs of the nation, it would then be possible to expand the types of providers serving as scholars and/or receiving loan repayment.

The group discussed the role of the Area Health Education Centers (AHECs) in promoting training and recruitment into health professions. The AHECs were established close to the same time as CHCs and the NHSC to be a partner in the pipeline, supply and assurance of appropriately trained providers. However, because AHEC boards are established to reflect the priorities of communities, many no longer relate to primary care needs. It would be beneficial to strengthen the original role of AHEC as a partner in the primary care pipeline.

The task force wants to avoid duplication of or reduction of the AHEC program. Members believe the alignment with NHSC and CHCs should be at the BHP level. Therefore, after a discussion of the AHEC program and in recognition of the differences among AHEC programs from state to state, task force members agreed to add an AHEC representative to the NRTE. McKenzie will ask the National AHEC Organization to recommend one of its top leaders to join the task force. Through this collaboration, the task force and AHECs will create a better working relationship to focus national efforts to meet the primary care workforce needs.

Small Grants to PCAs

One very positive new program being funded by the Bureau of Primary Health Care, HRSA, is a set of one-time grants of \$50,000 to each state Primary Care Association.

Note: Since the meeting, information has been received which documents the use of these one-time grants. A summary of these is appended as Attachment E.

Barriers Created by Medical and Residency Training Caps

The group discussed at length the problems caused by the caps on training. Even in CHCs and other safety net providers with the capacity to increase the numbers

of health professionals they train, the cap on training slots prohibits increasing the numbers.

The task force recommends training programs in CHCs be exempt from the cap. For example, in the Waco, Texas, program the hospital shares training funds with the CHC giving them 90 percent of the GME it receives for each resident trained at the health center and keeps 10 percent for hospital-based expenses. Other model programs were identified in northern California and Washington.

Samuels' study of CHC-hospital collaboration found that one of the most important factors to successful collaboration was getting the two CEOs together, away from their offices, for a half day per month.

Further Study Needed

Several times during the discussion, it became apparent that more information is needed about current and potential professional training in the health center setting. A matrix is needed to show which size center can participate in what type of training and what level of center is doing what. Gathering this data is important because the sites currently too small to participate in training programs are usually the same sites with the greatest difficulty recruiting providers.

This becomes important in other ways besides the training benefit for the provider. For example, with the un-affordability of locum tenens arrangements, in a two-provider site, annual leave and/or continuing education could be scheduled for the times when a resident was on-site at the center. This creates a benefit for the provider rather than a training/mentoring role being seen as yet another thing added to their workload.

4. Presentation: *Health Care Workforce – Examples of State Responses*

Speaker: Tara Lubin, senior policy specialist, National Conference of State Legislatures (NCSL)
(See Attachment D for presentation slides.)

Lubin began with an introduction to the organizational mission and structure of the NCSL and introduced recent and ongoing work related to health care.

HRSA partnerships with NCSL include a grant from the BPHC to work on health centers, which includes sending experts to testify on behalf of health centers at various legislatures and sponsoring a session at a

policy meeting of the NCSL. The federal Office of Rural Health Policy (ORHP) also has granted funds to NCSL, most recently to work on and present a session on the rural physician pipeline.

Lubin manages a health care grant from the Robert Wood Johnson Foundation, the Critical Health Areas Project, which has established four priorities:

- Health care access
- Quality of care for chronic conditions
- Substance abuse prevention and treatment
- Health care workforce

The grant targets emerging health leaders within the NCSL, legislators who may be future Health Committee chairs.

The Health Care Workforce focuses on areas where states have a role such as scope of practice, professional discipline, education, supply and distribution. Strategies being taken by legislators and NCSL include educational opportunities, grants, loans, service requirements; salary and benefits; and promoting health information technology.

The Minnesota Loan Repayment program was presented as a model that works. Established in the 1990s there are now more than 560 providers who have gone to rural areas in the state and according to a recent survey, more than 70 percent of the loan repayment recipients have stayed in the sponsoring community.

The Rural Health Initiative Act model program in West Virginia was passed creating partnerships between school districts, institutions of higher education and health professions training programs. The legislature also established a Rural Recruitment and Retention Committee for statewide coordination of efforts for rural rotations, pipeline initiatives and online tracking system.

Several states have programs to improve pay and benefits:

- Hawaii had a bill to establish Health Enterprise Zones, shortage areas that would then be eligible for additional resources and fees. Although the bill failed, the sponsors will try again.
- New Jersey already has Health Enterprise Zones and selecting to practice there affords tax relief to providers.
- New York provides malpractice relief in designated shortage areas.

- Maine has tax credits for dentists.
- Massachusetts has a pending bill that could provide financial incentives for primary care and dentistry.

Lubin believes there is a role for HIT in recruitment and retention. Employers with up-to-date technology are more attractive to people coming out of medical school where advanced technology is already being used. Massachusetts requires HIT competency for loan repayment. This was seen as problematic because many small practices and CHCs have not yet implemented HIT. An unintended consequence might make this requirement punitive, especially if adopted by other states with lower levels of competency and support than Massachusetts.

Task force members expressed interest in the Health Enterprise Zone concept and related tax incentives. In addition, the idea of cost-based Medicaid reimbursement for all providers in Health Enterprise Zones was raised. Members prefer payment incentives to tax credits although a combination of the two is ideal.

NCSL creates “legis-briefs,” two-page information sheets on various topics and has one on CHCs and one on safety net providers.

Caution was raised about the need to afford benefits equitably so rural areas do not compete against each other.

The group discussed using open source software like VISTA because it was developed and is upgraded by the federal government. There was frustration expressed about the challenges of choosing and affording information systems and problems resulting from turnover in hardware and software companies. The smaller and more rural CHCs have challenges finding qualified staff as well as ready access to expertise and technical support.

5. Task Force Roundtable Discussion

After hearing from the task force membership and the two expert presenters, the discussion turned to the goals the group had established as part of the Annual Work Plan finalized in January 2008. The group decided to focus on one topic and only one topic because of the crisis already underway. The crisis is the failure to train and place sufficient primary care workforce to meet the needs of CHCs and other primary care shortage areas.

The NRTF plan approved for this meeting was projected on the screen and is as follows:

Three desired outcomes for the meeting		
Desired outcome	Product	Action
1. Understand rural CHC workforce challenges.	Best practices: rural CHCs and application of best practices.	Develop and implement a plan to increase number of PCP with support of financing improvements.
2. Share goals regarding GME, PC development.	Strategies for collaboration: local public health, hospitals, local government, FQHCs.	Goals for moving forward.
3. Identify states interested in pilot programs.	Position paper on how current policy discriminates against current grantees.	Open dialogue with HRSA leadership.

Each of the goals and outcomes had explicitly and implicitly been addressed during the day.

Goal 3. Action step – open dialogue with HRSA Leadership had not been met for the meeting. During the course of the year, however, the goal had been partially met with a February 2008 conference call with HRSA leaders Marcia Brand, director of the Bureau of Health Professions and Rick Smith, director of the Bureau of Clinician Recruitment and Service.

The lack of HRSA participation in this meeting was a disappointment. Duke, BHPr and BCRS, were invited, and no one was able to attend. The meeting would have been much more productive with their participation.

Throughout the day, it was stated by the expert invited presenters, task force members and on behalf of the organizations they work for, that these same recommendations have been made for more than 30 years when looking at the Health Center Program. As Chen reminded us, the problem first came to light with the Flexner report 100 years ago.

From time to time, needed workforce and pipeline programs were funded and were successful. Then Congressional priorities changed or market pressures were applied and the programs ended until the next crisis.

We heard about ways legislatures have acted to improve the primary care workforce in their states.

However, the NRTF has consensus that there has to be federal involvement. The problems and solutions cross state lines, for example training, licensure, certification and reimbursement disincentives. The nation's primary

care resources currently are not distributed equitably to rural and frontier areas, and it will take a national initiative to train additional and provide incentives to current health professionals to relocate to shortage areas.

A mandatory year or more of national service in underserved communities was raised as part of the solution. The year of service is used in a number of countries, and it does help improve the distribution of the workforce. There is tremendous pragmatism about the problems service requirements bring with them. This point was followed by a discussion of the problems with providers begrudging service, too much turnover and the like.

Day 2: July 11, 2008

Part A

Matrix Presented at the Meeting

A rough draft of a matrix was presented at the end of the first day. The task force members agreed to the outline and that evening, Louise Pocock expanded and incorporated the notes from the first day of the meeting into a more detailed matrix. The matrix final draft was projected and discussed by the members and consensus was reached on the following:

Recommendations and Best Practices

The suggestions and policy changes made below can be approached at both federal and local levels, but it is important that any policy changes pursued should be mutually supportive.

Early Health Workforce Development: Elementary, High School and College

Goal	Action	Product
Encourage entry into health professions in high school and earlier.	Create partnerships between health providers, schools and educational institutions.	Create a compendium of best practices.
Target students most likely to enter primary care and related professions.	Advertise to and recruit from organizations that already work with youth.	Find and disseminate samples of successful student recruitment guides.
Create more supportive partnerships between large and small organizations. Increase outreach about health careers as early as elementary school. Provide quality science education throughout school.	Develop health extension programs similar to agricultural extension programs.	Create a compendium of best practices.
Evaluate and if successful, create more direct BA/BS-to-MD programs.		Create a compendium of best practices.

Health Workforce Development: Undergraduate, Medical School and Residency

Issues with workforce development

- Cultivating *demand* – Recruit ‘the right’ people.
- Increasing *capacity* – Improve the capacity to train health professionals with an emphasis on primary care.
- *Distribution* – Ensure there is adequate incentive and opportunity for people to work in underserved areas.

Goal	Action	Product
Recommendations for the National Rural Task Force		
Expand membership in the task force to include a CHC medical director.	Add a CHC provider who is also involved in provider training and/or residency programs.	Recruit a CHC medical director to the NRTF.
Expand and revitalize the role of AHECs in recruiting for CHCs.	Reach out to the NAO and develop a multi-lateral plan to improve recruitment.	Add an AHEC leader as a member of the NRTF, such as the NAO president.
Increase HRSA participation with the NRTF.	Continue to reach out to HRSA. Learn more about HRSA programs to meet rural CHC workforce needs.	Add two ex officio HRSA staff to NRTF to facilitate active dialogue about CHC workforce needs.
Identify and Disseminate Best Practices		
Find out which CHCs are most successful with retaining NHSC providers and what factors enable the retention.	Solicit support and data from Pathman and Konrad at the Sheps Center, University of North Carolina.	Disseminate best practices with a specific focus on unique organizational or legislative mechanisms that have been successful.
Expose undergraduate and medical students to rural and underserved areas as future work locations.	Work with medical schools and rural CHCs to develop rotations while assuring even busy and financially strapped providers can make a rotation work in their practice.	Collect and disseminate examples of rural rotations, including specific data about long-term success with recruitment and retention.

Address the payment system problems for rural providers so they can be more financially viable and able to focus on recruitment and sustainability issues.	Gather favorable payment system information.	Create a compendium of best practices.
Learn about the Mayo Clinic model and initiate a relationship to collaborate on system change.		
Recognize CHCs that succeed in community outreach and are gaining support for their programs	Design action plans that outline how CHCs can better integrate themselves into the community.	Disseminate best practices. Partner with public health offices.
Target students from special populations to consider primary care and other health professions.	Collect data on various incentives that encourage students to choose primary care in underserved areas.	Create a student guide outlining all of the different programs available to people.
Policy Recommendations		
Identify strategies that have proven successful in encouraging people to choose primary care and work in underserved areas.	Identify and reduce discouraging factors such as negative comments from professors, payment system disincentives, the loan burden, etc. Evaluate initiatives such as Health Enterprise Zones to determine how and if they work.	Promote concrete policy changes that will bring improvements.
Increase CHC funds allowed to be used specifically for recruitment.		Allow all or a portion of CHC capacity expansion grants to be used for recruitment purposes.
Ensure new providers are prepared and trained properly for the scope and intensity of care needed in rural health care.	Work with medical schools to develop more holistic family practice curricula that encourage a move away from sub-specialties.	Encourage the development of guidelines that protect quality standards, but are not prohibitive.
Create "buddy" programs between training institutions and the smaller CHCs.		Allow meaningful rotations of a month or so without increasing administrative burdens on smaller centers.
Public Education - "Branding"		
Combine recruitment efforts with an overall CHC branding campaign to educate people about what CHCs are and what they do. Have a special campaign to encourage young people to go into primary care careers and CHC work.	Focus on volunteer programs, specifically ones with a health care focus to create partnerships and their support for more funding.	Recommend expansion of the NHSC. With increased funding, expand SEARCH which gets first year medical students into rural areas.

Note: Numerous needs for information and materials have been identified as "Products". While some of these may in fact be products of the National Rural Task Force, most will be provided or completed by partners or other organizations.

Part B

Brainstorming to Develop Additional Points of Agreement

- **National service, social movement, social change**

It is no surprise that recent college graduate and meeting recorder Louise Pocock recommended that the idealism and desire to create a better world be channeled into a movement.

- **Build an expanded, well-funded second generation National Health Service Corps**

Like the Peace Corps or Americorps, Teach for America – the National Health Service Corps can be re-infused with funding, campaigns to raise public awareness and administrative support to recreate its best years and reach much higher. The creation of a second generation National Health Service Corps will have a key role in efficiently solving workforce problems.

- **Define health care workforce broadly**

Rural schools need to encourage science education from elementary through high school.

Workforce is not just physicians and physician extenders.

Every child is not going to college, but many key jobs in primary care clinics do not require college. For example the front desk is the important face of the clinic.

- **Components of a pipeline model (Alfero)**

- Begins and ends with the community.
- Health Extension Regional Offices (HEROS) based on county agricultural extension model, resources targeted to rural and minority youth very young and increasing resources from high school on. Field trips/classes at University of New Mexico, summer programs, etc.
- Supporting/incentives to keep people in rural. For example, New Mexico has a \$5,000 state tax rebate for working outside of Albuquerque.

- **Osteopathic training results in much higher rates of rural placement and retention**

Tasks Moving Forward

- **Identify models from Sheps Center studies**

Work with Pathman and Konrad at the Sheps Center, University of North Carolina, to identify the programs with the best retention of NHSC providers along the entire rural/frontier continuum. The task force should study, conduct site visits if sufficiently funded and do whatever it takes to learn how they did it. Analyze the data by service area population, number of providers, size of budget for sites who keep NHSC providers for five years, six to nine years and greater than 10 years.

- **Seek funding for site visits to models**

Prepare or work with the Sheps Center or other research institutions to prepare best practices publication for various sized rural and frontier success stories.

- **Continue workforce focus for 2008-09: Develop and implement the action plan**

- Sponsor a Plenary Session at NRHA and NACHC Annual Conferences.
- Provide information to advocacy networks.
- Conduct webinars to share the NRTF findings and plans.

- **Compile information on the intensity of practice and retention**

For example, does having a procedure room(s) keep skill levels high, consider the practice more interesting or is this anecdotal?



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