

**West Virginia Rural Health Education Partnerships/
West Virginia Area Health Education Centers Program
Recommendations of the Restructuring Task Force
Approved by the State Rural Health Advisory Panel
May 17, 2004**

Background:

The WVRHEP Partnership has actively educated health professions students and provided access to health care education and services in rural communities for over twelve years. The Partners operate from both an education role and an advocacy role by increasing higher education's responsiveness to the needs and concerns of rural communities, providers, and students. WVRHEP enjoys both a statewide and national reputation as a fully integrated rural health interdisciplinary education and community service program. WVRHEP fully recognizes its mandate to be responsive to the state's rural health needs and is fully aware of the current fiscal crisis in the state and the nation. WVRHEP stands ready to meet this challenge and continue to serve the people of the state. The state funds allocated to the communities to operate this program have not increased since 1995, yet have gradually decreased, and the Partnership has continued to grow and meet its legislated commitments.

Given our current fiscal crisis, the WVRHEP and WV AHEC programs are reviewing future options for cost reductions while maintaining and improving the quality of education and community services provided through this robust statewide training system.

The Current Issue:

On November 17, 2003, the State Rural Health Advisory Panel passed a resolution directing each of the local consortia boards and site coordinators to meet and develop proposals for cost savings to their respective consortia and to discuss mergers and/or consolidations as a means to reduce costs. Each consortia was directed to submit their recommendations to the Panel by May 1 for discussion at the May 17 Panel meeting. On February 16, the Executive Director met with the Chair of the Senate Education Committee, and at that meeting the Chairman requested that this process be expedited and that cost savings be implemented as soon as possible.

At the March 16 Panel Meeting an RHEP/AHEC Restructuring Task Force was formed. The Panel organized and charged the Task Force to develop options to reduce costs to the WV RHEP Partnership by looking at a number of means, specifically mergers and consolidation of consortia. Twenty-six partners volunteered to be on this task force. From this group the Executive Director developed a smaller eleven-member (with seven alternates) Executive Council to discuss the findings of the larger Task Force and finalize the recommendations to be presented to the Panel. The Task Force met on March 29 and the Executive Council met on March 30, April 20, and May 11, 2004.

These draft recommendations are based upon the work of the Task Force and the responses from the local consortia boards and site coordinators. The Task Force directed the central administrative staff to gather and report on a number of areas of data such as the number of recruits by county and by discipline, the cost per student week by consortium, the number of student weeks by county and discipline, and the number of recruits and student weeks by Health Professions Shortage Areas. This data and more are contained in a binder provided for each member of the Executive Council of the Task Force. A master copy of this binder and all data are available in the central administrative office. Some of this information is also available in the partnership's annual reports on the web site.

We respectfully submitted to the State Rural Health Panel, recommendations of the Task Force.

Recommendations

1. The Baker-Brody-Jackson Medical Student Distribution Plan. Require all medical students to complete one RHEP rotation in a Level II or Level III* RHEP site and allow the schools the option to give medical students who complete a rotation in a Level III* RHEP site additional credit toward meeting their 3 months rural rotation requirement.

Rationale: Throughout the history of the partnership, the program has been criticized both internally and externally, for the mal-distribution of medical student rotations, citing most frequently the number of medical student rotations which occur in more populous areas and/or areas that are within a commuting distance from one of the medical school campuses. This recommendation would encourage a more even distribution of medical students without capping any one location. It would also encourage rotations in the most underserved areas which have a history of very few RHEP rotations and are also HPSAs. Level I sites are sites located in counties which have had the bulk of medical student rotations over the past 2 ½ years. Level II sites are specific underserved towns and sites located within the Level I counties and other counties whose number of medical student rotations falls between the cut-off for Level I and Level III counties¹. Level III sites are sites located in counties which have had few medical student rotations *and* have a HPSA designation. RHEP restricted cities² are still ineligible as RHEP or “other rural” sites. The status of these sites will be annually reviewed by the Recruitment and Retention Committee. **See Addendum for a complete listing of all Level I, II and III counties/towns and a listing of all clinics with a designation as an FQHC, federal 330 Clinic (CHC) and/or free clinic as of 5/12/04.**³

¹If the number of medical student weeks over the past 2 ½ years was evenly distributed among all 53 RHEP counties, each county would have ~133 medical student weeks. All sites within counties with a history (over the past 2 ½ yrs) of ≥ 50 weeks **above** 133 weeks (i.e., 183 weeks) are Level I with the exception of sites that are in towns that fall within *partial* HPSAs or sites that are FQHCs, Section 330 Clinics or free clinics. Those sites are Level II sites. All sites within counties with a history (over the past 2 ½ yrs) of ≤ 50 weeks **below** 133 weeks (i.e., 83 weeks) are Level III *if* they are HPSAs. For those Level III counties that are partial-county HPSAs, *all* RHEP sites that fall within the HPSA area are Level III sites. All other sites in these partial-HPSA counties are Level II.

²**RHEP Restricted Cities:** Charleston (and South Charleston, Dunbar, Nitro, Institute); Clarksburg (and Bridgeport and Nutter Fort); Fairmont; Huntington (and Barboursville); Martinsburg, Morgantown (and Sabraton, Star City and Westover); Parkersburg (and Vienna); Weirton; and Wheeling. **Additional Cities, considered part of the eight restricted cities:** Barboursville, Cross lanes, Dunbar, Kanawha City, Little Falls, Nitro, Ridgeley, South Charleston, and St. Albans. **Exceptions** include Federally Qualified Health Centers (FQHCs), federal 330 Clinics (CHCs), free clinics and sites that have been granted a special variance by the Executive Director of RHEP located within these restricted cities.

³FQHCs and federal 300 clinics (CHCs) are considered HPSAs by the federal government. For an up-to-date listing of clinics with designation as an FQHC, federal 330 Clinic (CHC) and/or free clinic go to <http://www.wvprimarycare.org/>

2. **Combine RHEP and AHEC Staff positions:** Community Service Coordinator and Site Secretary positions in RHEP are to be combined with positions in AHEC areas where these currently exist. Over the next year, community service coordinators will be split funded salaried by RHEP and AHEC funds. All secretarial positions are to be shared as well wherever feasible, and any new support staff hires are to function for both RHEP and AHEC.

Rationale: The sharing of personnel will reduce costs and improve efficiencies in most areas. In addition, all RHEP funds used in support of these positions can be considered cost share for the AHEC grant. The combining of the Community Services positions for both programs will also serve to further integrate the programs at the local level and greatly enhance the staff needed to maintain and improve the AHEC Team projects and make the community service projects more relevant to student learning objectives where this component is weak.

3. **Enhance the Interdisciplinary Educational component of the curriculum:** Fully implement the revised interdisciplinary experience policy for all students and strengthen the Interdisciplinary Experience concept at all training sites. Revise current policy to support and permit the sharing of IDS resources among consortia as a cost sharing and encourage alternatives to current ID session.

Rationale: This recommendation is made as a quality improvement measure based on student response and as a further integration of the RHEP and AHEC programs goals. The Faculty Development Committee has a training session scheduled for the 2004 conference for Onsite Clinical Director's and site coordinators and will oversee implementation of the policy. **This recommendation is referred to the Evaluation and Faculty Development Committees for inclusion in the SERFE and TRACKER©.**

4. **Develop and implement Summer Placements In Rural Interdisciplinary Teams (SPIRIT)** AHEC/RHEP rotations for rising second year medical students. These SPIRIT rotations will be designed to introduce these students to the "spirit" of the rural community and rural health practice by placing these medical students between their first and second years with other disciplines of students in specific, well defined, and coordinated interdisciplinary team experiences. These rotations would be from 4 to 6 weeks between June and August and held, by priority, in county areas with low medical student rotation numbers. Schools could be given the option to allow students to receive credit for this work toward their three months of rural rotation requirement or possibly, financial incentives. **This recommendation is referred to the School Committee to define and implement by the summer of 2006. After the first year, these rotations will be for all disciplines.**

Rationale: These rotations would expand the pool of medical students who complete rural rotations and in some cases, would free up some of the elective slots for these students in their fourth year. This is the time in the medical school curriculum when most students are reviewing their options for residency training by taking electives in more sub-specialties and/or taking out of state elective rotations. Medical students would be exposed to specific HPSA counties and communities while not under pressure to complete clinical objectives in areas where medical preceptors are limited. Our program has become a national model and an experience such as this could be an avenue to develop a unique curricular experience offered through WVRHEP and AHEC.

5. Explore partnering with the regional Workforce Investment Boards: Local RHEP/AHEC consortia could partner with their local WIB to address regional health workforce needs. This partnership could provide these benefits: a) accurate workforce data and 'Labor Market Information' for planning, b) the regional WIB could help RHEP/AHEC boards determine their regional focus in recruitment and retention, and c) recruitment can be enhanced by WIB efforts to create a more friendly 'business' climate for young health professionals. **This recommendation is referred to Dr. Henry Taylor who will work with a small group of site coordinators and AHEC Directors to further develop this plan. Currently the site coordinators Little Kanawha Area, Rivers and Bridges, and Webster-Nicholas Consortia are participating in the WIB meetings in their respective regions.**

Rationale: The RHEP/AHEC boards and staff can bring a group of employers together to examine the health professional recruitment needs in the area and the impact of these positions on the local economy. RHEP/AHEC boards would prioritize student community service projects and target those needs. The WIB work well with community colleges and vo-tech programs and can bring these partners closer to the RHEP/AHEC partnership. RHEP/AHEC student projects often involve school-based presentations, which hopefully entice K-12 students to consider health careers, which meet the goals of the WIB as well as RHEP and AHEC.

Recommendations on Mergers and Consolidations

Once finalized by the State Rural Health Advisory Panel, these recommendations will be implemented over the next year, so that the new configuration of consortia will be effective July 1, 2005. The following recommendations reduce the number of consortia with minimal loss of positions and coverage. The goal of any and all changes is to reduce costs, share resources, and improve the quality of the overall program.

- 1. Consolidate MHC, LKA, and ROVER resources one consortium following the NWVRHEC (Northern AHEC) 23 county service area.** Current RHEP boards would remain as local advisory boards to the NWVRHEC, Inc. Board. Consolidate the current 6 offices (Gassaway, Grafton, Rock Cave, Grantsville, Cameron, and AHEC Office in Glenville) into 3 or 4 offices. Reduce secretarial positions by 2 as a result of office consolidations. Hire and/or retain 3 community service coordinators, funded by RHEP and AHEC, for the entire region. Consider restructuring the RHEP site coordinator positions to meet local needs. Seek other ways to restructure or job share existing positions. Reduce the OSCD costs by adhering to the recommended funding level, eliminating positions, or having the OSCD and AHEC Medical Directors be the same positions.
- 2. Merge Webster-Nicholas and Rivers and Bridges Consortia** and share one secretarial position and one community services position and have one lead agency. Consider restructuring the RHEP site coordinator positions to meet local needs. Seek other ways to restructure or job share existing positions.
- 3. Merge Cabwaylingo and Western Counties consortium.** Maintain both current office locations, lead agencies affiliation agreements, however, share one secretarial position and one community service coordinator to also work with the SW AHEC. Each local consortia board would remain in place with one representing expertise in rural hospitals and the other

in community health center networks. Consider restructuring the RHEP site coordinator positions to meet local needs. Seek other ways to restructure or job share existing positions.

4. Merge Kanawha Valley Health Consortium and Winding Roads Consortium.

Maintain both current office locations and lead agency affiliation agreements, however, share one secretarial position and one community service coordinator. Consider restructuring the RHEP site coordinator positions to meet local needs. Seek other ways to restructure or job share existing positions where feasible and practical. .

5. Merger AHEC and RHEP –Eastern Consortium: The goals for this merger are to reduce costs, reduce and avoid duplication of resources, and improve the quality of both programs.