

HEALTH CARE PROVIDERS FOR Medically Underserved Communities

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here are many states in this wonderful country that have counties with no health care providers for the residents. Many methods to lure health care providers to practice in these medically underserved areas have been tried. Some states have medical education boards that grant scholarships to students that promise to practice in medically underserved communities after graduation. There was even a TV show about one of these people from a large city who was assigned to a small town in Alaska and his difficulties adjusting to a frontier community.

While serving on the faculty at the Medical College of Georgia (MCG) several years ago, I became acquainted with the president and some of the members of the medical education board. I was told that some of the scholarship recipients at MCG dishonored their agreements and never practiced in rural Georgia; instead heading to the big city specialty practices presumably for the high pay and bright lights of the city. Some students followed through and practiced in rural areas, but only for the minimum time agreed upon. Only a few completed their commitment and did what was expected of them.

At the time, I was the associate director of the physician assistant (PA) program and my colleagues and I were looking for ways to help supply mid level practitioners to medically underserved communities. We appealed to the Sate Medical Education Board to include PAs and Family Nurse Practitioners (FNPs) into their scholarship program. The request was eventually granted, and a few PAs and FNPs did stay in rural communities after graduation to practice, but many left for the city just like their physician colleagues.

DL STUDENTS

Our motto was: “You Don’t Have to Move to Move Ahead.”

Next we decided to involve the communities to help recruit their own providers. Through the state Area Health Education Centers (AHECs), we set up a recruitment program that allowed the AHECs to recruit from their communities to send students to the didactic phase of the PA Program at MCG. The goal was for them to return to their respective communities for their clinical rotations. It was thought that they would stay in their communities to practice after graduation and some did — but not enough. There were four satellite programs throughout the state in medically underserved areas. Again, many of the graduates went to the city or left the state to practice.

I left the Medical College of Georgia to take a position at East Carolina

University (ECU) to start a new Physician Assistant Program. During my first year at ECU, the Robert Wood Johnson Foundation issued a call for proposals for institutions that trained mid level practitioners to apply for grant funding to train health care providers through distance learning. The idea was to take the program to the student in their home community and not bring them to campus. One of the requirements was that the initiative must include PA students, FNP students and nurse midwife students.

Two unlikely partners, East Carolina University, a state school and Duke University a prestigious private school, partnered to apply for one

of those eight grants. We became the Duke-ECU Partners for Training Program and trained PAs and Nurse

Midwife students from ECU and FNPs from both Duke and ECU.

Five core courses

were taught together: pharmacology, physiology, health promotion and disease prevention, physical diagnosis and role delineation. All the remaining courses were discipline specific and taught within the appropriate department.

As chair of the PA Studies Department and director of the PA Program I was most involved with the PA portion of the training and can speak more knowledgeably about that area.

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The selection process for the prospective distance learning students was a little different than for the on-campus program. We concentrated on 31 medically underserved counties and partnered with hospitals in those communities. The hospitals advertised in their local communities that a recruiting team was coming to the hospital and an information session would be hosted at a specific time. A presentation was done and applications accepted for the program during this recruitment drive.

We tried to select mature people that were already working in health care. Many were phlebotomists, nutritionists, nurses, EMTs and paramedics, nursing assistants, respiratory therapists and so on. Later, we even had two veterinarians and a couple of chiropractors apply. There were also two PhD psychologists and some doctorate level researchers that decided to participate. We wanted people that

were self-motivated and would stay with the program until graduation, take and pass the national boards, become licensed and then practice in their community.

We accepted our first on-campus class in the spring of 1997 and our first distance learning (DL) class in the spring of 1998. The average age of the on-campus class entering in 1998 was approximately 30 and the average age of the DLs was 35. The average number of years of prior medical experience for on-campus students was approximately 4.8 and the average for DLs was 11.

It was decided that due to the intensity and rigor of the program the DL students would take the didactic portion of the program over a two-year period. Approximately 90% of the didactic phase would be presented over the Internet asynchronously to the students' home computer. They would come to campus once each month for hands on training such as physical diagnosis with standardized patients, suturing, casting etc. While on campus there was time for them to have Q and A sessions with other

professors such as anatomy, physiology and so on. At the end of the didactic period the DL students quit their jobs at the partner hospital to do a year of full time clinical rotations like the on-campus students. Clinical rotations require a minimum of forty hours per week of hands on training.

This asynchronous distance learning worked very well. The DL students earned grades very similar to the on campus students and most importantly, the clinical preceptors could not distinguish DL students from

on-campus students. All the DL students passed the very rigorous national boards.

This program was so unique and interesting

that it deserves more space than we have in this article. However, all but one DL student stayed in their medically underserved community to practice. The one that did not remain in the community married a physician during her training and left to move to where he was accepted into a residency program. The program at ECU was extremely successful. Our motto was: "You Don't Have to Move to Move Ahead."

The dean of the School of Allied

...would stay
with the
program until
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DL STUDENTS

Health Sciences at East Carolina, who was very supportive of this project, left to become dean of the School of Health Related Professions at the University of Alabama at Birmingham. I was asked to come to UAB as Chair of the Department of Critical Care. The Critical Care Department consists of Respiratory Therapy, Nurse Anesthesia and Surgical Physician Assistant.

...become licensed and then practice in their community.

Like many states in the south, and the rest of the country for that matter, Alabama has many areas of the state with medically underserved communities. The population in Alabama has a very high rate of diabetes and obesity. In an effort to quickly begin to train health care providers for these areas, we set up a system for teleconferencing from the UAB campus in Birmingham to outlying hospital and community college sites throughout Alabama and one site

in Mississippi. For many years our nurse anesthesia program had about 13 students. We now have more than 70 students per year at eight sites. We have 29 students on campus and teleconference to small groups at seven other sites. We are currently preparing our on-line courses to begin teleconferencing our respiratory therapy program to rural sites this fall and hope to be able to offer primary care PA sites next year.

It appears that the way to get health care providers to stay and practice in medically underserved areas is to take the program to them and not to bring them to the campus. It seems that if you bring the students to the bright lights of the city they just don't return home. We have had a few students recruited from the city that went to rural areas but very few.

There have been many studies on educating and training health care providers through various methods of distance learning and the majority of the studies indicate that it is not only possible but often desirable. Distance education for health care providers then, seems to be one way to help our medically underserved communities obtain needed health care providers. The local medical schools and schools of allied health need to buy into the concept and foundations need to be willing to help fund these projects with educational and training grants because it does work!

