
MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: West Virginia Rural Health Education Partnerships

Location: Morgantown, West Virginia

Problem Addressed: Access to Primary Care, and Recruitment and Retention of Rural Health Professionals

Healthy People 2010 Objective: 1

Web Address: <http://wvrhep.org>

SNAPSHOT

The West Virginia Rural Health Education Partnerships (RHEP) was created to train health professionals in rural, underserved communities. State law enables rural, community-based facilities to provide this training in underserved, rural areas of the state. The higher education system requires a three-month rotation and service learning for degree completion for 10 disciplines of health professional students in a state-supported program. Students spend 20 percent of their time in the community on prevention and health education service projects. Local boards, site coordinators, and field faculty help the students choose projects that meet the community needs. The program is state funded and consists of 13 regional partnerships and over 47 rural counties in the largely rural West Virginia.

THE MODEL

Blueprint: The program was first developed in 1992 and fully implemented in 1996 with the purpose of addressing three problems: recruitment and retention of the health care workforce in rural, underserved areas; access to primary health care for the underserved population; and rural health leadership and service learning for health professionals. It is a statewide partnership of local rural communities, higher education (19 state and private health professional schools and programs), and state government.

The program consists of 13 regional partnerships, each with its own board, and covers 47 rural, underserved counties in West Virginia. There are 295 rural training sites that include, but are not limited to, community health and primary care centers, small rural hospitals, single specialty clinics, dental offices, pharmacies, home health and hospice agencies, physical therapy services, and substance abuse centers. In addition, there are about 700 local community partners including 498 rural practitioners who serve as preceptors for the students and residents that include physicians, dentists, pharmacists, and a variety of allied health professionals.

The program employs an executive and associate director, administrative secretary, director of research and evaluation, and 17 site coordinators and secretaries. Moreover, the program receives volunteer services from over half of the faculty preceptors and all 200 community member partners. It is funded by appropriations from the state legislature through a direct line item in the higher education budget.

The recruitment/retention program is critical to the state since West Virginia is the second most rural state in the country, with 64 percent of the population living in communities with under 2,500 people and spread over 24,000 square miles. The program covers 47 counties, or 85 percent of all counties in the state. The rural population of these counties represents 1,117,133 of the state's 1.7 million people. Eighteen of these counties are 100 percent rural, and all others are more than 50 percent rural. The state is very mountainous with many secondary two-lane highways and roads. In 1999, West Virginia became the oldest state in the country, with almost 18 percent of the total population over 65 and a median age of 36. The annual median family income is only \$25,602.

Making a Difference: The Rural Health Education Partnerships program primarily focuses on providing prevention and education services to predominantly rural, low-income populations of all ages. In 2001, 216,127 community service contacts were made, and of these 148,593 were prevention and education to the general public; 16,808 were prevention and education for adults, and 50,726 were prevention and education for children. These services are provided by approximately 120 health profession students per month and represent 10 disciplines; 1,402 student rotations were completed in 2001 for a total of 6,822 weeks of training. The program trains and recruits rural physicians in addition to supplying manpower to rural health care facilities through the use of students. An online tracking system called TRACKER® is used to evaluate the program, schedule rotations, and track the practice location following training. This helps the program identify how successful it is in recruiting and retaining health care professionals in rural areas.

Beginnings: In 1990–1991, the West Virginia state legislature examined the issue of the number of rural, underserved areas and the retention rate of state health professional school graduates. They also investigated the expenditures of state dollars to public higher education. This debate sparked community and school interest in developing a statewide system for community-based training as a strategy to improve recruitment and retention of state-trained graduates in the health professions. RHEP was actually created by this legislation and is a program of the higher education system of the state. All health professional students in a state-supported program are required to complete three months of training and service in underserved, rural areas of the state. The partnership began as two programs—the Community Partnership Initiative funded by the W.K. Kellogg Foundation from 1991 to 1996, and the Rural Health Initiative funded by the state's

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Rural Health Act of 1991. These programs were merged into the West Virginia Rural Health Education Partnerships in 1995, and the legislature increased the appropriations from \$6 million to \$7.5 million to cover the Kellogg funding levels. The merger expanded the program into more underserved counties in the state, bringing it to its present level of 47 counties and 13 consortia. Since 1992, the program has been solely funded with state dollars, but many federal and private foundation grants have been received by the partners on the strength of the partnership and the expansiveness of the statewide training network. These have included Health Resources and Services Administration (HRSA) grants for interdisciplinary training in rural areas, research grants, resident training grants, and demonstration and model replication grants.

Challenges and Solutions: Some of the initial challenges included extending the training in rural, underserved communities as a degree requirement; working with lead agencies and some partners in building a partnership that was not a traditional hierarchical organization; devising a decision-making model that was equally shared among all partners; and developing full trust within the partnerships to share resources.

These challenges were overcome by developing a clear, open, and concise system of communication; involving all partners in defining vision, values, mission, strategies, outcomes, and policies regarding operations; and spending time to develop trust. This was facilitated by encouraging partnership interaction and consistently engaging community members and students in the process as the focal point of the partnerships' outcomes. Keeping the focus on the community and the role of the community members as the stewards of the partnership helped to facilitate shared power in decision making.

The program is marketed through local newspapers, websites, and personal advertisements by practitioners. Presentations are also made at civic clubs, churches, social events, and special annual events. The program has been featured in a number of professional publications and is the recipient of numerous awards, including recognition by the U.S. Surgeon General. Examples include receipt of a Community-Campus Partnership, Inc. Award for Leadership, a spotlight in the *New York Times*, and a publication in the *Journal of the American Medical Association*.

PROGRAM CONTACT INFORMATION

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