

ISMS

# Best Practices in Recruiting Physicians to Rural Areas

*Ad Hoc* Task Force of the  
Council on Education and Health Workforce  
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## Introduction:

The issue of physician shortages has been an ongoing one for the state of Illinois. In recognition of this, the Illinois State Medical Society is committed to addressing the practice of medicine in underserved rural areas.

## Background:

Resolution 311 (A-14), *Promotion of Medical Practice in Underserved Areas*, was referred to the Council on Education and Health Workforce for review and recommendation. Based upon the Council's discussion, Unfinished Business Report D (A-15) was referred to the House of Delegates in 2014 and adopted. The ISMS Board of Trustees recommended that the following Substitute Resolution C314 (A-14) be adopted:

- That ISMS reaffirm existing policy addressing workforce shortages and the need for recruiting physicians to practice in underserved areas;
- That ISMS collect and disseminate best practices from other states, including state legislative action, for recruiting physicians to rural areas;
- That the ISMS Board of Trustees draft a letter to Illinois graduate medical education programs and medical schools highlighting the impending crisis of physician shortages in underserved rural areas and encouraging medical students and residents to consider practicing in underserved rural areas;
- That ISMS support or cause to be introduced state legislation to promote the growth of graduate medical education and funding programs that promote physician practice in underserved rural areas.

In support of the second part of this resolution, an *ad hoc* task force of the ISMS Council on Education and Health Workforce was formed to collect and review information on how other states are addressing workforce shortages, and disseminating best practices, including state legislative actions, for recruiting physicians to rural areas.

## Procedure for Identifying and Documenting "Best Practices":

The *ad hoc* Task Force identified six states – Georgia, Indiana, Minnesota, Missouri, Texas, and Wisconsin – to research regarding physician shortages and mechanisms for addressing this issue. ISMS staff contacted representatives at the applicable state medical societies (SMS) with the following questions:

- 1) Has your state experienced a physician shortage in rural and/or impoverished urban areas? If so, which type of area – rural or impoverished urban, or both?
- 2) What, if any, federal initiatives, such as J-1 visa waivers, do you use to attract physicians to underserved areas?
- 3) Have there been any state legislative initiatives designed to identify and address these shortages?
- 4) Are there any methods being utilized, whether by private industry, medical schools or training programs, health care systems or communities to attract and keep physicians in underserved areas?

## Results of Outreach to SMS:

Although Indiana and Wisconsin did not respond to inquiries, information has been located on Wisconsin's efforts in this area.

All of the states indicated that their state has experienced physician shortages in both rural and impoverished urban areas. Texas and Minnesota highlighted challenges for meeting the needs of residents in remote rural areas, in particular, with the specialty areas of primary care and OB/GYN requiring particular attention.

In regard to federal initiatives, physicians in both Texas and Minnesota utilize the J-1 Visa Waiver program, although there are more applicants than the cap of 30 per state that is allowed. State legislative and "private" initiatives seem to provide the most effective response to the physician shortage in rural and impoverished urban areas.

## Summary of "Best Practices":

### ➤ Federal Initiatives

#### Participation in the J-1 Visa Waiver Program

One way to address the shortage of qualified doctors in medically underserved areas is through the J-1 Visa Program.

Sometimes referred to as the Conrad 30 Program, the J-1 Visa Program is for international medical graduates who want to pursue graduate medical training in the United States. The J-1 exchange visitor visa allows international medical graduate students to remain in the United States until their studies are complete. At the completion of their studies they are expected to return to their home countries for two years before applying for employment authorization in the United States.

A J-1 Visa Waiver waives the two-year home residency requirement and allows a physician to stay in the country to practice in a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) if sponsored by an interested U.S. government agency.

Due to the difficulties some states experience recruiting and retaining physicians to underserved areas, many turn to international medical graduates and J-1 Visa Waivers.

Additional information can be found here: <http://j1visa.state.gov/programs/physician>

### ➤ State Legislative Initiatives

In an effort to convince physicians to practice in underserved areas, many states now offer incentive packages including loan repayment/loan forgiveness programs, flexible work hours and tax credits. In addition, some states are investigating the expansion of funding for GME.

### Loan Repayment/Forgiveness Programs

Medical school-related debt has continued to increase. Given the high debt load most new physicians carry, many states have found student loan repayment or loan forgiveness programs to be a strong enticement for physicians to relocate to underserved areas.

According to the Texas Medical Association, the most effective tool for impacting physician geographic maldistribution is the state's Physician Education Loan Repayment Program which offers a total of \$160,000 in return for four years of practice in a primary care or psychiatric HPSA. The program is open to primary care physicians and psychiatrists.

The shortage of physicians in rural areas of Minnesota was identified as an issue several years ago. A report entitled, *Minnesota's Primary Care Workforce, 2011-2012*, was published by the Minnesota Department of Health (MDH), Office of Rural Health & Primary Care, in September 2013: <http://www.health.state.mn.us/divs/orhpc/pubs/workforce/primary.pdf>.

There are currently two state programs in Minnesota – a Loan Repayment Program and a Loan Forgiveness Program which has been expanded to urban areas. Additional information can be found at: <http://www.health.state.mn.us/divs/orhpc/funding/loans/index.html>. It is worth noting that state funding for the Loan Forgiveness Program was increased in 2015.

Additional information regarding Minnesota state legislative initiatives can be found on the Minnesota Department of Health, Office of Rural Health & Primary Care website: <http://www.health.state.mn.us/divs/orhpc/>.

### Tax Credits/Preceptor Programs

The state of Georgia currently offers a tax credit for preceptors and the Minnesota Medical Association is currently investigating a preceptor program.

### Additional (Expansion of) Funding for GME

The expansion of state funding for graduate medical education also serves as an incentive for increasing the physician workforce. Two of the states that were identified for this study, Georgia and Texas, have recently earmarked additional state funding for GME.

In 2011, GME experts from the Medical College of Georgia met and developed a funding model that would allow hospitals access to GME start-up funds. This group recommended that funding should be used to establish 400 residency positions at new teaching hospitals, that hospitals should be required to match the funding they receive \$1:\$1, and that new programs should focus on training primary care physicians and physicians in specialties with significant deficits in Georgia. The governor and state legislature agreed to fund the start-up costs of the recommended 400 new residency positions beginning in fiscal year 2013. As of 2014, 11 hospitals had partnered to receive start-up funding, and \$3.275 million was made available to these hospitals. \$5.275 million was available to support ongoing efforts in fiscal year 2015, with \$4.275 million allocated for fiscal year 2016.

The Texas Legislature adopted a new GME expansion grant program in May 2015 that is open to community-based ambulatory care facilities, such as Federally Qualified Health Centers or

Teaching Health Centers. These facilities can apply for grants of \$250,000 over two years to evaluate the potential for establishing a new residency program. A total of \$3.5 million is available for this initiative in the state of Texas' fiscal year of 2016-17.

In addition to the states originally identified, this year the state of Montana will propose an increase in state funding for GME for the 2017 Montana legislative session.

➤ "Other" Initiatives

Medical School or Training Programs

Some medical schools have established rural training tracks for residents in an effort to encourage physicians to train, and possibly remain, in rural areas.

Texas:

The Texas Medical Association is supportive of the development of a state grant program to support rural training tracks. The TMA is aware that Texas Tech in Lubbock has a rural training track in Plainview, Texas, and considers the University of North Texas Health Science Center's Rural Osteopathic Medical Program (ROME) to be a successful model for training and preparing medical students and residents in rural areas: <https://www.unthsc.edu/texas-college-of-osteopathic-medicine/office-of-rural-medical-education/>. John Peter Smith Hospital, Fort Worth, has also assisted in recruiting physicians for rural areas in the north central region of the state.

Minnesota:

The Rural Physician Associate Program (RPAP) at the University of Minnesota Medical School is a nine-month, community-based educational experience for University of Minnesota third-year medical students who live and train in rural communities. More information can be found here: <https://www.med.umn.edu/md-students/rural-physician-associate-program-rpap>.

Wisconsin:

In 2003, a task force including representatives from the Wisconsin Hospital Association, the Wisconsin Medical Society, several health systems, and the state's two medical schools began meeting to assess the issue of physician shortages. The task force published its report, *Who Will Care for Our Patients?* in 2004, recommending that one of the medical schools develop a program to increase the number of students planning to practice in rural Wisconsin. With financial support from the Wisconsin Partnership Program, representatives from the Wisconsin School of Medicine and Public Health (SMPH) faculty, rural hospitals, the state academic affiliated institutions, and Wisconsin communities and county public health departments planned the design and implementation of the Wisconsin Academy for Rural Medicine (WARM), a rural program for 25 medical students in the School of Medicine and Public Health.

Preceptor Programs

See information above under "Tax Credits/Preceptor Programs" for information on programs in Georgia and Minnesota.

### Consortia/"Private" Programs

There is a consortium in southwest Georgia. It is believed that Tift Regional Medical Center, Phoebe Putney Memorial Hospital, and a couple of others have raised funds for additional residency spaces.

In addition, individual hospitals in rural areas of Texas offer incentives in the recruitment of physicians.

### Other

Missouri's response to the primary care physician shortage was the creation of, "assistant physicians." Missouri passed a bill in 2014: <http://www.senate.mo.gov/14info/pdf-bill/tat/SB754.pdf>, allowing medical school graduates who have not completed a residency to practice in underserved areas. They are able to call themselves "doctor" but will be licensed as "assistant physicians" with significant limitations on their practice. The Missouri State Medical Association supported this law and helped draft the original bill. It was designed to address the state's critical need for primary care physicians.

### Conclusion:

Physician shortages in underserved rural areas in Illinois will remain an ongoing issue. ISMS will continue to investigate this issue, support legislation, make recommendations, and disseminate information as it becomes available.