Rural and Community Health Clerkship
Orientation 2011-2012

Lisa Grill Dodson, MD
Director, Oregon Area Health Education Center (AHEC)
Associate Professor, Family Medicine
Course Director, RCHC

Carol Blenning, MD
Associate Professor, Family Medicine
Associate Course Director, RCHC

Paul B. McGinnis, MPA
Director of Community Health and Practice Development
Oregon Rural Practice-based Research Network (ORPRN)
Why this Clerkship is part of your training....
Why do we have a rural and community health clerkship?
OHSU’s role

• Oregon’s only allopathic medical school
  – Do we have an obligation to train physicians for all of Oregon? Why or why not?
  – What is the mechanism for this?
  – If yes, then who is responsible for funding, ensuring outcome and monitoring?
  – If no, then where should the future workforce for rural Oregon/USA come from?
Rural training in Oregon

• Area Health Education Center (AHEC) (since 1991)
  – Rural Community Health Clerkship (req’d since 1992)
  – Cascades East Family Medicine residency (Klamath Falls)
• 6th in US News and World Report ranking
Figure 2. Results of a Reanalysis of the Monthly Prevalence of Illness in the Community and the Roles of Various Sources of Health Care. Each box represents a subgroup of the largest box, which comprises 1000 persons. Data are for persons of all ages.

Figure 1. Monthly Prevalence Estimates of Illness in the Community and the Roles of Physicians, Hospitals, and University Medical Centers in the Provision of Medical Care. Data are for persons 16 years of age and older. Reprinted from the 1961 report by White et al. From: Green; N Engl J Med, Volume 344(26), June 28, 2001.2021-2025
Rural is different
Why “rural” health?

- Challenging demographics and socio-economics

—Demand Forecasts
### Community Health Improvement Partnership

**Estimates of Physician Visits Needed by Population and by Physician Specialty**

**Service Area**

<table>
<thead>
<tr>
<th>Age</th>
<th>Population</th>
<th># of Visits per Person</th>
<th>Total Visits</th>
<th>Primary Care Adjuster</th>
<th>Primary Care Visits</th>
<th>Distribution by Specialty</th>
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<tbody>
<tr>
<td><strong>MALES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;1</td>
<td>x</td>
<td>7.3</td>
<td>0</td>
<td>x</td>
<td>60%</td>
<td>0</td>
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<tr>
<td>1-4</td>
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<td>3.4</td>
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<td>5-14</td>
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<td>2.9</td>
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<td>x</td>
<td>60%</td>
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<tr>
<td>15-24</td>
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<td>1.4</td>
<td>0</td>
<td>x</td>
<td>60%</td>
<td>0</td>
</tr>
<tr>
<td>25-44</td>
<td>x</td>
<td>1.6</td>
<td>0</td>
<td>x</td>
<td>60%</td>
<td>0</td>
</tr>
<tr>
<td>45-64</td>
<td>x</td>
<td>3.2</td>
<td>0</td>
<td>x</td>
<td>60%</td>
<td>0</td>
</tr>
<tr>
<td>65-74</td>
<td>x</td>
<td>6.6</td>
<td>0</td>
<td>x</td>
<td>60%</td>
<td>0</td>
</tr>
<tr>
<td>&gt;75</td>
<td>x</td>
<td>8.0</td>
<td>0</td>
<td>x</td>
<td>60%</td>
<td>0</td>
</tr>
</tbody>
</table>

| **FEMALES** | | | | | | |
| <1 | x | 7.3 | 0 | x | 60% | 0 | |
| 1-4 | x | 3.4 | 0 | x | 60% | 0 | Psychiatry | - | 3.3% |
| 5-14 | x | 2.7 | 0 | x | 60% | 0 | Urology | - | 2.0% |
| 15-24 | x | 2.5 | 0 | x | 60% | 0 | Otolaryngology | - | 2.0% |
| 25-44 | x | 3.3 | 0 | x | 60% | 0 | Oncology | - | 1.9% |
| 45-64 | x | 4.3 | 0 | x | 60% | 0 | General Surg | - | 1.8% |
| 65-74 | x | 6.8 | 0 | x | 60% | 0 | Neurology | - | 1.6% |
| >75 | x | 7.4 | 0 | x | 60% | 0 | All Others | - | 10.6% |

| **TOTALS** | 0 | - | - | - | - | 100.2% |

National Ambulatory Medical Care Survey: 2007 Summary, National Health Statistics Reports No. 27, Nov 3, 2010
### Office Visits Accommodated by Local Primary Care Practitioners

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Number of this Type of Provider in Your Service Area</th>
<th>Multiply</th>
<th>Visits per Year&lt;sup&gt;1,2&lt;/sup&gt;</th>
<th>TOTAL Potential Office Visits</th>
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<tr>
<td>Family Physician</td>
<td>0</td>
<td>X</td>
<td>2,753</td>
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<tr>
<td>General Internal Medicine</td>
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<td>X</td>
<td>2,421</td>
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<td>Pediatrician</td>
<td>0</td>
<td>X</td>
<td>2,991</td>
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<td>OB / GYN</td>
<td>0</td>
<td>X</td>
<td>2,702</td>
<td>-</td>
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<tr>
<td>Physician Assistant/ Nurse Practitioner</td>
<td>0</td>
<td>X</td>
<td>2,550</td>
<td>-</td>
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</table>

**Total Primary Care Capacity**

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Why “rural” health?

• Health status disparities
  – *Intensity vs. Magnitude*
Why “rural” health?

• Workforce Maldistribution
  – Availability vs. Accessibility
Why “rural” health?

- Vulnerable infrastructure
  – Margin for Error
Definitions of “Rural”

1. Census Bureau
2. Office of Management and Budget
3. RUCA (Rural-Urban Commuting Areas)
4. Oregon Office of Rural Health
5. Frontier
RUCA v. 2 (Rural-Urban Commuting Areas) by WWAMI Rural Health Research Center

- Based on census tracts/zip codes
- 30 categories according to size and commuting patterns:
  - 1 – Metro area Core (>50,000)
  - 2 – Metro area, high commute
  - 3 – Metro area, low commute
  - 4 – Large town Core (10,000-49,999)
  - 5 – Large town, high commute
  - 6 – Large town, low commute
  - 7 – Small town core (2,500-9,999)
  - 8 – Small town, high commute
  - 9 – Small town, low commute
  - 10 – Rural area (<2,500)
<table>
<thead>
<tr>
<th>Name of “Rural” Designation</th>
<th>Makes you Eligible for:</th>
</tr>
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<tbody>
<tr>
<td>1. Census Bureau</td>
<td>• Clinics located outside of “Urbanized Areas” are geographically eligible for Rural Health Clinic designation</td>
</tr>
<tr>
<td>2. Office of Management and Budget</td>
<td>• Used to categorize hospitals as either rural or urban for purposes of Medicare reimbursement</td>
</tr>
</tbody>
</table>
| 3. RUCA | • Grants issued by FORHP (Federal Office of Rural Health Policy):  
  – Rural Health Outreach  
  – Network Development  
  – Rural Automated External Defibrillator Grant Program |
| 4. Oregon Office of Rural Health | • Oregon clinician tax credit qualification  
  • Rural areas only are included in Unmet Healthcare Need determination. Unmet Need areas qualify for loan repayment.  
  • Critical Access Hospital |
Health Care Economic Impact

- The Flow of Money
- Recapturing Dollars
- Direct and Indirect Spending
- Infrastructure
- Jobs
- Forward and Backward Linkages
- Local Control
- Social Value / Peace of Mind
### Table 1
Oregon Health Districts - Facts and Figures
Tax Year 2009-2010

<table>
<thead>
<tr>
<th>District Service</th>
<th>County</th>
<th>Assessed Value</th>
<th>Permanent Rate</th>
<th>Permanent Tax Imposed</th>
<th>Local Option Tax Imposed</th>
<th>Total Tax Imposed</th>
<th>Population</th>
<th>Per Capita Tax</th>
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<td><strong>CLINIC SERVICE</strong></td>
<td></td>
<td></td>
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<tr>
<td>Pine Eagle Health</td>
<td>Baker</td>
<td>$45,029,301</td>
<td>0.85</td>
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<td>Powers Health</td>
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<td></td>
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<td>Clatsop</td>
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<td>14,206</td>
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**Sources:**
Oregon Property Tax Statistics Supplement, Fiscal Year 2009-10; Oregon Dept. of Revenue.
Claritas Inc. for Population Data 2010
Local Governments May NOT Tax Federal Lands
Payments “In Lieu” of Taxes

• Federal money gained from sales of timber, cattle grazing fees and mining contracts are generally shared with the local area “in lieu” of taxes

• When those sales revenues decline, the local governments have less revenues

• There have been temporary cash payments from the federal government, but it is not expected to continue
Rural Health Policies

• Medicare Cost-based Payment— RHC, FQHC, Critical Access Hospitals (CAH)
• Medicaid Cost-based Payment— RHC, FQHC, Type A & Type B Hospitals, CAH
• State Clinician Tax Credit
• State Subsidy for Malpractice Insurance
• PA Practice Laws (remote supervision)
• Recruitment Services / Technical Assistance
• Loan Repayment
Two Methods of Payment for Clinical Services

Fee for Service
• Under this most common payment model, fees are charged by the clinicians based on the level of service provided. The actual payment is often less than the “charges” due to pre-negotiated terms between the clinician and insurers (including Medicare and Medicaid)

Cost-Based Reimbursement
• A payment method based on the allowable “costs” of providing overall primary care services. A payment rate for an encounter (patient visit) is determined by dividing the total clinic costs by the total number of encounters served in a year.
Data and Resources for Community Project and Ideas

• Six Page Community Profile
  – Denominator is zip code(s)
  – Deaths not age-adjusted
• Compdata – Hospital Patient Origin Reporting
• Community Health Improvement Partnership (CHIP)
There is a limit to what can be accomplished in 5 weeks...

Clerkship Requirements
RCHC Components

- Preceptor Evaluation
- Community Project
- Community/Clinical Question
- Mental Health Presentation (Sakai)
- Oral Health & Nutrition Assessment (Sakai)
- Palliative Care - POLST & Opiates Modules (Sakai)
- Reflection Piece
RCHC Requirements

- “Do what your doctor does”
  - You are here to learn more than how to treat congestive heart failure
  - Learn about a community
  - Learn about the physician role in the community
  - Learn about the role, limitations, and benefits of the health care system in a rural community
A word on preceptors

- Your preceptors are volunteer teachers
- Preceptors are busy physicians, community leaders, partners, spouses, parents etc., in other words, HUMAN
- You are important to them, but not always the first thing on their list
- Most have years of experience teaching and practicing
- Mutually respect and learn from your differences and similarities
- You will have one lead preceptor, but expect to interact with everyone in the practice or community.
- Your lead preceptor will collate evaluations from all who interact with you and provide one evaluation to the program office
Preceptor(s) evaluation  70%

- Discuss expectations early in clerkship
- Ask for formal midterm evaluation/feedback
  - We send reminder, but ask anyway
  - Be specific
    - Avoid the “how am I doing”, “you’re doing fine” trap
      - Define areas you want to work on
      - Ask for specific feedback on these areas
      - Negotiate a preferred or expected outcome
Outside experiences encouraged

- Community agencies: public health, law enforcement, EMT, hospice, nursing home
- Schools: Permission required!!!! Avoid controversial topics unless asked (ie gun control and contraception!)
- Occupational medicine (local industries, ie mills, canneries etc)
- Civic groups: Kiwanis, Rotary, hospital board
Other responsibilities

- Primarily an outpatient rotation
- Follow your hospitalized patients
- On-call:
  - Minimum one night per week, one weekend
  - “on-call” is defined by your preceptors role
  - More is fine
  - Be available for “interesting cases”
- Seek out the opportunities you want to have
  - OB
  - ER/EMT
  - OR
  - Specialty care
  - Home visits
RCHC Requirements

- Community project 20%
  - IS NOT (I repeat NOT) a “research” project
  - IS a way to learn about communities, how to define them and issues important to them
  - Approximately ½ day per week
    - not a Master’s thesis
    - ½ day/week x 5 weeks = 20-30 hours
  - Examples in orientation packet
  - Graded on debriefing day
    - Quality of project
    - Quality of presentation
    - Meeting your own goals (per worksheet)
Project worksheet

- Intended to help you organize your thoughts and time
- Recommended that you turn it in Week 2
- Use it to help the project stay on task
  - Remember: not a Master’s thesis,
  - \( \frac{1}{2} \) day/week \( \times \) 5 weeks = 20-30 hours
- Used by faculty evaluators to see if you met your own goals.
Making Something Happen

DATA

Perceptions of Data

Perceptions on Capacity to Solve the Problem

Your project
Project details

- A word on data and resources:
  - Use existing *quantitative* data when possible
  - Recognize that data collection, analysis and interpretation is *challenging* in less than 5 weeks
  - *Qualitative* data collection methods are useful
  - *Descriptive studies* may be well suited to your work
Community Project

- **No need** for a “p-value” (or any other statistical analysis unless you really, really, really, really have to)

- **Avoid survey research** unless you have experience, have a previously validated instrument and a reliable distribution and collection method

- **Qualitative** methods encouraged
  - Basic information posted to Sakai

- You **may** (but need not) produce a lasting product
  - Patient information brochures
  - Needs assessment
  - Resource guide

- Ideally, present your project to your preceptor, practice or community
Choosing your project

- Something interesting to you, useful to the community or both
- Don’t bite off more than you can chew
- Preceptor may or may not be involved in project selection.
  - Address a problem for your practice
  - Assisting other groups in the community
  - Satisfying your own curiosity
- Ok to pick up where someone else left off, or replicate a project done elsewhere
- Use existing data/resources when possible
- You may use existing community presentations (Tar Wars, health policy education)
- Work with other students on same or sequential rotations
Community project

- **Examples:**
  - Patient education
  - Provider education
  - Service/program development
  - Problem identification
  - Needs assessment
  - Community educational presentations
Community Project

- Write up your project including:
  - Abstract (1 paragraph)
  - 4-5 pages (max):
    - describe why you chose the project,
    - what you were hoping to do/learn/describe
    - what you learned, did or described
    - what you would do differently if you could,
    - barriers and resources encountered
    - future directions for others to consider
    - include any materials you develop or use (if any)
RCHC Requirements

- Clinical practice question 10%
  - Research your assigned question
    - Why did we ask the question? (What is/are the hidden question(s)?)
    - What is the significance of the information?
    - What resources are needed/available to answer the question?
    - Does it raise other questions?

- 1 Page Write-Up

- Graded by OHSU faculty at debriefing
  - Thoroughness of thought process
Debriefing

- Last Friday of clerkship:
  - **8:00-12:30**
  - pastries, coffee, juice provided

- Community project presentation
  - Small group (4-5 students, 1-2 faculty)
  - 15 minutes, with 5 min discussion
  - Powerpoint is **helpful** but is **not necessary**
  - If other technology is needed, alert Susan Brock at the AHEC office before returning
  - Provide electronic copy of project via email to Susan Brock.

- Clinical question:
  - All students, 1-2 faculty
  - Powerpoint not needed, discussion only
  - Prepare a brief summary to hand in (1 copy) but no handouts needed

- Turn in all paperwork, evaluations, procedure logs
- Return any borrowed laptop
Reflection piece

- Return in week 2-3 of clerkship
- Your choice of format/media
  - Written short essay
  - Poetry, haiku
  - Photo essay
  - Art
  - Songs
  - Interpretive dance

- Required but not graded
- Shared only with RCHC faculty/AHEC staff - not shared with preceptors or School of Medicine
- Unattributed excerpts may be used for educational presentations
RCHC requirements: Mental Health

- Mental health presentation (Sakai)
  - Required, not graded
  - Mental health cases that are confusing or troublesome to your preceptor or to you (consider this a free consultation)
  - Preceptor encouraged to participate
  - Adult, child, geriatric
  - All students must upload a focused history and physical to Sakai a case by the Wednesday of Week 2
  - Do not use real names
  - Ask up to 3 questions regarding your case
During the next 2 weeks, discuss cases on Sakai:

- Each student must contribute something to at least 3 different cases
  - Comment (blog format)
  - Answer questions
  - Ask additional questions
  - Provide resources

- Not all cases may receive comments

- Cases may be grouped for similarities (ie ADHD diagnostic questions)
RCHC Requirements

- Oral Health and Nutrition Modules (Sakai)
- Palliative Care – POLST Module (Sakai)
- Palliative Care – Opiates Module (Sakai)

- Modules to be completed anytime during clerkship
- Participation Grade
Data from the POLST Registry as of 5/19/2011

Active Oregon POLST Registry Registrants as a proportion of County population over the age of 65.

Data from 2006 census
Patient logs

- Focus on unique aspects of the rural experience
  - Dental assessments
  - Geriatric assessments
  - Health policy
  - Role of the physician
Mid term and final evaluation

- OHSU SOM midterm formative feedback form (required)
  - Sent to preceptors week 2-3
  - Remind/ask for formative feedback session
  - Set your own specific goals early in clerkship

- Final grade assigned by course director based on:
  - Preceptor input (70%) (combined from all preceptors)
  - Project (20%)
  - Question (10%)
  - Attitude counts
  - Timeliness counts
  - Completing assignments counts
Grades

- A necessary evil
- New evaluation form this year
- Standard OHSU policy (*guideline, not quota*)
  - Honors: not more than 25%
  - Near Honors: not more than 35%
  - Satisfactory: at least 40%
  - Marginal/unsatisfactory: rare but used as needed
Your preceptor **does not** assign your final grade

Preceptors **do not** have to write a separate letter to justify a grade of HONORS or NEAR HONORS, but must make comments on the grading form.

**Do not** tell your preceptor that you must have HONORS or your life is over, you will never get into a residency or any such nonsense

**You may** review your file at the AHEC office at any time by contacting Susan Brock

**Do not** contact your preceptor if you have questions or are unhappy with your final grade, contact the course director, Dr. Dodson.
Enjoy the experience outside of medicine

- Some tips for avoiding loneliness and isolation:
  - Learn something about local history, culture, arts, environment
  - Explore the area
  - Experience something new (learn to shoot a gun, ride a horse, ride a mountain bike, skim board, collect seashells)
  - Start a new hobby or pick up an old one
  - Read a novel - or write one
  - Explore the local museum or historical society
  - Watch a high school sports, music or dramatic presentation
  - Join in local events, clubs (book clubs, adult sports teams, cooking classes)
  - Volunteer (senior center, nursing home, daycare centers, schools, HS sports, animal shelter)
  - Research a topic of interest
  - Start your family genealogy
  - Watch some old movies
Behave yourselves: Your professional behavior on this clerkship is part of your evaluation

- You are a guest in the practice and the community
- You are representing yourself, your family and OHSU.
- You are a health professional. Act accordingly.
- You **may not** (NB: these are examples, not an exhaustive list):
  - Leave the clerkship **or miss any time** without notifying the course director
  - *Modify, trash, or otherwise abuse your housing*
  - Make unauthorized purchases for the housing or practice
  - Reprimand clinic/hospital staff
  - Dress inappropriately
  - Create a public nuisance
  - Use any equipment (e.g. computers, wifi or internet services) provided by OHSU, AHEC, the local hospital, clinic or preceptor or provided by your housing site to download pornography, music or any copyrighted materials that do not relate specifically to your clinical work (such as library materials) except through established legal sources such as a personal itunes account.
Contact the AHEC staff if you have any problems with your housing or practice site that cannot be settled quickly.

- You are personally responsible for your housing, even if shared
- If you have any roommate problems that you cannot handle easily, let us know immediately
- Housekeeping is not generally provided during your stay. You are responsible for emptying trash, keeping dishes clean, bathrooms clean and the public spaces of your housing uncluttered.
- You are expected to leave your housing CLEANER than you found it
- You must keep both public and personal space in a reasonable state of cleanliness and order

Verified complaints regarding mistreatment of housing, computer resources or violation of other rules will be grounds for a professionalism referral, or failure of the course on the grounds of lack of professional behavior.
Partners

- Oregon Rural Practice Research Network (ORPRN)
  - Paul McGinnis
  - Practice support/research (support)

- Oregon Office of Rural Health (ORH)
  - Scott Ekblad
  - Data collection, rural program administration
  - HERO (rural practice recruiting),

- Oregon Primary Care Association (OPCA)
  - NHSC collaboration (SEARCH program)

- Oregon Association of Hospitals and Health Systems (OAHHS)
  - Rural hospital representation

- Oregon Rural Health Association (ORHA)
  - Lobbying, political support and monitoring

- Professional societies (OAFP)

- Foundations (NWHF, Ford Family Foundation)

- The Foundation for Medical Excellence (TFME)

- OHSU School of Dentistry, Division of Community Dentistry

- OHSU Geriatric Education Center
Who ya gonna call?

- Dr. Lisa Dodson, course director
- Dr. Carol Blenning, associate course director
- Marcia DeCaro, Dean’s office
- Susan Brock, clerkship coordinator
- Patty Petersen, AHEC Deputy Director
- Todd Hannon, OHSU library liaison
- Paul McGinnis, Oregon Rural Practice Research Network
- Dr. Elizabeth Eckstrom, Geriatric Education Center