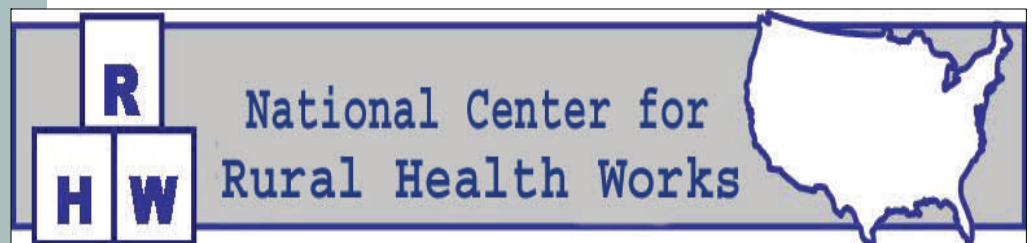


Rural Health Workforce Trends: The Future is Now - Act Now!

Meeting Summary (Draft)

A Partnership activity of NOSORH, Rural Health Works & 3R Net



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Summary

In March 2008, the National Organization of State Offices of Rural Health, the 3RNet and Rural Health Works hosted a partnership meeting of State Offices of Rural Health and their partners including primary care offices, primary care associations, area health education centers and other organizations.

The meeting was unique in its primary focus on five professional groups: health information technology professionals, oral health professionals, emergency medical services professionals, mental health, health professionals and allied health professionals.

Objectives of the summit were:

- * Articulate new trends in workforce development for a variety of health professions
- * Identify barriers and solutions for rural workforce development
- * Utilize model programs resources to implement improved models for planning workforce and recruitment needs at the community, state or national level
- * Strategize partnerships to address workforce, recruitment and retention issues at the community, state and national level

Presentations were made on model programs for addressing workforce needs of rural communities for Allied Health, EMS, HIT, Mental Health and Oral Health. Participants were divided into small breakout groups to focus on these areas of workforce professionals. Two sessions of breakouts were conducted and are summarized in this report. The first session focused on defining obstacles, gaps, opportunities and partners. The second session asked participants to focus on policy issues.

The summit was attended by over 60 participants representing 30 states. Participants reflected a strong satisfaction with the summit and continuation of the work began at this meeting. These comments illustrate that satisfaction.

- Thank you for this outstanding opportunity. Please continue to offer opportunities like this, we will come.
- I see 2 key things I found valuable: Info on topics I haven't heard before – very helpful - Started talking about solutions! Action steps!
- Thank you! I'm glad to be learning & talking solutions, not just listening.

Some of the most interesting discussion is highlighted by quotes from various presentations and discussions which encourage the participants to take action. A list of participants and a tally of their meeting evaluations is attached in [Appendix A](#). These random quotes and pearls of wisdom are provided in [Appendix B](#).

Recommendations: Initial recommendations provided by summit participants are provided in the table on page 44. Strategies and action steps will be developed by summit partners, participants with the NOSORH Workforce Committee.

Overview of Presentations

All presentations were planned to provide summit participants with role model programs and idea that can be implemented in their state. Each presenter invited to the summit has a key role in implementation of workforce initiatives or policy issues. The summit agenda and of all speaker power point slides are provided in [Appendix C](#).

Keynote

The first speaker was Jack Dillenberg, DDS, Dean Arizona School of Dentistry and Oral Health. Dr. Dillenberg outlined important qualities for workforce development and described the approach and success of the Arizona School of Dentistry and Oral Health. Dr. Dillenberg noted that there are 58 dental schools in the U.S., but that the Arizona School is unique in it's' commitment to training dentists who will provide care to underserved populations and who will understand the public health approach. The Arizona School of Dentistry guarantees admission interviews to all applicants to the school who have a letter of support from a Community Health Center. It is the only dental school with "oral health" in the name. He noted that dental concerns are the most prevalent chronic disease. Dr. Dillenberg defined health as the harmonious integration of body, mind and spirit within a responsive community. He noted that there is a great need for mid-level dental providers.

Recruitment, Retention, Collaboration: Trends and Model Programs

The remainder of the afternoon was spent describing trends and approaches for four model recruitment, retention and collaboration programs in a session moderated by Tim Skinner:

- ◆ Oregon Model – Bob Duehmig
- ◆ Colorado Model – Lou Ann Wilroy
- ◆ South Dakota Model - Halley Lee (presented by Tim Skinner)
- ◆ South Carolina Model – Mark Griffin

Rural Health Works: Making the Link to economic impact and workforce

The second day began with an overview of a tool to help communicate the economic impact of health facilities and providers in a community in a session moderated by Gerald Doekson:

- ◆ Gerald Doeksen, Rural Health Works
- ◆ John Packham, Nevada Office of Rural Health
- ◆ Val Schott, Oklahoma Office of Rural Health

The rest of the day followed with expert presentations on five professional areas:

HIT Professions: Their key role and community models for HIT workforce

Sally Buck, Rural Health Resources

Oral Health: Challenges, grow your own programs and other resources

Jerry Harrison, New Mexico Health Resources

EMS: A unique approach to addressing rural health needs

Anne Willaert, Minnesota State University

Mental Health: Workforce recommendations for a healthy rural America

Dennis Mohatt

Allied Health: Trends & models for training the health workers communities need

Roxanne Fulcher, American Association of Community Colleges

Key Questions and Considerations for Getting it Done!

The final session of the day was a combination of group breakouts and background information. Betty King presented reviewed the results of a survey sent to key informants prior to the meeting regarding perceptions of health profession shortages. Survey results are provided in [Appendix D](#). A toolkit composed of a directory of national membership organizations of allied health professionals was also provided and is available online at the NOSORH website, [Appendix E](#).

The day concluded with break out sessions by professional group to discuss gaps in knowledge, obstacle, opportunities and potential partners. [Appendix F](#) provides a summary of all breakout sessions.

Promising Research presentations were made by Gary Hart, Arizona Rural Health Office and Ann Peton, National Center for the Analysis of Healthcare at the beginning of the third day.

A second break out session followed to brainstorm policy issues and program recommendations. As indicated in Appendix G, many groups narrowed the first day's work to the top three priorities for most of the questions

Jerry Coopey and Gary Hart led the group to identify the key issues, potential actions and partners in the final session. The table in [Appendix G](#) is a summary of results of a final group discussion on next steps.

Appendix A
Participant List

2008 Workforce Summit

Name & Title	Company Name	Address	Contact Information
Workforce Summit		Total Attendees: 62	
Randall Anderson <i>Resource Coordinator</i>	Arkansas Department of Health	Office of Rural Health & Primary Care 4815 W. Markham, H22 Little Rock, AR 72205	Phone: (501) 280-4560 Fax: (501) 280-4706 Email: randall.anderson@arkansas.gov
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Name & Title	Company Name	Address	Contact Information
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Workforce Summit

Total Attendees: 62

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Workforce Summit

Total Attendees: 62

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Appendix B
Discussion Pearls

Discussion Pearls:

- Allopathic schools are increasing production by 15% Residencies are frozen
- Medical schools don't care about rural areas
- Only 7% of doctors get training in rural areas
- There will be a mid-level dental provider something between a PA and a hygienist.
- 35% of women perceive their OB/GYN as their primary care provider
- If you don't have a dental school you do have a dental school.
- 147,000 qualified nursing students are turned away from schools every year.
- Retail clinics are skimming the cream of the crop of paying patients
- How do we work with dentists to make sure people have the dental care they need?
- Wait until die!
- Don't be a threat – set up systems of referral to their offices from PAs and other providers
- Get a policy in place that pays for prevention.
- One lost opportunity: carriers measuring economic impact of HPSA designations.
- If you want to get policy done don't give a legislator elected to a 2 year term a 5 year plan!
- Switch thinking from primary care to comprehensive care
- Licensing boards are traffic cops they try to work on policy but that is not their focus.
- Is National Health Service Corps going to go away?
- As an active duty service corpsman I could see anyone in any place in the world. I lost that when I came into private practice.
- The way workforce is organized today doesn't have to be the workforce of tomorrow.
- Why have children come to the behavioral health center for care why not go to the schools.
- Don't worry about double counting – just count!
- There is no evidence based data on HIT workforce.
- Hustle the vendors for data and technology like they hustle us.
- Rural America is not trivial it's more people than live in England or France or Australia.
- A better word for a micropolitan area is “macro rural”.
- Cultivate servant leaders that are humble, teachable, reverent, open, caring models of authority service and contribution.
- Rethink the strategy from fix it to adapt to it!
- Are we going to look overseas?
- To develop programs start at the top – governor approved plans, cabinet leaders.
- Ask yourself does what we know match what we do.
- All programs support and promote each other.
- Try technology tools like Wisconsin's program modeled after monster.com for allied health providers, the professionals today are savvy website users.

Appendix C
Agenda and Presentations

Rural Health Workforce Trends: The Future is Now - Act Now!

A partnership activity of NOSORH, Rural Health Works & 3RNet

Phoenix, AZ
March 4 - 6, 2008

TUESDAY, March 4, 2008

11:00 - 11:30 AM	Registration
12:00 - 12:45 PM	Lunch (Buffet)
12:45 PM	<p>Welcome - Introductions</p> <ul style="list-style-type: none"> • Teryl Eisinger, <i>National Organization of State Offices of Rural Health</i> • Gary Hart, <i>Arizona Rural Health Office</i>
1:30 - 2:30 PM	<p>Keynote</p> <ul style="list-style-type: none"> • Jack Dillenberg, <i>Arizona School of Dentistry and Oral Health</i>
2:30 - 2:45 PM	Break
2:45 - 5:00 PM	<p>Recruitment, Retention, Collaboration: Trends and Model Programs</p> <ul style="list-style-type: none"> • Tim Skinner, <i>3R Net</i> • Oregon Model - Bob Duehmig • Colorado Model - Lou Ann Wilroy • South Dakota Model - Halley Lee (<i>presented by: T. Skinner</i>) • South Carolina Model - Mark Griffin

WEDNESDAY, March 5, 2008

7:30 - 8:30 AM	Breakfast (Buffet)
8:30 - 9:30 AM	<p>Rural Health Works: Making the link to economic impact & workforce</p> <ul style="list-style-type: none"> • Gerald Doeksen, <i>Rural Health Works</i> • John Packham, <i>Nevada Office of Rural Health</i> • Val Schott, <i>Oklahoma Office of Rural Health</i>
9:30 - 10:30 AM	<p>HIT Professions: Their key role and community models for HIT workforce</p> <ul style="list-style-type: none"> ◆ Sally Buck, <i>Rural Health Resources</i>
10:30 - 10:45 AM	Break
10:45 - 11:45 AM	<p>Oral Health: Challenges, grow your own programs and other resources</p> <ul style="list-style-type: none"> ◆ Jerry Harrison, <i>New Mexico Health Resources</i>
11:45 - 12:45 PM	Lunch (Plated)
12:45 - 1:45 PM	<p>EMS: A unique approach to addressing rural health needs</p> <ul style="list-style-type: none"> ◆ Anne Willaert, <i>Minnesota State University</i>
1:45 - 2:45 PM	<p>Mental Health: Workforce recommendations for a healthy rural America</p> <ul style="list-style-type: none"> ◆ Dennis Mohatt, <i>WICHE</i>
2:45 - 3:00 PM	Break
3:00 - 4:00 PM	<p>Allied Health: Trends & models for training the health workers communities need</p> <ul style="list-style-type: none"> ◆ Roxanne Fulcher, <i>American Association of Community Colleges</i>
4:00 - 5:00 PM	<p>BREAK OUT BY TOPIC...Key Questions & Considerations for Getting it Done!</p> <ul style="list-style-type: none"> ◆ Betty King, <i>NOSORH</i>

THURSDAY, March 6, 2008

7:30 - 8:30 AM	Deluxe Continental Breakfast	
8:30 - 9:00 AM	Policy, Programs & Partnership Considerations for Rural Workforce of the Future	Promising Research <ul style="list-style-type: none"> ◆ Ann Peton, <i>VCOM's National Center for the Analysis of Healthcare</i> ◆ Gary Hart, <i>Arizona Rural Health Office</i>
9:00 - 10:15 AM		Work groups - brainstorming, policy discussions, partnerships and education
10:15 - 10:45 AM		Break Check-out & Ready group reports
10:45 - 11:30 AM		Reports Back
11:30 - 12:00 PM		Wrap up...next steps <ul style="list-style-type: none"> ◆ Jerry Coopey, <i>Office of Rural Health Policy</i> ◆ Gary Hart, <i>Arizona Rural Health Office</i>

Safe trip home!

Speaker Presentations

- [*“Healthcare Workforce Research and Applications”*](#) (Ann Peton)
- [*“Addressing Population Based Health in Rural & Remote Areas”*](#) (Anne Willaert)
- [*“Rural Behavioral Health Workforce Development”*](#) (Dennis Mohatt)
- [*“Making the Link to Economic Impact and Workforce Development”*](#) (Gerald Doeksen)
- [*“Preparing for the Challenge – South Dakota’s Healthcare Workforce Initiative”*](#) (Halley Lee)
- [*“Look Ma! Cavaties & No Dentist, Too! Meeting the Oral Health Needs of Rural Communities”*](#)
(Jack Dillenberg)
- [*“Dental Workforce: Increasing the Supply in New Mexico”*](#) (Jerry Harrison)
- [*“Making the Link to Economic Impact and Workforce Development: The Nevada Experience”*](#)
(John Packham)
- [*“CoRRRN, CROP & CPR – Colorado’s Statewide Initiative”*](#) (Lou Ann Wilroy)
- [*“The South Carolina Office of Rural health’s Recruitment and Retention Program”*](#) (Mark Griffin)
- [*“Recruitment & Retention: The foundation of healthcare in Rural Oregon”*](#) (Robert Duehmig)
- [*“Addressing the Health Professions Shortages in Rural America”*](#) (Roxanne Fulcher)
- [*“The Health Information Technology Workforce: Addressing Pending HIT Worker Shortages”*](#)
(Sally Buck)

Appendix D

Survey Results

Rural Professional Shortages Survey

1) Please identify the type of rural health professional with whom your are most familiar.		
Answer Options	Percent	Count
Allied health not in a category below(e.g.s.dietician; occupational, physical, Emergency medical services	0.0%	0
Health Information Technology	0.0%	0
Mental health	1.3%	1
Oral health	2.5%	2
NP/PA/CRNA	0.0%	0
Pharmacy	0.0%	0
Primary care physicians	82.3%	65
RNs	2.5%	2
Other: (please specify)	11.4%	9
<i>answered question</i>		79
<i>skipped question</i>		0
Other: (please specify)		
All non-physicians, scopes of practice in all states, EDI challenges		
all of the above		
Health Networks and Alliances Directors and Staff		
J-1 Visa Coordinator, Specialists and Sub Specialists		
Equally familiar with physician, mental health, oral health, nursing, "mid-levels and direct care workers. Not as familiar with HIT, EMT, pharmacy, and allied health.		
I would check more than one - Oral/PA/NP/Physician		
work closely with multiple categories		
Rural Community Health Center (all of the above)		
para professionals i.e. nurse aide, lisc practical nurse		

2) Please identify the three most important reasons you think there is a shortage for the type of rural health professional you indicated in Question 1.:		
Answer Options	Percent	Count
High income, urban students are most likely to be admitted and least likely to choose under served locations	29.1%	23
Poor salaries and benefits	30.4%	24
School debt	20.3%	16
Demanding schedules	26.6%	21
Limited specialist support	16.5%	13
Concerns for/problems with spousal employment/"family happiness"	63.3%	50
Long hours	13.9%	11
Limited social stimulation	34.2%	27
Low professional status	15.2%	12
Other (please specify)	27.8%	22
<i>answered question</i>		79
<i>skipped question</i>		0
Other (please specify)		
Challenges with reimbursement from insurers/payers and lack of tools (such as codes) to bill for care electronically (this makes claims expensive to process)		
all of the above - just like the past 30 years		
Rural living environment		
Low primary care reimbursement, insufficient primary care scholarships that meet needs of PC interested in rural and underserved		
It's simply that rural communities are not what young people seek in general, not just physician-wise. There just isn't as much to do or see.		
lack of multi-service line hospitals		
Limited Experienced Directors		
Less interest in primary care fields		
Limited familiarity with the rural practice and therefore unclear that they would want to practice there		
The growth of IMGs creating lower status		
Educated in high tech medicine and in cities		
Specialist are over compensated		
Lifestyle		
Poor pipeline capacity for the professions		
We do not recruit from Rural venues		
limited resources in general, rural providers are usually limited in their options and funding		
Generally, individuals from rural areas are less likely be exposed to careers in the health professions during K-12. Therefore, they may be less likely to pursue a medical education and less likely to be academically prepared to be accepted into to medical school.		
I don't understand #1 "admitted" - I would overall say "assumptions" or preceptions		
Lack of professional and social opportunities, and for Hawaii High cost of living		
You should mention educational opportunities for children with Concerns above		
no support for para professional training		
Specilization		

3) Which three of the following strategies do you think will most effectively reduce this shortage?:		
Answer Options	Percent	Count
Combination of local, state, federal and educational strategies and resources	67.1%	53
Admit students of humble origin	3.8%	3
Support community colleges	5.1%	4
Emphasize much broader education for lower and middle income populations	7.6%	6
Increase number of students from rural areas and other students committed to rural health	58.2%	46
Urge schools to give priority to students from rural backgrounds	20.3%	16
Develop programs to teach skills needed for successful rural practice	29.1%	23
Eliminate barriers to accreditation for rural programs	11.4%	9
Increase loan repayment options	44.3%	35
Involve communities in the recruitment and retention of rural health professionals	41.8%	33
Educate the U.S. public about role of rural professionals	8.9%	7
Other:(please specify)	24.1%	19
<i>answered question</i>		79
<i>skipped question</i>		0
Other: (please specify)		
all of the above		
local community grows thier own		
Increase nursing faculty by offering better pay		
end war spending and re-invest in the people of the US		
Develop more rural training tracks in medical schools and residency programs with incentives for physicians willing to commit to rural practices upon completion of training. Programs such as the RPAP program in Minnesota		
double primary care reimbursement over time, 2 votes, as much as all of the above might help, especially coordinated statewide approaches, it is still policy, policy, policy		
support programs that stimulate students to stay in rural studies and that stay in contact with them throughout their educational career		
involve hospitals in e-health IT resources		
make H1-B's have a 3 year obligation		
establish a national health service		
locate training programs in rural areas		
Educate the U.S. public about health professional shortages and the consequences, both economic and quality of care.		
Subsidy of rural practice		
Economic and workforce development in our rural communities.		
Tuition waivers		
Establish more rural clinical medical school and residency rotations; mentor rural elementary through highschool students to generate interest in medicine and be sure they are academically prepared		
I have seen great succes with rotations/mentoring/opporuntity to test the waters - both from the student's perspective as well as the site or hiring agent		
From a conference of NHSC, social support in the area of practice seems to be the highest retention tool. Having provider that already have social supports in local communities and keeping them their may be the best strategy for retention.		
Build the capacity of rural communities by creating educational training in rural communities		

4) Please identify the professional category which best describes the majority of your work:		
Answer Options	Percent	Count
Researcher	16.4%	9
Administrator	60.0%	33
Educator	14.5%	8
clinical professional	9.1%	5
Other (please specify)		28
<i>answered question</i>		55
<i>skipped question</i>		24
Other (please specify)		
government		
Coding technology and healthcare reimbursement		
all of the above, long career		
primary care office		
Recruiter		
non profit recruiter		
Government/Program Administrator		
Physician recruiter		
advocate for rural health		
Recruitment		
Physician Recruitment Specialist		
Lobbyist		
rural health services policy analyst		
Immigration Issues		
State ORH Staff		
project director		
Administrator of state government programs (not administrator of a facility).		
Economist		
Recruiter		
recruiter		
Program specialist - workforce recruitment and retention resources		
Policy and Planning		
Recruiter		
Non-profit resource & technical assistance organization		
Community advocate		
Recruiter		
SORH		
Recruiter		

5) If we may follow up with you or if you would like feedback from this survey, please provide your email address:

Answer Options	Count
	50
<i>answered question</i>	50
<i>skipped question</i>	29

6) State

Answer Options	Count
	70
<i>answered question</i>	70
<i>skipped question</i>	9

Response Text

NM	North Carolina
NM	Maryland
New Mexico	North Dakota
I live in New Mexico but my company tracks over 18 million references by code, 50 states+D.C and profession (currently 17) to help reduce Fraud and Abuse fines (as high as \$10,000 per claim).	Iowa
	Kansas
	New Mexico
New Mexico	CO
NM	New Mexico
TN	Oregon
Virginia	Louisiana
Iowa	Texas
Wisconsin	CA
Ohio	Arizona
NM	Delaware
homeless between NE and AZ and TX	Ohio
TN	Maryland
VA	Alaska
VA	VA
Wisconsin	Arizona
VIRGINIA	Idaho
Tennessee	Michigan
Virginia	Pennsylvania
Minnesota	Hawaii
Ohio	Hawaii
KY	Nebraska
Oregon	Minnesota
Tennessee	NM
Washington	TN
Virginia	Hawaii
New Mexico	NM
GA	New Hampshire and Vermont
MA	Vermont
West Virginia	MN
South Carolina	MT
Nebraska	Colorado
Washington	CO
	Colorado

Appendix E

Toolkit



RURAL WORKFORCE TOOL KIT

A first draft compilation of primarily non-physician workforce reports, resources and websites

For SORH and their partners

For the National Organization of State Offices of Rural Health (NOSORH), 3R Net, Rural Health Works partnership meeting

March 4-6, 2008

Phoenix, Arizona

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BACKGROUND INFORMATION – HOW TO USE THIS DOCUMENT

In our efforts to inform State Offices of Rural Health and their partners regarding the future of the health workforce for rural America the planning committee endeavored to identify the most pertinent background information available regarding rural health workforce. In this search we found a broad range of information which may be helpful to summit participants and to all those who seek to improve the health workforce of rural America. This document focuses primarily on the non-physician workforce because fewer resources have been used to address these professions, even though many communities' needs in the future may increasingly be for other health professionals.

This document has been compiled as a toolkit for State Offices of Rural Health and their partners to inform them about associations of health professionals, policy initiatives, model programs and other sources of information on workforce. It is a first draft compilation of the work of many expert organizations. This is a simple report of many bodies of work which we hope will be a pliable resource to be added to and updated during the spring 2008 workforce summit and in the future.

There are three sections of information. The first section provides links to numerous professional associations and references identified for association workforce resource information. Websites or documents which may be accessed online are underlined, and specific document links are noted (Document). Health professionals categories are listed in alphabetical order. NOSORH conducted telephone surveys of most of the associations listed. Only a small number were able to identify rural workforce policy statements and very few identified profession specific model rural training and placement programs.

Section II lists workforce policies, programs and publication information by state. We hope this will begin the collection of state specific non-physician data and model programs.

Section III lists sources compiled primarily by the Rural Assistance Center.

SECTION I: NON-PHYSICIAN PROFESSIONAL ASSOCIATIONS

Source: American Medical Association webpage and professional categories identified through internet searches by NOSORH staff

- Anesthesiologist assistant
[American Academy of Anesthesiologist Assistants](#)
[Anesthesiologist Assistant Organization](#)
- Athletic trainer
[National Athletic Trainers' Association](#)
- Audiologist
[American Speech-Language-Hearing Association](#)
[Meeting the Challenge of rural service delivery](#)
[Rural Telepractice](#) - Document
- Cardiovascular technologist
[American Society of Echocardiography](#)
[Alliance of Cardiovascular Professionals](#)
[Society of Invasive Cardiovascular Professionals](#)
- Chiropractor
[American Chiropractic Association](#)
[HHS Initiative on Rural Communities](#) - Document
- Clinical laboratory science/ medical technology
[American Medical Technologists](#)
[American Society for Clinical Laboratory Science](#)
**Society has a Coordinating Council on the Clinical Laboratory Workforce which has developed a strategic plan, a career recruitment tool kit and workforce statistics*
[American Society for Clinical Pathology](#) - document
**Policy Statement on workforce (not specific to rural) - Document*
- Counseling-related occupations
[American Counseling Association](#)
[American Association for Marriage and Family Therapy](#)
- Dental assistant
[American Dental Assistants Association](#)
- Dental hygienist
[American Dental Hygienists' Association](#)
**Position paper on access to care; chart showing dental practice privileges by state*
- Dentist
[American Dental Association](#)
[American Association of Public Health Dentistry](#)
- Diagnostic medical sonographer
[Society of Diagnostic Medical Sonographers](#)
- Dietetic technician, dietician
[American Dietetic Association](#)
- Emergency medical technician-paramedic
[National Association of Emergency Medical Technicians](#)
- Health information management
[American Health Information Management Association](#)
HIT Workforce - Document
- Medical assistant
[American Association of Medical Assistants](#)
[American Medical Technologists](#)
- Nuclear medicine technologist
[Society of Nuclear Medicine - Technologist Section](#)
- Nurse
[American Nurses Association](#)
[National Association for Practical Nurse Education and Services](#)
[American Academy of Nurse Practitioners](#)
[American Association of Nurse Anesthetists \(CRNAs\)](#)
- Occupational therapy
[American Occupational Therapy Association](#)

- Optometry
[American Optometric Association](#)
[Joint Commission on Allied Health Personnel in Ophthalmology](#)
- Pathologists' assistant
[American Association of Pathologists' Assistants](#)
- Pharmacist
[American Pharmacists Association](#)
- Pharmacy technician
[American Association of Pharmacy Technicians](#)
- Physical therapist, physical therapist assistant
[American Physical Therapy Association](#)
- Physician assistant
[American Academy of Physician Assistants](#)
**policy on rural health care, workforce and recruitment and retention; conducts annual census of PAs with extensive information available*
[Physician Assistants and Innovative Solutions for Rural Hospitals](#) - Document
[Meeting Rural America's Needs](#) - Document
[Physician Assistant Education Association](#)
Physician Assistants in United States 1967-2000 - Document
- Podiatrist
[American Podiatric Medical Association](#)
Podiatric workforce study - Document
- Psychologist
[American Psychological Association](#)
- Radiation therapist, radiographer
[American Society of Radiologic Technologists](#)
- Rehabilitation counselor
[National Rehabilitation Counseling Association](#)
- Respiratory therapist, respiratory therapy technician
[American Association for Respiratory Care](#)
- Social Worker
[National Association of Social Workers](#)
- Speech-language pathologist
[American Speech-Language-Hearing Association](#)
Information on recruitment and retention available to members only
- Surgical assistant
[National Surgical Assistant Association](#)
- Surgical technologist
[Association of Surgical Technologists](#)

SECTION II: WORKFORCE PROGRAMS, POLICIES AND PUBLICATIONS LISTED BY STATE

NEW MEXICO

Program: Rural Practitioner Tax Incentive Program

Source: Harvey Licht, New Mexico Office of Rural Health/Primary Care (Harvey.licht@state.nm.us)

NEW YORK

Policy: In 2002, New York State Education Law was amended to waive the citizenship requirement for dental licensure to allow foreign dentists to practice on three year Limited Licenses. This license stipulates that they can only practice at sites located in federally designated Dental Health Professional Shortage Areas. To date, 68 dentists have obtained limited licenses to practice in NY - they are mostly on H-1B and TN visas

Source: Steve Swanson NYS Department of Health, Corning Tower - Room 1084, Albany, NY 12237 518-473-7019)

NORTH CAROLINA

Publication: [Trends in Licensed Health Professions in North Carolina, 1979-2005](#)

Brings together 27 years of data on the supply and distribution of practitioners in 17 categories of health care professions in North Carolina.

Organization: North Carolina Rural Health Research and Policy Analysis Center (Cecil G. Sheps Center) Date: 06 / 2007

Source: Cecil G. Sheps Center for Health Services Research, University of North Carolina

RHODE ISLAND

Program: [Nursing Reward Program](#)

Source: Carla Lundquist, Rhode Island Department of Health

TEXAS

Publication: Texas Physician and Physician Assistant Distribution in Rural and Remote Texas Counties

Source: American Academy of Physician Assistants

TRI-STATE HEALTH PROFESSIONAL WORKFORCE ANALYSIS (MICHIGAN, MINNESOTA, WISCONSIN)

Source: Sally Buck (sbuck@ruralcenter.org)

SECTION III: GENERAL RURAL WORKFORCE SOURCES OF INFORMATION

[Association of State and Territorial Health Officers](#) has conducted a number of studies of health professional shortages.

[Center for Health Workforce Studies](#) has prepared a number of reports for HRSA.

[Health Resources and Services Administration, Health and Human Services](#)

In-depth state health work profiles for many health professions may be located at.

[Health Workforce Solutions, LLC](#) - has produced a graphical profile of the frontline health and health care workforce for the Robert Wood Johnson Foundation

[National Rural Recruitment & Retention Network \(3Rnet\)](#)

National organization helps health care professionals, including dentists and dental hygienists find practice opportunities in rural areas throughout the country. Includes individual state information as well as a list of state contacts.

[NRHA Recruitment and Retention of a Quality Health Workforce in Rural Areas](#)

According to <http://www.nrharural.org/advocacy/sub/issuepapers/Workforce-intro.pdf> NRHA is working on the following papers. Some have been released and some have not been released yet:

- Rural Health Careers Pipeline: Medical School, Residencies, Physicians
- Rural Health Careers Pipeline: Nurses and Nurse Practitioners
- Rural Health Careers Pipeline: Pharmacists and Pharmacy technicians
- Rural Health Careers Pipeline: Dentists and Dental Hygienists
- Rural Health Careers Pipeline: Behavioral Health/ Mental Health
- Rural Health Careers Pipeline: Rural Public Health
- Rural Health Careers Pipeline: K-12 and Pre-College.
- Rural Health Careers Pipeline: Communities and Academic Partnerships
- Rural Health Careers Pipeline: Community Practice and Retention
- Rural Health Careers Pipeline: Healthcare Administration
- Rural Health Careers Pipeline: Allied Health/Technicians/Technologists
- Rural Health Careers Pipeline: Physician Assistants
- Rural Health Careers Pipeline: EMS/EMTs
- Rural Health Careers Pipeline: Issues of Preserving Rural Professional Quality of Life
- The following are the papers that are available online:
 - [Number 1: Physicians — November 2006](#)
 - [Number 2: Nursing — December 2005](#)
 - [Number 3: Pharmacists and Pharmacy Technicians — May 2006](#)
 - [Number 4: Oral Health — November 2006](#)
 - [Number 6: Rural Public Health—April 2007](#)
 - [Number 7: Rural Health Careers Pipeline: Kindergarten to 12th Grade Education — February 2006](#)
 - [Number 10: Hospital Administration — August 2007](#)
 - [Number 13: Emergency Medical Services — November 2005](#)
 - [Number 14: Issues of Preserving Rural Professional Quality of Life —May 2006](#)

[Recruitment and Retention of a Quality Health Workforce in Rural Areas, Introduction: Defining the Issues and the Principles of Recruitment and Retention](#)

Overview of the issues endemic to health care workforce recruitment and retention in rural areas. First in a series of issue papers addressing rural health care workforce development through career pipeline programs. (03/2005)

Source: National Rural Health Association; RESOURCE TYPE: PUBLICATION

[Rural Assistance Center](#) - The following is information gathered by the Rural Assistance Center raconline.org [Health Care Workforce Information Guide](#). Information and frequently asked questions on physicians, midlevel practitioners, pharmacy and dental health care providers; RESOURCE TYPE: TOOL OR WEB SITE

[National Health Service Corps](#) (NHSC)

Federal government works to improve the health of the underserved by recruiting and retaining the health professionals to deliver health care in underserved communities. Provides technical assistance to federally designated Health Professional Shortage Areas (HPSAs) on projects that enhance the NHSC's site development mission. Part of the Bureau of Health Professionals, Health Resources and Services Administration.

[Rural Health Research: Workforce](#)

Web site provides summaries of current and completed rural health research projects and related publications addressing the topic of health care workforce, produced by the Office of Rural Health Policy's funded rural health research centers.

Sponsoring organization: Rural Health Research Gateway

[National Center for Health Workforce Analysis](#)

Database provides detailed state-by-state data on supply, demand, distribution, education and use of health personnel. Collects, analyzes and disseminates health workforce information and facilitates national, state and local workforce planning efforts. Monitors trends to assure that all segments of society have access to quality health care professionals providing appropriate health care services in all geographic areas.

Sponsoring organization: Health Resources and Services Administration

[State Health Workforce Profiles](#)

Web site detailed state-by-state data on supply, demand, distribution, education and use of health personnel.

Sponsoring organization: National Center for Health Workforce Analysis

[2007 State Physician Workforce Data Book](#)

Examines the active physician supply in each state, current medical school enrollment, physicians in graduate medical education programs, and in-state retention rates. Includes data charts and tables for all 50 states, in addition to national averages. Date: 11 / 2007

Sponsoring organization: Association of American Medical Colleges

[Health Workforce Recruitment and Retention in Critical Access Hospitals](#)

Describes Critical Access Hospitals (CAHs) workforce and successful recruitment and retention strategies used in CAHs.

Journal citation: Findings from the Field Volume 3 Issue 5; Date: 11 / 2003

Sponsoring organization: Rural Hospital Flexibility Program Tracking Project Consortium, 1999-2003

[Quality through Collaboration: The Future of Rural Health Care \(Full Report\)](#)

Examines the quality of health care in rural America. Includes recommendations to improve health care quality and safety in rural communities. Addresses workforce, information technology, finance and other factors that impact rural health care quality. Date: 11 / 2004

Sponsoring organization: Institute of Medicine

[Shortages of Medical Personnel at Community Health Centers](#)

Author(s): Roger A. Rosenblatt, C. Holly A. Andrilla, Thomas Curtin, L. Gary Hart

Discusses staffing shortages at Community Health Centers (CHCs) in rural and urban locations and how these workforce shortages may impact efforts to expand the CHC program.

Journal citation: JAMA: The Journal of the American Medical Association Volume 295 Issue 9 Pages: 1042-1049;

Date: 03 / 2006

The RAC is not responsible for the availability or content of these web sites.

[**WWAMI Rural Health Research Center**](#) –has produced numerous workforce studies including *State of the Health Workforce in Rural America* (August 2003)

Appendix F
Breakout Summaries

Which professions are relevant to discuss for this topic area?

Occupational therapy, Physical Therapy, Rad Tech, Respiratory Therapy, Vet Tech, Clinical Lab Specialist, Lab Tech, Med Tech, Medical Assistant

What are the gaps between what we know and don't know about i.e.: supply, demand, producers, data etc...

- “The term gets in the way:” ”It’s too big” Catch all category. We don’t know how to use the term Allied health...combined licensed and non-licensed professions. States differ. Difficult to advocate for. Not enough commonalities.
- Can help with this by looking at subsets i.e.: Therapy occupations (rad therapy) and Diagnostic occupations (imaging).
- “Yes”
- “Go with what you’ve got.” Something is better than nothing.
- Urge professional organizations to make data available.
- Want optimum ratios – but data don’t exist.
- More research on what the workforce outcome goals should be: e.g. better health status? Efficiency access.

What are the obstacles to workforce development i.e.: availability, quality, appropriate training, “professionalization”, ensuring the professionals training meet needs of future rural communities?

- “Too few”
- Little backup
- Not enough work to keep all allied health professions on staff full time
- Some work to distance themselves from “allied health”
- Lumping title categorization devalues the professions
- Title/lumping devalues the professions
- Lack of structured education for some of these professions.
- Few distance learning opportunities
- Degree creep (i.e.: rad tech)
- Lack of faculty
- Salaries too low (for education, for life expenses).
- Shrinking middle class
- Better pay in larger areas likely to lure professionals out of rural lure
- Accrediting bodies – unlikely to give up turf
- Silos of professional organizations unlikely to break down barriers easily

What are the opportunities to improve workforce development?

- “Over 50” learners, 2nd, 3rd career
- Many educational programs can be done in technical and vocational colleges.
- Distance education can expand capacity.
- Can educate in place for many allied health professions.
- Redefine group scopes of practice
- Identify some core educational requirements (breakdown silos)
- Greater role of states in accreditation.
- More opportunities for allied health education in medical schools, nursing schools, etc...
- Interdisciplinary education of allied health with other professions
- Utilize on the job training

What are the areas are we most likely to impact?

- Look at natural grouping of allied health professionals and take to plans/proposals/projects for interdisciplinary education.
- Convene groups to prioritize data collection (recognizing limited resources for data collection and analysis). Make recommendations to feds and states.

Who are the most likely best partners at the local, state federal level?

- SORH
- AHECs
- Licensure Review Boards
- Department of Education
- NACHC
- State and Federal Departments of Health
- Hospital Associations (include rural hospital organizations)
- Departments of Labor (federal and state)
- Economic development and analysis
- Educators (institutions, students)
- Legislature
- Rural Health Clinics
- Businesses who get revenue from health care
- Geriatric interest groups including foundations
- Institute of Medicine

What are some policy issues that impede workforce development?

- Professional turf issues
- Higher education systems – competition and conflict over degrees, mode of education
- “Super AH” profession will require legislative change to happen.

What are some recommendations for new policies, programs or funding that could improve workforce?

- Identify good models of articulation agreements that could be replicated for allied health professions (e.g. high school to community college to baccalaureate)
- More K-12 programs for AL professionals, utilize AHECs with rural focus
- Study of the education needs, models, regulatory barriers, employer acceptance, special rural issues for “super allied health professional”
- Cross credentialing of health care specialist (WA proposed legislation)
- Improve dissemination of working models and best practices
- “Professional ambassadorship” help spread the word about the value of the Allied Health Profession

What professions are relevant to discuss for this topic area?

EMT 1, Intermediate, Paramedic, 1st Responder

What are the gaps in what we know?

- Turn over—Money not there , go on to RN
- Urban, turnover with bigger salary
- Paying for credentialing
- Administrators not trained to be administrators
- Lack of national data—outcomes, recruit
- Are EMTs nationally certified?

What are the obstacles?

- Lack of hospital support
- Availability—not available in rural areas
- Very local process—no state support
- Equipment—hand me downs
- Testing limits portability
- Liability insurance

What are the opportunities?

- Standardize test?
- Increase opportunities, e.g., paramedic
- Tax incentives
- Funds for training

What are the areas we are most likely to impact?

- Training
- Retention
- quality through large ORH activities—Flex
- Participate publically

Who are the best partners?

- EMS offices, ambulance operators, SORHs, NOSORH, health departments, state fire associations

What are some policy issues that impede workforce development?

- State policies that impede EMTs and Paramedics that are trained and certified in one state from working in another state.
- Need funding assistance for training EMTs and Paramedics. Often, these professionals have to pay for their own training. Tax incentives might be a start.

What are some recommendations for new policies, programs or funding that could improve workforce?

- Some states have limited training facilities. Need to work out distance learning opportunities for EMTs and Paramedics.
- Need to promote idea that EMS is a local public service and needs to be supported and funded just as police and fire.

What professions are relevant to discuss for this topic area?

- ★ *Computer IT geek*
- ★ *HIM clinical application*
- ★ *Health Professional super user*

What are the gaps between what we know and don't know?

- ★ *Catalogue of models – successes and failures*
- ★ *Don't know what degree, training skills*
- ★ *How much time/commitment is needed by tech support health care professionals to keep HIT running?*
 - Who has experience (professional, clinic, hospital)
 - What people skills are needed—organizational, development
 - Support from vendors (rural ideal health care experience)
 - What is needed with technical support?
 - What is needed to implement Geek vs. HIM

What are the obstacles?

- ★ *buy-in from health professionals*
- ★ *turnover of HIT staff – recruiting and retaining*
- ★ *Flexible/accessible educational preparation, is there a core curriculum for EHR other than HIT?*
 - time—2 years to implement
 - \$1 million software hardware cost, lost time to training
 - Site specific needs, identifying a champion
 - Lack of interoperability—systems are different
 - How to hire someone with no job description?
 - Lack of funding for curriculum development

What are opportunities?

- ★ *Incentives of working in rural/underserved HIT*
- ★ *Connection (network of facilities under a PCA, SORH)*
- ★ *Certificate training to become a specialist geek in EHR*
 - Military
 - Bonus for success
 - Bulletin of experiences (success/failure)
 - Coordinate ongoing IT (both geeks, HIM) CE through informal networks, bulletin board
 - Share information officer

What are the areas we are most likely to impact?

- ★ *Coordination and communication*
- ★ *Link education and health organizations*
- ★ *Develop new partnerships*
 - Qualifications for HIT staff

Who are the best partners?

- ★ *SORH, SHA, NRHA, AACC and local community colleges*
- ★ *Vendors*
- ★ *State and federal government*
- ORHP/AHRQ
- 3rd party payers
- Consumer groups
- AMIA
- HIMSS

What are some policy issues that impede workforce development?

- Lack of legislation /communication
- VISTA- tech support interoperability

What are some recommendations for new policies, programs or funding that could improve workforce?

- Loan repayment program – recruitment and retention incentives
- Job corp
- Signing bonus
- State of the art technology
- Pay for standardization of skill set/”degree”
- Support for distance education
- Technical assistance for HIT
- Catalog of models
- Grants for HIT network development

Which professions are relevant to discuss for this topic area?

- Psychiatrics
- Adolescents Psychiatrists,
- Counselors (not lawyer),
- Social Workers, Psychologists,
- Psychiatric NPs, PAs,
- Substance Abuse Expertise in all of the above,
- Cross trained,
- Marriage and family therapist,
- Case Managers,
- EMS-EMTs,
- Behavioral Health Aides,
- School Nurses

What are the gaps between what we know & don't know about (i.e.: supply, demand, producers, data etc...)

- ★ *Who will employ mental health workers - How will they be reimbursed?*
- ★ *Gaps in service for those who are not chronically mentally ill.*
- ★ *Need to know more about the effectiveness of telepsychiatry, so as to facilitate greater utilization*
- We do not know exactly where the demand is, especially by occupation/type of provider
- Impact of returning Vets, supply of mental health providers employed by the VA.
- Licensure lists don't actually reflect who is able to practice or provide mental health care.
- Growth of adolescent mental health issues.
- Which type of providers can direct bill?

What are the obstacles to workforce development (i.e.: availability, quality, appropriate training, "professionalization"), ensuring the professionals training meet needs of future rural communities?

- ★ *Reimbursement including Telepsychiatry reimbursement*
- ★ *Stigma – people experiencing illness and lack of respect for professionals*
- ★ *Geographic barriers – training providers, accessing care*
- Referral requirements for reimbursement
- Lack of funding
- Lack of mental health literacy and dealing with life stress
- Licensing requirements
- Territorialism of existing providers
- Lack of rural training

What are the opportunities to improve workforce development?

- ★ *Practice management expertise/skills*
- ★ *Don't have full-time mental health care needs can be addressed by part-time providers*
- ★ *Telepsychiatry – greater utilization of, all available technologies*
- Impact/feasibility assessment of ability to support mental health providers/services
- Use of psychiatric medical residents
- Interest of employers to reduce and deal with mental illness, wellness programs that include mental health.
- Tell the story with data – health care reform

What are the areas are we most likely to impact?

The opportunity to make the greatest impact is: "Shining a light on the problem through education".
That education includes:

Policy makers understanding that mental health care is not only important for the person with the problem but is essential for the family/care giver. Therefore the return on investment into mental health care is greater than what is usually reported because it affects so many other people.

Policy makers need to understand the economic impact that lack of mental health care has on our communities. Research shows absenteeism is greatly affected not only by the mental health problem but too many physical problems or to problems that are reported as physical. Therefore, once again, the investment into mental health has many financial benefits that go along with the obvious advantage to family and communities. Loss of wages by a head of household not only affects the employee, but the other household members and the state and federal agencies that must provide welfare.

Reimbursement needs to be a priority. Many of the out of the box thinking directed at rural mental health care has difficulty surviving due to the fact that it is financially prohibitive to practice in rural America. Telemedicine... who is going to bill? Will insurance accept it? Will Medicaid accept it...**reimbursement** issues. Midlevel provider can't bill...reimbursement issue. Solo practice in a community ... doesn't qualify for loan repayment and carries with it a risk that the provider will not make enough money to survive... major **reimbursement** issues. Given the difficulty built into our system regarding payment for mental health care in rural America, it becomes perplexing that we even ask why we have a shortage of care givers. No matter how philanthropic a care giver is, he/she also want to make a living. Why risk going rural? These issues can be addressed through policy changes on both the state and national level.

Once policy makers are educated, the public needs to be educated. The downside of going without care in rural America is that many have gotten used to idea that you just have to "pull yourself up by your bootstraps". Many who could get treatment before it reaches a crises level go without because of the stigma and the cowboy up attitude in Rural America. As one participant stated "suicide is the accepted treatment in my state. One the Wyoming representatives stated that the number one cause of death for men over 85 in her area is suicide with a gun. Therefore, a great deal of education needs to take in the community... even after the policy makers address the severe lack of mental health services in rural America.

Who are the most likely best partners at the local, state federal level?

We did not discuss partners but it is important that we get the various social service agencies along with the federal government on the same page.

What are some policy issues that impede workforce development?

Policies need to reflect reality. Was the sum of what was said. This means the reality of mental health parity in reimbursement etc. It means we need policies that allow mid levels, telemedicine, loan repayment policies etc that allow providers to be reimbursed for offering rural care.

What are some recommendations for new policies, programs or funding that could improve workforce?

Policies are based on urban practices and need to be changed to reflect rural realities.

What professions are relevant to discuss for this topic area?

- ★ *Dentists, hygienists, assistants, dental case managers*

What are the gaps between what we know and don't know?

- ★ *How do we know? Dental HPSAs, less dentists per capita then 10+years*
- ★ *Demand versus need—some rural areas cannot support a dental practice due to low population*
- ★ *Dentists view themselves as a “business”—we think of them as part of “the health care community”*
 - Less dentists per capita than 10 years ago
 - Some rural areas cannot support a dental practice due to low population
 - Definitions/scope of practice for dental hygienists vary greatly

What are the obstacles?

- ★ *ADA (Definitions/scope of practice for dental hygienists vary greatly)*
- ★ *lack of rural pipeline for dentists*
- ★ *business model*
 - 3rd party payers
 - Licensing boards
 - not adequate facilities/equipment
 - integration of dental and primary care and the subsequent issues (dental is considered second class)
 - not all dental graduates are created equally (new grads not a fit for some rural sites)

What are opportunities?

- ★ *We (PCOs, PCAs, rural leaders, etc.) go to the legislature to tell them what we need relative to dentists—hold state funded schools accountable for training dentists from and for rural and small communities*
- ★ *Increase communication between dentist (leaders, policy makers and those already in Public health) with groups like PCOs, PCAs, and SORHs)*
- ★ *Explore expansion of scope of practice for dental hygienists and consider programs like Alaska-dental tech*
 - Increase supply of all dentists, expand schools
 - Work with the foreign dentists during 2 year re-training programs and the public health licensing of these professionals while they are in programs
 - Mentoring programs for new grads going to rural areas
 - Use the family medicine model for learning for dentists

What are the areas we are most likely to impact?

- ★ *Learn how to communicate with dentists using their language relative to the dental industry and how it works in public health/rural*
- ★ *Establishing rural rotations*
- ★ *New dental administrative policies*
 - Loan repayment and forgiveness programs

Who are the best partners?

- state dental society and hygiene associations
- PCAs
- Bureau of Health Professions (Marcia Brand)
- Deans and dental schools/faculty
- Dentists
- State legislative – hygienist scope of practice
- State level dental societies – care of indigent
- State legislation – dental school financing – how many rural students – how many practice on rural.
- Lack of awareness – connection of oral health with medicine and primary care.
- Dental schools – expand number of students and??? capacity, restrict number of applicants due to cost of applying

What are some recommendations for new policies, programs or funding that could improve workforce?

- Subset of ADA – special populations, primary care dentists, cosmetics vs. total dental care
- Incentives – practice in rural areas (Loans)
- Legislatures – educate and communicate = accountability
- Federal loan forgiveness increase
- GME money and dental residencies
- NHSC lower dental professions shortage area – 18 for scholars.

Appendix G

Policy Issues & Program Recommendations

FINAL SESSION – WRAP UP ACTIONS TO TAKE

	National/Federal	State	Local
Data	Maintain federal workforce data – refund the National Center for Health Workforce Standardize data collection Standardize licensure data	State health workforce analysis and data, state models in NE, NC	Data consistency with state & federal
Training	Develop national standards for certification encourage their adoption ORHP leads partnership to encourage Rebuild Title 7 & 8 Programs Identify cross credentialed profession models (one in WA) and work with allied health groups (NOSORH& partners) – are these modes for mental health professions etc...	Use information from feds on standardization of cope etc... Cross credentialing of allied health for rural – legislatures and associations More effort and dollars rural students (all types) etc...from rural, train rural, loans, program accountability (SORH, legislators, AHECs, educators etc.) WIA	Grow your own (Flex\$) Recruit more people More training sites Work with AHECs Department of Labor
Accountability	Develop tools to increase accountability of legislators(NCSL linkage) – identify model deans – Develop rural legislators as advocates – use NOSORH webpage for information they can use	Legislators to give real rural expectations tied to dollars How to empower legislators (toolkit)	Empower rural legislators
Technology	Facilitate coordination of existing resources to help SORHs maximize telehealth	Flex et. bring IT folks together ID, IL	Treat geeks nice Bring IT folks together (CAH network)
Reimbursement	Support NRHA effort to comprehensively address reimbursement issues	Dollars to add to Medicaid SORH \$ Loans \$ etc. etc	

PROGRAM SUPPORT – PARTNERS

- Health Professions Associations
- NACHO
- NACO
- USDA- Rural Economic Development
- Department of Labor
- AHEC
- AARP
- NRHA
- NCSL
- AHEC
- AACC
- CMS Regional Offices
- NACHC
- Surgeon General’s Office

NOTE: SHOULD LOOK AT PUBLIC HEALTH PROFESSIONS