Professional Development Webinar
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Supporting Medical Education Reforms Through Data and Local Advocacy for Rural Pipelines

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Q&A from the webinar

Q	What is happening with funding for rural health education initiatives... on the state level... on the federal level?
A	In Alabama, state funding for the rural pipeline/pathway programs has been sustained with some increments in recent years. Federal funding for earlier pipeline programs through AHECs has been deemphasized.
Q	How involved is the Alabama College of Osteopathic Medicine inthese programs?
A	ACOM is producing an increased number of students who are choosing FM residencies. It is included in the state loan program that supplies tuition for students that commit to rural practice. The loan is forgiven by time in service, but there is a 300% payback for not following through on commitment.
Q	I'm wondering if having an osteopathic school in the state since 2010 has helped to influence the positive outcomes?
A	It is too early to see where these medical graduates end up in practice. Less than 50% of the students are from Alabama, (unlike the state allopathic schools), fewer are from rural Alabama (like the allopathics), and even fewer are from Black Belt (like allopathics). We have high hopes, but we shall see. We have seen an increasing number of Rural Scholars who do not access medical school via Rural Medical Scholars Program to enter osteopathic schools.
	Pipelines to pathways: https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12542
	Rural K-16 programs for health careers: https://ruralprep.org/how-can-we-strengthen-rural-opportunities-in-k-16-education-to-promote-primary-care-health- careers/
Q	Wondering what specific local leader or local programmatic efforts you would like to see occur to improve outcomes?
A	I (JW) would like to see local leaders exert influence on the state legislature to fund development of a medical and health professional education program that targeted our Black Belt and “grows our own” professionals in the community context.
Q	I am curious about the one-year rural community health program. Is there a tuition charge?
A	Yes. The student has to pay this.
Q	Do enrolled students receive some sort of credit?
A	They receive a Masters in Rural Community Health that is very much like the Rural MPH. Most are admitted as Rural Medical Scholars and are preadmitted to medical school. Others are admitted in hopes of becoming Rural Medical Scholars or entering medical school or another health profession. Some go further into graduate school and some into workforce in public health or related fields.
Q	Do you get a lot more applicants than you can accept?
A	We plan for up to 20 per year, but are flexible and have admitted as many as 25. 15-18 is a reasonable estimate of usual class size.
Q	You mentioned MCAT being a barrier. Does the Rural Health Scholars program include MCAT prep?
A	Yes, but not in the standard industry format. We have provided course credit for independent study that has included peer group self-study with faculty advisors and have offered supporting study materials
Q	Which stakeholders have you had most success working with in terms of buying into your models?
A	Rural physicians and farmers.

Q	Counties?
A	Rural counties that have alumni of our residency in them, others that have no educational institutions higher than 12th grade in them.
Q	State level?
A	AAFP, Medical Association of State of Alabama, Alabama Farmers Federation, Alabama Education Association.
Q	Health professional school deans?
A	The medical school deans when they have felt the warmth of legislative interest in the programs; otherwise, not so much, etc. Higher university administration when legislative interest was felt. Appalachian Regional Commission.
Q	Why do you think that rural students don't think they can go to medical school? It's disheartening to see but very pervasive.
A	Buy-in to the metrocentric perception of inadequacy; lack of role models that look and think like them; inadequate social responsiveness to rural community culture and needs; institutional figures who do not inspire their confidence. (Nice question for 3-5 focus groups in a rural community of interest: students, parents, teachers, other local interest groups.)
Q	What strategies would you recommend for building up rural/minority pipeline programming with limited existing infrastructure?
A	Target a population where these kids concentrate. Find several teachers in the local schools whose culture and/or heart is in the underserved population and engage them in discussions of identifying and nurturing promising students. Identify advocacy groups whose priorities include building up this underserved community. Expand the discussion to include them. If not already involved, expand to include local health professionals and administrators. Determine who will be responsible for the program and who will be the continuing advisors. Determine what educational and shadowing experiences can be programmed within the existing programs and facilities of the community and how many students it can accommodate and still maintain a high-quality personal experience for each student. Set up a selection committee, including someone from each group involved in the discussion, especially with people from the target population and some parents. Select the number of students that you can accommodate well. Activate the educational and shadowing program, retaining a close program director-student-parent interaction throughout to monitor and reflect on progress and any issues. Record diaries or periodic interviews with students, families and participating community members. At the end of the first year, review the experience with the advisory group, students, and parents, asking what could be improved and consider what is needed to make the improvements. Engage the community advocacy groups in this discussion and ask where are the resources to make this improvement, e.g., staff, materials, field trips? Form a delegation from the group to develop a script and share it with local sources of the needed resources. Act according to the support you gain. If at this stage the delegation has not been directed already to public officials who influence local governmental purse strings, expand the delegation with local advocates who are positioned to carry the script to city and county officials and to the local state representatives. Seek their attention to the developments and ask them to visit with some meetings with the students to see what is happening. Then ask their support to make the program grow.
Q	What steps should be prioritized?
A	First priority is engaging with local community members and learning from them, then facilitating their initiative in these developments. Priorities follow roughly as outlined above, but each community will have its own ways of getting things done. Facilitate, do not direct, as these ways unfold.
Q	You may have mentioned it, but can you speak to the funding channels used for the high school

	programs (minority rural health scholars and rural health scholars)?
A	We started with local small grants (from AAFP-AL Chapter, Medical Association of State of Alabama, Alabama Family Practice Rural Health Board, for example) to pilot the program and build enthusiasm. The next step was to get advocates to the state legislature to invest in the program, which resulted in yearly special appropriations for these programs for about three years. Then, with further demonstration of success, the legislature decided to make funding a regular part of the state's education budget, where it remains now after 2 decades. There have been supplemental grants from federal agencies and foundations, but these have been secondary to the basic support from the state and of limited utility for growing the programs.
Q	Do students who participate in the rural health scholars programs get special consideration when they later go to apply for medical school?
A	Yes. In the early years, the admissions committee had a point system that added a point for being a rural health scholar. As the admission processes have changed, knowing that one was a Rural Health Scholar lends credibility to the statement that "I always wanted to be a doctor" or "I really became motivated … as a RHS." Of course, the Rural Medical Scholars Program brings with it early acceptance to medical school after completing the Masters of Rural Community Health.
Q	Have you thought about a legacy mentor program that could teach health classes in the rural public schools, attend 'career days, etc.
A	We have modeled this type of interaction in local schools for the scholars, especially during the Rural Medical Scholars' Masters of Rural Community Health. Some of our alumni are conducting such activities in their home communities-- some in schools, some in churches. A natural step, that you suggest and we have discussed, is to encourage local communities where alumni reside and practice to organize with the alumni the opportunity to meet with students in settings that promote student-alumnus interactions. This has not been activated programmatically, only by word of mouth.
Q	What do the students actually do during these summer programs?
A	Reside for a summer term and 7 hours of college credits (4 Chem, 3 English) on university campus with courses designed for and limited to them (25 per year). Take field trips to various sites where local health care needs and responses are demonstrated. Engage in seminars with various rural health advocates to hear the needs and the praise they get for working in response to them. Pizza parties.
Q	...that could engage retired FPs to teach...
A	And some do. But we get more traction with the students' interest by hearing from peers who are only 1 to 5 years ahead of them.
Q	To what extent do the high schools in your target areas offer AP and Honors courses?
A	The larger schools in more privileged areas can make these available. The Black Belt schools only rarely provide these—it is a matter of economics at family and community levels.
Q	College performance is often impacted by what is available to the student as a high school student.
A	Yes. As well as by the attention that they often must give to "paying their own way." They are bright and can compete by working harder, if they can find the time to do so. This shows up in GPA. However, the MCAT is very much impacted by very early and continuing exposures. And once they get to college it is rarely possible to catch up with age-group urban peers, because the competition propels those peers to also keep raising their scores, driving up the minimal levels that excite admission committees.
Q	Curious, what is the total expense from the first intervention model, through medical school and through residency for one physician?

A The State of Alabama invests about $16,000 per student to get them through RHS, RMHS, and MS year of RMSP. Though they have to pay their own tuition for the Masters year. For those in medical school who accept the state loan to be repaid through rural practice, the state invests another $200,000 (est). The program/state does not finance their graduate medical education. These estimates may need to be bumped up since my administrative experience with the program is now about 2 years out of date.

Addendum: The Black Belt

Alabama's Black Belt is strip of about 17 +/- counties across southern part of the state with a rich dark soil that generated much historical wealth via cotton and enslaved peoples. This region maintains a population that is over 50% African Americans in 10 counties and that was disenfranchised politically by the state's constitution of 1901. As a result, education, economic development, health care and other markers of modern population advancement have been suppressed.

There is widespread awareness of the inequity and disparities, but Alabama's political environment, like that of other similar states, has not yet generated the appetite for social interdependency required for generating equity.