Legislative Health Care Workforce Commission
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A charge to this Commission is to identify causes and potential solutions to barriers related to the primary care workforce, including training and residency shortages.

I am a rural Family Physician and will address this charge from that perspective. I also serve as the Rural Dean for the University of MN Medical School. You have received reports and testimony on the status of the rural MN Physician and Provider workforce from others and I will not repeat it.

Your predecessors in the 1960's responded to this same concern with the creation of the Rural Physician Associate Program (RPAP)(1971) and the School of Medicine in Duluth – now the University of MN Medical School Duluth Campus (1972 first class entered). Time has shown both to be successful in helping to increase the number of rural family and other physicians as well as earning us the distinction of being number two in the US in training Native American Physicians.

I was an early preceptor for both RPAP and the Duluth School of Medicine. I have since been fortunate to bring my voice to the University of MN Medical School as we address primary care (Family Medicine, general Internal Medicine, general Pediatrics, general Surgery) in rural MN. We have Land Grant responsibilities.

You have been provided a copy of our Ladder of Opportunities for preparing rural physicians.

As you are aware it is important for medical students to have early and frequent clinical patient care experiences. We have known this for decades and it has been a focus of RPAP and Duluth. In Duluth we also have our own curriculum (focused on rural as much as possible) and our own admissions, which focuses on known predictive qualities for rural practice. This requires rural and other adjunct faculty preceptors who love to teach.

As a preceptor my reward for teaching was the time and gratitude of the student. Teaching time was not a part of my day, it was carved out of lunch and family time in the evening. Some systems have started to make time and reward for teaching, but most physicians who teach are still facing the clinic driven patient load and crisp office visit times. For RPAP my clinic in Moose Lake also pays $4000/ year to the student.

With sixty students in each class in Duluth we need sixty local and rural preceptors for each class as well as ~40 main preceptors and up to 10 others for each RPAP student. Finding preceptors is difficult and further matching students to the right site and preceptor makes this process difficult.

Medical Education and Research Cost monies are available to the preceptors. Reporting is complex. The monies are sent to the clinics and many add them to the general fund

without the preceptor being accredited or being aware of the payment. This amount may be as little as ~$10K for nine months of RPAP teaching and formative and objective evaluation. These dollars are also determined by Medicaid patient care. If nothing else, would it not be possible for learning institutions to deliver the checks to the preceptors personally? How the clinic handles it after that is up to them.

As you can imagine the number of adjunct faculty is quite large. In our case the Family Medicine Departments in Duluth and Twin Cities are cost accounted ~1500-2000K for each preceptor for library access and other university services. This is a benefit to the preceptors but frankly today we all have email and web access and seldom if at all utilize the services charged to the department. Is there another way to reward the preceptors?

Finding preceptors is time consuming and requires intense faculty involvement from contact to ongoing visitation.

Post Graduate Medical Education (GME).

Many states have established Rural Training Tracks for Family Medicine. Physicians tend to fall by the tree when completing post grad education. We train 60 students a year in Duluth – all of whom have expressed and interest in rural practice. At present we have ~ 16 family medicine residency slots in Duluth, St Cloud, and Mankato.

Rural Training Tracts (RTT) utilize one year in an anchor hospital and the last two years in a rural community – where we need to train primary care. Each Resident costs about 150K/year. None of our systems have been able to financially establish or fund a RTT. CMS is not going to do it. Georgia has addressed this issue (Nuss MA, Robinson B, Buckley P. A statewide strategy for establishing graduate medical education by establishing new teaching hospital and residency programs. *Academic Medicine.* 2015; 90(9):1264-1268.).

This is a very complex problem, but we have a wonderful resource available for teaching clinical education in rural communities in our rural preceptors.

A final problem is housing. It is time for communities to help. Consider taking tax forfeit or other housing and converting it to student housing for all professional student whatever profession or discipline. What a great way to stimulate future professional services in a community.

Thank you, and questions?