ENDOWMENT for Health
Forward Fund

Tomorrow's Healthcare Workforce:

Strengthening NH's Clinical Placement Opportunities

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NORTHERN NH AREA Health Education CENTER

AHEC Southern New Hampshire Area Health Education Center

nhAHEC New Hampshire Area Health Education Center

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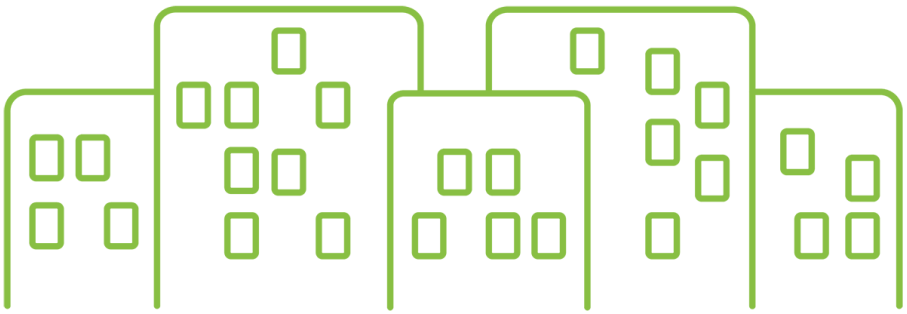

Executive Summary

Purpose

The New Hampshire Legislative Commission on the Interdisciplinary Primary Care Workforce has prioritized investigating the disconnect between the workforce needs in New Hampshire and the limited availability of placement sites for health professional students here. Community-based clinical sites and preceptors face the challenge of managing a heavy stream of requests from multiple training programs from within New Hampshire and from out-of-state. The overall question for this Clinical Placements Project (CPP): how to best address these challenges in order to increase the healthcare workforce in New Hampshire?

Methods

The report used a qualitative research design involving semi-structured interviews with academic institutions, community practice sites and preceptors, as well as representatives of a sample of National Area Health Education Center (AHEC) Organization Programs across the country. The project is approved by the Institutional Review Board of the University of New Hampshire and Dartmouth College. Twenty-eight (28) interviews were conducted with representatives of 18 academic institutions and 24 interviews with placements sites. Sixteen (16) preceptors also participated in the semi-structured interviews.

Disciplines included: behavioral health, human services, public health, clinical psychology, marriage and family therapy, mental health counseling, undergraduate and graduate nursing, medicine, occupational therapy, physical therapy, social work, physician assistant, pharmacy, radiology, paramedicine, medical assisting, dentistry, and dental assisting.

Themes

The following themes were identified through the National AHEC Organization interviews: Coordinate clinical placements for health professions students, incentives for preceptors, and systems. Challenges in the areas of Housing, Competition, and Funding were also identified. Themes that emerged from the semi structured interviews conducted with clinical sites, academic institutions and preceptors from New Hampshire include: Relationship Building, Site Recruitment, Site Priority Setting, Recruitment/ NH Workforce, Preceptor Burnout, Administration, Centralized Clinical Placement, COVID-Response, Payment for Preceptors, Learners, Equity, Preceptor Expectations, Preceptor Development, Internal System Capacity, Policy Requirements, Interprofessional Experiences, and Collaborative Planning.

Recommendations

The semi-structured interviews conducted with academic institutions, sites and preceptors generated recommendations for action to help resolve challenges with the placement system in NH. Interviewees shared recommendations for enhancing the community placement system in NH. Recommendations are organized into the themes of action at the individual, institution/ site or community level and at the system level. The following table outlines a summary of CPP recommendations.

Summary of CPP Recommendations

Individual
Offer Training to Preceptors
Recognize preceptors for the work they do
Prepare students to go to community
Community
Conduct Outreach & Awareness
Streamline Processes
Foster Interprofessional Education (IPE)
Consider Equity
Explore Funding Opportunities
Promote Professional Development
Address Scheduling
Consider innovative collaborative partnerships with academia & community-based sites
System
Recognize & Promote Precepting
Expand Pipeline Programs
Develop Career Pathways
Promote Collaboration & Planning
Explore Financing
Share Business Models for Precepting
Foster NH Workforce
Pursue Policy Change
Expand Data Collection

Additional recommendations

Semi-structured interviews conducted with eight (8) National AHEC Organization offices generated the following recommendations:

- If funding weren't an issue, many AHECs reported they would like to see a centralized system for all placements and tracking students, all in one system.
- Relationships are the key to success in placing students. Any system created must be built around trusting relationships.
- System focused on tax incentives for preceptors like that established by the Georgia AHEC would be useful in sustaining a placement program.
- Continue to build a system that is neutral ("like Switzerland") trusted by all stakeholders and continues to build on those trusted relationships (which is "what we do as AHEC").
- Explore workforce data collection efforts that support workforce development strategies.
- Identify housing for students, either through a shared agreement with another academic institution or alone. Housing is a huge barrier to student placements in underserved areas.

Relationships are the key to success in placing students.

Tomorrows Healthcare Workforce: **Strengthening NH's Clinical Placement Opportunities**

I. Overview

Overview of the issue: A paradigm shift has occurred in the management of health conditions from more hospital-based care to care in community settings. Accordingly, academic institutions have adapted by including more community-based clinical placements in their curriculum. Yet the capacity of community-based rotation sites is limited. The Recruiting and Maintaining U.S. Clinical Training Sites Joint Report of the 2013 Multi-Discipline Clerkship/ Clinical Training Site outlined significant challenges in the community rotation environment.[1] Medical schools (DO and MD degrees), nurse practitioner, and physician assistant programs describe increased pressure in obtaining clinical training sites. Respondents reported that competition for sites and preceptors has an impact on program enrollment capacity[1], limiting their ability to address workforce needs. In addition, we must account for professions from behavioral health training programs who work in an integrated primary care environment. To address the challenge of placements, institutions implemented strategies such as: reimbursing preceptors, expanding the radius of search for sites, adopting simulation and supplementing with didactic or computer-based curricula for students.[1] The Association of American Medical Colleges and other national medical education organizations have stated concerns about "**preceptor recruitment and retention and the ability** to provide high-quality educational experiences in **community-based** practices".[2]

Collectively, academic institutions and preceptors are working to address the health and behavioral health workforce needs. Academic institutions have increased their class sizes and introduced new health professions programs. This growth requires access to more clinical placement sites, creating an environment where academic institutions are 'competing' with each other for clinical experiences. Clinical training sites and preceptors in New Hampshire are struggling to accommodate growing numbers of health professions students from throughout New England and beyond. Consequently, academic institutions in the state are finding it difficult to identify adequate placement opportunities for New Hampshire-based students. Similarly, the clinical sites and preceptors that provide opportunities for training are navigating a growing number of requests for training without benefit of context or adequate administrative support. These multiple requests compete with a reimbursement system that is built on provider productivity. Preceptors struggle to balance clinical care with providing high quality learning experiences for students.[3]

In New Hampshire, the Legislative Commission on the Interdisciplinary Primary Care Workforce has prioritized investigating the disconnect between the workforce needs in New Hampshire and the limited availability of placements for health professional students here. This misalignment contributes to barriers within the primary care and behavioral health workforce pipeline across the state. Training programs work diligently to find high-quality primary care clinical sites. With the growing need for sites to train students from New Hampshire academic institutions, the request for these clinical sites come from academic institutions from within and outside New Hampshire, and the growth of online schools with a community placement component also exacerbates the tension in finding sites. Therefore, community-based clinical sites and preceptors are in the challenging position of managing the steady stream of requests from multiple training programs. These requests are from instate and out of state institutions who operate on different schedules, with different requirements. Some academic institutions, provide financial compensation for precepting, but not all are able to do so. The overall question for this Clinical Placements Project: how to identify and

1 https://www.aamc.org/data-reports/students-residents/data/recruiting-and-maintaining-us-clinical-training-sites-joint-report-2013-multi-discipline-clerkship. Accessed on May 12, 2021

2 https://www.tandfonline.com/doi/abs/10.1080/10401334.2016.1152899. Accessed on May 12, 2021

3 Christner, Jennifer & Beck Dallaghan, Gary & Briscoe, William & Casey, Petra & Fincher, Ruth & Manfred, Lynn & Margo, Katherine & Muscarella, Peter & Richardson, Joshua & Safdieh, Joseph & Steiner, Beat. (2016). The Community Preceptor Crisis: Recruiting and Retaining Community-Based Faculty to Teach Medical Students-A Shared Perspective From the Alliance for Clinical Education. Teaching and learning in medicine. 28. 1-8. 10.1080/10401334.2016.1152899.

best address these challenges in the service of an adequate healthcare workforce in New Hampshire?

Through existing relationships with academic institutions and clinical sites, preliminary discussions have identified the long-term goal of establishing a sustainable model to place health professions students from New Hampshire's academic institutions in clinical primary care sites in New Hampshire in a systematic and streamlined way. To achieve this, the New Hampshire Area Health Education Center team focused on interviewing health professions training programs, clinical sites in New Hampshire, preceptors, and select Area Health Education Centers across the United States to help better understand what is working within the current system, what is not working, and what can be improved.

II. Methods

The study was designed and implemented by three directors of the New Hampshire Area Health Education Center offices located in Raymond, NH, Lebanon, NH and Littleton, NH. We used a qualitative research design involving semi-structured interviews. The University of New Hampshire assisted the NH AHEC team by working with their institution's Committee for the Protection of Human Subjects (CPHS) to approve the study protocol. UNH CPHS office worked with Dartmouth College CPHS to ensure protocols were approved by all participating research institutions. These protocols were adjusted from the initial research strategy due to the COVID-19 pandemic. Our methods to obtain the data shifted from face-to-face regional preceptor site meetings to of individual zoom semi-structured interviews. Same shift occurred working with academic institutions, a shift to individual zoom meetings instead of regional face-to-face meetings. The interviews with the National AHEC Organization were conducted as originally planned via Zoom.

For academic institutions semi-structured interviews sites were identified by a collaborative process of the NH AHEC team, the list of 31 academic institutions in New Hampshire that offered health professions training programs were identified. This list was distributed between the Northern NH AHEC office and the Southern NH AHEC office primarily. In addition, regional AHEC offices reached out to clinical sites within their region. National AHEC Organization interviews were identified by random selection representing all regions of the United States, all ten National AHEC Organization interviews were conducted by the NH AHEC Program Office.

The AHEC Centers conducted interviews with 18 different academic institutions in NH representing a variety of disciplines. A total of 28 interviews took place as some Universities and/or Colleges preferred to interview by discipline resulting in ten additional interviews. Disciplines included: behavioral health, human services, public health, clinical psychology, marriage and family therapy, mental health counseling, undergraduate and graduate nursing, medicine, occupational therapy, physical therapy, social work, physician assistant, pharmacy, radiology, paramedicine, medical assisting, dentistry and dental hygiene. Twenty-four (24) placement sites were interviewed representing a sample of hospital systems, federally qualified health centers, mental health centers, visiting nurses' organizations, private primary care practices, home health, and human service organizations. Sixteen (16) preceptors were interviewed representing twenty-six (26) sites. Table 1 below describes the Number of Interviews, Sites and Disciplines.

Table 1: Number of Interviews, Sites and Disciplines

Northern NH AHEC data			
Category	*# of interviews*	*# of sites represented*	*Disciplines*
Academic Institutions	7	8	12
Placement Sites	8	27	20
Preceptors	6	16	14
Southern NH AHEC data			
Category	*# of interviews*	*# of sites represented*	*Disciplines*
Academic Institutions	21	10	15
Placement Sites	16	16	NA
Preceptors	10	10	NA

III. Literature scan

A scan of the peer review literature around clinical placements for health professions students resulted in limited published articles addressing the 'system' (or lack-there of) within the United States. The topic has been studied in Australia with a limited number of peer review articles published addressing the issue of clinical placements for health professions students[4,5]. One article[6] focused on preceptor perspective in education medical students (limitation to medicine). Other articles address recruitment of physicians. However, limited findings of a 'system approach' during our literature search. Therefore, the NH AHEC team reached out to Scott Shipman, MD, MPH, the Director of Clinical Innovations; Director of Primary Care Initiatives at the American Academic of Medical Colleges (AAMC) to gauge the accuracy of our search findings. Dr. Shipman has studied healthcare workforce extensively and confirmed that limited studies have been published assessing clinical placements of health professions students in the United States. However, Dr. Shipman shared some insightful peer review articles identifying areas of study in regards to particular findings around recruitment of the health care workforce, that could provide insight further downstream in the pipeline with a focus to potentially inform strategies upstream.

Areas addressed in a peer review article based on a focus group of 26 family practitioners from different regions of the United States. The study highlighted the 'Self-Determination Theory' (SDT) in the assessment of the providers and their input on precepting medical students. This limited study found motivating factors for preceptors to work with students include:

Autonomy in teaching; benefits to staying current on literature; maintaining competency in their teaching skills; giving back to their 'home' university and relationship with students; and, the rewards of teaching, including: financial, academic titles, certificates, CME. However, their motivation to teach is decreased by: time to teach students reduces productivity and/or personal time; occupational burn-out; questions regarding teaching competency; lack of connection to academic institution; and finally, concern that payment for preceptors reduces the "quality of the preceptor"[6]

Areas identified impacting provider's recruitment, although these factors are not in silos as they are listed in this report, many confounding influence the provider's decision on where to practice. Many published studies focus on rural communities, including:

Growing up in a rural area is reported to be the strongest predictor of future practice in rural area[7]; Rural training is important to future recruitment[7],with a focus on increased exposure resulting in increased likelihood of provider selecting a rural area of practice. In addition, more exposure leads to greater success. Lifestyle shows some influence, although not as strong as other areas of focus.[7] Recreational opportunities, although may be important, not been an area providers have identified as a high priority within their decision to practice in an area.[6] Findings around salary are unclear and would require additional exploration.

IV. National AHEC Organization

Background on AHEC. The Area Health Education Centers, first authorized by Congress in 1971, receive a portion of their support through a cooperative agreement with the Health Resources Services Administration (HRSA). Of the 48 program offices, 46 are located in medical schools, while two are in schools of nursing (because their state does not have a medical school), and 261 center offices across the country focus on developing and enhancing education and training networks within community-based organizations, academic institutions, and communities. As noted in HRSA's summary of the AHEC program for President Biden's FY2022 budget proposal: the AHEC networks "develop the health care workforce, broaden the distribution of the health care workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. In 2017, the AHEC program was redesigned. This redesigned AHEC Program

4 Moran, A., Nancarrow, S., Cosgrave, C. et al. What works, why and how? A scoping review and logic model of rural clinical placements for allied health students. BMC Health Serv Res 20, 866 (2020). https://doi.org/10.1186/s12913-020-05669-6

5 Allied Health Professions Australia [AHPA]. What is allied health? 2019: https://ahpa.com.au/what-is-allied-health/

6 Minor S, Huffman M, Lewis PR, Kost A, Prunuske J. Community Preceptor Perspectives on Recruitment and Retention: The CoPPRR Study. Fam Med. 2019;51(5):389-398. https://doi.org/10.22454/FamMed.2019.937544.

7 MacQueen IT, Maggard-Gibbons M, Capra G, Raaen L, Ulloa JG, Shekelle PG, Miake-Lye I, Beroes JM, Hempel S. Recruiting Rural Healthcare Providers Today: a Systematic Review of Training Program Success and Determinants of Geographic Choices. J Gen Intern Med. 2018 Feb;33(2):191-199. doi: 10.1007/s11606-017-4210-z. Epub 2017 Nov 27.

invests in interprofessional networks that address social determinants of health and incorporate field placement programs for rural and medically-underserved populations."[8]

The AHEC programs support an array of pipeline programs and continuing education trainings for "thousands of trainees across the country,"[3] while partnering with training sites to provide clinical training experiences to health professions students.

National AHEC data on clinical placements: assisting academic institutions with student placements is a longstanding role the AHECs have been engaged in over the years. As reported by the Health Resources Services Administration,[9] during academic year 2018 – 2019 the AHECs across the nation supported more than 3,400 different types of training programs including pre-pipeline and pipeline activities, as well as community-based field placements for health professions trainees. A total of 306,584 students and residents participated in these programs. Approximately 40 percent of AHEC students and residents reported coming from a financially or educationally disadvantaged background, and 48 percent reported coming from a rural background.

Of the 24,124 trainees participating in AHEC-sponsored community-based field placements nationally, 49 percent were medical students. The remaining trainees represented a variety of health professions, including nursing, pharmacy, dentistry, and physician assistant programs.[9]

8 https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf Pages 126-128. Accessed on June 7, 2021.

9 https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/area-health-education-centers-2019.pdf

During the Academic Year 2018–2019:
AHECs across the nation supported more than

3,400
training programs.

The AHECs have up to 50 years of experience working within rural and underserved communities with a focus on recruitment, training, and retention of the health care workforce, making them an ideal organization to interview for insight into strategies and innovative programmatic initiatives.

Summary of AHEC interviews

Themes that emerged from the interviews with AHECs in the 8 regions of the country are discussed below.

Challenge: Coordinate Clinical Placements for Health Professions students

Generally, the AHECs who were interviewed conduct work with the academic institutions in their state to place health profession students in clinical or community based experiences, focused primarily in rural or underserved locations. The AHEC's role varies across programs, however, most work with a select number of students, not the entire class and for specific rotations. The scope and scale of the AHEC's role in student placements across the AHEC network varies based on when the program was established and in part, funding sources outside of the federal AHEC grant.

For example in Maine, the AHEC office places about 48 third-year osteopathic medicine students per year in a rural experience, and also assists in the placement of other professions such as PA. Whereas in Missouri, the AHEC office works closely with four students for a longitudinal experience, this includes working with these students for their entire third and fourth year, and had often been engaged with the students prior to medical school and continue to work with the students after training, resulting in a longitudinal experience culmination in a multi-year (up to 10 years) relationship. AHECs report that limited federal funding for the AHECs results in limited staff time to assist in this capacity.

Since 2018, the AHECs have developed an **AHEC Scholars** program nation-wide. This Scholars program is a core requirement of the AHEC funding for health professions students with a focus on exposing students to issues such as social determinants of health, cultural competency, diversity and equity, interprofessional education, and practice transformation. The AHEC Scholars program criteria include a 40-hour didact and a 40-hour community-based experience per year for two years for each scholar. While engaging with the AHEC Scholars, AHECs place their scholars in community-based

experiences (in addition to their academic institution required clinical rotations) while offering them didactic learning opportunities.

Strategies employed by the AHECs interviewed vary. For example, in **Florida** the AHEC center office works in the Tampa area closely with different academic institutions to assist in placing students in rural communities where housing is sparce. The Florida AHEC has created a partnership where the academic institution pays student rent, and Florida AHEC houses students for their rotation, including covering the cost of cleaning and supplies for the housing unit. Limited space is available due to limited resources, however, students are able to stay in the community, offering valuable exposure to social determinants of health of the population in those communities. Whereas in **Alaska**, the AHEC receives funding from the Department of Labor and the State of Alaska for vocational training opportunities. AHEC uses these resources to support AHEC Scholars travel to remote communities, which is a barrier in this geographically challenging state.

Challenge: Incentives for Preceptors/Preceptor Development

The AHECs interviewed do not report offering financial stipends for preceptors, however, some provide incentives in the form of free continuing education or, in the case of AHEC offices at an academic institution, access to the research library, or titles. For example, the **North Carolina AHEC** has a robust online preceptor development training series, along with statewide conferences and workshops. In addition, with financial support from the state, the North Carolina AHEC issues requests for proposal for Clinical Site Grants to help develop clinical sites to facilitate educational efforts of students in North Carolina. The development of these sites targets rural and underserved communities, at-risk populations, primary care, workforce shortage areas, long-term care, public school settings, and clinical sites for nursing education graduate programs. Priorities of the North Carolina Clinical Site Grant program are to: expose the greatest number of students at all levels of education; expand clinical site training models; utilize and develop well-trained preceptors who practice in these new sites; and develop these sites so that they can become self-supporting in three years or less.

In **New York**, the AHEC Center in Staten Island builds opportunities for students by creating and enhancing relationships outside of clinical settings with a focus on community-based sites that address the social determinants of health. In addition, they work with preceptors from hospital systems in Staten Island and Manhattan.

Challenge: Placement Systems

Many AHECs (including New Hampshire) collect data using excel spreadsheets. For statewide reporting, AHEC offices manually compile the data from each office-maintained spreadsheet. In addition, community-based placements are established through relationships, and information collected on each student varies by site. However, the **West Virginia** AHEC uses a statewide computer-based system "Tracker", a customized tool used to facilitate community-based student placements, data collection and reporting on rural outreach activities such as community service, continuing education, interprofessional activities, and K-12 outreach among others.

AHEC evaluators have a range of custom tools that simplify data collection, review, verification, and analysis. Additionally, Tracker provides tools to collate data and generate HRSA data tables for the annual progress report. This time- saving feature frees grant administrators to focus on content and accuracy instead of manually collating data from general reports or data visualization tools.

Tracker is available to all colleges and universities in West Virginia and provides tools for scheduling rural and community-based housing for students who, as part of their curriculum, travel away from their home campuses to learn and serve throughout West Virginia. In addition, universities from surrounding states may also request access to housing via Tracker. Tracker's tools include interfaces to request, approve/deny, verify, and initiate billing for housing. These tools serve campus users, housing managers, financial services personnel and grant evaluators who manage a West Virginia Higher Education Policy Commission (HEPC) grant that partially funds rural housing.

Serving West Virginia University, Tracker collects data about students' rural and community-based rotations for health professions programs at the WVU Robert C. Byrd Health Sciences Center. This data allows the Institute to report outreach by WVU students throughout the state. This de-identified data is analyzed and reported to the West Virginia Higher Education Policy Commission yearly.

Tracker is a scheduling and data collection system maintained by the WVU Institute for Community and Rural Health (ICRH). Tailored to each type of user, Tracker provides custom tools targeted to specific user needs and can be adapted with changing program, research and reporting requests. With 24 years in operation, Tracker contains years of data covering a range of outreach and educational activities crisscrossing the state of West Virginia.

In addition to data collection and reporting duties, Tracker is also a research tool with an approved IRB. The repository for rotation and student evaluation responses is unique in consideration of the 20-year timespan covered. Tracker was developed for West Virginia use, however, the developers have met with interested AHEC offices to discuss offering the system to other AHEC networks to track AHEC-related activities. The anticipated cost to use Tracker (when it is available to other AHECs) for AHEC programs will begins at $10,000 per year/per AHEC.

In **Utah**, the Utah legislature provided funds to the **Utah AHEC and Utah Medical Education Council (UMEC)** to focused on workforce supply and demand, with a targeted approach on how to improve estimated need for the healthcare workforce in the state of Utah in a primary care, team-based care delivery setting. This effort came together out of requests from state legislators and other policy makers to receive more detailed information about healthcare workforce needs when making decisions about how to allocate government funding for these programs. Discussions about sufficient supply of workforce in healthcare have long centered around the supply of a single profession to 100,000 population ratios (federal health professional shortage designations as well as many other programs for distributing government resources are based on these ratios). However, the UMEC and AHEC identified the limitations of this approach and focused on how to include: how healthy a given population is, or how efficient the healthcare delivery system is in determining whether or not supply is sufficient to meet population need. Especially in context of team-based care delivery.

This initial work of the UMEC/AHEC team resulted in identifying a way to go beyond the metric of provider to population ratios by calculating an estimate of FTEs needed to deliver health care across the state based on the needs of the population in comparison to the number of FTEs in the current healthcare workforce supply. The team focused on: the **prevalence** of Chronic Diseases and **incidence** of Acute Conditions in the population; evidence-based **services** for care of common Chronic and Acute Conditions and for Prevention; how much **time** is needed to deliver each of these services; and which **medical provider** should deliver each service to optimize cost, quality, and suitability to license/profession in a team context. The focus of the work is around: Provider Supply (number of providers/population) and Provider Requirements (the number of providers required to ensure sufficient "flow" of healthcare services to meet the needs of the population).

With the foundation of that work, the Utah AHEC and UMEC were strategically positioned to respond to a Request for Proposals (RFP) by IBM to use system's approach and data to identify a way to go beyond the metric of provider to population ratios by calculating an estimate of full time equivalent (FTE)s needed to deliver health care across the state based on the needs of the population in comparison to the number of FTEs in the current healthcare workforce supply. It created a functional modeling tool prototype designed to provide a source agnostic modeling framework to feed data into. Data includes:

> **Population**—Estimated counts categorized by age, gender, geography and social determinant of health score.
>
> **Healthcare needs**—prevalence in population categorized by chronic condition, acute incident, and preventive services. Preventive prevalence is determined by the population size in different ages and genders.
>
> **Encounter details**—categorized by encounter type, category and services delivered. Service details- categorized by service type, assigned time values and professional suitability to task (aligns with need-based analytical framework requirements for productivity data).
>
> **Provider supply**—categorized by age, gender, geography and wage.

The programming work done by IBM advances the need-based analytical framework by providing a way to optimize the estimate through the use of linear and quadratic programming equations designed to find the optimal number of FTEs required in terms of constraints set on what services are required to be delivered in the population, which providers are

suited to the task of delivering the service, cost of different providers and the number of providers currently available in a given geography and year.

Outputs of the model can be filtered by population age, gender and geographic location. Outputs can also be projected forward to any given year for which there are population statistics. Utah's current population projections go out to the year 2060.[10] Estimated cost of the work provided by IBM through the grant was ~$500,000.

Challenge: Housing

Since AHECs across the country focus on placing students in rural and underserved locations, student housing was reported to be an important part of students receiving experiences in rural or underserved communities. Some rural communities are too far from academic institutions that students can only spend time in those communities if they have housing as they are too far to commute to and from. However, some AHECs interviewed have been able to identify funding to cover the cost of the housing. For example: in West Virginia, the WV AHEC works with a Higher Education Policy Commission (HEPC) on grant that partially funds rural housing. And, in **Florida**, the Florida AHEC partners with another academic institution to cover the cost/ expenses for a housing unit in a rural community. The Florida AHEC ensures the housing unit is cleaned and has supplies for the students while the other academic institution covers the cost of the rent. Together, the AHEC students and the students from the Academic institution share the house.

Challenge: Competition

Every AHEC interviewed referred to 'competition' for clinical placement sites is an ongoing challenge. In addition, every AHEC also reported that building personal relationships with the sites is critical to the success of obtaining placement sites. Although it was mentioned that due to turnover at sites, and sites are becoming part of larger health systems – the competition continues to be a growing concern. AHECs report that they offer non-financial incentives, yet they recognize that many health systems opt for the financial payments that are offered by other organizations/academic institutions. Some sites recognize the recruitment potential in the rural and underserved communities – but not all.

Challenge: Funding

Many AHECs interviewed do not pay preceptors. However, funding to cover student travel, housing, meals is helpful to the success of the program. Since the federal AHEC resources are limited, most AHECs across the country have some type of external funding from their state legislature or other state mechanism (tax structure) to cover expenses for students' transportation, housing, meals so the students can participate in rotations in rural or underserved areas. For example, the **Missouri** AHEC has created a system where AHEC placements would be fulfilled without payment, as it was noted that keeping the expectations consistent across the state is an important aspect of the system, maintaining the working relationships and expectations is key to their success.

Recommendations by AHECs interviewed

- If funding weren't an issue, many AHECs reported they would like to see a centralized system for all placements and tracking students, all in one system.
- Relationships are the key to success in placing students. Any system created must be built around trusting relationships.
- System focused on tax incentives for preceptor like the Georgia AHEC established would be useful in sustaining a placement program.
- Continue to build a system that is neutral ("like Switzerland") trusted by all stakeholders and continues to build on those trusted relationships (which is "what we do as AHEC").
- Explore workforce data collection efforts that support workforce development strategies (like Utah).
- Identify housing for students, either through a shared agreement with another academic institution or alone. Housing is a huge barrier to student placements in underserved area.

V. Findings from Clinical Site and Academic institution interviews

The following themes emerged from the semi-structured interviews conducted with clinical sites, academic institutions, and preceptors from NH. We requested interviews with schools who have

10 https://umec.utah.gov/team/

online health professions programs that attempt to place students in NH. They did not consent to be interviewed.

Relationship Building

Across the interviews with academic institutions, placement sites and preceptors, one of the most recurring themes was the importance of relationships. Personal and professional networks and connections are regularly leveraged to connect students to experiential learning opportunities. Some of the strongest processes exist for programs that have long-standing relationships with their placement sites, which has the collateral effect of making it difficult for newer programs to establish connections and set up recurring opportunities for their students.

Alumni are key to the pipeline of placements, with programs stating that they leverage the alumni networks to seek willing preceptors, and alumni stating that they feel a duty to "pay it forward" by providing real-world experience to the next generation of providers. Several respondents indicated a preference to wait two to three years after an alum graduates before making an ask for precepting, in order to give those providers the opportunity to establish their practice. Some nursing sites indicated that they are willing to use newer nurses as preceptors if they show early signs of interest and competency for the precepting process.

> Personal and professional networks and connections are regularly leveraged to connect students to experiential learning opportunities.

In many cases, sites indicated that they were quicker to accept placements of students who were already their employees, which reinforces a state-wide interest in "Grow Your Own" models that acknowledge the benefit of hiring and developing local residents who are more likely to stay in the area, affording the state to benefit from the effort put forth to develop these professionals.

While many interviews shone a light on the vital role that personal and professional relationships play in successful placements, they also revealed the fragility of a system that may be reliant on the relationships between individuals, rather than institutions. Several interview participants expressed concern that their current processes are working well but are the result of personal commitment of specific individuals who are carrying out the processes, or the personal relationships between various players in the system. The worry in these situations is that if those critical participants in the process were to no longer be available, the processes could degrade quickly, even when well codified at the schools and sites.

Site Recruitment

Interview participants acknowledged that there is a national shortage of clinical sites available for student placement. Academic institutions have a powerful desire to broaden their network of sites, especially in ways that provide students the opportunity to work with underserved and diverse populations.

Within the theme of Site Recruitment, discussions of capacity were frequent. Sites spoke to the need to have adequate physical space for students while they were on site, an issue that became even more challenging during the COVID-19 pandemic in 2020 when physical distancing was a critical transmission mitigation strategy. Interestingly, some sites viewed the move to telehealth as a unique and important opportunity for students to explore, while others found the move to telehealth appointments limited students' ability to participate in care processes. The issue of personnel capacity was also frequently mentioned, and sites work to ensure that they had adequate staffing to accommodate the incoming requests for placement, which were sometimes duplicated by both programs and students reaching out concurrently with their requests.

Both programs and sites also spoke to the lack of resources on both sides of the placement process, and a frustration with documentation redundancies, poorly aligned deadlines, and the disruption that staff turnover creates. The more successful partnerships typically cited the importance of a "gatekeeper" at the placement site who was familiar with the onboarding processes and comfortable with the administrative processes that need to be completed prior to a student arriving at the site. When skilled gatekeepers are in place, even the most burdensome processes move along smoothly. When multiple individuals are responsible for coordinating unique placements, the administrative burden is more significant, and sites are less likely to connect with new programs or host

multiple students at the same time. Even systems with central coordinators have challenges in obtaining timely decision-making from the departments they are working with to coordinate placements.

Discussion with both sites and preceptors also frequently touched on the topic of provider productivity. A majority of respondents expressed concern that, especially for providers who are compensated based on Relative Value Units (RVUs), adding the duties of precepting can decrease the productivity of the provider and possibly have negative financial impacts on both the provider and the site. Conversely, some sites have identified that the addition of one or even multiple students can actually increase practice productivity, even when carving out specific time for preceptors and students to review their shared cases and have didactic conversations.

Site Priority Setting

Sites were asked to share their mechanisms for prioritizing the students/programs that they accept for clinical placements. Generally speaking, prioritization seems to center around those variables that increase the likelihood that the hosted students pursue their careers at the placement site (preferred) or at least within the region in which the placement site is located. It is clear that sites view the clinical placement process as a significant recruitment tool, using time with students as an opportunity for both parties to contemplate a longer-term relationship. To that end, priority is often given to students who are already employed by the placement site, those who grew up in the area and/or are currently living locally.

> It is clear that sites view the clinical placement process as a significant recruiting tool...

Sites also expressed an interest in prioritizing placements from programs that have reputations as high-quality academic programs because they perceive that the students from these programs will begin placements with strong backgrounds and skills. Several sites also expressed an interest in prioritizing students of professions for which their organization experiences high vacancy or turnover rates. Interviewers also noted that there was a difference between urban and rural sites, with urban sites more frequently indicating a prioritization scheme, and rural sites being more open to taking as many students from as many programs as they can accommodate. This may be indicative of the increased challenges that rural settings face in terms of recruiting and retaining qualified healthcare workers.

Recruitment/NH Workforce

Both sites and programs recognized that the purpose of clinical placements was two-fold. First, clinical placements provide students with experiential learning opportunities to strengthen their classroom learning. Secondarily, though, clinical placements are a critical reinforcement of the recruitment and retention pipeline for the organizations that serve as placement sites. Students are viewed as potential future employees, with several sites and preceptors referring to the placement period as a "trying on" of the relationship or "interview for the interview" during which the organization contemplates whether they want that person as an employee, and the student thinks about what it would be like to work at the site permanently.

There is also a strong interest in keeping NH students placed within the state. Several programs shared those students who were placed out of state frequently sought employment in the state where they were placed, creating a state export of skill and knowledge. The reverse is also true – students placed in NH often stay in NH. This was confirmed by both NH schools and schools from neighboring states who place their students in NH.

Preceptor Burnout

Interviews with sites and preceptors explored the topic of preceptor burnout. Across the interviews, this was either a non-issue, or a significant issue ... moderate concerns were rarely expressed. For those sites sharing that burnout was a non-issue, they frequently named strategies like having a deep bench of preceptors and being thoughtful about the frequency and duration of precepting periods as critical to preceptors being energized, rather than drained, by the experience. They also noted that strong connections to program faculty and clear expectations regarding deliverables for the placement period are important supports.

In practice sites where preceptor burnout is seen as a significant issue, things like productivity expectations, acuity and complexity of patients/clients, and less experienced students and preceptors

were contributing factors. At Behavioral Health sites, secondary stress for the providers was also cited as a cause of preceptor burnout. Participants explained that productivity requirements rarely allow providers with the time necessary to process the client stories they have heard and attend to their own neurophysiology before moving on to the next appointment. Adding student precepting time to this already compressed and stressful day can sometimes be the breaking point for these providers.

> ...strong connections to program faculty and clear expectations regarding deliverables for the placement period are important supports...

In several interviews of rural providers, participants expressed that the providers were experiencing burnout for other reasons and found that well-coordinated student placements provided an important reprieve from the usual stressors of the day, giving providers the opportunity to shift focus and enjoy teaching time with students.

Administration

Many interview participants expressed a desire to streamline processes, and specific suggestions will be explored in the Recommendations section of this report. Discussion about administrative burden included mention that the negotiation over contracts and affiliation agreements took too long, particularly if they needed to be reviewed and approved by multiple layers of the program and placement organizations. There are redundancies, too, in the documents that students need to provide to both schools and clinical sites to prove that they are safe to participate (health and immunization information, criminal background check results, etc.) and demographic information necessary to complete onboarding processes. These documents take time to create and, in some cases, come with a financial cost for the sites and students. Participants expressed a desire to find more efficient ways of reassuring all parties that the placements met accreditation and certification requirements for credentialing and safety.

Several academic institutions and sites shared that having a centralized coordinator on each end of the relationship made the processes of onboarding and evaluating student placements easier. This benefit is limited, though, by how responsive faculty, students and preceptors are to requests for information. If the participants in the process are hard to track down or delinquent in providing necessary information, it can stall or draw out the processes to the point that it compromises the long-term viability of the placement relationship.

Several participants also cited the way expectations are shared as factors in the success of clinical placements. Some schools have clear structured placements while other programs are more nebulous in the description of expectations for the placement. Different schools, and even different programs within the same school, have different requirements and guidelines, which can limit the opportunity for interprofessional placements to occur.

Centralized Clinical Placement (CCP)

Discussions included consideration of centralized clinical placement programs that coordinate placements with schools and sites for nursing programs and include online clinical orientation models. Schools and placement sites shoulder a cost for use of these software models, and not all sites are participants in these programs. Those who use the programs say that "it works until it doesn't work." These sites noted that the use of software removes the relationships that, as noted above, are essential to successful long-term placement relationships. Sites also noted that schools still call before the deadlines set by the centralized clinical placement system, creating redundant communication pathways and undermining the efficiencies realized by this tool. Some health care institutions are using a different system than CCP which duplicates efforts for other parties who now need to toggle between two systems.

COVID Response

All placement programs and placement sites recognized that there were significant changes to the community placement experience in 2020 as a result of the COVID-19 pandemic. Staff furloughs and decreased appointment hours at placement sites decreased capacity to host students, as did policies aimed at minimizing the presence of non-employees for the purposes of reducing the risk of transmission. Physical distancing practices reduced

the number of people who could be physically present within the practices, and particularly at the start of the pandemic when the state faced shortages in personal protective equipment (PPE), sites were unable to provide PPE for students and students were challenged to provide their own. These challenges strained relationships between organizations in some cases.

Conversely, there was also a recognition across programs and sites that the pandemic afforded students some incredibly unique learning opportunities. Telehealth services were expanded under the Governor's Emergency Orders, providing students the opportunity to connect with patients and their preceptors remotely when it wasn't possible to be present in person. Curricula were adapted to include topics specific to the pandemic, including increased attention on the transmission of respiratory illnesses and communication strategies to allay patient fears and encourage ongoing engagement with their healthcare providers.

Payment for Preceptors

Payment to preceptors was another topic on which there were strong feelings across the board—participants were either largely in favor, or not at all in favor, of financial compensation for precepting, with limited neutral responses. For those opposed to the practice, their concerns were that financial motivation for taking students could potentially result in a poorer learning experience for the students. Those in favor of preceptor payments spoke to the importance of acknowledging their contribution to the workforce pipeline and fairly compensating them for their effort. This was especially true for preceptors whose employment agreements established their pay based on productivity standards or RVUs billed, and who decreased their patient volumes to accommodate student rotations.

Payment to perceptors...there were strong feelings across the board—participants were either largely in favor, or not at all in favor.

There was discussion regarding whether the preceptor or the site should be compensated for the placements, with many site administrators acknowledging that there was a cost to hosting students in terms of staff time spent on administrative coordination of the placements and increased staffing in order to accommodate teaching time. For example, hospitals that hosted nursing students shared that it was common to decrease the patient load for preceptors in order to afford more teaching time, so included the number of students in the acuity matrix used to determine staffing needs each day.

Preceptors also saw value in some of the other benefits offered by sending programs. Access to low- or no-cost CME and the prestige of being named as adjunct faculty were benefits accessible and appreciated by preceptors in both rural and urban locations. Benefits like access to fitness centers and libraries decreased in appeal as the distance from the preceptor to the school increased.

Learners

In terms of trends related to the learner experience, it is important to note that students have not yet been participants in the data collection for this project. The following findings come from the response provided by schools, sites, and preceptors, and reflect their perceptions of the student/learner experience.

Several participants made a point of mentioning that the level of preparedness – both clinically and in terms of student attention to administrative details – was a variable worth considering when accepting students at their sites. Inexperienced or difficult learners make the preceptor's job harder and can affect their willingness to accept future students. This was also mentioned as a factor in preceptor burnout. Participants also anecdotally noted a change in characteristics of students over time that contributes to the challenge of precepting. These include students who may be less receptive to feedback, have firmer requests for scheduling flexibility and in some cases lack the professionalism and written/verbal skills necessary to successfully participate in patient care. One participant noted that, "Sometimes students don't want the placements I have."

This underscores a misalignment between the available opportunities and students' areas of focus.

Functionally, participants also spoke of the challenges that logistical needs such as housing and transportation pose to successful placements.

Many areas of the state were already facing a housing shortage before the COVID-19 pandemic exacerbated the situation. Students seeking placements in more rural corners of the state are hard pressed to find a place to live if they aren't already a local resident, and some commutes are unsustainable for longitudinal placements, particularly if the students lack reliable transportation and the site locations are not in communities with access to public transit.

Equity

While not specifically queried in the semi-structured interview protocols, the issue of equity was a recurring theme during interviews with both programs and placement sites. In the interviews, AHEC staff heard issues related to how many students from under-resourced environments are not even applying to school. Many can't afford the tuition of a full-time program and cannot dedicate time to learning while they continue to work to support their families, so don't even begin the learning process. For others, unpaid internships and/or supervision requirements are cost-prohibitive and cause them to abandon plans to enter the healthcare workforce. Participants also expressed concern that people in recovery may face stigma and discrimination, preventing them from entering the workforce on more than a volunteer, part-time basis.

> Many students from under-resourced environments are not even applying to school.

Participants discussed the potential of interventions like stipends for internships, funding to support tuition and living expenses and flexible scheduling that accommodates adult learnings (i.e., classes and placement hours on evenings, nights, and weekends) as possible strategies to overcome these inequities.

Preceptor Expectations

Themes related to preceptor expectations were also explored with interview participants. Participants noted that it was sometimes difficult to locate the expectations, particularly if they were embedded in contracts seen by administrative staff but not providers, and that they varied from program to program in terms of specificity and clarity.

Participants also discussed preceptor confidence and noted that many people do not feel ready to precept or believe that they will not be a good teacher, so never offer themselves up as this resource. At sites where some form of education on the topic of precepting is offered, this is less of a concern, but even those sites noted that there are a number of precepting models and providers have varying levels of confidence with them. Some expressed concern regarding their ability to provide feedback in meaningful ways to students, and to their ability to respond when students don't take that feedback well.

Some preceptors also set boundaries around what type of students they will accept. For example, some will not take a student on their first rotation. Others are willing to accept interprofessional students, or only take students from their alma mater. Generally speaking, however, there was a strong interest among interview participants to learn more about other models of precepting, and to have more preceptor development opportunities available to providers.

Preceptor Development

On the topic of preceptor development, there was wide variation in responses regarding the resources available to preceptors. Some preceptors were unaware of any opportunities to develop the skill set or perceive that it was necessary. Some sites offered CE, and several even required that preceptors complete educational models on the activity of precepting before they would be given a student to precept. Participants also noted the availability of university courses, professional conferences, and the Southern NH AHEC Preceptor Development Modules as resources available for preceptors to improve their skills.

Preceptors spoke frequently of the need for balance when asked about preceptor development activities. Specifically, they noted there is a need to balance the time needed against the educational need for the learning. Participants shared that the assessment of return on investment for preceptor development be explored.

Sites and programs spoke to the importance of high-quality preceptors in the learning process. There was concern that in some cases, particularly if financial incentives were offered, the preceptors were little more than warm bodies who left much of the learning to student self-discovery or relied heavily on the participation of school faculty. Schools also noted that it was difficult to give critical feedback to

preceptors because they are an essential part of the process and there are fears that critique may lead preceptors to refuse future assignments.

Internal System Capacity

A common internal system capacity highlighted by interview participants was the shortage of medical assistants. Sites and academic institutions identified that there were limited resources to address this shortage. Many interviewed specifically identified the need for more time, more staff, and more funding to address the shortage in a systematic way rather than the band aid approaches currently identified. Shortages of medical assistants decreases the flow and patient volume overall. Fewer patients are able to be seen in a specific time because there are fewer MAs to complete the initial screening. This decreases the number of patient visits to the provider and other interprofessional team.

Recommendations made included having the administration at sites develop internal processes to streamline the processes of coordinating MA placements. Many of those interviewed suggested that academic institutions support sites by offering incentives such as continuing education credit, access to the library, and use of recreational facilities like the pool.

Policy Requirements

Those interviewed noted that policy requirements from accreditations, state licensure boards, and CMS regulations often affect community placements. Sites, programs, and preceptors identified challenges of accreditation in several ways including: mandating the academic institution specifically find the placement; placing restrictions on the credentials of those acceptable to precept; limiting the ability of student to learn inter-professionally; and creating barriers to innovation.

State licensing boards were identified in restricting those who can precept by their credentialing. For example, the NH Board of Nursing requires that a nurse have a Master of Nursing in order to precept. They do not consider that a nurse with a Bachelor of Nursing degree and 10 years' experience could precept as well as MSN with less years of clinical experience. In the field of behavioral health, there are differences in billing regulations for Licensed Independent Clinical Social Workers (LICSW) and Licensed Clinical Mental Health Counselors (LCMHC) and Licensed Marriage and Family Therapists (LMFT). Exploration with the Centers for Medicare and Medicaid Services about mental health parity may help address this inequity. Interprofessional

Sites, academic programs, and preceptors had varied opinions and experiences on Interprofessional experiences (IPE). Some academic institutions facilitate IPE with students on campus. Some had previously participated in the AHEC SBIRT IPE program across 5 different schools and appreciated the cross school educational opportunity to build IPE skills. Overall, there was interest in fostering more IPE to help students and practicing clinicians develop more of an interprofessional identity; not just thinking about their own discipline. All acknowledged the challenges of timing and scheduling. Space was also mentioned by sites as a challenge for bringing together interprofessional learners. Future activity in this area comes up when we talk about recommendations.

Collaborative Planning

There was a strong interest from academic institutions, sites, and preceptors alike in addressing placement issues collaboratively. Participants expressed a desire to coordinate placements opportunities across programs at statewide level, perhaps starting by conducting needs assessments.

There were concerns noted about competition in the current system. "The way the system is set up it sets people against each other" and "You play by the rules of the system in which you live." They questioned how they could collaborate AND compete? Adding to the competition is the increased number of schools and online programs. Those interviewed identified the need to add capacity to the entire system or it is a zero-sum game. One student gets a placement another does not. "NH is a small state, can we come together & make it work?"

One behavioral health site recommended piloting a model of applied academics for an accelerated BS to MS degree where an academic institution and a workplace collaborate to place students in human services agencies while they are in school. Students receive pay for doing their job and use the work experience to inform their schoolwork. "Students get experience, agencies get a workforce, and students get paid…and academic institutions have a direct feed to their institution". Students could work in one setting or rotate through sites over the course of the program.

Table 2: Summary of CPP Recommendations

Individual
Offer Training to Preceptors
Recognize preceptors for the work they do
Prepare students to go to community
Community
Conduct Outreach & Awareness
Streamline Processes
Foster Interprofessional Education (IPE)
Consider Equity
Explore Funding Opportunities
Promote Professional Development
Address Scheduling
Consider innovative collaborative partnerships with academia & community-based sites
System
Recognize & Promote Precepting
Expand Pipeline Programs
Develop Career Pathways
Promote Collaboration & Planning
Explore Financing
Share Business Models for Precepting
Foster NH Workforce
Pursue Policy Change
Expand Data Collection

Recommendations from the academic institutions, sites and preceptors interviewed

Interviewees shared recommendations for enhancing the community placement system in NH. Recommendations are organized into the themes of action at the individual, institution/site or community level and at the system level. Table 2 outlines a summary of CPP recommendations. The narrative provides comments from interviewees that elaborate on the theme.

Individual

Offer Training to Preceptors

Recommendations within this theme included providing formal training to all preceptors that would include teaching methodology and skills. This could include exploring preceptor competencies. Participants asked, "How do we test the experience of people who act as a preceptor?" There was concern that we "can't just want a warm body". Some academic institutions and sites provide preceptor training while others do not. There are opportunities to enhance the training of preceptors.

Recognize preceptors for the work they do

Individual preceptors deserve recognition for educating students. Recognition can be a gift card or a bar of chocolate. Recognizing preceptors is a key role in education. This recognition can be from faculty, site representatives or students.

Prepare students to go to community

There were several suggestions to better prepare individual students for community rotations. Interviewees recommended that we talk to students about past, present, and future orientation, to reinforce the understanding that school helps with their future, not just the present with a job with benefits. This relates to students being hired by their internship site as an employee, resulting in the student dropping out of school and not completing their education.

Schools were encouraged to prepare students to be responsible for their own learning before going out to sites. Faculty can model language to help students, for example, "Be willing to say, "I don't know. We will do A, B & C to find out." Students need to be aware of their own boundaries and know what they don't' know. We want to avoid the Dunning-Kruger Effect, where people with less ability overestimate their competence.

> Recognizing preceptors is a key role in education.

Schools were also encouraged to engage students in metacognition and reflection. We don't want to promote the industrial model of education and just placing students without regard for their learning. We want them to be able to give and take feedback.

There was significant support for paid internships for students. This is also mentioned under the Equity theme as well.

Community

Conduct Outreach & Awareness

Representatives of academic institutions and sites as well as preceptors spoke about the importance of increasing outreach and awareness of the need for precepting. Some comments related to broadening outreach efforts to let sites know what placement opportunities exist and to give students diverse experiences. Efforts should be made to share the success stories of students in practice; universities and colleges should activate alumni and be aggressive about encouraging precepting. There is a significant need to encourage administration at sites to promote preceptorship.

More should be done to encourage organizations to have a philosophy of being a teaching institution and support the culture of learning. At the preceptor level and/or at the organizational level, we can highlight the benefits of precepting to organizations and preceptors to encourage staff to take students.

Other suggestions within this theme include fostering more community engaged learning and peer mentorship, asking sites to be clear on the opportunity they are offering to students, and working with employers to find out what they want or need in order to get students in the door.

Some suggestions were more specific, such as doing outreach and expanding sites willing to take a variety of behavioral health students by providing the appropriate preceptor from the academic institution to support onsite preceptors. This would allow us to explore opportunities to place other types of learners in integrated behavioral health sites. For example, Marriage & Family Counseling students could see families and couples to augment services. This would help place students at sites that do not have a preceptor with the specific credentials required by accreditors. Another example was to expand awareness of the possibilities of more Occupational Therapy students in primary care sites to show what students can do for wellness and prevention, not just an identified need.

Streamline Processes

Many interviewees echoed this theme. There is a significant need to streamline administrative processes within organizations and statewide, being cognizant of risk management issues. So many sites need different pieces of paperwork that it would be helpful to identify what is the same across agencies and schools and what might be outliers. It takes up so much time for all parties to get forms signed, submitted and the follow-up can be overwhelming.

Another suggestion was for hospitals to consider offering orientation to students as a group so the students learn how the hospital runs. Health care disciplines do their own orientation for preceptors and it can be choppy. Someone shared that it would be nice for students to attend a board meeting or an ethics committee to see other structures within the setting. Work can also address streamlining guidance about who can enter into the electronic medical record for Medicare. One interviewee shared that "an NP student can enter data but the preceptor has to redo it". Streamlining this process would be less of a barrier for preceptors. This relates to some of the policy related recommendations below.

Foster Interprofessional Education (IPE)

There is interest in promoting interprofessional interactions at the site and academic levels. Creating opportunities for students and practicing clinicians to engage in IPE is important. It was noted that in the past SNHAHEC held multidisciplinary case discussion forums to promote IPE. Offering more ECHOs is another opportunity for interprofessional learning. Many interviewees mentioned that we work in silos and recommended that we explore how to do more teamwork and model for students. We should build understanding of roles across discipline, for example, "what does OT, PT, nutrition do and how can behavioral health help"? We can explore how to strategize on a collective level about how to use sites in a broader way and engage different types of students.

It was recommended that we build more of an interprofessional identity at the academic institution level as some disciplines are perceived to be less open to working with others. Some sites are interested in driving interdisciplinary learning and others requested that we work across schools to do IPE, as AHEC did with the Screening, Brief Intervention, and Referral to Treatment (SBIRT) project a few years ago. The SBIRT project was helpful in promoting IPE. At the time we used Moodle but could also now use ZOOM. AHEC Scholars is another opportunity for IPE. "We don't do enough of this and we know it."

Consider Equity

There were a lot of questions about how we can make community placements more equitable so that people can get what they need. There is also significant concern about how many students from under-resourced environments are not even applying to school. These individuals are not able to afford to enter a full-time program as they need to work to support their families and doing an unpaid internship is not possible. This may result in an individual who does not consider a career in health care. There are sometimes grants from schools that help with tuition or other support. Recommendations in this arena focus on how to restructure programs from full to part time and how to provide tuition and living expense support, as well as addressing the impact of unpaid internships which is a barrier.

Creating opportunities for students and practicing clinicians to engage in interprofessional education is important.

It was suggested that NH develop more opportunities to access diverse populations to allow students to see all aspects of a person's life and boundaries. There was specific mention of addressing issues related to persons in recovery.

Explore Funding Opportunities

Discussions about funding fell into the community and the statewide overarching theme. In this section recommendations relate more to action steps that can happen at the site or academic institution. It was acknowledged that some schools bring in grants that help support sites but this is not a long term solution. Providing stipends to preceptors so they can take time out of seeing patients to attend training was raised.

Another suggestion was to reallocate some student tuition to clinical sites for education done by preceptors. Students could also be asked to pay for preceptors. One participant stated "I think some students would be willing to pay for preceptors. If they get all their placements organized themselves they could waive the fee".

At the site level, there were suggestions of revenue sharing and offering bonuses for students who become employees. "If the student is bringing in funds to the entity, could some of the revenue dollars be shared with the preceptor? The student is productive on behalf of the preceptor." Another recommendation was to "explore offering a conversion bonus for students who stay on as an employee and also for the preceptor/supervisor if their student becomes an employee."

Promote Professional Development

Recommendations in this area include offering webinars or conversations among preceptors and help them be champions for students and talking about what is working and not working. PEER ECHO, Provider Education to Enhance Rotations ECHO is a current opportunity for preceptor development. It was also stated by several sites that continuing education and preceptor development is a balance between staying current by taking training and seeing the patients.

Address Scheduling

Scheduling was seen by some individuals as a challenge. One interviewee recommended that schools flex their calendars and allow students to be placed at different times of the year, not just during the typical semester. This may provide more open slots for students. If we can be flexible with placement schedules, sites could also be more flexible as sometimes calendars for students do not match up with needs of sites. Schools may be in session during certain parts of the year but health care operates year round. It was also suggested that we make space in the schedule for wellness. If we add this time to schedules, it could decrease staff turnover in mental health and avoid burnout.

Consider innovative collaborative partnerships with academia and community-based sites

Recommendations include exploring programmatic models, such as the applied academics workforce partnership described above to move people on career pathways and help them leverage their work experience. Medical and behavioral health academic programs can also assess the feasibility of adapting their programs to allow part time enrollment allowing students to work as they attend school, broadening the pool of potential applicants. Programmatic adaptations may assist in addressing equity issues mentioned above as more students may see the possibilities of becoming a health or behavioral health clinician if they get more financial support.

System

Recognize & Promote Precepting

Aligned with the desire for more outreach and awareness as mentioned above, there is interest in promoting and recognizing preceptors on a statewide basis. It was recommended that NH design a public system of recognition of the contribution of preceptors, for example holding a statewide recognition event where each school could nominate a program or supervisor for recognition or an award.

There was interest in creating a sales pitch about the benefits of taking students where we could share highlights of student projects and be explicit about the benefits of taking a student. Ask the question "What would it take for you to be interested in being a preceptor?" and raise awareness of placement opportunities across the state. One way to do this might be to design a visual graphic of what it means to be a preceptor. For example," if you think about the impact of one preceptor – how many students can they teach, where does that student go and who do they teach? It is exponential. How many people do they take care of?"

Another recommendation in this theme was to "encourage more support from state and national professional organizations. What is the carrot? What can be built into recertification that would encourage precepting?"

Expand Pipeline Programs

There was much discussion about planting the seed early and getting into the classroom to engage students earlier. Pipeline programs are important as they help students to think about variety of careers. In addition, enrichment programs that help students with study skills and career exploration should be expanded and include human service careers not just medical.

The Running Start Program was mentioned as a blessing and curse. This is a program where students earn college credit while in high school. It is a good opportunity for students, but there is a concern that it may need some attention. "Some students come in with more than half their credits, but they don't know anything. Are they really doing college level work?"

Develop Career Pathways

Related to the pipeline is the recommendation to build career pathways. One example is a pathway from LNA and MA to RN. There was strong interest in investing in medical assistants (MAs) in primary care as they are often poached to go to specialties. There is interest in building articulation agreements and flexible arrangements for pathways within the state.

One interview participant suggested an innovative pathway for a workforce development model. There was a proposal for a pilot program for Applied Academics where a Bachelor's degree led to Masters in Counseling. There are core courses and students are paid to work in human services agency. "Students were getting experience, agencies get a workforce, and students get paid." This pathway could be recommended for funding as a pilot program.

Promote Collaboration & Planning

There was much discussion about solving the community placement problem in a collaborative way. For example, encourage more talk about placements at the College & University Council. There is concern that the marketplace for clinical rotations is purely competitive. "Bucks or name wins." It was recommended that this project create a consortium, or collaborate, to work together to keep people in NH. Consider how to foster more collaboration between sites and universities, for example, "can schools provide more education and sites precept more students?"

We need to identify a strategy to balance the needs of schools with the needs of sites. The process should be fair and transparent, flexible, and use our resources in more innovative ways. There is a disconnect between expectations and needs of schools, students and sites. One participant shared "the 10-year mental health plan is a priority, but centers say they can't get students in".

One participant shared the following observation: "The nationwide primary care provider shortage is projected to be 52,000 by 2030, nine years from now. This was projected to be 40,000 a few years ago, but is larger at least in part due to the movement of primary care doctors (and PAs) into hospitalist and specialty practice, where incomes are higher. Rural areas will be more affected by this shortage than more urban areas. We need medical school scholarships which are forgiven when the physician practices in a rural/ underserved area, to reduce the migration of the providers to non-primary care carriers. And we need to expand the number of FP/IM residency positions and enable those trainees to rotate through FQHCs. This is a crisis that is much closer and will be much worse than policy makers and medical educators appear to recognize."

Explore Financing

Several recommendations were made to assist with the financing aspects of clinical and community placements. Alternative payment structures could be explored. We need to invest at a federal level. Medicine gets graduate medical education (GME) money, yet GME has not carved out money for nursing.

The feasibility of a statewide incentive was also suggested, including precepting hours as part of licensing or certification or some sort of tax break (it was acknowledged that we don't have income tax). "Two years ago we had a panel discussion about preceptor challenges w/Annie Kuster. Would the State consider giving preceptors tax credits at the state level for precepting?" It was also suggested that we lobby for tax benefit on a national basis for people to take students. It was recommended that we explore what could be done at a state level.

In the past, the state identified and distributed funding to support preceptor stipends. Can the state help to have their own incentives for behavioral health or small agencies to help with internships? It was also recommended that we explore student debt and its impact on workforce.

Share Business Models for Precepting

NH needs to invest up front in workforce and structure things that support clinicians. "It looks like billable hours go down, but they actually go up." We need models and blueprints to learn how to do this. It was recommended that we share more precepting models where provider productivity actually goes up when taking students and provide technical assistance as to how to put that into action. For example, there is research that shows that having two students with one preceptor is effective. Can we dispel misconception that it is a big drain on productivity? It was suggested we explore the MAYO Clinic as an example. It was recommended that we also explore the feasibility of creating an interprofessional integrated primary care site staffed by students and preceptors. This would provide ongoing interprofessional experience to preceptors and students and provide additional access to care for patients.

Foster NH Workforce

Keeping workers in NH was also a theme. "Critical problem in NH is brain drain. How do we make sure the next generation doesn't leave?" We need to invest in our own future and need to have state level commitment. There is interest in directing students to fields that will be expanding so they can fill jobs in NH. Hospitals can develop nursing and other career ladders that encourage precepting of students as a path to advancement. Pay incentives would also help nurses and other health care workers to stay within the state instead of going elsewhere. It was recommended that we address the need for workforce housing. This was mentioned in both rural and more urban areas of the state.

Pursue Policy Change

Accreditors are perceived to be the largest challenge schools face in being innovative. There is a need for approval from an accrediting body for programmatic changes related to placements. It was stated that accreditation changes for nurse practitioners will likely change preceptor requirements and increase hours needed for clinical placement. "This is likely 2-3 years out. How do we adapt in NH?" It was recommended that we convene a group of people together to suggest respective changes at the accreditation levels.

There is also interest in exploring Board of Nursing rules changes to loosen restrictions on who can be preceptor. They are in charge of patient safety. One interviewee stated, "a person with an MSN and no experience can't be worth more than BSN with 5+ years". It was also suggested that a requirement for precepting hours could be added as part of nursing re-licensure. Organizations might consider this more of a priority to allow precepting; the caution is that not all clinicians make good teachers.

> We could create a catalog or database of area human services, public health, or behavioral health agencies that were willing to take on interns....

Exploring parity across mental health fields is a policy recommendation tied to reimbursement. We could also look at financing policy for other disciplines. For example, Medicare and Medicaid do not let Occupational Therapy (OT) students perform a service, it has to be a preceptor. What kind of reimbursement changes and policy can be proposed?

Expand Data Collection

There was interest in having more data to support workforce and placements. It was suggested that we develop a State database of possible internships specific to pathways. It was recommended that we develop a statewide system of internship opportunities with the ability to search and find, for face-to-face and remote experiences. We could create a catalog or database of area human services, public health, or behavioral health agencies that were willing to take on interns so students don't have to cold call all the time.

It was recommended that we evaluate data to examine the productivity of a preceptor with and without a student. "Who has this data and is willing to share". "If we could track data of productivity of preceptor and student over time it would help us understand the impact of precepting." One site shared that the productivity doesn't change, the preceptor just stays later to finish up when with a student.

Next Steps

The AHEC team has identified some short term achievable next steps and is in the process of developing a workplan and budget proposal for a second year of this work. Activities include:

- Presentation of findings to key stakeholder groups including the Forward Fund Advisors and the Legislative Commission on the Interdisciplinary Primary Care Workforce.
- Brief overview of the use tax incentives employed by other states to fund preceptors.
- Review systems identified during interviews such as:
    - My Clinical Exchange
    - Castle Branch
    - Centralized Clinical Placements system (Massachusetts)
    - TRACKER (West Virginia)
- Student Survey:
    - Fine tune student survey protocol
    - Seek IRB
    - Administer survey
    - Hire consultant to analyze data
- Continue working with the Forward Fund advisors to prioritize recommendations in this report for future action.

Appreciation

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