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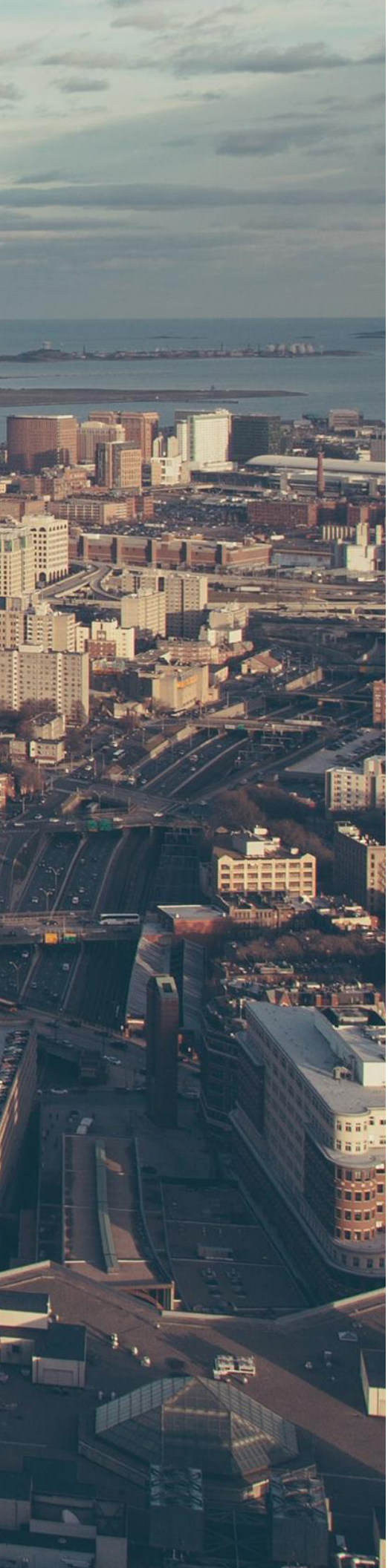

The Transformation of the West Virginia Recruitable Community Program

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Abstract

Attracting and retaining primary care providers is a significant issue for many rural communities. For more than 15 years, The West Virginia Recruitable Community Program (RCP) has worked to address a wide range of community development issues that impact rural West Virginia communities' attractiveness for rural health care providers and their families. The program began in the late 1990s as a partnership between the West Virginia University (WVU) School of Medicine's Community Medicine program, and the Community Design Team (CDT) program of the WVU Extension Service. The model was to meet with community leaders to determine their issues and then to recommend potential solutions through the CDT two-day planning charrette.

In late 2010, the state Department of Health and Human Resources took over operation of the program and continued it along a similar trajectory. The model had to change as the CDT, which had left the direct control of the Extension Service shortly after the partnership began, ceased doing planning charrettes. These changes resulted in a more "top down" approach for the RCP.

Recently, the RCP effort has expanded by adding more locally-based community-building activities to evaluations and reports prepared by external experts. The resulting program shows evidence of strengthening local capacity in an effort to sustain development initiatives.

Keywords

Health Care,
Community Development,
Engagement,
Planning

Introduction

West Virginia ranks poorly in health outcomes. Primarily rural, its challenging topography with mountains, valleys, and rivers has resisted population growth and economic improvement. For example, West Virginia is one of only three states that showed a net population loss from the 2010 Census to the 2016 population estimates (Census Bureau, 2017). The Mountain State also ranked 44th in its individual poverty rate and 47th in median household income, according to the 2015 American Community Survey (Census Bureau, 2015). Thus, it should come as no surprise that West Virginia has had shortages of health professionals.

In an effort to improve this situation, West Virginia created the Recruitable Community Program (RCP). Its 2015 brochure states that the program "offers assistance and support to communities seeking to preserve quality health care in rural areas of West Virginia" (WV DHHR, undated). The effort assesses and evaluates the livability of communities, generating suggestions and ideas that can be implemented to make places more amiable to health care professionals who consider locating there.

This CD Practice article describes the evolution of efforts to create community change that supports the recruitment of medical professionals. First, it describes the situation in the Mountain State, both generally and with respect to health care. It then describes the Recruitable Communities Program, its history and the recent changes to the program which have made it more community-focused and potentially more effective. The report closes with a discussion of the impact of these changes and the challenges that had to be overcome as the program changed.

Background

West Virginia has a history of poor health outcomes and a problematic health care system. The state consistently ranks low in health outcomes. Since 1990, the state has ranked between 40th and 50th in overall health outcomes, according to the United Health Foundation's American Health Care Rankings® (UHF, 2015). Its 2015 overall health care ranking was 47th – a drop of three positions from 2014. The state ranked 47th in health determinants. It was in the middle of all states for community and environment (25th) and policy (27th); however, it was near the bottom in behaviors (49th) and clinical care (49th). Most importantly, West Virginia ranked 50th (last) in overall health outcomes.

Meanwhile, health care availability is consistent with the American Health Care Rankings. Physician shortages in rural areas have troubled West Virginia for decades (Balleydier, 2009). Recent data from the U.S. Department of Health and Human Services shows this as well. In 2016, 52 of the state's 55 counties were designated as Medically Underserved Areas with an Index of Medical Underservice (IMU) of 62.0 or less (US DHHS, 2017a). The IMU is a weighted average of four variables: providers per 1,000 persons, infant mortality rate, poverty rate for the entire population, and share of population age 65 and over.

Likewise, current data show that 46 West Virginia counties have at least one area designated as a place with a health care shortage for primary care (Primary Care HPSA). These areas have fewer than one physician for every 3,500 people. Areas are also designated as an area with a primary care shortage if they have fewer than one physician for every 3,000 people and rank poorly on other health and socio-economic indicators (e.g., percentage of the population below 100% of the Federal Poverty Level, infant health, including infant mortality rate and low birth weight rate, and travel time to the nearest source of care outside of the HPSA designation) (US DHHS, 2017).

The reason for these shortfalls is not a lack of facilities. Unlike other states, West Virginia has not suffered the closure of rural hospitals. Data shows 62 hospital facilities in 42 counties. (WV DMAPS, undated.). This includes four Veterans Administration hospitals, three rehabilitation centers, and the state's acute care psychiatric facility. This leaves 54 regular care hospitals in state, corresponding to data from the Kaiser Family Foundation (2015), of which 20 were critical care facilities (Flex Monitoring Team, 2016). The state's small hospitals are key providers of health care in rural areas. They provide both inpatient and emergency services vital to the health and well-being of the isolated communities that they serve (Balleydier, 2009). They are also located in places where it is difficult to attract and retain health care professionals – rural areas often characterized by sparse populations, high poverty rates, homogenous populations of a single racial or ethnic group, and a lack of cultural amenities (Wheeler et al., 2013).

To help alleviate this situation, the Recruitable Community Program (RCP) was created in the late 1990s (Shannon, 2003; Melton, 2013). The idea was to help places improve their economic conditions and the quality of life they offer, making them more desirable locations for medical professionals. The program began as an effort of the (former) WVU Department of Family Medicine, in collaboration with other university units (such as the Extension Service) and state agencies (such as the Department of Health and Human Resources – DHHR). Changes at the WVU College of Medicine and state agencies led to oversight of the program being transferred to the Division of Rural Health and Recruitment within DHHR, which continued to work in collaboration with the WVU Extension Service and other agencies (Balleydier, 2009; Melton, 2013). The focus on making places more attractive to medical professionals, however, did not change.

Recruitable Community Program History

Over the course of its 18-year history the Recruitable Community Program has undergone several iterations and changes in coordination, structure, and program offerings (Table 1).

The original RCP model was used in seven communities between 1999 and 2002. One of the essential components of the program was the use of multidisciplinary community assistance teams drawn from WVU Extension and academic departments (Shannon, 2003). For example, two Extension programs integrated into the program model from the outset were the First Impressions program and the WVU Community Design Team (CDT). First Impressions draws from goals and processes of both traditional needs assessments (Watkins, Leigh, Platt, & Kaufman, 1998) and asset-based community economic development strategies (Kretzmann & McKnight, 1993; Mathie & Cunningham, 2003) to construct an inventory of a community's assets and challenges. Findings from these assessments noted the strength and weaknesses of community's appearance and aesthetics, considering how the town's appearance helps and hurts downtown revitalization, business retention and expansion, and professional recruitment. While the spotlight has been on outward appearances of physical infrastructure and public spaces, observations frequently stimulated broader discussion and a collaborative process that created stronger community development and an enhanced quality of life (Nix, Eades, & Frost, 2013).

Community development-related issues were examined in greater detail during the CDT visit. The teams consisted of 10 to 20 volunteers from a variety of disciplines including engineering, public administration, landscape architecture, historical preservation, and community economic development. In RCP communities, the Community Design Team added healthcare topics to the general examination of the community. The CDT also included a local RCP physician project director and personnel from health care disciplines such as family medicine and community medicine. And just as in a standard CDT, the community hosted team members, provided input, and participated in an intensive three-day design and planning charrette. Findings and recommendations were presented to the community at the end of the visit followed by a written report to community leaders.

Early successes of the original model, as reported by Shannon (2003), included the recruitment of 27 healthcare providers. Additionally, surveys of community recruitment board members indicated that community programing raised awareness of community development issues including appearance and leadership issues, and promoted community knowledge of and readiness for recruitment, personal leadership, and cooperative skills (Shannon, 2003).

In the mid-2000s both the Recruitable Communities Program and the Community Design Team effort underwent dramatic changes. As noted above, the RCP shifted from university control to state control as a result of funding and administrative changes. Grant money that had been used to start the effort were replaced by direct state expenditures. This led to greater state involvement in the management of the program. Eventually, supervision of the RCP moved from the West Virginia University College of Medicine to the state agency that deals with health and related issues – the West Virginia Department of Health and Human Resources.

Meanwhile, the Community Design Team had its own issues. Program administration for the CDT moved to the WVU Landscape Architecture Program (from the Extension Service) about the time the Recruitable Community Program visits started. For almost a decade, the CDT generally made two visits each year. The West Virginia DHHR, through the RCP efforts, became a primary funder of the CDT program as there was one visit focused on enhancing places to promote medical personnel recruitment each year between 1999 and 2007.

In 2007, things began to change. The combination of decreased demand for the traditional planning charrette, increased difficulty in getting non-university professionals to participate on visit teams, and changes in CDT leadership resulted in the program deemphasizing two-day visits. Only five visits occurred between 2008 and 2012, of which three occurred as part of the Recruitable Communities Program efforts. In 2012, the RCP announced that the DHHR would no longer fund Community Design Team visits. Lacking other funding sources, the CDT program was suspended and eventually discontinued.

Table 1

Recruitable Community Program Models and Outcomes

SHANNON MODEL 1999-2002	SHANNON MODEL 2003-2010	RE-VISITS 2012-2013	DEPT. OF PUBLIC ADMIN. MODEL 2013-2015	CURRENT MODEL 2015-Present
Number of Communities: 7 Grant funded	Number of Communities: 10 State funded	Number of Communities: 2 State funded	Number of Communities: 1 State funded	Number of Communities: 2 State funded
Sponsorship: University led	Sponsorship: Program and funding shifts from University to state control.	Sponsorship: State control with technical assistance provided by the University	Sponsorship: State control with technical assistance provided by the University	Sponsorship: State control with technical assistance provided by University Extension
Components: First Impressions and CDT framework including multi-disciplinary teams drawn from University Extension and academic departments; inclusion of local physician project director and health care personnel.	Components: First Impressions and CDT framework including multi-disciplinary teams drawn from University Extension and academic departments; inclusion of local physician project director and health care personnel.	Components: Focused development projects; no explicit emphasis on healthcare.	Components: Student action research and service learning over 4 semesters. Emphasis on community involvement and deep engagement; programing includes community health initiatives but no explicit emphasis on healthcare recruitment.	Components: Emphasis on community involvement and engagement with local health care personnel and facilities as key stakeholders; Extension facilitated work sessions with stakeholders and residents; mini-grants/seed funding for projects.
Outcomes: Recruitment of 27 healthcare providers; increased awareness of issues related to community leadership and built environment	Outcomes: Recruitment of 27 healthcare providers; increased awareness of issues related to community leadership and built environment	Outcomes: Community housing plan; mural project	Outcomes: Community financial analysis, comprehensive plan, action on built projects.	Outcomes: Completion of funded projects; self-identified and directed projects and actions beyond program goals.

A New Paradigm

For one year, the Recruitable Communities Program revisited places as it determined how to move forward without the CDT. In 2013, a revised Recruitable Community Program process was used in Ravenswood, WV. It was the initial attempt to mitigate issues that had arisen over time with the original model that featured a Community Design Team visit. Though the model provided a breadth of university resources to communities, the short time spent in the community frequently resulted in limited public engagement and little follow-through, especially when communities were not required to commit their own resources to the process.

In the revised program design, the RCP spent more time in the community, encouraged broad engagement from a diversity of community stakeholders, and hosted several community conversations to involve residents. In 2013 and 2014, the WV DHHR provided funds to support community-based service learning and action research as part of an existing four-semester sequence of graduate student courses focused on community development and public engagement taught by the WVU Department of Public Administration. Each semester, students would work in community on specific issues. At its conclusion, student-produced deliverables from the effort were synthesized into a draft comprehensive plan for the city. In 2015, community leaders began initiating projects outlined in the draft, specifically the development of tourism and recreation assets along the Ohio River. Additionally, the planning commission worked with a WVU Land Use and Sustainable Development Law Clinic to formalize the comprehensive plan.

This revised model successfully encouraged broad community participation and produced results. However, course requirements and university schedules hampered flexibility and responsiveness to community needs. Also, both the state agency and the community wanted quicker turnaround and more direct and immediate program impacts. So additional alternations in the model were deemed necessary.

Beginning in late 2015, the Recruitable Communities Program utilized a new, blended model led by the WVU Extension Service that incorporated design and place making tools to initiate conversations, followed by planning activities that occurred over a six-month time frame. As with previous iterations of the program, the process began with a First Impressions assessment of the community. In order to encourage open and honest dialogue about community needs, initial planning events included separate discussions between community members and stakeholders, who were identified by the local hospital or sponsoring health initiative. These meetings introduced the project, presented the results of the First Impressions team report, and started a discussion about potential community projects to address needs identified by the assessment and the community. After community and stakeholder groups identified priority projects, the groups were brought together into a work team. Although projects were prioritized separately, the identified projects overlapped to a significant degree. Later meetings featured a brief review of past work, work assignments, progress reports, and work to resolve any issues and concerns that had arisen. The final meeting was a celebration of community accomplishments to that point; RCP representatives presented funds to priority projects.

The new Extension-led model was piloted in Keyser, WV, a small community in the state's Potomac Highlands. Planning activities began in the late fall of 2015 and took place over a seven-month period. The program achieved both community development process impacts and impacts to the built environment. For example, participation in community meetings nearly doubled from 17 attendees at the initial meetings to as many as 31 at subsequent meetings. Community and stakeholder participants represented a diversity of organizations and interests including local businesses, city and county officials, a local arts organization, hospital and health department employees, the local Chamber of Commerce, and the local college (WVU Potomac State College). Meanwhile, other participants included local residents interested in seeing their community – and their local healthcare options – improve.

The shortened time frame and streamlined planning process allowed more RCP funds to be directed to community-based end products rather than the process itself, resulting in positive program outcomes. For example, the grant program successfully funded seven programs and organizations. Many projects specifically addressed issues identified by the First Impressions program and community stakeholders. Welcome signage around the city was improved. Exercise equipment and an electronic race timer leveraged existing local recreation assets and events. Flowers and planters for downtown enhanced beautification projects. Seed money helped create a new dental program at the county health department. In the spring, Potomac Valley Hospital in Keyser, in conjunction with the WV DHHR partners, hosted a grant writing workshop which was attended by 22 local residents. Representatives from the local newspaper –the Mineral Daily News Tribune – developed the "Mineral County Answer Book" to increase resident's awareness of clubs, organizations, and recreational opportunities available in the community – a recommendation directly linked to First Impressions report recommendations and early community conversations.

The group committed to continue working together after the close of the grant period. A representative from the local hospital agreed to take a leadership role and continue convening meetings. Group members organized themselves into teams to undertake additional

projects including a series of murals that showcase community history and serve as a visual welcome to the community. A quilt trail will link local farm tourism operations within and across neighboring counties. Finally, a local community ambassador program has been proposed to showcase the area's history, art and culture, and outdoor activities, promoting these features for locals, visitors, and potential residents – including medical professionals.

As a result of these program successes, the Recruitable Communities Program has had the WVU Extension Service work in additional communities using this new model. The program worked in Williamson, WV, a small town on the state line in the southern coalfields from the fall of 2016 through the summer of 2017. As in Keyser, the program brought together a diversity of local residents and stakeholders and created positive community impacts. The group purchased materials for signage improvements to better link downtown and tourism assets. Additionally, informal collaborations between attendees resulted in a regular open-mic event at a local business; the local health clinic, which also coordinates community events, began work on a community-operated webpage for internal community marketing and news. Meanwhile, work began in Harrisville, a small county seat in the middle of the state with a medical clinic, in August 2017.

Challenges

The changes in the model used by the Recruitable Communities Program occurred because of the need to reinvigorate the RCP effort after the demise the Community Design Team, which had been a major component of the original model. The most notable change between the current model and the earlier one was increased participation by residents of the RCP communities. The original model had only limited public participation in developing the ideas for community improvement – and the majority of this participation occurred during the two-day CDT charrette. The current model requires substantial citizen engagement over a several month process, in both periodic formal meetings and informal settings to define and develop projects.

This higher level of citizen involvement creates a challenge to gain local "buy in." Participants must now make decisions regarding the details of their community's improvement plan rather than having a plan presented to them. Now, the community members themselves actively recruit participants, build commitment through idea generation, and keep the activity on track.

Staff from WV DHHR and faculty from WVU have increased the guidance they provide the community, even as they require more local ownership for decision-making and action. Preparing for and participating in multiple meetings over a several month period requires much more work – and travel – than a two-day charrette. Additionally, DHHR officials have become much more active and present in the communities throughout the RCP than they had previously been, which has necessitated more planning on their part. Being proactive and using flexible scheduling have helped in this area.

Finally, there has been the issue of resource availability. The program currently costs the community nothing and recent visits have offered funding from WV DHHR for projects that were identified as part of the RCP effort. But the funding has restrictions that are problematic. The funds made available to a community must be spent by June 30. They cannot be used for general supplies, and are limited to a maximum of $10,000 per project (out of which operational expenses must also be paid). The hope is these funds will act as seed money that leverages other resources. It is also hoped that the new RCP process will create greater local support, and increased commitment will lead to increased funding from other sources.

Concluding Comments

For nearly 20 years, the Recruitable Communities Program has worked to improve communities for health care professionals and resident. Early iterations included citizen participation and education, but the planning approach tended to be largely top-down. As a result, leadership capacity and community conditions in many places did not improve substantially. One major positive aspect of the changes in the RCP is that the effort is now very much aligned with standard rubrics of community development process, such as the Community Development Society's Principles of Good Practice.

The RCP seeks broad and extensive community participation in the process of planning for community improvements to make places more desirable destinations for health care professionals. As part of this, a conscious effort is being made to ensure that all interested and/or impacted parties and groups are involved in the planning process. In Keyser, WV, the process produced synergies such as the collaboration between a local realtor and representatives from a regional arts council to develop murals as part of welcome signage at a community entrance.

The program also provides education about the community – in the forms of data and assessments – that heighten awareness of persistent community issues and to serve as an aid in decision-making. Although the assessment comes from an outside perspective, it quickly stimulates community discussions about strengths and weaknesses. This enhances the leadership capacity of community members as they begin to identify ways to make their community a better place, rather than be told by "experts" what needs to be done.

The community driven model is in line with best practices, but is also a practical reality of the program. Each of the places that have used the current model have had their own set of challenges and their own needs. In order to get residents to become active, stay energized, and create the projects that improve the overall well-being of the community, the RCP has had to be flexible. This flexibility is perhaps the program's greatest strength. By meeting the community where they are, and leveraging their unique assets, the program has yielded positive outcomes for participating communities. More importantly, it has allowed the program to change, to continue to incorporate new tools and methods, and remain relevant to West Virginia's rural communities for nearly 20 years. We believe this flexibility also makes the program valuable for other rural states and communities working to address rural healthcare professional recruitment.

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