

Opportunities to improve rural health and rural economies

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Assumptions

1. That you have already heard all of the general demographics and statistics about rural health in Georgia; ***(attachment provided)***
2. That you understand the repercussions in Georgia of the Balanced Budget Act of 1998 which froze GME slots at 1998 levels; ***(attachment provided)***
3. That you have a general understanding of the pathway to medicine including length of study and general requirements. ***(attachment provided)***
4. That you have a general idea of the special programs and admissions tracks currently available in the state. ***(attachment provided)***

If any of these assumptions are untrue, I would be glad to provide written information addressing any or all of these assumptions to the committee within the next week.

1. How does the health care workforce, and lack thereof, impact rural health?

Rural Population Health Outcomes

- Rural populations are more likely to suffer from mental illness and chronic disease (such as ischemic heart disease, COPD, and obesity)
- They have higher rates of adolescent pregnancy
- They have higher mortality rates

*Meit M, Knudson A, Gilbert T, et al. Rural Health Reform Policy Research Center. The 2014 Update of the Rural-Urban Chartbook. Bethesda, MD: NORC at the University of Chicago; 2014.
Jones CA, Parker TS, Ahern M, Mishra AK, Variyam JN. Health Status and Health Care Access of Farm and Rural Populations. Washington, DC: US Department of Agriculture; 2009.*

- **Nearly 84 % of US residents could reach a level one or level two trauma center within an hour, but only 24% of rural residents have access within that time frame.**

*National Academy of Sciences, Emergency Medical Services: At the Crossroads (Washington D.C.: The National Academies Press, 2007).
<http://www.iom.edu/Reports/2006/Emergency-Medical-Services-Atthe-Crossroads.aspx>.*

Financial vs. physical access

Financial access is one issue, but physical access is another.

159 Georgia Counties:

6 without a Family Physician

31 without a General Internist

63 without a Pediatrician

79 without an OB/GYN

66 without a General Surgeon

Georgia PCP projected shortage

To maintain the status quo, Georgia will need an additional **2,099** primary care physicians- an increase of **38%- by 2030.**

- 20% of this growth is projected based on increased utilization due to aging (rural populations aged 55-75 are projected to grow by 30% from 2010-2020);
- 66% due to population growth; and
- 13% due to greater insured populations following the Affordable Care Act.

Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.

2. How does the health care workforce, or lack thereof, impact rural economies?

Why is the rural healthcare workforce important?

To recruit industries for economic development, communities must have:

- **Healthy workforce**
- **Educated / skilled workforce**
- **Transportation systems / access**
- **Strong Primary and Secondary education systems**

Economic impact of rural health professions workforce

Physicians support the health of their local and state economies through:

- *Creating Jobs with related wages and benefits;*
- *Purchases of goods and services; and*
- *Large scale support of local and state tax revenues*

In Georgia...

In 2015, there were **19,021** total physicians in Georgia:

- They supported an estimated **88,037** direct jobs
- They supported **117,832** indirect jobs
- For a total of **205,869** jobs supported by the physician industry- or an average of **10.8** jobs per doctor.

◦Source: *The Economic Impact of Physicians in Georgia State Report*, Published: March 2014, Prepared for: The American Medical Association, Prepared by: IMS Health Chicago, IL

Comparator Industry Total Economic Impacts in Georgia

Industry Output	Sales Revenues (\$ in millions)	Support of Jobs, Wages & Benefits (\$ in millions)
Physicians	\$29,663.1	205,869 / \$16,633.6
Higher Education	\$7,824.5	75,019/ \$3,269.9
Nursing Home/ Residential Care Facilities	\$6,520.9	87,432/ \$2,849.5
Legal Services	\$11,122.5	82,926/ \$4,089.5
Home Health	\$2,772.5	37,953/ \$1,322.5

Source: *The Economic Impact of Physicians in Georgia State Report*, Published: March 2014, Prepared for: The American Medical Association, Prepared by: IMS Health Chicago, IL

Sales Revenues and Taxes

- In 2015, \$29.7 billion in Sales Revenues were generated by physicians, representing 6.8% of the GSP/GDP in Georgia
- Georgia physicians supported \$16.6 billion in Wages and Benefits for their employees and created an estimated 205,869 jobs.
- And generated an estimated \$1.1 billion in local and state tax revenues.

Source: The State Level Economic Impact of Physicians Report (IMS Health, March 2014); US Bureau of Economic Analysis: Current-Dollar GDP by State, 2012

- Impact per family physician per year: \$1,028,774
- Total impact of family physicians in the state: \$1,674,844,376

Source: Robert Graham Center, AAFP, *Economic Impact of Family Physicians*. January 2015

3. What are the primary challenges in recruiting, training, and retaining a physician workforce in rural communities?

To make a Rural physician...

The physician education pipeline is quite long:

- K-12 education (High School diploma)
- 4 years of undergraduate education (Baccalaureate)
- 4 years of medical school (UME)
- 3-8 years of residency training (GME)

11-16 YEARS POST HIGH SCHOOL TO EDUCATE A NEW DOC!

Challenges: Recruiting

*ADMITTING AND GRADUATING STUDENTS LIKELY TO PRACTICE IN
RURAL AND/OR UNDERSERVED AREAS*

To make a Rural physician...

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- *K-12 education (High School diploma)*
- *4 years of undergraduate education (Baccalaureate)*
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11-16 YEARS POST HIGH SCHOOL TO EDUCATE A NEW DOC!

Identifying qualified applicants

- ❑ “Rural Background Effect” - growing body of evidence demonstrates that medical students with a rural background are more likely to practice in rural areas.
- ❑ Requires focused recruiting, such as pipeline programs targeting rural and disadvantaged communities, to expose youth early and frequently to health career options.
- ❑ Requires assistance with academic performance to insure potential rural candidates are competitive in the higher education applicant pool
- ❑ Need to create / support / expand Medical School Rural Admissions Tracks

Declining interest in primary care as a career choice

- Linked to growing disparity between pay for primary care practitioners and for specialists.
- Today specialists can earn more than **3x** the annual income of a primary care practitioner.
- In 2016, Medical school debt averaged around **\$180,000** in Georgia, a further deterrent to choosing primary care.

Solutions: Recruiting

1. Capitalize on the “Rural Background Effect”

- *Encourage the addition of rural physicians to admissions committees at any school receiving state funds (**GBPW**)*

2. Emphasize clinical training in rural and/or disadvantaged areas, recognizing these sites are harder to recruit and develop

- *Provide graduated stipends to students completing multiple rotations in the same region to incentivize more time in rural areas (**Statewide AHEC**)*

3. Address medical education debt for primary care physicians to increase attractiveness for primary care practice in rural Georgia.

- *Reimburse tuition, at the rate charged by public institutions, (currently +/- \$29,000/ year) for students admitted to a rural track program at a Georgia medical/ osteopathic school. (**GBPW**)*

4. Incentive creation and expansion of Rural Admissions Tracks at Georgia medical and osteopathic schools

- *Provide incentive administrative support dollars to schools offering this option, e.g. \$350,000 / year / per program (**GBPW**)*

5. **Establish / Continue health workforce programs that recruit students from communities where providers are needed most.**

- *Continue funding for the **Statewide AHEC Network's** health careers recruiting programs occurring throughout the state. Consider additional funding for more intensive programming (20+ hours) which has the most ROI.*

Challenges: Undergraduate Medical Education Training

To make a Rural physician...

The physician education pipeline is quite long:

- K-12 education (High School diploma)
- 4 years of undergraduate education (Baccalaureate)
- ***4 years of medical school (UME)***
- 3-8 years of residency training (GME)

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2016 Medical School Graduate Survey- GBPW

There were **624** graduates from Georgia Medical Schools in 2016; **375** completed the survey (**60%** response rate)

OF THE RESPONDENTS:

53% intend to practice in an underserved area (inner city or rural)

36.5% intend to practice in a rural community

51% intend to practice in Georgia

53% declared a primary care specialty

47% ranked a Georgia GME program among their top 3 choices

21% *matched to a Georgia Primary Care or Core Specialty residency; 27%* indicated they matched to a Georgia GME program

15% *of those leaving the state wanted to stay but did not match with a Georgia GME program*

UME: Placing medical students into rural and underserved communities for training

The more exposure a learner has to rural communities during his/her training, the more likely they are to practice in a rural setting.

- 1. Recruiting and preparing community based teaching sites**
 - Site identification
 - Site Credentialing
 - Rewarding volunteer community based faculty (Preceptor Tax Incentive Program- PTIP)
- 2. Addressing practical barriers to off campus / off site rotations.**
 - Housing issues
 - Travel issues
- 3. Working with communities to develop Social Integration strategies**

Solutions: Undergraduate Medical Education Training

-
- 1. Providing housing for students completing short term (2-8 week rotations) in communities remote from their campus**
 - *Continue and increase funding the Statewide AHEC Network to provide housing for students completing community based clinical training remote from their campuses.*

 - 2. Support development, expansion, and/or maintenance of the regional campus models of education to place medical/osteopathic (and perhaps APRN and PA students) for training in more communities across the state.**
 - *Support MCG's regional campus model*
 - *Support PCOM's Anchor program*
 - *Support Mercer's distributed campus model*
 - *Support MSM's regional campus program*

3. Develop training for social integration strategies for communities hosting students and residents to provide them with tools to recruit these individuals for eventual practice.

◦ *Offer technical assistance to communities to develop social integration plans. (Statewide AHEC)*

4. Offering tangible rewards to community based physicians supporting medical education.

◦ *Convert Preceptor Tax Incentive Program (PTIP) from a tax deduction to a tax credit. **This is a priority. (Statewide AHEC)***

5. Create an incentive program for graduates of Georgia medical or osteopathic schools who choose a family medicine or **GENERAL internal medicine residency program in the state.**

- *AHEC has prepared white paper detailing this program with a staggered implementation plan beginning with just Georgia family medicine programs; would be administered through the **GBPW**.*

Challenges: Graduate Medical Education Training

To make a Rural physician...

The physician education pipeline is quite long:

- K-12 education (High School diploma)
- 4 years of undergraduate education (Baccalaureate)
- 4 years of medical school (UME)
- ***3-8 years of residency training (GME)***

11-16 YEARS POST HIGH SCHOOL TO EDUCATE A NEW DOC!

Characteristics of Georgia Residency Graduates, 2016

2016 Georgia GME Exit Survey Report, Georgia Board Physician Workforce, 2016

- Median age of **31**
- **68%** were native born US citizens; 18% were nationalized US citizens
- **24%** graduated from a Georgia high school (**15%** of these went to an international medical school)
- **25%** graduated from a Georgia medical/osteopathic school
- **42%** indicated they would practice in Georgia

Cont.

- Of those that graduated high school in Georgia, **11.9%** graduated from an overseas medical school
- **29%** graduated from a medical school in another country
- **38%** of respondents that graduated from both high school and a GME program in Georgia plan to remain in state to practice
- **39%** indicated plans to work in a small city, suburban, or rural area

Cont.

- **64.0%** of the respondents had debt over **\$200,000** (up from **44%** in 2015); **16%** had debt over **\$350,000**.
- **49.4%** of respondents indicated a starting salary of **\$200,000** or less.
- The top reasons for graduates leaving Georgia are “Proximity to Family;” “Better jobs in desired location outside Georgia;” and “Better Salary offered outside of Georgia”

“Layering Works”

Graduates that went to high school, medical school and completed GME in Georgia had an **81.8%** retention rate (2014)

Return on Investment: GME

CHALLENGES: TRAINING

Georgia's growth in GME: 2013-2018

- Governor's Initiative began in **FY 13** with a goal of opening **400** new GME slots throughout Georgia.
- By June 30, 2018, the total invested state funds will be **\$19.1 million**.
- In FY 13, there were **16** teaching hospitals in the state supporting GME.
- Expansion funding will end on June 30, 2018.

Results:

- On track for **600+** new slots; **192** are currently filled (includes PGY1, PGY2, PGY3, and PGY4 slots)
- Increased number of teaching hospitals from **16** to **23** with **2** more potentially coming on line in FY 18; only one, Colquitt Regional, is a rural GME program (9 residents, 3-3-3), although Archbold would be the 2nd if successful
- Increased GME training capacity (PGY 1 slots) in the state by **30%**

Challenges: Retaining

Challenge: Non-clinical skills training for residents and students Needed

1. Preparedness for medical conditions encountered in rural practice was less important for retention than preparedness for rural living.
2. Preparedness for rural culture, rural community leadership, and community engagement have been identified as the three most important non-clinical competencies needed for retention.

Rural culture refers to the core values and way of life embodied within rural communities; Rural community leadership refers to the leadership roles physicians are expected to take as prominent members of the community; Rural community engagement refers to the ability to build community relationships, understand community members perceptions, and interactions with communities to address health problems.

Challenges: Practicalities

1. Concerns about Family life, including Partner/ spouse preferences and employment opportunities and children's education
2. Professional isolation and lack of peer support and interactions
3. Financial costs of establishing a practice, or in buying out an existing practice, or in paying back student loans
4. Issues with billing for telemedicine and telehealth services- both of which are invaluable in rural practice

Solutions: Retaining

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- 1. Develop classroom training opportunities and seminars for medical students and medical residents on topics related to: Rural culture, Rural community leadership, and Rural community engagement.**

Invest in a single program to develop these resources and to offer annual programs in addition to live and asynchronous training opportunities; programming must be open to all medical / osteopathic schools and residencies. (Statewide AHEC)

- 2. Concerns about Family life, including Partner/ spouse preferences and employment opportunities and children's education**

Provide spousal employment assistance through a one time grant to purchase employment search assistance; Provide an education stipend for private education if that is a better option in a community (GBPW)

3. Professional Isolation and lack of peer support and interactions

- *Encourage life-long clinical skills training to retain competence and clinical competitiveness through funding support for CME faculty and logistics for programs designed specifically for rural practitioners (Statewide AHEC)*
- *Develop a Locum tenem program to provide temporary office coverage for a rural physician attending CME training or needing medical leave (Statewide AHEC/ SORH)*
- *Incentivize engagement of rural community based faculty with population based researchers at academic centers through a small grants program. (Statewide AHEC)*

4. Support workforce development policies that provide incentives to providers who practice in underserved and/or rural communities

- *Continue to offer Rural Provider Tax Credits and increase the marketing of this resource. (Provide funds to the **SORH** for marketing)*
- *Continue the State Loan Repayment program (Physicians for Rural Areas Act) at the **GBPW** at its current level or at an expanded level, for communities with <35,000 population, or for larger areas if authorized by the **GBPW**.*

5. Consider policies that strengthen the Medicaid provider network such as enhanced reimbursement for primary care providers and care coordination services. Historically, primary care services (such as those that are cognitive or non-procedural) have been reimbursed at lower rates than procedural services performed by specialist.

◦ *Increase state reimbursement to primary care providers practicing in rural Georgia (DCH)*

6. **Examine current state funding and policies supporting health center development and expansion.**

- *Direct or encourage contracted health plans to include federally qualified health centers in their networks? (DCH; USG)*
- *Expand loan repayment programs to accept practice in a Federally Qualified Health Center or a state funded health center (GBPW)*

7. Issues with billing for telemedicine and telehealth services- both of which are invaluable in rural practice

- *Remove practice barriers for health care practitioners who provide telehealth services*
- *Examine existing reimbursement and licensure policies for telehealth services to insure they are not actually barriers to expanding telehealth services in rural communities*
(Utilize GA Partnership for Telehealth as advisors)

8. Offer faculty loan repayment assistance for faculty in rural residency programs as recognition of the recruitment challenges faced with these individuals as well as their impact on outcomes.

- *Develop funding pool to support this program using a year for year service provision for eligibility. (GBPW)*

4. What are strategies the state might employ to further develop and support rural residency (GME) programs?

GME: Creating more rural residency training options

At least 56% of residents practice within 100 miles of the location where they complete their training.

Heck, J Currie, C Fagan, E. Blake Mountain AHEC Expands training in family medicine and adds new programs in Psychiatry and General Surgery. NCMJ vol. 78 No. 1. Electronically published January 23, 2017.

Rural physicians are significantly more likely than urban physicians to have had rural rotations during residency training.

Recruiting and Retaining faculty, program directors, and program coordinators with rural experience has been correlated to increased placement of rural physicians.

Anna Beth Parlier, Shelley L. Galvin, MA, Sarah Thach, MPH, David Kruidenier, MLS, and Ernest Blake Fagan, MD The Road to Rural Primary Care: A Narrative Review of Factors That Help Develop, Recruit, and Retain Rural Primary Care Physicians. Academic Medicine. Association of American Medical Colleges. 2017

Challenges to creating rural residency programs

- ❖ Major challenges are Financial and ACGME accreditation requirements
- ❖ Given the current rise in strategic partnerships (mergers, acquisitions, and consolidations) between rural and urban hospitals, health systems, and healthcare providers. Rural hospitals with such partnerships with urban healthcare systems with existing residency programs could actively participate in that residency program rather than creating their own.
 - Examples include St. Mary's Health System sending residents to Good Samaritan Hospital and Tendercare FQHC (both in Greensboro).

Financial Challenges: St. Mary's Hospital in Athens

St. Mary's Hospital in Athens received state funding to help it establish a new GME program; it is in the process of building its Medicare Cap (DGME and IME) but is committed to providing rural training to its residents.

- St. Mary's is currently sending PGY3 residents to Greensboro for one month rotations and to Tendercare FQHC for a month. So all residents will complete two months of rural rotations in Greensboro.

When Residents are away from the hospital for a rural rotation, St. Mary's cannot collect the Medicare DGME and IME for those months, nor can they count that time towards their Medicare Cap (which will be permanent after the five year cap building period). There are 10 residents doing 2 months each in Greensboro. This results in a loss to St. Mary's of:

- 20 months of lost DGME and IME payments (which is substantial)
- Loss of 20 months "Cap" time

Why they do it: AU/MCG Medical Partnership

“The goal for these rotations in rural Greensboro, is to increase access to care, and enhance the quality of medical care for patients – the resident physicians will have a much broader and richer educational experience with the addition of these rural rotations and will further the residents' understanding of the resources available to physicians in rural communities”

“Our goal is that some of the resident physicians will fall in love with rural practice as well as the rural communities, and choose to settle there as a primary care physician.”

Michelle A. Nuss, MD, FACP, AU/UGA Medical Partnership, Campus Dean

Why they do it: *St. Mary's Healthcare System*

“St. Mary's continues to invest in promoting excellence in rural healthcare through its commitment to Graduate Medical Education and expanded partnerships in NE Georgia. By creating a rural medicine experience for our 3rd year residents, we not only enhance their appreciation of the practice setting of referring rural hospitals, but also advance our very intentional efforts to generate interest for rural medicine in Georgia as a rewarding career choice.”

Don McKenna, FACHE, President & CEO, St. Mary's Health Care System

Other rural residency tracks developing or established (*not exhaustive*)

1. MCG- Satilla Regional (Waycross) Family Medicine 1+2 (**established**)
2. St. Mary's and Good Samaritan / Tendercare Clinic (**established**)
3. Navicent Health and Upson Regional (***developing***)
4. Emory General Surgery Residency is planning to add two slots to create a Rural / Global health track. (***developing***)

Solutions?

Incentivize efforts to create a “hub and spoke” model to partner existing GME programs with willing rural hospitals / FQHCs to develop rural training tracks/ rotations (*GBPW / USG*)

- Provide **financial relief** to urban residency programs seeking to create rural rotations, to offset lost DGME and IME
- Provide **financial assistance** to rural hospitals / FQHCs partnering with urban GME programs to offset costs of faculty teaching time, resident housing and food, etc.
- Provide **technical assistance/ consultation and training** to rural communities to develop social integration strategies for residents / students completing rotations in their community

5. How can the state further market its programs to keep students in state, and specifically to practice in rural areas?

Ideal world

1. Medical /Osteopathic schools would actively recruit rural applicants and create specialized admissions and training opportunities for these students;
2. The number of PGY1 slots in the state would equal and surpass the number of medical school graduates in the state each year (become an importer not exporter of medical students);
3. Graduates from Georgia medical / osteopathic schools would choose Georgia GME programs for residency training;
4. 75%+ of graduates from Georgia GME residency programs would remain in the state to practice in primary care
5. GME graduates would choose to locate in rural and underserved areas to practice.

Heavily market existing incentive programs

1. Loan Repayment Programs (GBPW)

- *Continue the traditional Physician for Rural Areas Act Program for practice in rural communities with <35,000 population; consider increasing the length of time a recipient can receive the loan repayment to six years. (GBPW)*
- *Consider creating a new eligibility for PRAA to include practice in communities with <55,000 population, at a lesser level than the traditional PRAA program*
- *Expand eligibility to include working at a Federal Qualified Health Center*
- *Direct the **Georgia Department of Economic Development** to prepare a marketing campaign highlighting Georgia's investments and incentives in primary care.*

2. Rural Provider Tax Credits

- *Currently available for 5 years, at \$5,000 credit per year*
 - *Consider expanding length of time eligible*
 - *Consider increasing amount of the credit*
- *Direct the **Georgia Department of Economic Development** to prepare a marketing campaign highlighting Georgia's investments and incentives in primary care.*

Proposed New Programs

- Implement a new Loan repayment Program for Georgia medical / osteopathic school graduates who choose a Georgia primary care residency program, beginning during PGY 1. **(GBPW)**
- Provide educational loan forgiveness to graduates from a rural training track in Georgia if they are matched to a Georgia residency program. **(GBPW)**
- Develop a sophisticated marketing campaign promoting Georgia's new and existing residency programs. **(Department of Economic Development / GBPW/ AHEC)**
- Develop a "Bring them Home" outreach and recruiting program to Georgia residents attending medical school (in good standing) out of state or off shore. **(GBPW)**

Create the Georgia Collaborative for Rural Graduate Medical Education

Utilize the **GBPW** to host a task force to explore creation of a *Georgia Collaborative for Rural Graduate Medical Education*. Suggested exploration of Wisconsin's highly successful program (WCRGME), engaging hospitals, clinics, residencies, and organizations with an interest in developing or sustaining rural GME to address primary care physician shortage and maldistribution.

Established in 2012, the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME) is a collaborative entities with an interest in developing and sustaining rural graduate medical education to address the primary care physician shortage and maldistribution.

WCRGME: Services Provided

Resident & Medical Student Assistance

- Centralized listing and information on GME opportunities for rural rotations, residencies, and fellowships
- Communicate benefits of training in rural communities

Rural Hospital & Clinic Technical Assistance

- Initial site assessments • Informational presentations
- Help with GME funding questions • Accreditation & administration assistance
- Best practice resources • Faculty and support staff development
- Grant writing • Communicate rural GME opportunities at regional and national conferences

Urban Residency Assistance

- Recommend rural rotation sites
- Support in developing rural tracks
- Help with training on-site coordinators of new rural rotation sites

WCRGME: Specifics of the program

As part of the State's Critical Access Hospital Assessment to raise additional funding to match Medicaid reimbursement, Wisconsin Act 190 became effective July 1, 2010. This Act provides an annual **\$750,000** to fund a rural physician residency assistance program.

In 2016, 80% of the WRPRAP budget was allocated to grants and the remaining 20% was allocated for program administration.

- Grants were competitively awarded to programs that share the goal to expand opportunities and prepare new physicians to practice in rural Wisconsin communities.

ORGANIZATION	AWARD DATE	PURPOSE	AMOUNT
Gundersen Health– La Crosse	12/22/2015	Education development for rural family medicine faculty and residents	\$4,888
Monroe Clinic	12/22/2015	New development of “Women’s Health Curriculum” for family medicine residents	\$72,153
RWHC/Northeast WI AHEC (Joint Award)	12/22/2015	Continued support to develop community academic partnerships for rural GME in northeast Wisconsin	\$36,118
UW Baraboo RTT	12/22/2015	Education development for ongoing rural training track program	\$9,170
Aurora Lakeland RTT	04/26/2016	Second phase of developing a rural training track in southern Wisconsin	\$125,000
UW Department of Obstetrics and Gynecology	04/26/2016	Second phase of developing a new rural track within the urban residency program	\$124,913
Wisconsin Collaborative for Rural GME	04/26/2016	Continued development and operations to expand rural GME programs statewide	\$156,624
		TOTAL	\$528,866

Next Steps

1. Determine what interests the legislature and what strategies they wish to promote
2. Develop white papers and fiscal notes as appropriate

The Statewide AHEC Network is ready to assist. Please contact me with any requests.

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