

SOUTHEAST IDAHO AHEC

# EVALUATION REPORT

HOST SITE INTERVIEWS – SUMMER 2020



## Southeast Idaho AHEC

*Where students and health professionals thrive!*

*The “truths” of narrative accounts are not in their faithful representations of a past world, but in the shifting connections they forge among past, present, and future (Riessman, 2005, p. 6).*

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## INTRODUCTION

In the summer of 2020, researchers from the Southeast Idaho Area Health Education Center (AHEC) at the Institute of Rural Health, Idaho State University, conducted a qualitative, exploratory evaluation of the AHEC Scholars Program. The purpose of this qualitative, exploratory study was to evaluate AHEC Scholar host experiences, build relationships, and gain a richer understanding of the perspectives of providers in the SEID AHEC service area, especially in relation to health needs and interprofessional dynamics. It was also done to add to the sparse amount of literature available about Idaho in general and southeast Idaho more specifically.

This evaluation included conducting qualitative, semi-structured interviews with representatives of the host sites where scholars participated in community, experiential and clinical (CEC) learning activities (n=8). Semi-structured interviews were chosen as the means of data collection because broad, open-ended questions prompt narrative responses that allow respondents to relate their own experiences to the subject matter (Behre, 2019). The interview guide was cooperatively constructed by the SEID AHEC director and the evaluator (SEID AHEC executive director and Institute of Rural Health interim director, Idaho State University). Consistent with qualitative approaches, the guide was developed to be broad enough to elicit responses of interest to respondents, but guided enough to ensure that three central questions were answered:

- 1) How do site personnel (hosts) evaluate their experiences with CEC training?*
- 2) How do site personnel (hosts) explain and contextualize health issues and solutions facing the communities where SEID AHEC Scholars complete CEC training?*
- 3) How do site personnel (hosts) describe the interdisciplinary nature of healthcare in their communities?*

Respondents were asked to discuss these issues from their own perspective so that thematic narrative analysis of responses could be conducted, which promotes a clearer understanding of the contexts within which respondents experience events (Riessman, 2005). It also allows for a deeper understanding of how respondents characterize their experiences and weave them into stories that help make sense of wicked problems, like those associated with healthcare systems (Cunningham et al., 2019).

Respondents from host sites were purposefully selected based on the type of organization they represented and their geographic location SEID AHEC's 24-county region. Respondents were contacted via email and telephone, based on information provided from the director.

All interviews were conducted via Zoom and recorded for transcription and analysis. A total of 15 host site representatives were approached and eight agreed to be interviewed. Pseudonyms for students, practitioners and geographic locations are used throughout this report to protect the identity of respondents.

## BACKGROUND AND SIGNIFICANCE

According to data from the Health Resources and Services Administration (HRSA), the state of Idaho is experiencing significant shortages of primary care providers, including dental and mental health care providers (*2016 Idaho Primary Care Needs Assessment*, 2016). In relation to primary care, there are 43 HRSA shortage designations that cover 96.36% of the state's total land area. There are 43 dental care shortage designations that cover 97.01% of the state's land area, and there are seven mental health care shortage designations that cover 100% of the state's land area.

In addition to the problem of existing shortages, primary care physicians are aging out of the workforce. In 2016, the mean age of 2,910 physicians providing direct care in Idaho was 51 (Skillman SM, Dahal, 2017). Thirty-eight percent of them are over the age of 55. This is concerning given that Petterson, Rayburn, & Liaw (2016) found that the average age of retirement for U.S. primary care physicians retiring from all activities between 2010 and 2014 was 64.9 years.

Beyond the issue of provider shortages, rural Idaho communities face access-to-care barriers that put them in even more vulnerable positions than many of their urban counter-parts. Thirty-five of Idaho's 44 counties are rural (< 20,000 residents) and 16 are frontier ( $\leq$ six people per square mile) (*2016 Idaho Primary Care Needs Assessment*, 2016). Access-to-care barriers include: lack of transportation, distance from healthcare facilities, poor roads and weather conditions; the need to take additional time off of work to get to and from appointments, lower rates of health insurance coverage compared to urban areas, concerns about privacy, social stigma and low health literacy (Rural Health Information Hub, 2019).

In order to address these challenges, several initiatives have been undertaken by HRSA's Area Health Education Centers (AHECs). AHECs are required to provide health professions students (AHEC Scholars) in professional degree programs with community, experiential or clinical (CEC) experiences in rural and underserved communities. It is predicted that participating in CECs in these communities will result in higher rates of recruitment and retention once students enter the workforce.

There are more than 300 AHEC program offices and centers that cover 85% of the counties in the United States. This advantageously positions them to locally recruit and retain health professionals (National AHEC Organization, n.d.). The Southeast Idaho Area Health Education Center (SEID AHEC) is doing exactly this. It is in its second year of training AHEC Scholars in its 24-county service area, which comprises Idaho public health districts five, six and seven and spans almost 40,000 square miles (American Fact Finder, n.d.)

SEID AHEC Scholars are selected based on their dedication to working in, and personal experiences coming from, rural and underserved communities. They are health professions students at Idaho State University (ISU), Pocatello, Idaho, who are at least two years from graduating. They are selected in an annual competition, and only 15 are chosen each year. They may be from the following disciplines (ISU): Nursing, Physician's Assistant Studies, Radiographic Sciences, Occupational Therapy Assistant, Physical Therapy Assistant, Physical Therapy, Occupational Therapy, Dental Hygiene, Pharmacy, Social Work, Psychology, Clinical Mental or Behavioral Health Counseling, Audiology, Master in Health Administration, Master of Public Health, Master of Health Education and Athletic Training.

Part of the requirements for receiving a nationally recognized AHEC Scholar certificate include completing 40 hours per year, for two years, of CEC training. This training can take place as part of students' clinical rotations for their respective programs, or it can take place as part of volunteer efforts to serve the community. CEC site locations vary in relation to these options. For example, a student in the Physical Therapy program may already be doing clinical rotations in an area clinic. This would be a good place for the student to complete their CEC hours. Some students do not have clinical rotation requirements, due to various factors including the year of study they are in in their program. These students may complete CEC hours in the role of volunteers at locations such as the Idaho Food Bank or the Shoshone-Bannock Community Health Center.

SEID AHEC Scholars engage in a variety of CEC activities. In the 2018-2019 school year, one student from the Physical Therapy Program worked in Salmon, Idaho to conduct health assessments as part of clinical rotations. One provided mentoring and ran groups at the Bannock Youth Foundation (Pocatello, Idaho) for at-risk youth and homeless adolescents as part of clinical rotations. One served as a volunteer at a Veteran's Home (Pocatello, Idaho) to develop social activities and organize outings, and one was an actor at Idaho State University's inter-professional education case day.



## RESULTS

Study results are divided into multiple sections that describe responses from host sites. The sections address the major themes that were produced from transcript analysis. While each section can be understood independently, it is the combined nature of all themes that characterize the experiences of these eight health practitioners in southeast Idaho.

At first, the host sites are broadly described. Subsequent sections describe major themes resulting from thematic narrative analysis. These include a description of responses relating to the three overarching questions posed for this evaluation: 1) how host site representatives evaluated scholars, 2) how they spoke about community health issues, and 3) how they understood and defined interprofessional work. These sections also include a description of three additional themes that emerged from analysis: 1) rurality and push-pull service provision and healthcare access, 2) COVID-19 and 3) solutions to problems. These latter three themes are key to understanding the dynamics of working in and studying the health professions in southeast Idaho. The sections are ordered in terms of how they relate to each other. Therefore, rurality comes before the evaluation of scholars because it should be considered next to the description of host sites.



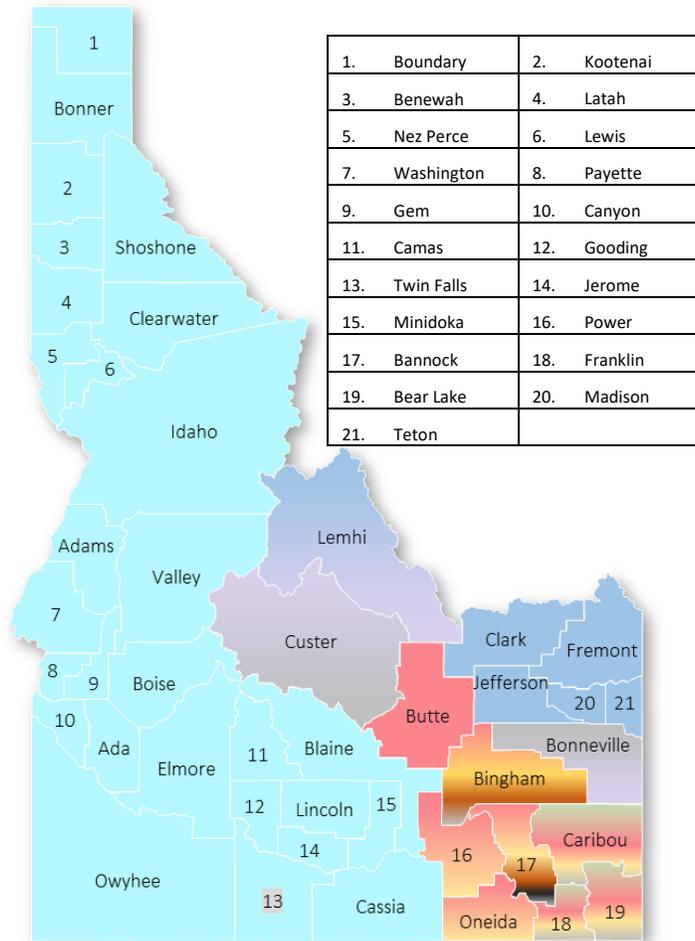
## HOST SITES DESCRIPTION

The following describes who the host site representatives are and how they conceptualize their service areas in southeast Idaho. It also includes a map that illustrates how far reaching their services are in the region.

The eight respondents who agreed to participate in the host site interviews included two who hosted scholars for community hours, five who hosted scholars for clinical hours and one who hosted scholars for community and clinical hours. Two interviewees hosted scholars in year two of their program, five hosted scholars in year one of their program, and one hosted scholars in years one and two of their programs.

They represented the professions of nursing, social work, physical therapy, radiography and physician’s assistants. They supervised a variety of students both within and outside of their professions. They worked at hospitals, social service organizations, clinics, nursing homes and mental health facilities. Interviews were conducted with providers from five different communities in Southeast Idaho AHEC’s 24 county service area. All of them were responsible for serving clientele from rural locations in Idaho and Southeast Idaho.

Figure 1 represents the locations served from the perspective of the providers. During interviews, they mentioned working with clientele and organizations from 12 of the 24 Southeast Idaho AHEC counties. The service area for one respondent was looked up separately, to clarify their reach, and 4 additional counties were added. The existence of color gradients in the counties indicates that more people mentioned these areas. Two providers served the entire state, which is reflected in the light blue shading of the remaining counties to the west. While Figure 1 is by no means a comprehensive list of service locations, it demonstrates that providers work across county lines. Many of them travel to multiple rural locations for their work, even though they may have their main offices in more populated areas. This becomes important for discussions relating to the rural nature of this part of the state and the “shifting connections (Riessman, 2005, p. 6)” between locations that providers deal with on a daily basis.



**Figure 1: Service and collaboration counties as discussed by providers at host sites**

*Mobility entails the freedom to seek opportunities to improve living standards, and health and education outcomes, and/or to live in safer, more responsive communities (United Nations Development Programme, 2010)*

*No matter how short or how long, how easy or how difficult, every act of migration involves an origin, a destination, and an intervening set of obstacles (Lee, 1966).*

Results from this evaluation indicate that a deeper consideration of push-pull dynamics associated with migration theory (Lee, 1966) and mobility will be critical to understanding the unique challenges and opportunities that present themselves to practitioners and their patients in southeast Idaho. Respondents described the complex dynamics of living and working in rural communities, as well as how these dynamics shape provision of and access to care. There was no shortage of descriptions explaining the impacts of working in rural areas:

We are not a city with all the resources. We have to bring people in a lot of times to get the resources and some of em travel a long distance like coming in from [Valley] or whatever. We don't have a lot of you know, providers out in those areas for health, mental health or even substance, and sometimes those areas get... because they can't get the resources. And I've had some of em that had to move to [larger towns] because they, they were so far out like in [Valley] or stuff like that (H013).

Respondents grappled with their appreciation of living and working in rural settings and the stark realities of what that means in terms of transportation, providing the right mix of care, and reaching the most vulnerable with limited resources. Some of them lived in more populated areas and travelled out to rural areas. As practitioners, they experienced the same traversing of distances to clientele as their clientele experienced when trying to reach them. Provision of and access to care relies upon everyone using roadways:

They might not have a car that is reliable enough to drive. Cause it's two and a half to three hours to the nearest, like larger area that you could obtain that healthcare, and for a lot of people they just, they don't have a reliable vehicle, or in the wintertime it's even more challenging because the roads could be bad. So some people just don't get the care that they need (H008).

Sometimes the topic of conversation was the push to get patients out of communities:

We always push them to go to an area where they would have more support, whether it's assisted living, skilled nursing, or family support, but usually they fight us on that and they keep going back home (H002).

Other times respondents addressed the push from organizations in more populated areas to get providers out into the rural areas:

We have a 10,000 square mile area that we cover....It's quite the yeah, we go everywhere (H005).

Those who are, like our patient out in [Randall], I mean what are the chances of them getting service? It's an hour and a half away from us just to get there... and they're so grateful. Those outlying areas, that they need the help, but they don't know how they're gonna get it. Once they find that we will come to them, their gratitude is just incredible (H005).

Sometimes the pull by providers in populated centers to get clientele to come to them was discussed:

We had one [person] who was bringing the kiddos up every week and that helped us out a ton so that we weren't out til 10 o'clock at night... if a foster family is willing to do that, we're like, "Here's a [free dinner] card! (H003)"

And other times it was the pull by organizations in rural areas to get the right mix of providers that was discussed:

There's huge waits, and often times patients will be waiting in the waiting room for hours on end, which isn't good either. So, we need to either be able to increase our capacity to treat those patients, get somebody in here a little more frequently or we might even be able to have the capacity to hire our own [provider] (H002).



## AHEC SCHOLARS

This section discusses three thematic findings from analysis that relate to host site respondents' experiences working with AHEC Scholars in southeast Idaho. They include: 1) What is AHEC?, 2) Confidence, Hesitance and Order of Learning – Scholars and Students as “Go-getters, and 3) Rating the experience.

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### WHAT IS AHEC?

Many of the respondents had very little understanding of what Southeast Idaho AHEC is, what its mission is, and what is expected of scholars when they complete CEC hours. After being invited to participate in the interviews, some respondents sought more information on the internet. Others displayed surprise that they were participating in the AHEC Scholars program at all;

So, it's interesting. When you told me that I had worked with an AHEC Scholar, I thought, "That's interesting. I don't remember doing that!" (H008)

I guess I don't really know the expectations or, you know, what our site expectations were...I didn't know how many hours they needed, or what qualifies as their site or what it took for them to get into the program. So I still don't even quite know what the program involves. (H010)

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### CONFIDENCE, HESITANCE AND ORDER OF LEARNING – SCHOLARS AND STUDENTS AS “GO-GETTERS”

The first group of questions in the interview guide addressed host site representatives' thoughts and perceptions about working with AHEC Scholars as well as other students – including students at the high school level. Interviewees often worked with students who were in their same profession, but they also frequently worked with students from other professions. A nurse might work with social work students, a physician's assistant might work with pharmacy and nursing students, and a physical therapist might work with high school students interested in some type of health profession.

A central theme that emerged from these discussions, regardless of whether or not they were about scholars, was the dynamic of displaying the right amount of confidence and overcoming hesitance. One thing that was admired most by respondents was when students actively asked questions or sought out additional activities. These students were referred to as confident or “go-getters:”

Those are the ones that you want to become nurses... I think it's just because they want to learn. They wanna get out there and experience. They're go-getters. They're, and I'm not talkin about being extroverts. You know that, because I don't think [Susan] is an extrovert. She just goes and gets what she wants. If she wants to learn this, she'll get it, or she'll say, "Oh, can I go? I'm gonna go do this, is this okay?" She just does it! (H007)

The challenge for some respondents was to work with students who were too hesitant or not hesitant enough. Regarding the former, they acknowledged how difficult it can be to build confidence and become secure in the activities that are being performed, but those students who could find that right level of security were highly valued:

She's very driven. She's forward thinking, but not without some hesitation. Every once in awhile I'll catch her hesitating when I know she knows how to do something. And so, that happens and that's a personality thing, you know, for maybe her in particular... She does very well, and I'm guilty of that as well. Sometimes you have that situation that maybe you're not super comfortable going into, even if you know what you're doing. And so I've been working with her on, "Okay, even if you're not super comfortable you still gotta jump in, and you still gotta do your job," ... So that's a big thing we're workin on with [Carma], is just, "You still gotta do your thing, even if you're not super confident in what you think you need to do." (H004)

This issue of finding balance between confidence and hesitance also relates to respondents' discussions about the amount of experience students have when they get to host sites. An issue that respondents mentioned wanting to change or re-visit was student order of learning. They were grappling with how much students should know, or have hands-on experience with, before they got to a host site. These conversations were reflective of respondent experiences with all students, not strictly scholars. There was no perfect solution to the dilemma of how much students should know, or how comfortable they should be. There was a great deal of speculation about what might or might not work better. One thought that students should have more classroom/didactic learning before they entered the clinical setting (H004). Another thought students needed more hands-on learning first, and another recognized that the amount of clinical hours that students get is not always enough:

What we typically see with most students that come in, and I think this is true of any program, is they are more lacking in clinical skills or hands-on skills. Most tend to know the information - the research. They know what to do, but as far as how to actually put their hands on a patient and work with them - usually most are lacking, and, it's understandable, because when you're in the setting in school you're mostly working on your peers, and they are not patients with real pathologies. So any opportunity they have to get out and get more hands on, which is what they do when they come in to shadow with us, so no complaints there, but that was always one of the biggest things - is if they are usually a little more unsure of how to put hands on patients and work with them in the clinical setting (H002).

I do one-on-ones with all the students to see what they're thinking, and make sure they're gettin experiences, cause working with mental illness is sometimes a - you don't feel comfortable with it. We don't give our students, any student, a long time to get real comfortable (H007).

Discussions about students also included comments about difficulties finding opportunities for them. One program worked mostly with students from out of state (H002). Some respondents discussed the difficulties of not having enough locations for students to gain experiences. Others were very concerned about how COVID-19 would reduce opportunities to provide students with experiences, and others discussed the challenges of finding time for students:

I think part of it is we tend to work in a number of different settings here, because we are so rural and small, and so, one of my [colleagues] does a lot of work in the school setting, and she feels that it's difficult for her because of confidentiality, and like, other issues to have a student with her in the school (H008).

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## RATING THE EXPERIENCE

Interviewees were asked to rate their specific experiences working with the scholars on a scale of 1-10. They were also asked why they gave the rating they did. The lowest score given was a 7-8 and the highest was a 10 (Figure 1).

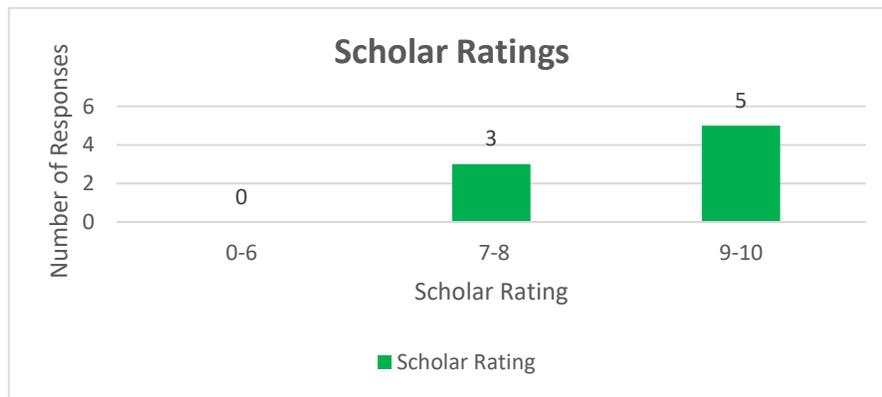


Figure 2: Scholar Ratings

One rating in the 7-8 category had more to do with not knowing what the expectations were for the student, and finding out after being asked for an interview that the student was an AHEC Scholar. It had less to do with the student.

Although many providers did not understand what Southeast Idaho AHEC is, or what expectations for scholars were, it was clear that the providers enjoyed working with students. It was part of their job, and they looked forward to exposing students to experiences that would shape them as health professionals:

I'm always one of the first ones to volunteer. "I'll take em!" I love to take em! and give people new experiences and learning...it makes my day longer, but I don't mind, because it's so important to answer questions that they may have, and then I try and just share. I'll ask what they're going into, and even though I may not have a lot of information in regards to their area that they're pursuing, I can give them some feedback on what I see (H005).

I enjoy it, and, I mean, I complain about paperwork, but that's part of the game. But once you're out on the clinical floor, it's great! You know? And it's great every time (H007)!

The following section discusses perceptions about community health issues that were more commonly discussed by respondents. When asked about health issues that were faced by the communities where they worked, respondents spoke mostly about what they encountered on a daily basis as health professionals. If a respondent worked with children and families then they were more likely to spend time discussing that population. There were, however, several community health challenges discussed by a majority of respondents, regardless of profession. COVID-19 was discussed by all respondents, and it will be addressed in the next section. The other five issues that dominated conversations were:

- mental health, substance abuse and suicide
- the elderly
- rugged individualism
- lack - of providers and resources
- social determinants of health

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#### MENTAL HEALTH, SUBSTANCE ABUSE AND SUICIDE

Respondents were very concerned about mental health problems, substance abuse and suicide in their communities:

I've got ten families. Eight of them are there for substance abuse and are being pulled out at different times to try to do treatment and that kind of thing. So I think it's a big problem (H003).

We see it a lot in the emergency room, because people don't know where else to go, so they bring their mental health to the emergency room. And we're a small community - so yeah, they don't know where else to go. "I guess I'll go to the ER cause I'm depressed" (H004).

[There is] a huge problem with mental health, substance abuse and suicide risk... and several of these things tend to travel together. So, we have populations that may have come from very traumatic upbringings, and the literature's showing a lot more about adverse childhood traumatic events, and how they impact future health - both mental and physical health (H010).

The challenge with this issue was also related to how students are trained:

I think a little bit more education before they come in, on some substance abuse and mental health and how they, co-exist, and the difficulties that you can see with both of those two areas... so it's just I guess knowledge and trying to help my students whenever I work with them, understand there is this crossover, and you have to really understand both to really get a good idea how to help that person (H013).

I feel like some of the universities kinda gloss it over...give basics and then throw you out there (H013).

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## THE ELDERLY

Many respondents work directly with elderly patients. They shared large degrees of concern about elderly health status and resources available to address health needs. More than one mentioned the struggle for independence that the elderly face in rural communities, and how the healthcare system contributes to the problem:

Was it yesterday or the day before? Talking to students, and she mentioned, she worked at a long-term care... "Well they have respite care!" And I said, "How many times do you see it used?" And she goes, "Maybe once a year." Do you know, it's like, "Once or twice a year." I mean there's some there IF they have a long-term care, but they don't use - resources are not used that may be available to give the caregiver, to prevent that burnout (H007).

I see for our elderly people that they just kind of get left, almost – like, [if] they can't get somewhere, they're too proud to say something because they still are clinging to their independence, and I'm hoping that unfortunately with all this Covid stuff that it brings a huge awareness to [it]... I think a lot of our elderly - because they grew up in a generation that worked from sunup till sundown - and you didn't ask for help. It just, it wasn't what you did. You just took care of your own, , and so, I think that they get - their emotional well-being isn't intentionally forgotten, but that it just kind of slips because our insurance companies are running everything (H005).

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## RUGGED INDIVIDUALISM

The concept of rugged individualism revealed itself in particularly complex discussions about the culture of rural communities and generational divides. Health problems among the elderly were attributed to having an independent mindset, and in contrast health problems with youth were attributed to the opposite:

I think you're used to doin it on your own. I thinks it's more of a rural, I don't know. I don't know if it's a rural mentality or, "I just don't think of it," or, "Nobody says to me," or, "Nobody makes it an option," or, "I think I'm gonna have to pay for it," or, I don't know, but I see that the healthcare for older people - and a lot of it's just my personal bias - they're jus, they're given medications, and that's also the individual. There's a generation that the only thing that helps you know, "I need a pill. That's why I went to a doctor. If I didn't need a pill I could of taken care of it myself." (H007)

We see those, that they've never had the opportunity to do anything for themselves because mom and dad were really really good at providing all of that - almost to a fault, and we see, you know, you talk about the millennial kids that are coming out - that they haven't had to do the farm labor. Where we're a big agricultural, well we used to be a big agricultural provider, and so kids went and worked on farms, and there's something about working on a farm that I think really toughens you up mentally, and so these students that are coming from bigger places to our little community with not as much to do, with all these new stresses...(H004)

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## LACK - OF PROVIDERS AND RESOURCES

Conversations about lack of providers and resources also reflected a great deal of complexity – demonstrating that blanket designations like health provider shortage areas (HPSA) do not sufficiently address the multiple ways that communities suffer “lack.” Nor do they highlight the dynamic of simultaneously lacking in one area and having abundance in another:

For example:

As far as our primary care providers, our general family practice docs, they are excellent, and they are stable. They usually stay with us for quite a long period of time. Our specialty practices though, I think that's where we sometimes struggle a little bit more, because [we] don't always feel like we can justify bringing our own doc (H002).

sits in contrast to:

...and then the lack of doctors - and that we have right now too. You don't have a lot of general practitioners anymore like you used to. Everybody's specializing. We need to get back to the general practitioners that can do basic care...(H005)

Others spoke about how their own facilities have enough providers, but other facilities of the same type in the area are severely lacking:

I think in some [facilities] they're limited because of not having enough staff, not having enough maybe educated staff, and we meet. I meet with the nurses at least three times a week, and on one of those weeks, I mean one day, I meet with the whole team, which is the doctor included, the psychiatrist, myself, the administrator who attends and the PA and the director and the nursing director, and we go over what our clients need (H013).

The complex nature of not having enough providers and resources at the patient or provider level included discussions about needing to transport patients hours away to receive services:

We do see on the ER tracking board, we see, you know, suicide attempt, or depression, or anxiety, or suicidal thoughts, and then it lists a time after those patients and sometimes it's up to 23 hours 24 hours because there's nowhere to take this patient (H004).

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## SOCIAL DETERMINANTS OF HEALTH

All providers were keenly aware of the social, political and systemic issues that contribute to health problems in their communities. They expressed deep concern and related to the challenges their patients faced. They spoke of transportation needs, health insurance needs, lack of affordable care, income inequality, education, and health literacy, among other things. They also addressed the importance of well-being, wellness, emotional health, prevention and positive health status. In and among the discussion, it is worthy to note that no one used the phrase “social determinants of health.” Nor did they refer to what they were discussing in terms of a social-ecological framework. This notable absence may be worth further consideration in relation to cognitive theories (Pierce & Bandura, 1977).



COVID-19 was the source of a great deal of discussion in the interviews. No one did not talk about it voluntarily. The subject wended its way through the entire set of responses to questions. Respondents talked about how the pandemic has affected their interactions with students and how it has impacted their communities and work. They discussed a very concerning dilemma, which was whether they, and their communities, should proceed “as if everything were normal.” They discussed how their inter-professional activities and use of technology changed. They also mentioned several things that they believe will result in positive changes for healthcare. To begin this section a description is provided of when the interviews were conducted in relation to the spread of the pandemic.

TIMEFRAME AND DESCRIPTION

The interviews, which were conducted between June 8 and July 15 of 2020, captured people’s perspectives and knowledge about the pandemic as the state of Idaho was transitioning between stages 3 and 4 of its COVID-19 reopening plan: *Idaho rebounds: Our path to prosperity* (State of Idaho, 2020). Most of the interviews were conducted in June and only two were conducted in July. The transition plan was geared to opening the state back up after it had been in a period of lockdown between March 25 and May 1, 2020 (Jeppesen, 2020). The majority of the state had not yet been severely impacted by COVID-19. Cumulative cases on June 8 totaled 3,189. By July 15, that number had risen to 12,445. As of August 30, 2020 cumulative cases total 31,867. After the lockdown, the number of deaths started rising, and it was not until mid July that the state began to see prolonged and consistent increases in deaths (Figures 3&4).

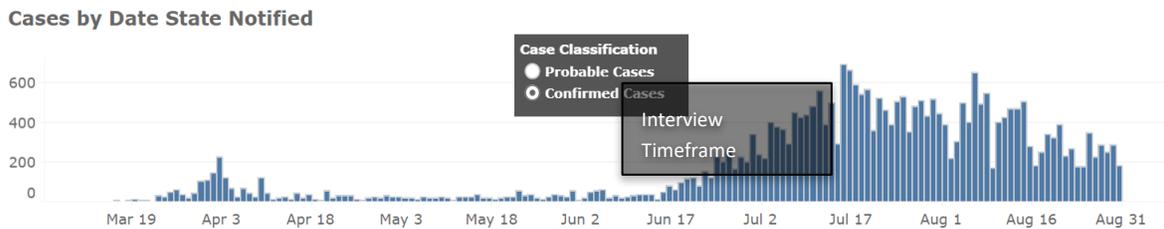


Figure 3: Confirmed COVID-19 Cases in the State of Idaho, Idaho Department of Health and Welfare (2020)

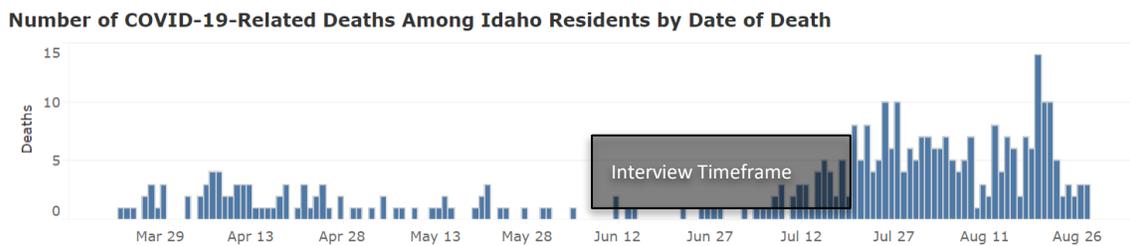


Figure 4: Covid 19 Deaths in the State of Idaho, Idaho Department of Health and Welfare (2020)

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## IMPACTS AND PROCEEDING “AS IF”

The impacts of COVID-19 left respondents trying to figure out how much they should or should not proceed “*as if everything were normal.*” They were trying to negotiate what was normal and what was not.

In terms of guidance, people were juggling what they were told officially with realities in their communities:

We had a couple families that were upset with us because we weren't gonna meet in person even when the state said, "You can do youth activities." and we're like, "Yeah, but we can't stay six feet apart in our playroom, and we've got toddlers and they all lick everything (H003).

I live in [Valley], um, we don't have a ton of cases, and it's frustrating as a member of the community and as a healthcare worker to not see all of the cases but still continue to do all of the things we're asked to do with the masks and the hygiene. The hygiene we're doing anyway, but it's ya know, people ask us as healthcare workers, "Oh aren't you so overwhelmed?" and we're not because things have slowed down, because we're small (H004).

Respondents discussed how they were handling student needs during the pandemic and also what the future will bring:

Well [COVID-19] dramatically affected our staffing initially because ... we lost three or four employee students who could no longer come in. It took our dispensary volunteers that were staff ... also out for quite some time. So it put us down to I think three, maybe four, employees who are all part time trying to run this clinic. Then in addition we were asked to provide jobs for the AHEC students to do, but they couldn't be in the clinic...I think unfortunately it's still gonna be awhile before we can have a lot of students back full-time in our clinic like we had. So, it just forces us to come up with additional ideas in how to utilize students, how to reach out to patients (H010).

I'm hoping our volumes come back... that will definitely affect the number of people that we can employ in the hospital or the amount of students that we can effectively train (H004).

It means for the patients that students don't come. I mean, it's a safety issue. It's for protection. You know, I mean, family members couldn't go visit in any hospital, so, students just didn't get the experience, and we had to do alternative experience. Which is, okay, it's good, but not, you need that combo! You need that hands-on, that face-to-face (H007).

Respondents commented on community responses as well:

...so if you go into public, yeah, a lot of people are not wearing masks. They're not, taking precautions at all... I'm just really cautious. And I keep my six feet away, but some people don't understand how far that is - six feet. So, anyway, a lot of times it's a public belief that they don't need it or they're never gonna get it (H013).

It seems to be perhaps a little short-sighted, but it's really easy to fall into feeling like we're safe here because we're so isolated, and so, I don't know. We'll see how it all plays out. Like I said. I think we maybe just got a positive today, or yesterday, so I think once we get more positives in town, people will probably be taking more caution again... It seems unlikely that we can remain safe for forever (H008).

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## INTERPROFESSIONAL ACTIVITIES AND TECHNOLOGY

The use of technology was mentioned in terms of how respondents were trying to stay connected with clients and other professionals. Zoom and the telephone were commonly used. There were some issues with patient confidentiality and the use of Zoom. On the telephone, patients could have more privacy. Figuring out how to give them access to Zoom or Skype and still protect them was more challenging (H013).

Technology and new ways of doing things also created challenges:

I don't know what on their end made it more difficult to get information, but it just seemed like it was taking longer and longer to get people to get back in touch with you (H003).

...and then THIS happened, and so everything had to go to Zoom for visits which, was not a great format for [visiting] (H003).

Usually, when I do an assessment, I've had to do... it over the phone with - the nursing staff is there. They're doing, they're my eyes to a certain extent (H013).

It's certainly not as gratifying I suppose, to call and you've been staring at a computer screen for 20 minutes or so. I think that personal interaction for a long term would be a loss for both the patients and the staff, but for the short term I think our patients were very grateful that we were still able to reach out to them (H010).

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## THE FUTURE

Respondents talked about the positives that might come from the pandemic. These included things like being able to slow down and being safer in the healthcare setting:

You know things have slowed down in our small community because things slow down when patients don't come. You know, things slow down, and so it's easier sometimes to work together on the patients that we do have because we're not so busy, and we don't all think that we all have more to do than we have time to do (H004).

After every kind of event healthcare changes. I think it's gonna, It's always changed for the best. I've been through wars where war has changed how care is given. Infection - AIDS changed the way we did

healthcare, how we perceived people different than us. I mean it still exists - how we use antibiotics, how we, this whole thing, and so I think Covid will just improve infection control - make healthcare healthier... So I think Covid's gonna say, "Cut that little nonsense out." It's gonna say, "You come to work healthy. You don't have a temp." (H007).

When asked about interprofessional work, respondents talked at great length about how they already work very closely with colleagues and families in multiple professions within their organizations and in the community. They were more familiar with what happened inside of their organizations, but they all shared similar ideas in terms of what to do, how to do it and the challenges that arise because of not working interprofessionally.

When a trauma comes in, it's like it's a choreography... and I wanna see that interprofessionally. I want to see that choreography where the team comes together with that family and it's a team, not just, "Well, because we practice together over and over and over." We discuss. We debrief (H007).

This section details narratives that arose from discussions about interprofessional work. Most importantly, it can be stated that everyone engages in interprofessional work on a regular basis. How they described what that actually means varied. Under this one theme, “everybody’s doing it” five critical perspectives emerged: things work better when physicians engage fully in interprofessional activities, being in closer proximity enables more interprofessional interaction, legal barriers block interprofessional work, results are better when the focus is on the patient and their needs, and sometimes patients act differently if there is not enough interprofessional communication.

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### THE IMPORTANCE OF PHYSICIANS

Some of the most relevant findings from these questions pertain to ideas that physicians need to be an integral part of care, all professionals should be respected, meetings and communication are critical to success; and focusing on patient outcomes, rather than what is brought to the table professionally, produces the best results. Another element of interprofessional work that was discussed by many was the problem of information sharing – how to share it, when to share it, when was sharing too much?

Active physician participation and appreciation of the roles of others was something that was valued and sought after:

Working with other departments in the hospital can be frustrating when they're stuck in their thing and we're stuck in our thing, and then you know, the physicians in the community can be a little frustrating sometimes because they send vague orders... We can only do what's on the order, by law, and so you give us a vague order and then they get upset when we call them to clarify the order, and so, a little more patience or you know, of course doctors are busy. We totally understand doctors are busy (H004).

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## PROXIMITY MATTERS

Respondents highly valued being in close proximity to a variety of professionals. This improved their ability to meet regularly and to communicate more effectively. Regular and consistent meetings were seen as paramount to success when working interprofessionally:

I saw a physician this morning ...had a question, asked it, had a brief conversation about the patient, and then you know I also talked with a nurse about [a patient] today, so we have that opportunity to talk with other staff members, because we see them all the time (H008).

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## LEGAL BARRIERS AND CHALLENGES

Respondents also expressed frustration about the legal barriers to interprofessional work:

There was some legal issues surrounding that, that made it more challenging for us to make that work in a seamless fashion. Like, the school requires background checks and then [our organization] required certain things and the potential for like kids' parents to not have given their permission for them to work with the [professional] that was there at the practice...and so, it turned out to just be a lot of barriers, but I did like that program, and I thought it was really helpful (H008).

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## INTERPROFESSIONAL FOCUS

There was discussion about the importance of focus. If focus was on the patient rather than on issues of scope of practice, outcomes would be better, and team unity would be stronger. Collaborative decision-making was also said to play a role in effective interprofessional work. Meeting for the sake of meeting was not the same as being able to take an active role in what happened with clientele:

Being able to work that closely and intimately with an interdisciplinary team and develop those relationships, to where you trust them and they trust you, I don't know that you find that everywhere. Sometimes I feel like out in the workforce you just feel like you're out there on your own, and when you can develop those interpersonal relationships within your team that you really are working as one unit, all for the same goal, and care of each individual patient - it is very very fulfilling (H005).

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## PATIENTS ACT DIFFERENTLY

Also, one respondent pointed out that patients interact with professionals differently if those professionals are not communicating with each other:

A lot of times [patients] will try to triangulate, because they're not coming to their appointments here, and then they're giving a sad story to their substance person, and yet the substance person thinks that, "Well, we need to give em one more chance." and I'm not the one that makes that decision. We make it as a team (H013).



## SOLUTIONS TO PROBLEMS - CAPACITY

Throughout the interviews respondents were regularly asked what solutions to problems might be. Their answers could best be described as the appropriate addition of money, personnel, access to care, a better understanding of rural communities, resources, time, and training. These are issues of capacity, and though the details vary, there is consistency in solution identification. Provision of care can be improved when there is sufficient capacity:

Sometimes I feel like we don't always, being a smaller community, we may not have all the capacity we need to keep up with their needs. We treat them well. We treat them as best we can, but oftentimes, they're very isolated from family and other support systems, so we don't have a lot of support that they may need (H002).

Most significant is the combination of all of these elements and how they interact. Working across counties, pulling providers into remote areas, pushing away patients who can't receive local services, struggling with the dynamics of being latecomers to the ravages of COVID-19, articulating exactly how provider mixes impact individual communities in unique ways, and advocating for rural lifeways all take resources. This is something to consider when allocating funding based on population size.

Bringing the discussion of themes back to the beginning, a lack of understanding about the challenges that rural communities face is a contributor to the sentiment held by respondents that:

*"I don't think they understand how rural we are. (H013)"*



## CONCLUSIONS

Capturing the stories of site hosts for AHEC Scholars in southeast Idaho helps us understand their lived experiences (Grant et al., 2019). These experiences include how they relate to and make sense of the world around them, what they weigh when making decisions, how they experience their professions in the face of emerging health issues, how they approach rurality and interprofessional work; and how they weave these separate dynamics into the values, attitudes beliefs and actions that shape the culture of healthcare in southeast Idaho.

Results from the study revealed a dedicated group of health professionals who, while not clear about what Southeast Idaho AHEC is, were very pleased with the scholars that they worked with. They shared a deep understanding of the push-pull dynamics associated with working in rural areas. Though some did not live in highly rural communities, they all worked in them. Their dedication to overcoming geographic and structural barriers to care was pronounced. Though the locations of their primary organizations were in five different communities, interview results revealed four health issues, plus COVID-19, that can be considered pressing in all of southeast Idaho: 1) combinations of mental health problems, suicide and substance abuse, 2) care for the elderly, 3) rugged individualism and 4) lack of providers, resources and terminology. COVID-19 presented the most pressing health problem for all respondents. They were in the midst of balancing new ways of doing this with proceeding *“as if everything were normal”*. Even with the challenges presented by technology and communication, they pointed to several areas where healthcare might improve as a result of the pandemic. Interprofessional work is integral to the work that they do. It is highly valued, especially when done in a way that includes everyone in decision-making processes, values patients as the priority and involves strong, constant communication. Solutions to problems related to capacity development.

Results will improve how Southeast Idaho AHEC interacts with site hosts and scholars; how programs are developed, and how information about the region is shared. They provide an opportunity to expand the footprint of southeast Idaho in decision-making circles, contribute to a much-needed pool of literature about this area of the state, build partnerships, and justify the need for continued support of rural and underserved areas.

## RECOMMENDATIONS

1. Require all AHEC Scholars to personally deliver to site hosts an information packet about Southeast Idaho AHEC. This packet should include information about the mission, vision and values of SEID AHEC, responsibilities and expectations of AHEC Scholars, contact information for the director, a statement indicating that they may be contacted by the director, and a form that is signed by both the site host and the student. This form should indicate that both parties are aware of all information provided. It should include the full name, credentials and most efficient contact information of the site host. The AHEC Scholar is responsible for returning this form to the program director.
2. Work with programs to ensure that scholars have AHEC nametags on when doing CEC hours.
3. AHEC Scholars should make the director aware of their sites prior to performing CEC hours.
4. Incorporate findings into lessons for the didactic portion of AHEC Scholars' requirements, ensure they are somehow considered/explored during CEC hours, or highlight them when scholars engage in extra activities like field-trips. Lessons could include interactive discussions and reflections about:
  - a) what site hosts prefer in terms of "go-getters,"
  - b) how to self-recognize and address confidence and hesitance,
  - c) how mental health problems, substance abuse and suicide relate to each other,
  - d) what challenges are faced by elderly populations
  - e) how to adjust to the future of healthcare, given the COVID-19 pandemic
  - f) how to assess the level of interprofessional activity that takes place at CEC sites,
  - g) what it means to live in one town but work in many,
  - h) push-pull dynamics of provision of and access to care
  - i) how to include the phrase "social determinants of health" where it is lacking
5. AHEC funds might be used to visit host sites once it is safe to do so, given the COVID-19 pandemic.
6. Work with health professions programs to compile a list of how they organize student "order of learning."
7. Develop continuing education opportunities that address the unique circumstances faced by southeast Idaho providers.
8. Communicate to decision-makers the complexities associated with designations like "rural" and "HPSA."
9. Share these results broadly with health professions programs, health professionals, other AHECs, academic advisors, organizers of pipeline activities, decision-makers, funders and the academic community.
10. Build upon this evaluation to expand knowledge of, and capacity to address, the unique educational needs of students and providers in southeast Idaho.

## REFERENCES

- 2016 Idaho Primary Care Needs Assessment (Issue January). (2016).  
<https://healthandwelfare.idaho.gov/Portals/0/Health/Rural Health/2016 IDAHO PRIMARY CARE NEEDS ASSESSMENT.pdf>
- American Fact Finder. (n.d.). *Geographic identifiers: 2005-2009 American Community Survey 5-year estimates*.  
[https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_09\\_5YR\\_G001&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_5YR_G001&prodType=table)
- Behre, K. A. (2019). Deconstructing the Disciplined Student Narrative and Its Impact on Campus Sexual Assault Policy. *Arizona Law Review*, 61.  
<https://heinonline.org/HOL/Page?handle=hein.journals/arz61&id=911&div=34&collection=journals>
- Cunningham, F. C., Ranmuthugala, G., Westbrook, J. I., & Braithwaite, J. (2019). Tackling the wicked problem of health networks: The design of an evaluation framework. *BMJ Open*, 9(5), e024231.  
<https://doi.org/10.1136/bmjopen-2018-024231>
- Grant, A., Rix, A., & Shrewsbury, D. (2019). 'If you're crying this much you shouldn't be a consultant': the lived experience of UK doctors in training with mental illness\*. *International Review of Psychiatry*, 31(7–8), 673–683. <https://doi.org/10.1080/09540261.2019.1586326>
- Healthcare Access in Rural Communities*. (2019). Rural Health Information Hub.  
<https://www.ruralhealthinfo.org/topics/healthcare-access#barriers>
- Jeppesen, D. (2020). *Order to Self-isolate for the State of Idaho*. [https://coronavirus.idaho.gov/wp-content/uploads/2020/06/statewide-stay-home-order\\_032520.pdf](https://coronavirus.idaho.gov/wp-content/uploads/2020/06/statewide-stay-home-order_032520.pdf)
- Lee, E. S. (1966). A theory of migration. *Demography*, 3(1), 47–57. <https://doi.org/10.2307/2060063>
- Mission & History*. (n.d.). National AHEC Organization. <https://www.nationalahec.org/index.php/about-us/mission-history>
- Petterson, S. M., Rayburn, W. F., & Liaw, W. R. (2016). When do primary care physicians retire? Implications for workforce projections. *Annals of Family Medicine*, 14(4), 344–349. <https://doi.org/10.1370/afm.1936>
- Pierce, W. D., & Bandura, A. (1977). Social Learning Theory. *Canadian Journal of Sociology / Cahiers Canadiens de Sociologie*, 2(3), 321. <https://doi.org/10.2307/3340496>
- Riessman, C. K. (2005). Narrative analysis. In N. Kelly, C. Horrocks, K. Milnes, B. Roberts, & D. Robinson (Eds.), *Narrative, Memory, and Everyday Life*. University of Huddersfield Press.
- Skillman SM, Dahal, A. (2017). *Idaho's Physician Workforce in 2016*.  
<https://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2015/09/idaho-physician-workforce-in-2016.pdf>
- State of Idaho. (2020). *Stages of Reopening*. Idaho Rebounds: Our Path to Prosperity.  
<https://rebound.idaho.gov/stages-of-reopening/>
- United Nations Development Programme. (2010). *Mobility and Migration*.  
[http://hdr.undp.org/sites/default/files/nhdr\\_migration\\_gn.pdf](http://hdr.undp.org/sites/default/files/nhdr_migration_gn.pdf)

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### HUMAN SUBJECTS

This project was approved as proposal number IRB-FY2020-162 on March 11, 2020 by the human subjects committee at Idaho State University.

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