

Paul Weber Award Application 2011

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Overview of the Trover Campus Rural Pathways Programs

The ultimate purpose of the University of Louisville School of Medicine (ULSOM) Trover Campus is to place more graduating medical students in practice in small Kentucky towns by providing first-class medical education in the small town of Madisonville, Kentucky. Medical students tend to choose practice sites that mirror their site of clinical training. Madisonville is a town of 20,000 located 150 miles southwest of Louisville, in the western Kentucky coal fields. Trover Campus (ULTC) students complete their first two years of medical school (M-1 and M-2) in Louisville, then move to Madisonville for all of their clinical rotations during the last two years of medical school. For the first six years of our campus development (1998-2004), interested students had the opportunity to complete summer programs in Madisonville before and after their M-1 year, and then make a decision whether they were ready to move to the Trover Campus during the M-2 year.

At this early stage, the campus was only able to attract 2-4 students per year, while 12 per year was the goal to begin to meet the health care needs of the Commonwealth. This was despite clear indicators that ULTC graduates had strong academic and clinical performance and compared well to Louisville-based students. The Trover Campus Associate Dean did a careful survey of medical and premedical students from the region as well as faculty and directors of rural health programs around the US and determined the following causes (1):

1) There were too few pre-medical students from rural Kentucky attaining admission to the ULSOM. This was felt to be because of inadequate academic preparation prior to the rigorous pre-medical curriculum and also that some students simply set their sights too low because of the lack of role models and social support, and

2) Most of the rural students who were successful in attaining ULSOM admission were from central or eastern Kentucky. For these students with very close family ties and a strong sense of place, moving to Madisonville for two years (150-350 miles from home) was just too great an obstacle.

So the required solution was clear: we needed to create a series of programs that would provide a comfortable path for a cadre of pre-med students from western Kentucky to be successful academically and choose medicine as a career, resulting in matriculation to ULSOM and a full ULTC class. These ULTC Pathways programs have been successful, with the ULTC Class of 2012 having a full 12 members, mostly from western Kentucky. And so far 64% of ULTC rural graduates are currently practicing in small Kentucky

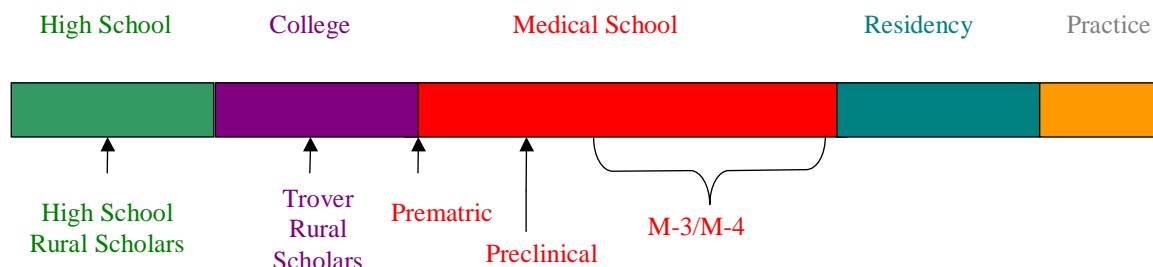
towns. These programs also had to reinforce rural Kentuckians' sense of place and ties to the land and to their communities. Simply beginning programs that were successful in other regions was not to be enough. Through the last 8 years, the ULTC Pathways programs have been continuously modified, based on student feedback, to arrive at their state today. While an individual faculty member's name must be placed at the top of this document, this effort has involved hundreds of individuals, including community based physicians, health department nurses and other staff, the students themselves, premedical advisors, and patients and their families as collaborators.

PATHWAYS PROGRAMS

The High School Rural Scholar (HSRS) program (the earliest Pathways program) includes rising seniors in 5 counties in and around Madisonville and has had 157 participants over an 11 year period so far. While there are many programs that bring students from small towns to urban areas for enrichment activities, the message of these programs is that to do something really special in health careers, one must leave the rural areas. HSRS reverses that process, with the individual student shadowing in their home counties and doing an assessment of what careers are needed and where training is available (2). The academic portion is provided as ACT prep using virtual tutors and a Blackboard Internet site as the classroom. Occasional group sessions at regional resources provide personal interaction. ACT scores are increased by 1-2 points over the 4 weeks and scholars show a clearly increased knowledge of resources and needs in their home county. To date 90% of HSRS are in training or have completed training for a health career.

The Trover Rural Scholar (TRS) program is for pre-med students from western Kentucky who are nominated by their college science teachers early in their college careers. TRS complete a 4 week session in Madisonville that includes shadowing physicians, small group clinical case studies, and academic preparation in organic chemistry, physics, biochemistry, and physiology taught by regional college and ULSOM faculty (3). They also participate with the Preclinical medical students (see below) in completing county health assessments and providing free school physicals for kindergarteners and 6th graders in 2 counties that are health professional shortage areas near Madisonville. To date, 46 students have participated, 6 have finished medical school, and 25 are currently either in medical school or college. TRS with outstanding performance are considered for early assurance admission to the ULSOM with assignment to the ULTC for their clinical years.

University of Louisville School of Medicine Trover Campus



Students admitted to ULSOM with assignment to the Trover Campus are termed Trover Rural Track (TRT) students. During the summer before their M-1 year, TRT students

participate in a 4 week Prematriculation program in Madisonville. This program is a good example of how student feedback has changed the Pathways curriculum through the years. At first it was largely shadowing and lectures. Students at this stage are concerned about 1) being able to talk with patients effectively, and are anxious to try out their skills. They are also 2) mystified by the process that clinicians use to problem-solve. So, a series of community-based efforts was begun that placed students in pairs in rural doctors' offices where they interviewed patients while they waited for the doctor. The focus was first on medication health literacy and then risk factor reduction based on patient attitudes about health behavior change. The group was trained to use the Prochaska (4) model and weekly de-briefing sessions with Dr. Crump honed their interviewing skills. A report was completed and presented to the group by each pair of students (see Appendix, item 5) that was then shared with the host practice site. TRT students report remarkable progress in their comfort and efficiency speaking with patients, and they are much better prepared for continuing their medical studies.

To address the student interest in the problem-solving process, a series of case discussions, facilitated by Dr. Crump, were added twice per week. These sessions used the iterative process approach to problem-based learning (PBL). This is an ideal process for those with little content knowledge of medicine, allowing the discussion to be driven by the hypotheses generated by the students themselves. The boundaries of the discussion are determined by the student group, and may be very different among groups. The result of adding this PBL experience has been that not only do the students report that they now understood what the physicians they shadowed were doing, but that they themselves actually began "thinking like clinicians."

The next step in the Pathways is the Preclinical program during the summer just after the M-1 year. Again, as this program was begun it was only shadowing and lectures. The medical students by this time are comfortable talking with patients and now their focus is on the physical examination. They are anxious to try out their newly learned skills. In the modified curriculum, Dr. Crump provides them a 3-day tutorial for them to hone these skills, and then they, as a group, provide free school physicals (see TRS above) to K and 6th graders. Dr. Crump sees each patient after the student does, discusses any health problems discovered, and makes referrals through the school nurse for ongoing health care. The physical exam is assisted by the TRS students. Then a TRS student accompanies each 6th grader to an anticipatory guidance area where they discuss safety, risky behaviors, and nutrition (see Appendix, item 6). Feedback from the 6th graders and their parents has been remarkably positive, and the youngsters accept this advice well from someone nearer their age who is motivated and focused. At one site, health department nurses supervise the preclinical students as the exams are conducted, creating interdisciplinary collaboration around a common shared task.

The final step in Pathways is a Rural Medicine elective that is taught by Dr. Crump, assisted by other rural physicians. They meet monthly with M-1 and M-2 students in Louisville during the academic year. This maintains the TRT students' focus on rural practice as they live and study in an urban environment. The realities of rural practice are discussed in detail, and a pre- and post-test of knowledge and attitudes demonstrates that the students accomplish the objectives (7, 8).

Thus the Pathways programs, which have been under constant revision for the last 8-12 years, provide a structure that facilitates student success in the first 2 years of medical school and prepares them for entry into the clinical years in Madisonville and their training to become rural physicians. Outcome measures such as standardized clinical examinations show that these students who started medical school slightly below their classmates from urban environments are on a par with the other students by the end of their clinical training. Residency directors have consistently rated ULTC graduates more prepared than their residency classmates from other campuses on most measures of clinical performance.

- **Commitment to Exemplary Teaching:** Describe how the teaching in your unit or department is exemplary or unique. How do best practices in teaching and learning inform your efforts? How do pedagogical practices reflect best practices in your discipline or field of study? How do the efforts of your unit or department contribute to teaching excellence at the University of Louisville?

The key teaching strategy for all Pathways programs is the case studies small group teaching sessions, using the iterative process established by Kassirer (9). Dr. Bill Crump was trained in this process in the UNC Chapel Hill Family Medicine Faculty Development Fellowship, and received formal supervised training at the University of Texas Medical Branch at Galveston in the mid 1990's. The level of discussion in these small groups is determined by the level of the learners, but the process is similar. This innovative alternative to lecture is now widely used in a small portion of the curriculum in most medical schools. Pathways is unique in that the iterative process is at the heart of all student-centered learning.

The other key strategy designed by Dr. Crump that makes Pathways exemplary is community-based, interdisciplinary service learning activities. This process moves students out of the classroom and allows them to provide a needed medical service while learning. By assuring that non-physicians are in key leadership, clinical, and management positions in these activities, the medical students learn the value of truly interdisciplinary work, rather than just talking about it. The list of participants in these activities is listed in the Appendix, and includes a hospital chaplain and medical anthropologist. Pathways programs also engage students more advanced in their medical training to work with and assist less experienced students, in a grouping termed the "learning family" (10).

Our unit's activities contribute on a large scale to teaching excellence at the University of Louisville. Within the university community, Dr. Crump received the U of L Outstanding Community Engagement Award in 2009. The recipient of this award is selected from faculty of all U of L's 12 schools. Our activities have been recognized by key national organizations including the National Rural Health Association and the Society of Teachers of Family Medicine as well as by publications in the 2 premiere journals publishing rural medical education studies (1, 3, 8, 11, 12). In addition, international interest has included the most well-established rural medicine training campus in South Australia (13, 14).

Because of space constraints, we have limited our discussion to Dr. Crump's innovative design and implementation of the preclinical Pathways programs. In addition to Pathways, he has designed and modified curricula for all 8 clinical rotations and teaches

weekly in the Family Medicine, OB/GYN, and Surgery clerkships, where he has received regular positive feedback from students and fellow faculty. He also has used the iterative process to establish a unique twice-monthly group session termed “Dean’s Hour” that includes all the third-year medical students at the Trover Campus. He also is the primary Family Medicine faculty teaching Obstetrics in the residency, and is responsible for the performance improvement process used, including a monthly noon conference. These activities have been recognized by 2 other awards (15, 16).

- **Collaboration:** Describe how members of your academic unit collaborate to enhance student learning. What is the role that individual faculty play in assuring a rich culture of faculty, student, and staff collaboration?

Our “academic unit” includes all of our community partners (see list in Appendix, item 17) in a real and tangible way. True, working collaboration is interwoven through every aspect of the Pathways programs, as detailed above and in the Appendix. County-specific community health councils were established early in the development of these programs, and they guide our efforts, even having full responsibility for interviewing and choosing the HSRS students each year. Continuous performance improvement is important at every stage of learning and practice. Each year the students’ reports are provided to the community participants, providing a valuable summary of the students’ perceptions which can be used by the communities to plan for improvement.

- **Research-Based and Data-Driven Results:** What is the evidence that the work of your unit or department has impacted student learning in the past? What is the procedure for collecting and analyzing data to inform ongoing improvements? How is impact on student learning measured?

Each program includes pre-and post tests and surveys as well as student and community informal focus groups. As shown in the evaluations and course materials in the Appendix, item 20, each component of each program is reviewed twice per year, and many changes have been made along the way. Impact on student learning has also been presented at national meetings and published frequently (1, 2, 3, 7, 8, 10, 11, 12, 13, 14, 18, 19)

- **Evidence of Sustainability:** Describe how your unit’s record of teaching excellence will be sustained beyond the award period. How will members of your unit ensure the long term success of your innovations in teaching and learning? What provisions have been made to make your efforts self-sustaining?

The ULTC has become an integral part of the ULSOM, having been cited in the last LCME accreditation visit as one of the 10 strengths of the entire ULSOM. However, the ULTC is funded on a 2-year grant cycle from the Kentucky Department of Local Government, using coal severance tax proceeds. The amount of funding has not increased over the last 10 years, as M-3 and M-4 class size and costs have increased. The result is that the number of participants in the Pathways programs will have to be decreased until the next full legislative session when our request for increased funding will be considered. So, the Pathways are now self-sustaining, but the Weber award would allow us to avoid decreasing the size of the programs in the short term.

Addenda

1. Crump WJ, Fricker S, Barnett D. A Sense of Place: Rural training at a regional medical school campus. *Journal of Rural Health*, January 2004; 20(1):80-84.

Context: Traditionally, rural students experience urban disruption during the many years of education and training in urban environments before choosing a practice site. Regional rural campuses that allow students to live and work in small towns during the last 2 years of medical school are one strategy to address this issue. **Purpose:** To report the results of the first 10 years of a rural campus in western Kentucky, including response to difficulties filling openings for third- and fourth-year medical students at the campus. **METHODS:** A survey was sent to all 76 students who had shown interest in the rural campus, asking them to prioritize the important issues in their campus choice. **Findings:** Students not choosing the rural campus placed a higher priority on large-city amenities, better opportunities for their spouse, and proximity to family in eastern and central Kentucky. Students who chose the rural campus placed a higher priority on one-on-one clinical training and interest in small town life. **Conclusions:** For the rural clinical campus to reach its potential, more rural students from the western part of the state must be admitted to medical school and then choose this campus. Strategies to reinforce the sense of place among rural students focus on experiential programs in rural areas. Initial results suggest that medical educators should consider geography more carefully when designing approaches to address physician maldistribution.

2. Crump WJ, Fricker S, Brown A, Coakley V. An innovative method for preparation for rural practice: The High School Rural Scholars Program. *Journal of the Kentucky Medical Association* November 2002;100(11):499-504.
3. Crump, WJ., Fricker, S., Crump, A. M., Just what are rural pre-medical students thinking?: A report of the first 6 years of a pathways program. *Journal of Rural Health* , January 2010; 26(1): 97-99.
4. Prochaska JO, Norcoss, JC, DiClemente, CC. Changing for good: a revolutionary six-stage program for overcoming bad habits and moving your life positively forward. New York, NY: Avon Books; 1994.

Addendum, Item # 5
 Change Assessment Project (CAP)
 ULSOM Trover Campus Prematriculation Program
 Summer 2010

I. Summary

The following table presents the Stages of Change identified by the Summer 2010 Trover Prematriculation Students. A total of 35 interviews were conducted in [the office of a private physician] located in [rural], KY. 15 of the interviews focused upon smoking, 20 focused on exercise.

19 respondents were definitively identified by the students as falling into one of the stages of change and 16 had relapsed from another stage.

Stage	[Physician's Office].		All Sites	
	Number	Percent	Number	Percent
I	3	8.6%	26	13.0%
II	0	0.0%	10	5.0%
III	0	0.0%	14	7.0%
IV	2	5.7%	12	6.0%
V	7	20.0%	66	33.0%
VI	7	20.0%	31	15.5%
Relapsed	16	45.7%	38	19.0%
Not Staged	0	0.0%	3	1.5%
Total	35	100.0%	200	100.0%

Prochaska's Stages of Change	
Stage I	Pre-contemplation (Apathy) "I don't have a problem." "My grandpa smoked till he was 90."
Stage II	Contemplation (Entry Stage) "I have a problem." "There's something about myself I need to change."
Stage III	Preparation (Commitment) "I've tried to change, but failed." "I really need to do something."
Stage IV	Action (Implementation) "I'm working hard at this." "I need to talk to someone."
Stage V	Maintenance (Success) "I've made the change, but I feel like I'm slipping back." "I need a boost to keep on."
Stage VI	Termination (Cure) "I quit smoking 35 years ago when my kids were born."

Change Assessment Project Report Summer 2010

As part a Change Assessment Project (CAP), we were assigned to [a] Medical Center with [a private physician] to study the health habits of Kentuckians. In particular, patients were surveyed on their previous and current smoking or exercising habits. A Prochaska and DiClemente's Stages of Change Model was used to classify the patient based on their survey answers.

[The] Medical Center (MC) is located in [rural], KY has six exam rooms with a pharmacy located within the building. [The physician] is the sole medical provider at the location and there are no visiting clinicians. The clinical staff consists of two LPNs, one X-ray technician, and two members of the office staff. On-site diagnostic capabilities include EKG, X-ray, and CLIA waived lab. In this lab, they can perform rapid strep tests, pregnancy tests, and urine dipsticks.

The patient mix at MC in terms of gender is approximately 50% male and 50% female. Overall, 75% of the patients are adult while 25% are pediatric. The average age of patients seen in the clinic vary by the time of the year. For example, more children are seen in the fall to have school and sports physicals performed. Approximately 90% of the patients are Caucasian with the remaining 10% varying in ethnicity. Roughly half of the patients have private health insurance, 45% have Medicare, while the remaining 5% have Medicaid or no insurance.

During a six-day period we performed CAP surveys on 35 patients. Of the 35 patients, 15 were classified with respect to smoking and 20 were classified with respect to exercise. Of the smoking survey patients, currently 75% were in the maintenance or termination phase of quitting smoking. These patients had not smoked for a minimum of six months, although many had not smoked in decades. Most of the patients who had quit smoking did so without the help of medication or drugs. As one patient exclaimed, "I tried to quit, and that was all I needed. I quit with my grandfather. We made a bet to see who could quit first." The other 25% of smoking survey patients were pre-contemplative or contemplative and had all relapsed from a higher stage such as action or maintenance. We found it surprising that out of these smoking relapse patients, only one was even considering quitting again. As one patient said, "I'm 62 years old, so I don't plan to quit. I like to smoke while I drive." There was a wide variety of reasons that the relapsed pre-contemplative patients did not want to quit. These included significant recent hardships at home and general lack of desire due to past failed attempts.

Of the exercise survey patients, a little less than 75% were currently not in a regular routine of exercising. A majority of these patients attributed their sedentary lifestyle to their poor physical health. All of the patients who were not currently exercising due to their health had previously led a more active lifestyle; their reasons for not exercising at this time include problems such as arthritis, chronic pain, acute injuries, and old age. For example, one patient said, "It hurts to exercise. I know I need to though." We found it interesting that many of the patients believed that they were getting adequate exercise through their jobs. However, many of these job activities only involved short periods of physical exertion that is typically insufficient for an exercise routine. Of those participants that were currently exercising, many were fairly new to the habit and had started the routine in the past couple of years. Many of the people currently exercising had begun to reduce health complications such as diabetes. One patient said, "When I learned that I had diabetes, I didn't want to be like my mother. So I started to exercise." Out of all of the patients surveyed about exercising, well over half had relapsed and tried multiple attempts to begin an exercise regiment.

As part of our recommendation for this site, we suggest printing flyers with low strain exercises. Since many of the patients were not physically able to perform strenuous exercise routines, providing them with handout from a website such as <http://extension.missouri.edu/publications/DisplayPub.aspx?P=MP696> could give them easy alternatives that can be done at home. Additionally, we suggest that smoking patients be reminded that smoking is bad for their health, even if they currently have no intention of quitting. Simply briefly mentioning the topic at each visit and reminding the patient that the physician can offer aid requires little time and could have benefits. Furthermore, electronic smoking devices are now easily found online that offer the same smell, taste, nicotine and habitual movements of smoking but without carcinogens. These devices could be discussed with a contemplative patient. Our final recommendation for the site is to use the hand sanitizer more frequently. It is very easy to forget to sanitize hands between each patient. However, it is important to remember that you are not only sanitizing for the safety of your next patient but also for your own health.

We found the smoking and exercising algorithms to be helpful in staging each patient. It provided a clear guideline as to what to ask patients based on their previous response. One area that was not entirely clear was the definition of exercise. Many people have very different ideas and definitions of exercise. One person may think that getting out of bed and cooking a large breakfast for her family is exercise while another considers 3 hours at the gym exercise. This ambiguity sometimes blurs the staging results. It may be useful to come up with a clear definition of exercise to explain to the patient so there is no confusion and less subjectivity. We believe the CAP scoring sheet should be edited so that there is not a category with "Least exercise minutes per week." Everyone goes a week or two without exercising at all at some point. Therefore, most of our results contained a "0" in that column. Perhaps if it were changed to "Longest length of time without any exercise," it might give a better representation of overall health.

Addendum, Item # 6

Anticipatory Guidance Check Sheet used by Trover Rural Scholars Pre-clinical Student Screen Teams (PSST) 6th Grade School Physicals

POINTS TO REMEMBER

SAFETY

What are some things to do to keep safe at home?

- ASK your parents to install smoke detectors in your home and CHANGE the batteries twice a year. (When the time changes in the Fall and the Spring.)
- AVOID high noise levels, especially music headsets.
- DEVELOP a fire escape plan and CONDUCT fire drills occasionally.

How do you stay safe outside home?

- ALWAYS wear a seatbelt correctly when riding in an automobile. NEVER ride in a vehicle if you suspect the driver has been using drugs or alcohol.
- LEARN to swim and know the safety rules of the water.
- ALWAYS wear sunscreen when outside, even on a cloudy day.
- NEVER carry or use guns or any other types of weapons. LEARN and USE gun safety.
- ALWAYS wear a helmet when riding a bicycle or a four-wheeler.

NUTRITION

How do you get and keep a healthy body?

- EAT three meals a day and CHOOSE a variety of health foods.
- When you snack, choose nutritious foods, such as fruit, raw vegetables, yogurt, cereal, or crackers. LIMIT high fat, low nutrient snacks, such as candy, chips, or soft drinks.
- MANAGE your weight through good eating habits and regular physical activity.
 - ◆ For nutritional guidance, you can call the Health Department at 273-3062 or the University of Kentucky Extension Office at 273-3690.

HEALTHY TEETH

How do you keep your teeth healthy?

- CONTINUE to brush your teeth at least twice daily and FLOSS your teeth daily.
- WEAR protective sports gear such as a mouth guard or face protector for contact sports.
- SCHEDULE a dental visit every six months, unless your dentist recommends otherwise.
- DO NOT smoke, chew or use smokeless tobacco.
 - ◆ For additional information, you may call the local dentist, Dr. Thacker at 273-2385 or free McCauley Clinic, you may call the FRYSC at 273-0065.

MENTAL HEALTH

How do you keep your mind healthy and you happy?

- TAKE on new challenges that will increase you self-confidence.
- CONTINUE learning about yourself. (what is important to you, what you believe in)
- LEARN to feel good about yourself through learning what your strengths are and listening to what good friends and valued adults say about you.
- FOLLOW family rules, such as those for curfews, television and internet viewing, and chores.
- BECOME responsible for your own school attendance, homework, and course selection.
- LEARN to recognize and deal with stress.
- UNDERSTAND the importance of your religious and spiritual needs and try to fulfill them. If you often feel scared, depressed, angry or hopeless, talk to an adult you trust or to your guidance counselor.
- PROTECT yourself from physical, emotional, and sexual abuse by taking care of your mental health and always being aware of your environment.

- ◆ If you are experiencing emotional, physical, or sexual abuse (If someone is hurting you or making you do things with your body you don't want to do) TELL your healthcare provider, a responsible adult, or call the abuse hotline at 1-800-752-6200 for help. For additional help, you can call Oasis, based in Ohio County, at 298-4485, or New Beginnings, in Owensboro, at 926-7273.

SEXUALITY

How do you know what to do about all the changes in your body?

- ➔ ASK your healthcare provider any questions you may have about body changes during puberty.

What are the options concerning sex?

- ➔ NOT HAVING SEX is the safest way to prevent pregnancy and sexually transmitted diseases, including HIV infection/AIDS.
- ➔ LEARN about ways to say NO to sex. KNOW the concept of "COERCION," which means tactics used to get a person to do something they do not want to do. These tactics include: PERSUASION ("I know you really want to. . ."), PRESSURE ("If you loved me you would. . ."), BLACKMAIL, ("If you don't, I will. . ."), GUILT ("I took you out, you owe me"), and PUT DOWNS ("No one else will ever want you").
- ➔ LEARN techniques for being ASSERTIVE about sexual activity. USE statements like "When you _____, it makes me feel _____" or "I want you to _____ or I will _____." AVOID use of alcohol and drugs as these agents may be used to manipulate a person into sexual activity. AVOID situations that may lead to coercive attempts (being home alone with your boyfriend or girlfriend). SUGGEST alternatives ("Let's go get a pizza"), IDENTIFY consequences ("I could get pregnant"), or LEAVE and WALK away if necessary. Individuals have the RIGHT to REFUSE to engage in sexual activity or to END the activity at any time.
- ➔ IF you are engaging in sexual activity, including intercourse, ask your healthcare provider for an examination and DISCUSS sexually transmitted diseases and methods of birth control.
- ◆ For more information, you may call the McLean County Health Department at 273-3062.

INTERNET SAFETY

- ➔ NEVER give any personal information to anyone you meet on the internet.
- ➔ NEVER meet someone or have them visit you without the permission of your parents.
- ➔ Make sure you KNOW everybody on your "buddy" list.
- ➔ DON'T give out personal information in a chat room or on a bulletin board.
- ➔ There is no such thing as PRIVACY on the internet.
- ➔ Be careful about posting pictures of yourself. ANYTHING you post can be viewed by anybody.
- ➔ NEVER share your password with anyone but your parents.
- ➔ Don't download content without your parent's permission.
- ➔ Social networks should be entered with caution.
- ➔ For further information you can visit www.safekids.com .
- ➔ BOTTOM LINE: Always stay alert when on the internet. People are not always who they seem to be.

TEXTING

- ➔ Turn your cell phone OFF at night to get the best night's sleep.
- ➔ Do not let anyone you are riding with text while driving.
- ➔ If you receive an inappropriate text – simply DELETE it and notify your parents. Do not forward it.
- ➔ When walking KEEP your eyes ahead of you not on your phone.

SEXTING

- ➔ Sexting refers to sending a text message or IM message with sexual content or pictures.
- ➔ This type of texting can cause emotional pain.
- ➔ Don't take or send sexually suggestive photos of yourself or anyone else.
- ➔ Sexting is considered a CRIME in some states.

7. Crump WJ, Moore AC. Experience with a rural medicine elective for preclinical medical students at an urban medical school. *Journal of the Kentucky Academy of Family Physicians*, Winter 2004; 50(1):9-14.

8. Crump WJ, Fricker RS, Ziegler CH. Outcomes of a preclinical rural medicine elective at an urban medical school. *Family Medicine* 2010; 42(10):717-722.

Background And Objectives: *The University of Louisville School of Medicine Trover Campus (ULTC) was established in rural west Kentucky in 1998 with the purpose of increasing the number of rural physicians. Utilizing the affinity model, a primary goal of the ULTC is to encourage rural students to pursue a medical education and return to rural Kentucky for practice. One aspect of this geographically separate clinical campus includes a Rural Medicine Elective (RME) offered during the basic science years. We report here the effect of the RME on student opinions and knowledge concerning rural practice, as well as initial effects on specialty and rural practice choice. Methods:* Opinion responses and knowledge on a written exam using a pre-RME and post-RME survey for the 2004-2009 classes were analyzed. Pre-RME opinion items were examined descriptively (n=36). Pre-and post-opinion responses (n=23) and summation scores of 11 domains on exam questions (n=50) were compared using the Wilcoxon Signed Rank test. The proportion of students choosing family medicine and subsequent practice site choice were also measured. **Results:** RME student opinions about rural practice indicated improved agreement with information as presented in the course material. Similarly, on 11 knowledge examination summation scores, pre- and post-exam results showed significant increases in 10 domains. The pre-test answers provided an interesting baseline of beliefs. RME students were far more likely to choose family medicine than their classmates, and initial results show an increased likelihood of subsequent rural practice. **Conclusions:** The initial outcomes of the RME are encouraging and indicate such an elective can maintain positive opinions about rural practice among rural students attending an urban medical school. The RME is also successful in increasing students' knowledge about rural practice and may maximize the likelihood that they will choose rural practice.

9. Kassirer JP. Teaching clinical reasoning: Case-based and coached. *Acad Med* 2010; 85:1118-24.

10. Crump W, Quertermous P, Crump A, Fricker S, Hughes G. Providing Free School Physicians: A Lab for Developing "Learning Families" of Rural Pre-Med and Medical Students. National Rural Health Association Annual Meeting. Anchorage, Alaska, May, 2007.

11. Crump WJ, Fricker RS, Wiegman DL. The role of a rural medical school campus in developing a sense of place: the first 10 years. *Family Medicine* 2010; 42:160-161

12. Crump WJ, Fricker RS, Wiegman DL. A 10-year Evaluation of the Trover Campus: Lessons learned for addressing the need for more rural physicians. *Journal of the Kentucky Medical Association* 2010; 108(5):137-143.

Context: *In response to the perceived looming shortage of physicians, most medical schools are increasing their class size and several states are establishing new regional clinical campuses to provide adequate patient populations for the increased number of students. Regional campuses with a rural focus provide the opportunity not only to increase the number of graduates, but to address the issue of maldistribution as well. Purpose:* We report here the first ten years of experience with a regional rural campus in a town of 20,000 in western Kentucky, part of the University of Louisville School of Medicine. The host community had almost 35 years of tradition hosting visiting medical students and full time family medicine residents when the campus was begun. There was a slow, incremental increase of class size from 4 to 12, allowing for the development of a full support infrastructure, including student affairs functions. **Methods:** Early in

*campus development the recruitment of rural students from western Kentucky was hampered by the low number applying successfully to medical school. A series of pathways programs from high school through the M-2 medical school year was developed that has successfully addressed this issue. **Findings:** Initial data on residency choice of graduates shows 88% choosing primary care and 51% family medicine. Of those graduates establishing practice so far, 70% are located in rural communities. **Conclusions:** A rural regional campus can address the maldistribution of physicians. Key issues are 1) student affairs, 2) curriculum adaptation, 3) faculty development, 4) accreditation, and 5) admissions.*

13. Crump WJ: Five Questions You Should Ask Your Students and Yourself. Convocation Address to Flinders University Parallel Rural Clinical Curriculum (PRCC) Faculty. Mannum, South Australia. May, 2008

14. Crump WJ: Co-facilitator, "How to Give Feedback To Students In a Busy Clinical Setting." Flinders University, Parallel Rural Clinical Curriculum Symposium. Mannum, South Australia. May, 2008

15. Rural Medicine Development Award, University of Louisville. 2002

16. Distinguished faculty member, University of Louisville School of Medicine, Chapter of the Alpha Omega Alpha Honor Medical Society. 2003.

Addendum, Item # 17
ULTC Rural Pathways Program Community Partners

Community Physicians	Specialty	Community Physicians	Specialty	Others cont'd
Akram, Dr. Muhammad	Cardiology	Popescu, Dr. Tudor	Internal Medicine	Dodson, Whitney
Asriel, Dr. John	Family Medicine	Prunty, Dr. Marshall	Family Medicine	Dunnihew, Pat
Ataqi, Dr. Basel	Hospitalist	Quijano, Dr. Rennan	Pediatrics	Edwards, Kathy
Bandy, Dr. Eric	Internal Medicine	Rajner, Dr. Collette	Family Medicine	England, Leigh
Bone, Dr. Bill	Family Medicine	Ricketts, Dr. Heather	OB/GYN	Ferrell, Carolyn
Chaney, Dr. Herbert	Family Medicine	Roe, Dr. Joe	Sugergy - General	Ford, Marjorie
Chapman, Dr. Darren	Surgery	Schluckebier, Dr. Deidre	Forensic Pathology	Ford, Pam
Chumbley, Dr. Eric	Sports Medicine	Sedlak, Dr. Steven	Hematology	Gibson, Robin & Mack
Cole, Dr. Kelly	Family Medicine	Shah, Dr. Satish	Oncology	Goldston, Susan
Cole, Dr. Wayne	Family Medicine	Siddique, Dr. Muhammad	Oncology	Gray, Jim
Cost, Dr. Quinn	Family Medicine	Snell, Dr. Beth	Surgery - General	Hammack, Pat
D'Amico, Dr. Anna	Urology	Soriano, Dr. Alex	Neonatology	Holt, Laura
Davis, Dr. James	Sleep Medicine	Sparks, Dr. Brad	Family Medicine	Hurst, Jan
DeNeen, Dr. Andrea	Cardiology	Sreekumar, Dr. B.N.	Cardiology	Hutcheson, John "Chip"
Devineni, Dr. Suresh	Oncology	Steinfeld, Dr. Carroll	Gastroenterology	Jones, Robbie
Dodds, Dr. Carrie	Pediatrics	Stulc, Dr. Jari	Surgery - General	Kelley, Nancy
Dodds, Dr. Jimmy	Orthopedics	Tackett, Dr. Mark	Family Medicine	King, Arlene
Dsa, Dr. Joylin	Family Medicine	Taha, Dr. Wael	Hospitalist	King, Mary Ann
Dysert, Dr. Gerald	OB/GYN	Taylor, Dr. Dawn	Family Medicine	Knight, Danny
Ewing, Dr. John	Family Medicine	Taylor, Dr. Tanika	OB/GYN	Knott, Denny
Farmer, Dr. Joey	Family Medicine	Taylor, Dr. Terri	Optometry	Larin, Joe
Fazenbaker, Dr. Stacey	Family Medicine	Turley, Dr. Karla	OB/GYN	Locke, Kim
Fitzmaurice, Dr. Mark	Ophtalmology	Vettiankal, Dr. George	Cardiology	Lovell, Charles Jr.
Galloway, Dr. Stuart	Family Medicine	Vincent, Dr. Kelly	Family Medicine	Lowther, Owatta
Galyen, Dr. Billie	Family Medicine	Wood, Dr. Mont	Family Medicine	Matera, Elizabeth
Garrett, Dr. Kristy	Family Medicine	Zent, Kevin	Family Medicine	McCall, Gray
Gilkey, Dr. Sandy	Family Medicine	Neely, Dr. Tom	OB/GYN	McCann, Rev. Bill
Gonzalez, Dr. Ramon	OB/GYN	Newsome, Dr. Tara	Family Medicine	Menser, Christina
Goodale, Dr. Dianne	Family Medicine	Parsons, Dr. Jeremy	Family Medicine	Mitchell, Beth
Goyal, Dr. Lalchand	Cardiology	Health Department	Schools cont'd	Moore, Linda
Hack, Dr. Michael	Family Medicine	Barber, Sandy	Campbell, Judy	Moser, Kevin
Hamman, Dr. Jack	Surgery - Vascular	Brown, Laura	Hayden, Judy	Oglesby, Lorie
Hanke, Dr. Forrest	Family Medicine	Burnett, Carolyn	Higdon, Kristi	Perry, Pam
Harbin, Dr. Stacy	Surgery - General	Calvert, LaDonna	Kimbrell, Lisa	Peterson, Ron
Hardison, Dr. Barry	Internal Medicine	Casebolt, Shirley	Mayes, Jeannie	Phebus, Carol
Hawkins, Dr. Susan	Family Medicine	Coakley, Alice	Melloy, Earl	Pierce, Beth
Henning, Dr. Glenn	Podiatry	Donahoo, Kelly	Moore, Shannon	Pleasant, Martha
Henson, Dr. Hope	Family Medicine	Donahoo, Lesia	Powell, Mary	Powell, Elizabeth
Holder, Dr. Kenneth	Family Medicine	Eubanks, Carla	Ransom, Tommy	Powell, Randall
Howard, Dr. Mike	Family Medicine	Farris, Beth	Spear, Rhonda	Pugh, Debbie
Huber, Dr. Carrie	OB/GYN	French, Sophie	Vanover, Lori	Riley, Christi
Hunt, Dr. Allison	Forensic Pathology	Hagan, Jenny	Vick, Deborah	Roberts, Martha
Johnson, Dr. Allen	Psychiatry	Hardy, Jeanie	Walker, Judy	Rogers, Eva
Johnson, Dr. Tommy	Family Medicine	Hodges, Kelly	Wolford, Susanne	Rutledge, Kelsey
Jones, Dr. Jayna	Family Medicine	Klaas, Athena	Wooton, Lori	Scott, Margaret
King, Dr. Richard	Family Medicine	Lewis, Beby	Others	Shadrack, Vickie
Klompus, Dr. Bill	Urology	Morris, Jack	Adams, Sheria	Son, Kathy
Kluger, Dr. Neil	Oncology	Nall, Renee	Alexander, Dottie	Soto-Garcia, Yuli
Kovtun, Dr. Natalia	Internal Medicine	Nalley, Connie	Arbuckle, Roger	Springer, Lorrie
Larsen, Dr. Ferris	Internal Medicine	O'Neal, Peggy	Braden, Myra	Stanley, Glenda
Leigh, Dr. Lynn	Family Medicine	Owen, Anita	Bradshaw, Robbie	Steele, Joey
Lineberry, Dr. Tristan	Family Medicine	Patterson, Joanie	Brooks, Debbie	Steely, Mary
Littlehale, Dr. Mark	OB/GYN	Renfrow, Cristen	Brooks, Robert	Stovall, Nancy
MacDougal, Dr. Bruce	Surgery - Plastic	Rich, Brea	Caskey, Rick	Tapp, Linda
Martin, Dr. Dan	Family Medicine	Ricles, Tammy	Cates, LaDonna	Tapp, Melanie
Martin, Dr. Jim	Family Medicine	Scott, Pat	Chaney, Megan	Todd, Dale
Mayer, Dr. Lee	Dentistry	Taylor, Lisa	Cherry, Gale	Tolley, James
McEntire, Dr. Brent	Med - Peds	Taylor, Melissa	Crispin, Dr. Bethany	Whitaker, Mr. Bert
McNeal, Dr. Reed	Pediatrics	Schools	Crump, Allison	Wilhelm, Sr. Fran
Miles, Dr. Rick	Family Medicine	Atherton, Becky	Cullen, Bro. Barry	Yonts, Jan
Mufti, Dr. Nagma	Neurology	Brown, Will	Dampier, Bob	Yonts, Vicki
Murphy, Dr. Tim	Family Medicine	Bumpus, Donna	Dickerson, Michelle	Zea, Steve

18. Crump WJ: A Rural Free Clinic as Curriculum: Developing a Sense of Place in a Medical Home. Poster Presentation Society of Teachers Family Medicine Conference. Savannah, GA. January 2009

19. Todini, Carole R and Crump WJ. Building a Regional Clinical Campus: Experience with Preclinical Students. Family Medicine January 1999; 1(1):6-7.

Addendum, Item 20
High School Rural Scholars program Evaluations 2002-2010
Average Responses by Participants

Curriculum Component	9 Yr	2010	2009	2008	2007	2006	2005	2004	2003	2002
	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg
HSRS Program overall	9.6	9.4	9.8	9.6	9.7	9.8	9.1			
AHEC Medical Dictionary	6.1	5.5	7.0	6.0	5.4	6.1	5.8	7.0	6.4	
AHEC Health Careers Resource Guide	6.8	5.1	6.7	5.7	6.1	8.3	7.0	6.6	8.6	
Kaplan ACT Book	8.1	8.8	9.5	5.7	8.4	9.5	8.7	6.0	8.3	8.5
ACT Pre-test/Post-test/Assistance	8.4	8.5	8.4	7.8	8.0	9.5				
Tutors available on line (internet)	7.1	6.8	7.8	7.3	7.7	8.2	6.3	5.4	6.7	8.1
Blackboard posting process	8.0	8.3	8.5	8.1	8.4	8.9	7.3	6.5		
Interaction/Shadowing health professionals	9.6	9.7	9.9	9.3	9.6	9.8	9.8	8.6	9.8	9.6
Basic Life Support Training	8.7	9.5	9.7	8.3	9.2	9.4	7.7	6.6	8.8	8.9
Tour of Madisonville Technical College	8.1	9.2	8.8	8.2	7.6	9.2	9.1	5.9	6.9	7.7
Tour of CRNA Program	8.5	8.8	9.1	8.5	8.9	9.0	8.9	7.1		7.7
Tour of Western Kentucky Veterans Center	8.4	8.8	9.2	8.6	9.1	8.8	9.1	7.3	7.9	6.4
Tour of Medical Examiner's office	8.9	8.8	9.9	8.9	9.2	9.3	9.1	7.3		
Tour of Western Kentucky Hospital Services	6.2					6.1	6.6	6.0	6.6	5.6
Working at the host site	7.2				5.7	9.1	8.5	6.4	6.3	7.3
Presentations by Health Professionals	7.8					8.2	7.4	7.3	8.4	
PT Session	8.8	8.4	9.3							
Pharmacy Session	8.7	8.5	8.8							
Nursing Session	8.5	8.5								

*Participants asked to rank from 1 to 10 the degree to which they felt the program's components met the goals of the program. 1=strongly disagree, 10=strongly agree.

Addendum, Item # 21
Trover Rural Scholars Program Evaluations 2003-2010
Average Responses by Participants

Curriculum Component	8 yr	2010	2009 Jun	2009 Jul	2008	2007	2006	2005	2004	2003
	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg
Case Studies - Dr. Crump	9.3	8.5	9.3	8.7	9.5	9.6	9.5	9.4	9.4	10.0
Preceptor Shadowing	9.2	9.4	10.0	8.8	8.8	9.4	9.9	9.3	9.8	9.3
Working with Preclinical students on case studies	8.7	8.1		8.1	8.7	9.6	9.8	8.0	8.7	8.9
Working with Preclinical students on PSST Project	9.1	8.6		8.7	8.6	9.7	9.9			
Physiology Tutorial	9.2	9.0		9.0	9.5	9.8	9.6	9.3	9.5	7.6
Organic Tutorial	8.5	9.5	9.3		10.0	8.7	7.8	8.7	6.8	7.6
Biochemistry Tutorial	8.5	8.3		6.7	8.3	9.7	9.3	8.3	8.8	
Physics Tutorial	7.7		8.0		6.4	6.0	9.7	7.9	8.2	
PSST (Preclinical Student Screening Teams)										
Webster County Panel	8.6	8.3		8.1	9.5	8.6				
History/Physical Prep	9.0	8.5		8.4	8.9	9.7	9.4			
Anticipatory Guidance Prep	8.7	8.5		7.6	8.7	8.9	9.9			
Community Assessment Prep	8.3	8.4		8.3	8.5	8.2				
Key Informant Visits	8.3	7.4		8.3	9.0	8.6				
Physical Exam Sessions - McLean	9.7	9.6		9.4	9.5	9.9	9.9			
Physical Exam Session - Webster	9.5	9.6		9.0	9.2	9.7	9.9			
PSST Final Report	8.0	9.2		7.7	7.6	7.6	8.1			
Quiz Bowl	7.1	7.0	8.0	6.3	7.0	6.9	7.4			
Reflective Reading	8.2	8.7	8.0	8.4	9.0	7.8	7.5	7.8		
Trover Rural Scholar Key Note Address	7.6	8.1		9.0	8.4	8.1	6.1	4.8	7.8	8.6
Seminar with Key Note Presenter	7.7	8.4		8.6	9.4	8.8	7.1	3.8		
Noon Conferences	7.7		7.5	7.3	8.6	7.3	6.6		9.1	7.7
Rural Seminar: Trover Rural Scholar Key Note Address	7.6	8.1		9.0	8.4	8.1	6.1	4.8	7.8	8.6
Rural Seminar with Key Note Presenter	7.7	8.4		8.6	9.4	8.8	7.1	3.8		
Rural Seminar: Rural Hospitals	8.5	8.4	7.3		9.7	8.3	9.0	7.8		8.7
Rural Seminar: Community Health Centers	8.7	8.7						8.3	9.0	
Rural Seminar: Coal Mining	7.3		7.3		7.8	6.7				
Vascular Session	7.1	8.4	7.0	5.9						
West AHEC medical dictionary	6.9	7.5	6.3	6.2	8.7	8.1	6.0	5.7		
Merck Manual	8.8	8.9	8.0	8.2	9.0	9.0	9.1	8.6	8.4	10.0
Essays	8.1	8.2	8.0	8.1						
"Family Medicine" Book	8.2	7.9	7.3	8.8	8.6	8.9	7.5			
Tarascon Pocket Pharmacopoeia	5.9		5.3					6.5		

*Participants asked to rank from 1 to 10 the degree to which they felt the program's components met the goals of the program. 1=strongly disagree, 10=strongly agree.

Selected comments from participants:

The PSST is unique, real-world application of what we learn. There could never be a stronger motivator for academic and professional success than the patients. Just having a role during the screenings challenged me to do well in school and ultimately to learn medicine .

The "coursework" definitely gave me an idea of some of the things to expect while in medical school and that was good. The academic counseling session helped a lot of too. I definitely enjoyed all the PSST clinics. The tutorials were also great.

I most enjoyed working with other TRS and children during PSST. I was able to have direct contact with the children and I got a feel for the responsibility the physician takes.

I really enjoyed working with my preceptor, for he was a great educator. Also, PSST sessions were full of excitement and fun. I loved interacting with the kids and got a sense of achievement after educating them on serious health topics.

I enjoyed the program and would love to do it again in the winter/summer. [My preceptor] was great, The actual views in the rooms were almost always the same. Almost all were drug refills. This is a not a problem with [my preceptor] but just comes with what he does. It was rather enlightening to see the drug seekers and the applications of drugs given to users and how they are handled.

[My Preceptor] helped me learn a lot of tactics he uses to deal with patients. He made every attempt to fill me in on the patients and their history before the exam and he told me why he had given the patients whatever treatment he had ordered after the exam had finished.

Addendum, Item # 22
Prematriculation Program Evaluation 2004-2010
Average Responses by Participants

Curriculum Component	7 Yr	2010	2009	2008	2007	2006	2005	2004
	Avg	Avg	Avg	Avg	Avg	Avg.	Avg.	Avg.
Overview of patient evaluation	9.3	8.6	9.2	9.4	9.7	9.2	9.5	9.3
Overview of community assessment	9.0							9.0
Community assessment project	8.5							8.5
Health Literacy Overview	8.3				8.3	8.0	8.6	
Health Literacy Survey (field work)	8.5				8.6	8.7	8.4	
Health Literacy report	7.5				6.1	8.0	8.3	
Change Assessment Project (CAP) Overview	8.6	8.4	8.6	8.9				
CAP Weekly Reports	7.4	7.1	7.7					
CAP Final Report	7.7	7.1	7.9	8.1				
Change Assessment Project (CAP) Interviews	8.6	8.2	8.2	9.3				
Lunch Sessions with Medical Students	7.7	7.6	8.8	8.1	6.8	7.1		
Case Studies with Dr. Crump	9.3	8.6	9.4	9.4	9.7	8.0	9.8	10.0
Preceptor Shadowing	9.0	8.367	9.2	9.9	9.6	9.2	9.8	9.8
The Patients' View	7.7	7.5	7.8					
Quiz Bowl	6.7	6.7	8.1	5.9	6.1	6.4		
MD 101	8.3	7.9	8.8	8.3	8.5	9.6	8.3	
Published Essays	8.1	7.5	8.0	8.6	8.1			
Reflective Reading	8.2	7.8	7.8	9.1	9.1	8.0	7.3	
Embryology Tutor	9.1	8.6	8.8	9.8				
Embryology Tutorial Text	8.7	8	8.4	9.7				
Noon Conferences	7.2	6.8	7.4	7.8	7.5	6.0	7.5	7.3
Family Medicine Book	8.1	8	8.9	7.9	8.3	7.6		
Merck Manual	8.8	8.8	8.7	9.0	9.0	8.4	8.9	9.0
Tarascon Pocket Pharmacopoeia	7.4	6.8	6.3	7.5	8.0	8.3		
BLS (Basic Life Support)	8.7	8.5	9.1	7.6	9.0	8.1		10.0

*Participants asked to rank from 1 to 10 the degree to which they felt the program's components met the goals of the program. 1=strongly disagree, 10=strongly agree.

Selected comments from participants:

I really enjoyed precepting and getting the chance to go behind the curtain seems like preceptors really wanted to teach us and help us become good docs.

The part that I enjoyed the most was getting to actually interact with the patients during the CAP interviews instead of just watching a doctor do it.

I enjoyed interacting with patients the most. They are so willing to open up to health professionals.

Spending 3 weeks talking about 1 case. Going through methodically and step by step as extremely helpful.

I loved getting to know my classmates. I have a great support group now.

Talking with M3's and M4's, about 1 st tear and embryology really helped. 1st year seemed less daunting.

{My two preceptors} are both terrific and love to teach. They always asked me questions to keep me included, taught me what was going on, and asked for my diagnosis. They also taught me how to look at and read x-rays. I feel a lot more confident after the I spent there.

I loved the CAP site and the shadowing. My preceptors were all super friendly and helpful. It was really refreshing to know I would be with such great people during my clinical years.

[My preceptor] was great at teaching. He also had me stand close to see the in-office surgeries and explained things as he went. I would recommend him for next year's group if shadowing a surgeon is doable.

Addendum, Item # 23
M1 Rural Pathways Program Evaluations 2004-2010
Average Responses by Participants

Curriculum Component	7 Yr	2010	2009	2008	2007	2006	2005	2004
	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg
The following increased my understanding of rural medicine:								
Overview, Rural Definitions and Federal Designations Review - Dr. Crump	4.6	4.5	4.6	4.8	4.4	4.6	4.8	4.6
Medicare/Medicaid/Rural Health Clinic - Dr. Crump	4.8	4.9	4.6		4.8	4.8		4.8
Resident Panel: Residency Training for Rural Practice	4.3	4.3	4.3	4.0	3.8	4.4	4.6	4.8
Views of experienced rural physician rural Community Health Centers	4.2	4.2	4.2					
Practicalities of Rural Practice (new graduate perspective)	4.3	4.4	4.3					
Practicalities of Rural Practice Experienced Physicians	4.3				4.3	4.1	4.4	4.4
Rural Hospitals - Dr. Crump	4.6	4.6						
Student Panel: Rural Training and Specialty Choice M-4's	4.5	4.1	4.1	4.7	4.4	4.7	4.6	4.8
Rural Emergency Care - Dr. Crump	4.6		4.3	4.6		4.9	4.6	4.6
Rural Health Departments, SBC, Rural Mental Health Dr. Crump	4.8			4.8				
Maternity Care, Residency Training - Dr. Crump	4.9			4.9				
Cases - Dr. Crump	4.3				4.3			
Rural Hospital Issues - Dr. Crump	4.6					4.7	4.4	4.6
Concerning all 16 hours of the elective:								
My understanding of the realities of practicing in a rural area is increased	4.8	4.6	4.9	4.9	4.6	5.0	4.8	4.8
The content of the elective was relevant to my career objectives	4.8	4.7	4.6	4.9	4.8	4.9	4.8	4.6
There was enough time for and encouragement of group discussions	4.6	4.4	4.5	5.0	4.4	4.9	4.4	4.8
I recommend fellow students take this Elective	4.6	4.4	4.8	4.9	4.6	4.9	4.4	4.4

*Participants asked to rank from 1 to 5 the degree to which they agreed with the statements.
1 = Strongly Disagree, 5 = Strongly Agree

Selected comments from participants:

I learned a lot. Only thing I would change is more time to discuss topics/review info, possibly a course packet to keep all info together for future reference.

I really enjoyed the program a lot. It was a really great opportunity.

The tour guide was very helpful in answering questions about beginning clinical years and moving to Madisonville. As always Dr. Crump is good at giving us the dirt and helping us look for the questions we need to ask later in our careers.

I would recommend this elective for students considering rural medicine. I really enjoyed talking about the "numbers" in this elective. We learned a lot of information about financial aspects that I would not have learned anywhere else.

I feel like I got a lot of information from this elective that probably isn't available anywhere else in medical school. I feel that it will be helpful to me when I start practicing.

I enjoyed the elective, and I feel that now I have a solid foundation on which I can build a better understanding of the practical workings of medicine as a career.

Beginning this elective, I had no idea how Medicare and Medicaid reimbursement operated. This elective has shed a lot of liehg on what was once a mystery to me. I feel much more confident in choosing rural medicine as a career.

Addendum, Item # 24
Preclinical Program Evaluations 2002-2010
Average Responses by Participants

Curriculum Component	9 Yr	2010	2009	2008	2007	2006	2005	2004	2003	2002
	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg	Avg
Overview of Patient Evaluation - Dr. Crump	9.1		8.3	7.8	9.3	9.2	9.3	8.5	10.0	10.0
Overview of Practice Site Assessment	8.6							7.8	9.0	9.0
Practice Site Assessment	9.0							9.5	8.0	9.5
Case Studies - Dr. Crump	9.3	9.3	9.1	8.6	7.7	9.8	10.0	10.0	10.0	9.5
Working with TRS on cases	7.9	6.3	8.4	6.6	8.0	9.0	9.0			
Preceptor Shadowing	9.7	9.8	9.4	9.0	7.7	10.0	9.7	9.5	10	10
PSST (Preclinical Student Screening Teams)										
PSST County Panel	7.2	8.0	8.4	5.8	6.7					
History/Physical Prep	8.3	8.3	8.4	8.2	7.3	9.2				
Anticipatory Guidance Prep	7.4	6.3	8.6	6.8	7.0	8.4				
Community Assessment Prep	7.1	6.7	7.9	6.8	6.0	8.0				
Key Informant Visits	6.5		6.9	5.4	7.3					
Physical Exam Sessions - McLean	9.7	9.7	9.6	9.4	10.0	9.8				
Physical Exam Session - Webster	9.4	9.7	8.8	9.0	10.0	9.6				
Working with TRS on PSST project	7.8	7.0	8.8	5.2	9.0	9.2				
PSST Final Report	7.0	7.0	8.1	3.6	7.3	8.8				
Noon Conferences	6.5		7.6	5.0	6.3	7.0	6.7			
Physical Exam Overview - Dr. Crump	9.2			8.6	9.3	9.6	9.3			
HEENT, heart, lung exam - Dr. Crump	9.0	9.3	9.7	9.0	9.3	9.4	9.7	9.3		6.5
Pelvic Exam - Dr. Crump	9.5	9.3	9.6	9.4	10.0	9.2	9.7	9.3	10.0	9.0
Breast Exam	8.6	9.3	9.3	9.2	5.0		9.7	8.0	10.0	
Newborn Exam - Dr. Soriano	9.0	9.3	9.3	8.3	10.0	8.8	9.7	9.3		7.0
Prostate exam - Dr. Klompus	9.1	9.3	9.3	9.2	10.0	8.6	8.3	8.8		
Suturing - Dr. Mont Wood	9.0					8.3	9.7			
Free Clinic	8.1			5.5	9.7	7.5	9.7			
Reflective Reading Assignment	7.4	8.3	7.2	7.2	6.0	6.4	9.0			
Merck Manual	7.9	7.0	7.1	7.0	7.3	6.8	9.0	9.5	10.0	7.5
Family Medicine Book	7.3	7.7	7.3	7.0	7.7	7.0				
West AHEC Medical Dictionary	6.9	6.3	5.3	6.0	7.0	6.2	5.0	7.5	9.5	9.0

*Participants asked to rank from 1 to 10 the degree to which they felt the program's components met the goals of the program. 1 = strongly disagree, 10=strongly agree.

Selected comments from participants:

I really enjoyed giving physical exams and shadowing. It helped me get much more comfortable and confident examining patients.

[My Preceptor] was very eager to teach and pushed me to apply and improve any skills with history taking and patients interaction.

PSST- It was great working together with TRS students. We had a clear impact on patients and learned about different roles in the health care process.

Performing the physical exams "on my own terms" meaning without someone standing over me but available if I had questions

Loved working with [my preceptor]. He really taught me a lot and let me examine nearly every patient. [He] treated me much like the 4th year and the resident on his service. I had to work to achieve that - which was a great experience.

I really enjoyed both of my preceptors. My first preceptor] allowed more one on one interaction between students and patients but this also slowed his practice. I think it really helped to have a 3rd year student there too. [My second preceptor] did a good job explaining and I liked having a female physician to shadow.

Addendum, Item # 25

Doctoring 101

Case One

4/10

A 26 year-old well dressed white female presents to your office as a new patient with severe back pain. She is visiting her sister, helping her move, and twisted her back. She cannot bear to sit on the exam table, standing with her shoulders against the wall with both hands pressed against her lower back. She tells you that this happened once before about a year ago. She tried anti-inflammatory medicines then, and ended up with a bleeding ulcer. This AM she took 4 Tylenol, and it hasn't helped at all. Last time, the only thing that worked is Lortab. She has to help her sister with some remaining small things tomorrow, and then she'll head for home in 2-3 days.

You attempt an exam, but she is tender everywhere in her back, and she cannot sit for any further exam. What else do you need to know? What do you do?

Case two

A 32 year-old black man dressed in slightly dirty work clothes presents to you as a new patient, on the recommendation of a friend. He says that he has run out of his nerve medicine and he's started back to drinking to try to calm his nerves. His doctor has been prescribing him Xanax 0.5 mg 3 times a day. He had trouble paying his bill with that doctor, and is embarrassed to go back to him. He says he has to have something or he's afraid his wife will leave him again.

He's shaky, but coherent and answers questions appropriately. You can smell alcohol on his breath and cigarette smoke on his clothes during the exam.

What else do you need to know? What do you do?

Case three

A 68 year-old Hispanic woman, one of your regular patients, presents in tears. She has a long history of chronic neck pain, having endured 3 neck surgeries over the last 20 years. She usually gets by with Tylenol and one Lortab every morning, with another at bedtime about twice a week if she can't get to sleep. Over the last 10 days she's had to step in as the primary caretaker for her 16 year-old grandson when his mother had to go out of town on business, and it's been too much for her. She's used up her next 2 weeks' worth of Lortab, and when she went to the Wal-Mart to refill it, the tech was rude and said she'd have to have a new prescription.

She moves extremely slowly, holding her head as still as possible. The remainder of the exam is unremarkable.

What else do you need to know? What do you do?

Addendum, Item # 26

Doctoring 101

Geriatric Issues

6/10

Case One

A 91 year-old man with mild diabetes and a history of a heart attack 30 years ago presents to the ED with 2 hours of chest pain. His EKG shows a new heart attack. The cardiologist wants to take him to the cath lab for catheterization and balloon angioplasty. His daughter asks you if they should be this aggressive.

- 1) What other options do you have?
- 2) What do you need to know about this patient and his family to give good advice?
- 3) What should you advise about “heroic measures” (CPR, shocking for an abnormal rhythm, intubation and placement on a ventilator) if they should be needed?

Case Two

A 76 year-old woman has severe Parkinson’s Disease that has become unresponsive to treatment, leaving her mostly confined to a wheelchair. She is occasionally incontinent of urine, and sometimes falls when trying to get to the bathroom. She was admitted to the hospital for being “out of her head” because of too much medicine, she’s better now, and it is time for discharge. The family asks you if she’ll be okay at home.

- 1) What other options do you have?
- 2) What do you need to know about this patient and her family to give good advice?
- 3) What does insurance pay for “custodial care” in a nursing home? How much does the average nursing home cost per month?

Case Three

An 82 year-old woman with severe rheumatoid arthritis, GERD, and near-blindness from macular degeneration is brought to your office for treatment of her headaches. She has been unable to walk for the last 3 months, and all the medicines for her arthritis bother her stomach so much that the only relief she can get is from narcotics. She sleeps a few hours at a time and says she is tired all the time. At the end of the visit, her daughter takes you aside and says that the patient recently has said several times that she is “ready for God to take me home now.”

1. What more do you need to know about this patient?
2. What do you say to the daughter?
3. What is your plan of action?