Rural Healthcare Workforce Needs Assessment

MAHEC Rural Health Initiative
Western NC Region

MAHEC

EXECUTIVE SUMMARY

Introduction

Rural residents across North Carolina continue to face disproportionate barriers to care compared to urban residents (Baxley, 2023; North Carolina Rural Health Association, 2024; Sisk, 2024). Many of these barriers, such as geographic isolation, lack of reliable transportation, and mistrust in the healthcare system are exacerbated by workforce shortages that are projected to worsen over time (Baxley, 2023). A growing deficit is expected over the next 10+ years as many physicians approach retirement age, with HRSA projecting a national shortage of nearly 90,000 primary care physicians by 2037. As many organizations, community colleges, and universities work to address critical gaps in the healthcare workforce in Western North Carolina (WNC), the importance of understanding trends and patterns in workforce needs cannot be understated. As WNC recovers from Hurricane Helene's catastrophic damage, major gaps in care delivery and accessibility in its rural communities have been revealed. This analysis seeks to identify the specific workforce and infrastructure needs within WNC's rural primary care network to inform targeted strategies for sustainable improvement.

Background

Despite decades of targeted efforts, WNC continues to experience persistent health inequities driven by limited access to essential healthcare services in rural and under-resourced communities. The region's most recent community health assessment underscores ongoing challenges in accessing both primary care and mental health services, with far-reaching consequences for population health and well-being. These disparities are compounded by WNC's unique demographic and geographic realities, including an aging population, elevated rates of chronic disease, and pervasive income inequities relative to state and national averages. In the aftermath of Hurricane Helene, a disaster that further exposed vulnerabilities in care delivery, the region, more than ever, needs a workforce strategy grounded in sustained investment and collaborative partnerships.

Methodology

Information for the needs assessment was captured through a survey deployed via REDCap, a secure survey platform. The survey was sent to all regional healthcare organizations with outpatient services in rural counties, including hospital systems, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), independent practices, health departments, and more. The survey was also sent to independent rural dental practices in the region. Survey questions asked for the specific number of vacant positions by type, specialty and county, in addition to qualitative questions about recruitment challenges and the appeal of working in WNC's rural communities. Survey questions were developed by MAHEC's Rural Health Initiative (RHI) and evaluation team, in partnership with the Dogwood Health Trust.

Survey responses were collected through in-person interviews conducted by MAHEC's RHI staff or via email, with a minimum of three follow-up attempts made either via email or by phone. Data was collected between March and May of 2025.

Key Findings/Analysis

Health workforce surveys across WNC indicate that shortages exist in all counties, across multiple roles, and with increased intensity in certain geographic areas. Survey respondents indicated medical assistants (MAs) are the most needed type of clinical provider across the region, with reported needs far outweighing every other type of healthcare provider. After MAs, the second most reported clinical vacancies were for nurses and behavioral health providers, followed closely by physicians and dental providers, including dental hygienists. There is also a notable need for administrative staff among respondents. The positions with the fewest reported vacancies included community health workers and clinical pharmacists with the caveat that few practices have fully adopted integrating clinical pharmacy.

Recruitment barriers: Participants indicated that the most significant barrier to rural recruitment is the inability to provide a competitive salary, accompanied by a lack of affordable housing. Respondents also indicated limitations of the applicant pool's quality and geographic isolation.

Retention strengths: When asked about WNC's strengths that contribute positively to retention, organizations overwhelmingly emphasized the natural beauty of the region, the close-knit culture of rural communities, increased personal and professional fulfillment, and opportunities for outdoor recreation.

Conclusion

Survey findings suggest that an increased regional focus on training programs for medical assistants, nurses, behavioral health providers, and dental hygienists is most needed. In addition, the outcomes support the need for targeted mechanisms to attract, incentivize, and retain those graduates who trained in WNC. With a pronounced need for physicians and dental providers as well, it is imperative that regional workforce development supports pathway programming to nurture allied health providers to choose rural practice.

Numerous efforts are underway across regional organizations and educational institutions, including new programs for clinical and dental support staff, community health assessments, and regional workforce coalitions. These efforts have encouraged collaboration across organizations and have created educational pathways for professions in WNC that are strongly needed. Furthermore, these conclusions can guide strategic investments and collaborative initiatives that address critical workforce gaps translating to clinics that are resourced to provide sustainable and equitable access to care for our WNC communities.

Recommendations and Next Steps

Regional educational organizations like MAHEC, community colleges and universities, in addition to hospitals, and other stakeholders, should consider strategies to increase the number of training opportunities for identified professions of highest need. Incentivizing rural recruitment through a multipronged approach that includes early pathway programs and promoting the positive attributes of rural primary care while also promoting long-term retention through continuing medical education, rural preceptor opportunities, and strong community relationships that support placement, transition, and recruitment efforts.

Based on the extensive need to recruit all types of clinical providers and administrative staff, an enhanced collaborative approach is needed to bolster existing pathway programs, to build new ones, and to develop financial incentives to support all rural allied health providers. A well-rounded approach to recruitment and retention would also include addressing barriers such as affordable housing, social isolation and supporting the quadruple aim: improving the work life and well-being of the care team.

1. Summary of Respondents

MAHEC's RHI team compiled a comprehensive list of the region's hospitals and clinics, including Federally Qualified Health Centers (FQHCs), private practices, health departments, direct primary care (DPC) clinics, hospital systems with outpatient clinics, and dental offices for survey distribution across 17 WNC counties including: Cherokee, Clay, Graham, Swain, Macon, Jackson, Haywood, Transylvania, Madison, Polk, Rutherford, McDowell, Yancey, Mitchell, Avery, Watauga and Ashe. In total, the RHI team sent the survey to a total of 73 healthcare organizations across WNC and 38 independent dental practices.

Table 1. Survey respondents

Organization Type	n (%)
Health Department	14 (24.14%)
Independent Dental Practice	9 (15.52%)
Private Practice	8 (13.79%)
Federally Qualified Health Center (FQHC)	7 (12.07%)
Rural Health Center	4 (6.90%)
Hospital System	4 (6.90%)
Federally Qualified Health Center Look Alike (FQAC LAL)	2 (3.45%)
Other	10 (17.24%)
Total	*58*

Healthcare organizations: 49 responded for a 67% response rate. Many of these organizations—especially large hospital systems and FQHCs—have multiple locations, so 49 responses represent 88 different practice sites.

Independent dental practices: 9 responded, for a 23% response rate. These are dental offices not connected to larger health systems or health departments.

Additional dental data: FQHCs and health departments that offer dental services were also asked to report dental provider openings in their overall organizations' response.

To assess care for low-income patients in rural counties, organizations were asked if they actively accept new Medicaid patients. Of the 58 total respondents, including 49 healthcare facilities and 9 independent dental practices, 47 (81%) indicated they are actively taking new Medicaid patients, and 11 respondents (19%) are not.

Survey respondents were also asked to indicate their overall level of staffing from short staffed, moderately staffed, or fully staffed. Those staffing levels were defined as:

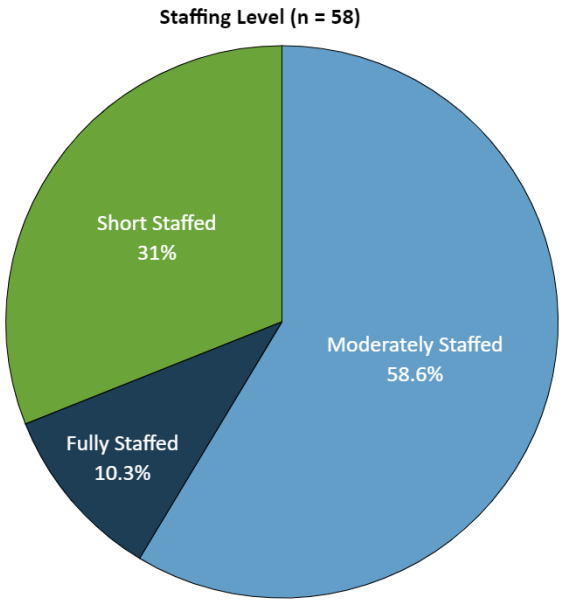
Short staffed: we do not have adequate staff to operate at maximum capacity/efficiency, which impedes the ability to meet the needs of the community and organizational goals.

Moderately staffed: we have the ability to meet the needs of the community and organizational goals but could do a better job with additional staff members.

Fully staffed: we can operate at maximum capacity/efficiency and fully meet the needs of the community and our organizational goals.

Of the respondents, 31% indicated they are short-staffed, 58.6% indicated they are moderately staffed, and only 10.3% indicated they are fully staffed; suggesting that a significant proportion of WNC's healthcare facilities are operating below optimal staffing levels.

Figure 1. Staffing levels



2. Rural Workforce Needs

To capture a point-in-time snapshot of open positions, organizations reported the current number of clinical and administrative vacancies across all clinical sites. Respondents who selected positional vacancies were then asked to specify the quantity, county, and type of those positions to provide a more detailed picture of regional needs.

Of the current clinical vacancies, the highest reported need was for medical assistants with 68 open positions across the region. This represents approximately 21% of all open positions regionally. After medical assistants, reported total openings included: nurses (49), behavioral health providers (47), physicians (43.5), dental providers (35) and advanced practice providers (APPs) (26). The least reported number of openings included: pharmacists (4), community health workers (6), and other/unspecified types of clinical specialties (9). Organizations also reported a notable need for administrative staff (29.5). Note that vacancies reported at a 0.5 FTE represent a part-time position.

Across the region, a total of 317 clinical and administrative vacancies were reported.

Of the data collected on current vacancies, the counties that reported the highest number of total vacancies (30+) were Jackson, Macon, and Swain. The counties with the lowest number of reported vacancies (less than 10) were Clay, Polk, Avery, Rutherford, Yancey, and McDowell.

The vacancy figures in this report are based on survey responses and may not fully reflect regional needs. Ideally, vacancy rates would be scaled to county population sizes for greater accuracy. However, because survey response rates varied significantly across counties, it was not meaningful to adjust vacancies proportionally by population.

Figure 2 shows the distribution of reported vacancies by county. Figure 3 depicts the quantity of vacancies by profession by county.

Figure 2. Where we need providers: vacancy count by county in Western North Carolina
Reported by regional health systems and provider organizations

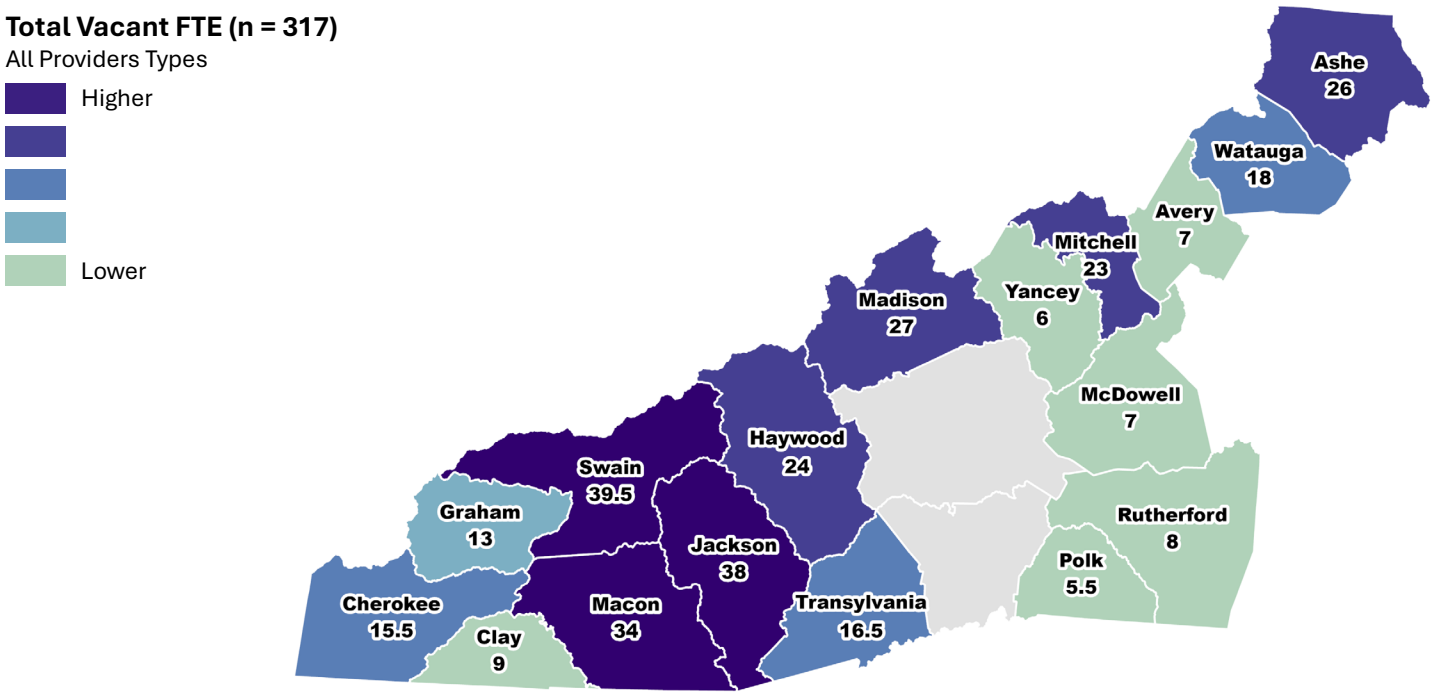


Table 2. Physician need by specialty

Among physicians, respondents indicated the largest FTE need for family medicine specialists

Physician Subspecialty	FTE
Family Medicine	29
Internal Medicine	6
OBGYN	2
Pediatrics	3.5
General Surgery	0
Psychiatry	1
Specialist	0
Geriatrician	2
Other	0
Total	*43.5*

Table 3. Behavioral health need by specialty

Among behavioral health practitioners, the largest FTE specialty needs are those with a master of social work, licensed clinical mental health counselors, and licensed clinical social workers

Behavioral Health Subspecialty	FTE
Psychologist	1
Licensed Clinical Addiction Specialist	5
Master Social Work	15
Licensed Clinical Mental Health Counselor	11
Licensed Clinical Social Worker	10
Peer Support Specialist	5
Unspecified	0
Other	0
Total	*47*

Table 4. Nurse need by specialty

The largest FTE specialty need among nurses is for registered nurses

Nurse Subspecialty	FTE
Registered Nurse	37
Certified Nurse Assistant	0
Care Manager	2
LPN	9
Other	1
Total	*49*

Table 5. Advanced practice provider need

Among advanced practice providers, the largest FTE need is for nurse practitioners

Advanced Practice Provider	FTE
Physician Assistant	6
Nurse Practitioner	13
PA or FNP	7
Total	*26*

Table 6. Dental provider need

Among dental providers, the largest FTE needs are for dentists and dental hygienists

Dental Provider	FTE
Dentist	15
Dental Hygienist	13
Dental Assistant	6
Unspecified	0
Other	1
Total	*35*

Table 7. Pharmacy need

Among pharmacy needs, the FTE need is split evenly between pharmacy techs and pharmacists

Pharmacy	FTE
Pharmacy Tech	2
Pharmacist	2
Unspecified	0
Total	*4*

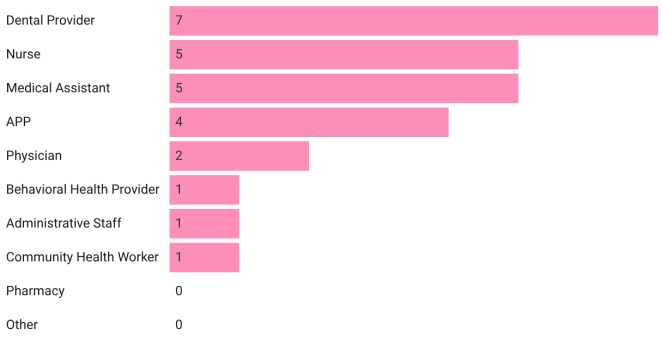
Table 8. Additional needs

Among additional FTE needs, the highest needs were for medical assistants and administrative staff

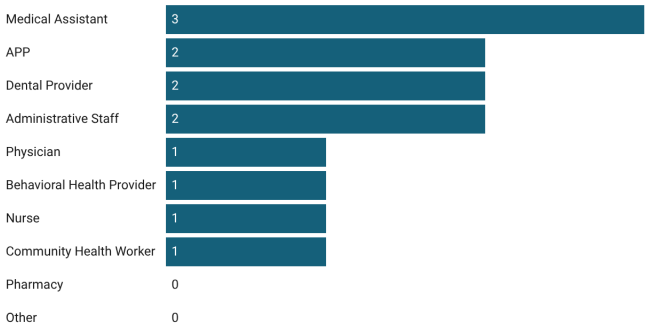
Additional Openings	FTE
Medical Assistants	68
Administrative Staff	29.5
Community Health Worker	6
Other	9
Total	*112.5*

Figure 3. Quantity of vacancies by profession by county

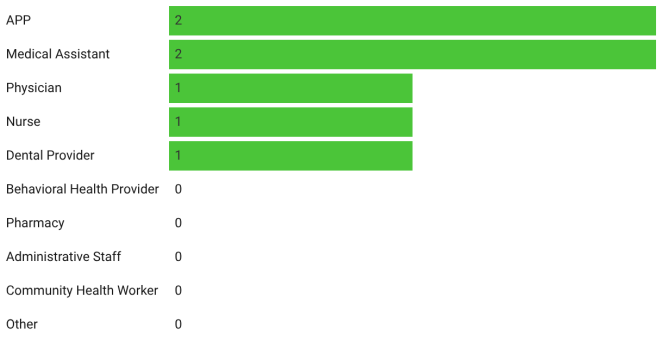
Number of FTE Vacancies by Profession in Ashe County



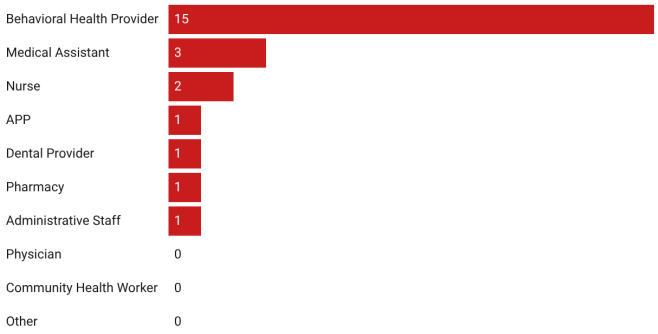
Number of FTE Vacancies by Profession in Graham County



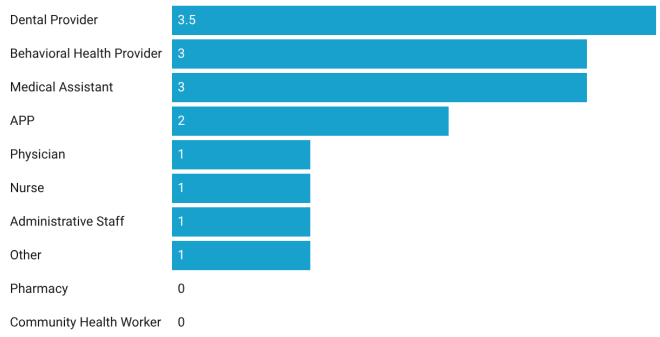
Number of FTE Vacancies by Profession in Avery County



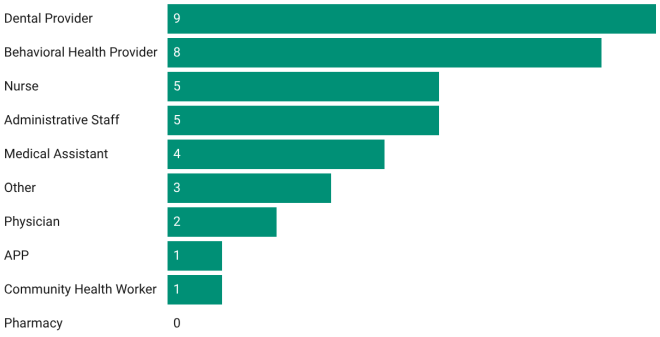
Number of FTE Vacancies by Profession in Haywood County



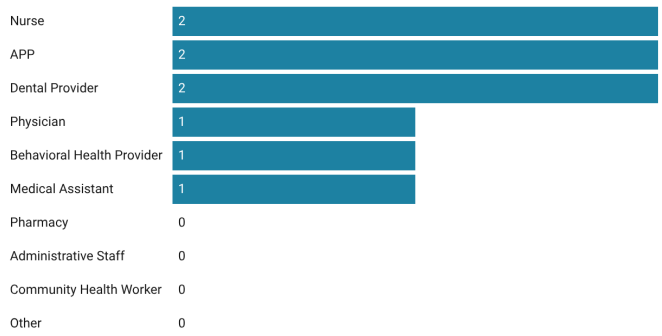
Number of FTE Vacancies by Profession in Cherokee County



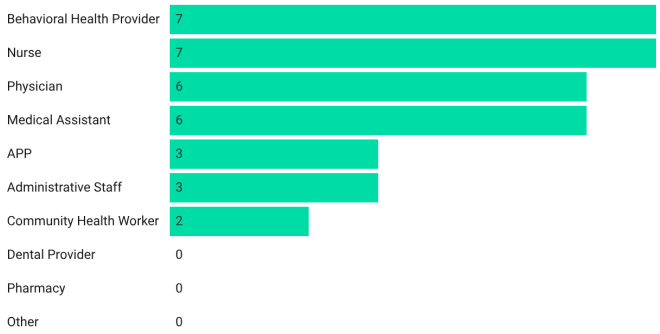
Number of FTE Vacancies by Profession in Jackson County



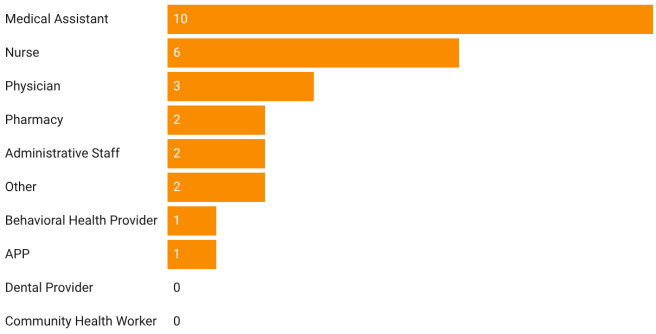
Number of FTE Vacancies by Profession in Clay County



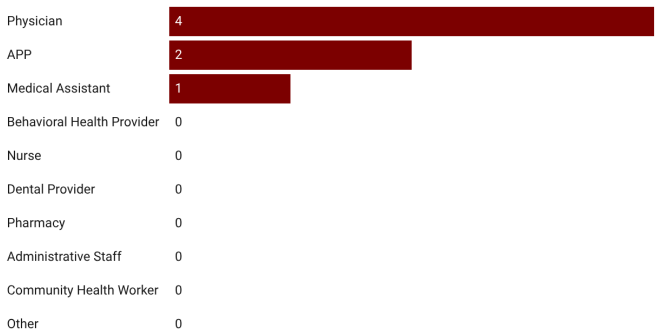
Number of FTE Vacancies by Profession in Macon County



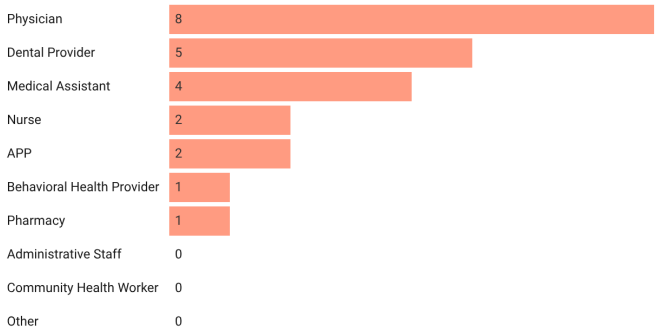
Number of FTE Vacancies by Profession in Madison County



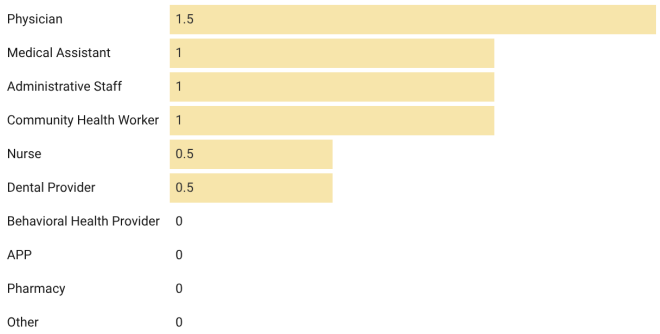
Number of FTE Vacancies by Profession in McDowell County



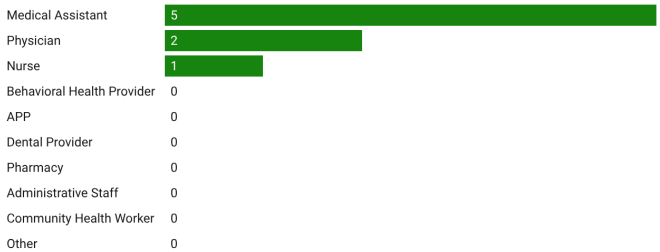
Number of FTE Vacancies by Profession in Mitchell County



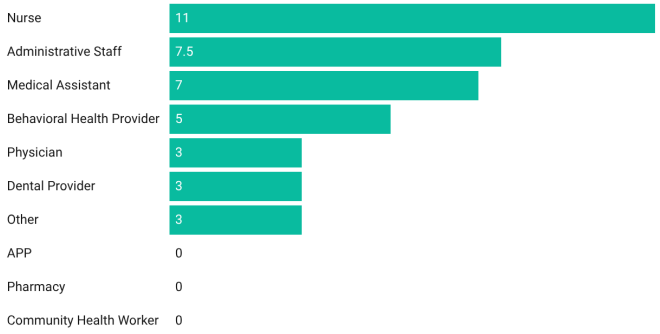
Number of FTE Vacancies by Profession in Polk



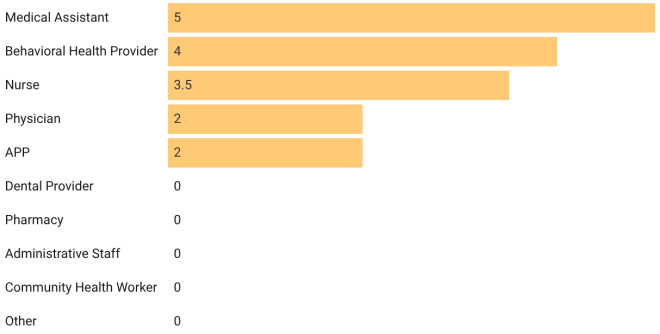
Number of FTE Vacancies by Profession in Rutherford County



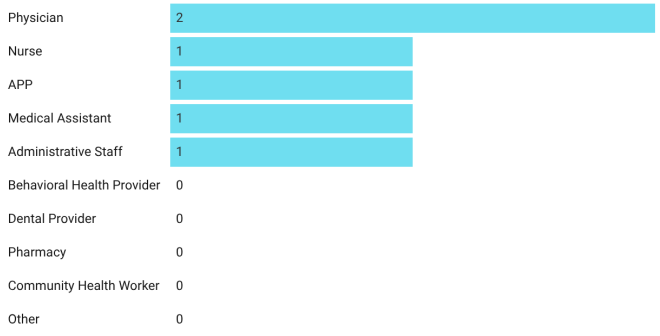
Number of FTE Vacancies by Profession in Swain County



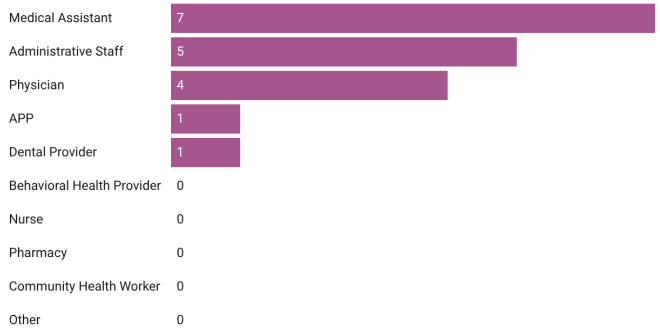
Number of FTE Vacancies by Profession in Transylvania County



Number of FTE Vacancies by Profession in Yancey County



Number of FTE Vacancies by Profession in Watauga County



2a. Rural Clinical Training Needs

Beyond the need for clinical staff, providers in rural clinics are often unable to provide needed clinical services due to lack of training, reduced access to specialists, and other organizational limitations. Participants identified areas of clinical need for their patient populations.

Several trends emerged from the responses, notably a strong need for specialized behavioral health care, medication assisted therapy (MAT) for substance use disorders, and complex diabetes care management. Figures 4-6 highlight the top three indicated clinical needs. For each clinical need that a respondent selected, they were asked to check which specific types of that need apply to their clinic.

The reported clinical needs highlight the importance of advanced clinical training for primary care providers who are often the sole providers of specialty care in rural places with responsibility for managing chronic disease, substance use disorder treatment, and behavioral health.

The defined need for additional training in these specific clinical areas highlights the importance of offering affordable, and easily accessible Continuing Medical Education (CME) that is aligned with patient population needs. Research shows that cost and travel time are significant barriers to rural providers in obtaining CME and that there is often an inadequate organizational budget for CME attainment (Pott et al., 2021, Campos-Zamora et al., 2022).

Figure 4. Specialized behavioral health clinics

17 of 58 respondents indicated specialized behavioral health clinics as a clinical need

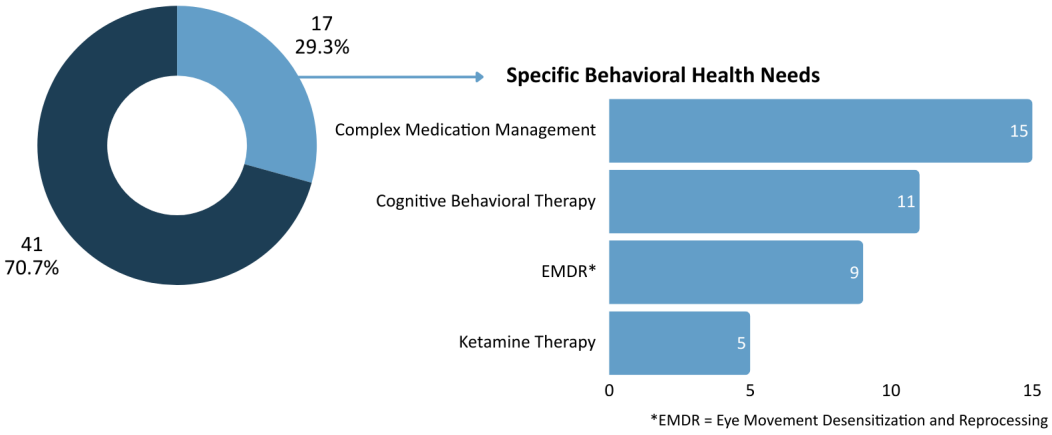


Figure 5. Medication assistance therapy (MAT)

14 of 58 respondents indicated medication assistance therapy as a clinical need

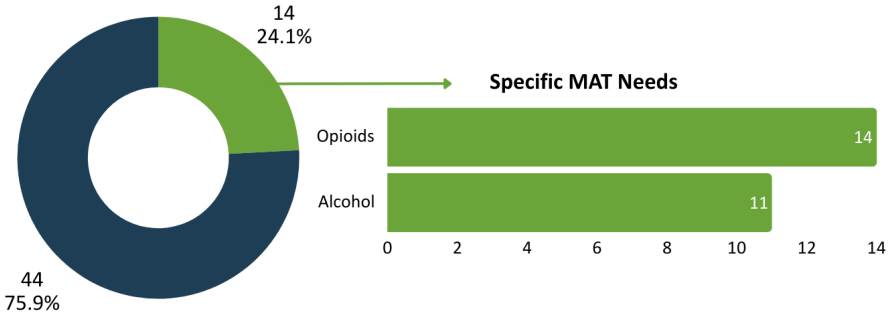
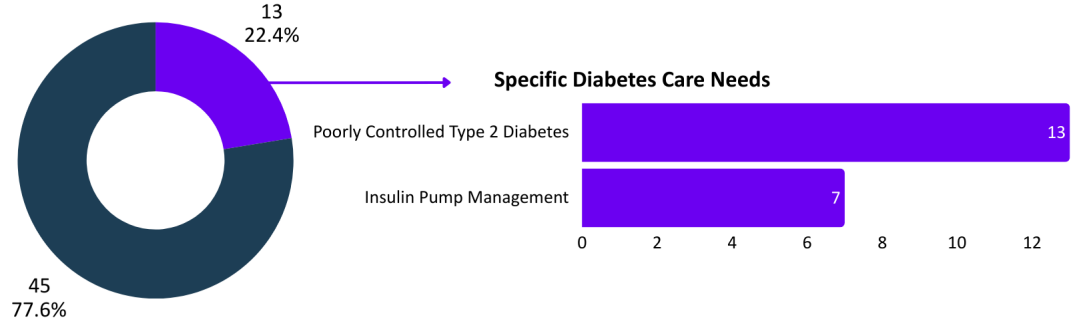


Figure 6. Complex diabetes care

13 of 58 respondents indicated complex diabetes care as a clinical need



3. Recruitment

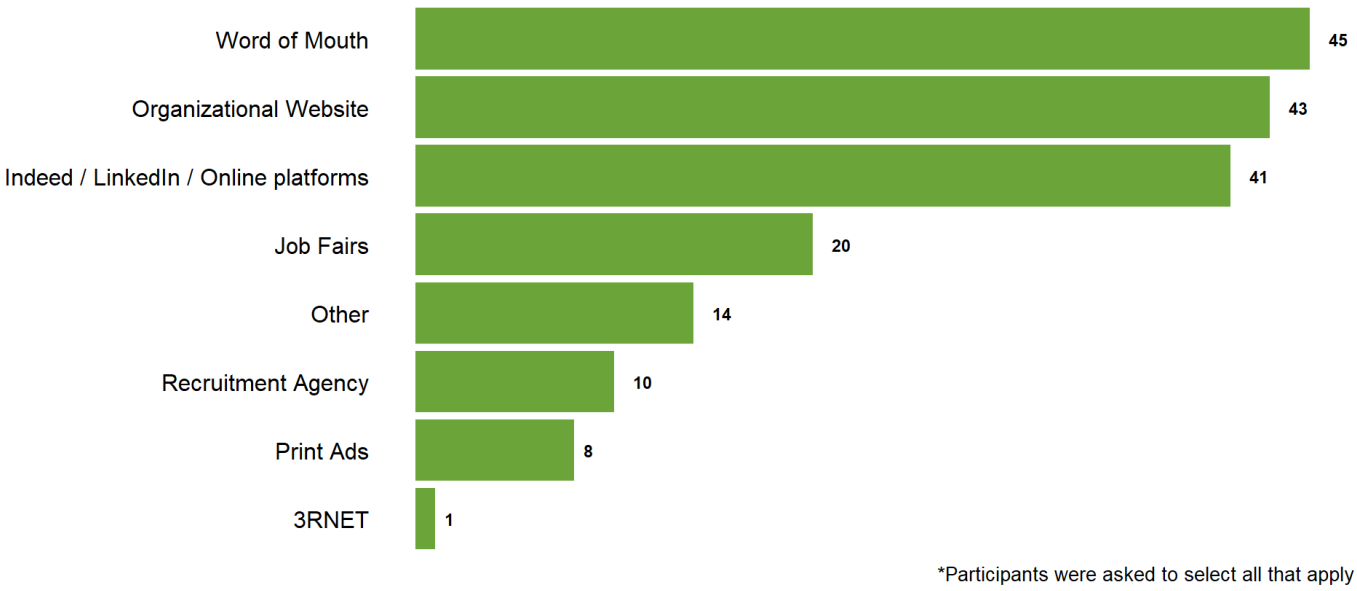
Survey respondents were asked to select all current methods used to recruit new staff. The most highly indicated selection was "Word of Mouth," emphasizing the importance of close-knit relationships in rural communities. "Word of Mouth" was closely followed by "Organizational Website" and "Indeed/LinkedIn/ Online Platforms." Less frequently used recruitment methods included recruitment agencies, job fairs, and print ads. For the participants who selected "other," the most popular recruitment method was social media, which was still infrequent when compared to the top recruitment methods. Participants were not asked to indicate if varying recruitment methods are being used to recruit different staff types. Different roles may require different recruitment strategies to be effective and pair organizations with the appropriate candidates.

Respondents provided additional insight into recruitment challenges such as long commute times and the need for better engagement with community colleges.

Challenges: Respondents were asked about barriers to recruiting staff in rural clinical settings and whether those barriers differed between clinical and administrative recruitment. Participants identified competitive salaries (25 mentions) as the most significant barrier to recruiting clinical staff, followed by poor applicant pools (9), limited affordable housing (9), and isolating geography (8). High cost of living (6) and overall workforce shortages (4) also contribute to recruitment challenges.

For administrative roles, barriers include turnover, limited promotional opportunities, and low starting pay. Additional general concerns include commute times, lack of system-level support, and limited time for professional development. While some practices report no major issues, most face persistent financial and geographic hurdles in attracting qualified candidates for clinical and administrative positions. These challenges highlight the need to create clear career pathways for healthcare administration professionals, as their expertise in managing clinical operations is essential for ensuring efficient care delivery and access in rural communities.

Figure 7. Recruitment methods



Hurricane Helene

The impacts of Hurricane Helene on rural WNC infrastructure were catastrophic. The widespread devastation to WNC rural communities exacerbated the already-existing barriers to care facing the region. Hurricane Helene highlighted gaps in emergency preparedness, medication access, access to behavioral health services, and more. Survey deployment took place approximately six months after Helene, and respondents were asked about the impacts of Hurricane Helene on their clinical staffing. 30% of respondents indicated that Helene caused additional difficulty in recruiting new staff and 17% indicated that they experienced increased attrition.

Of the 22% who selected "other" and elaborated on their response, impacts such as hiring freezes, additional accommodations for staff (extra flexibility and time off), travel difficulty for staff members due to infrastructure damage and home loss, and an intensified housing crisis were all shared as notable impacts from Helene. More than one year later, these issues are still present and will continue to contribute to challenges with recruitment and retention throughout the WNC region.

Table 9. Impact of Hurricane Helene

A third of survey respondents (31%) indicated that Hurricane Helene caused difficulty recruiting

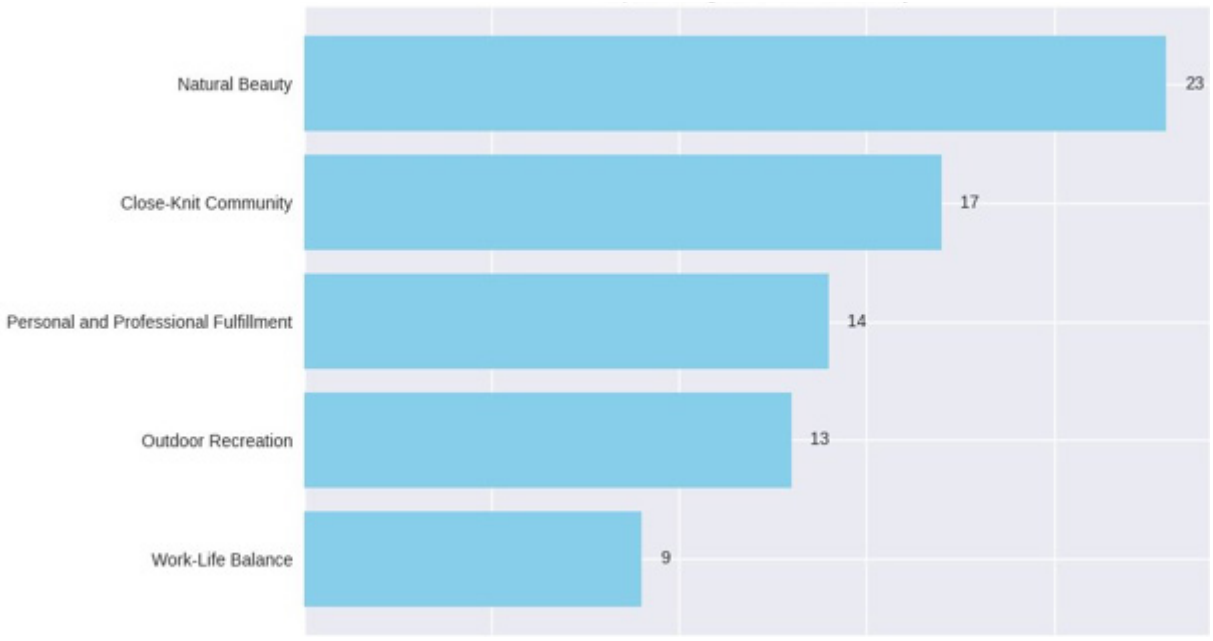
Impact of Hurricane Helene	n (%)
Attrition (Staff Turnover)	9 (15.52%)
Difficulty in Recruiting	18 (31.03%)
Other	13 (22.41%)

3a. Recruitment Strengths & Retention Factors

When asked what strengths of their communities would attract new regional employees, partners overwhelmingly pointed to four key draws in order of importance: the natural beauty of the mountains (mentioned 23 times), the warmth of close-knit communities (17), a deep sense of personal and professional fulfillment (14), and abundant outdoor recreation (13). In addition, many practices also noted work-life balance (9), broad scope of practice (8), family friendliness (6), cohesive team environments (5), competitive wages and benefits (5), and the kindness of the people in the area (5) as important factors that make their communities attractive to new employees. Competitive wages appearing in both the challenges and strengths reported by practices highlights potential pay disparities across systems, with larger hospital systems often having better ability to pay staff a higher salary in comparison to other practice types.

Regional practices request stronger recruitment support from WNC organizations in rural and underserved areas. Suggestions include expanding resident and student rotations and provider fellowships—particularly in behavioral health—and connecting medical residents to local opportunities earlier in their training. There's a clear need for dental hygienist and medical assistant programs in the westernmost counties in WNC, along with opportunities for continuing education and loan forgiveness to attract and retain talent. Many respondents emphasized the importance of promoting job openings, offering pay incentives, and helping practices reach ideal candidates—especially those interested in holistic care, rural medicine, or long-term settlement in WNC. Better alignment between educational institutions and clearer career pathways could strengthen recruitment and retention of the region's clinical and administrative healthcare workforce.

Figure 8. Top five strengths of the community

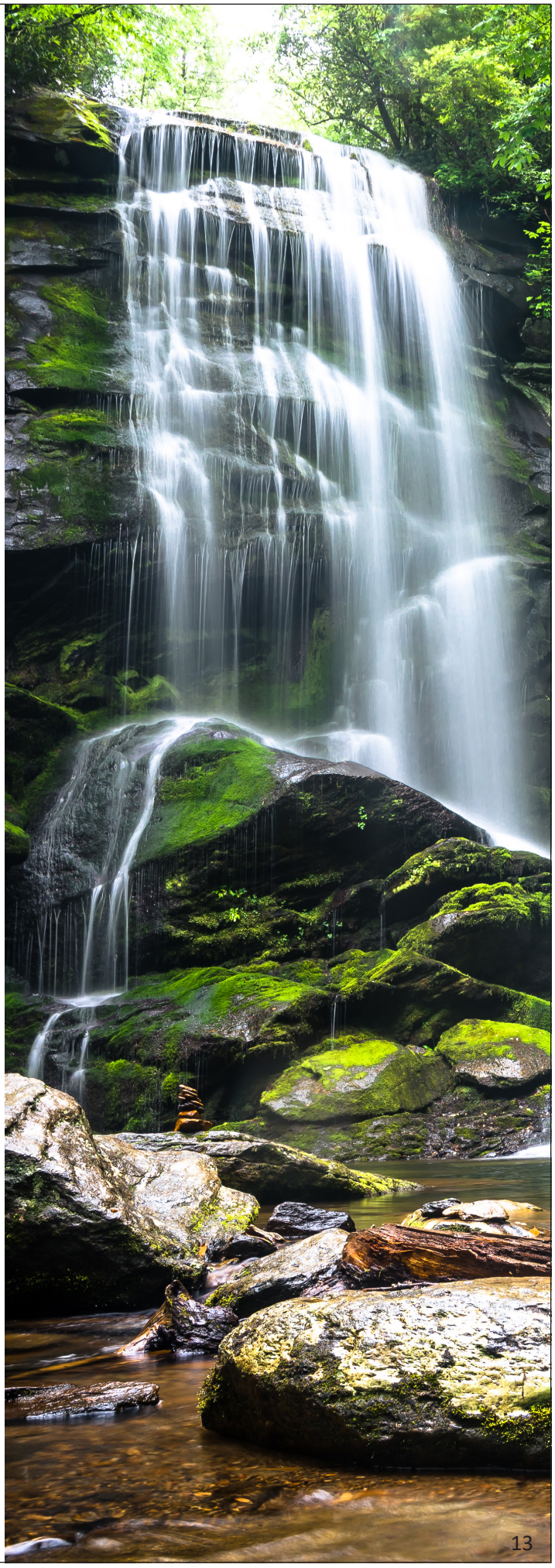


4. Summary and Opportunities for Change

WNC is experiencing a significant healthcare workforce shortage that disproportionately affects rural and underserved communities. This shortage is a major driver of worsening health inequities, access to essential services, social disparities, and economic growth. Survey results show that only 10% of practices are fully staffed, while nearly 90% operate with moderate or severe staffing gaps. Across the region, 317 vacancies were reported, with the highest vacancies reported for medical assistants, nurses, behavioral health providers, physicians, and dental professionals. Staffing ratios should be considered when interpreting vacancy numbers. For instance, many organizations employ two medical assistants for every physician, meaning high MA vacancy rates also signal a significant demand for physicians. Given the 67% response rate, and the fact that several large hospital systems did not respond to our survey, we can extrapolate that the total number of regional vacancies exceeds 30% of the reported total above, likely translating to an excess of 400 vacancies.

The challenges extend beyond staffing numbers. Recruitment is hindered by low salaries, housing shortages, geographic isolation, and limited applicant pools. At the same time, providers report a pressing need for advanced clinical training in behavioral health, substance use disorder treatment, and chronic disease management. These gaps highlight the urgency for coordinated action to build a resilient workforce that meets the unique needs of WNC communities.

Despite these obstacles, the region has strong assets to leverage—such as its natural beauty, close-knit communities, and collaborative spirit. By aligning educational institutions, healthcare systems, and community organizations, WNC can create sustainable solutions that strengthen recruitment, retention, and training pathways.



Priority Area	Potential Action Steps
Collaborative Workforce Strategy	• Establish a regional rural workforce task force including healthcare systems, educational institutions, and community organizations. • Develop a shared recruitment and retention plan with measurable goals. • Align local efforts with state and federal incentives for rural placement.
Expand Workforce Training	• Launch new training programs for MAs, nurses, behavioral health providers, and dental hygienists in WNC. • Create rural clinical rotations and fellowships to expose learners to underserved communities. • Partner with community colleges and universities to scale enrollment in high-need fields.
Strengthen Nursing Pipeline	• Increase nursing school capacity through scholarships and faculty recruitment. • Implement retention strategies such as mentorship programs and flexible scheduling. • Support career ladders for CNAs and LPNs to advance into RN roles.
Recruitment Incentives	• Leverage loan forgiveness, relocation assistance, and sign-on bonuses for rural placements. • Advocate for competitive salary adjustments through policy and funding initiatives. • Offer retention bonuses tied to service duration. • Partner with NC DHHS on loan forgiveness education and awareness.
Comprehensive Career Pathways	• Strengthen health career exploration programs in middle and high schools. • Provide immersive internships and mentorship opportunities in rural clinics. • Align educational curricula with regional workforce needs.
Behavioral Health Integration	• Continue to embed behavioral health professionals in primary care clinics. • Expand access to MAT for substance use disorders. • Increase psychiatric and counseling services through telehealth and in-person care.
Addressing Clinical Training Needs	• Develop accessible CME programs focused on: - Behavioral health care - Medication-Assisted Treatment (MAT) - Complex diabetes management. • Offer CME scholarships and virtual learning options to reduce cost and travel barriers. • Create interprofessional training modules for rural providers.
Housing Solutions	• Partner with local housing authorities and nonprofits to develop affordable housing options. • Explore employer-supported housing and relocation stipends. • Advocate for regional housing development incentives.
Data-Driven Planning	• Use vacancy and county-level data to prioritize investments in high-need areas. • Create a regional dashboard to track workforce trends and progress. • Conduct regular workforce assessments to inform strategy updates.

4a. Existing Regional Programs and Workforce Efforts

Significant regional efforts are underway to address current and anticipated shortages in the rural healthcare workforce. MAHEC's residency programs have continued to grow with the recent addition of the Boone Family Medicine residency and the expansion of Internal Medicine to include a Tribal and Rural Health track through partnership with Cherokee Indian Hospital. MAHEC's interdisciplinary Rural Fellowship has been instrumental in targeting practices of need and delivering high quality interprofessional providers to rural communities. Since 2017, the Rural Fellowship has placed 45 interdisciplinary providers in clinics across 15 rural WNC counties. This approach enhances the region's ability to support allied health providers of all types and can be scalable depending on fluctuating needs.

The NC Health Talent Alliance (NC HTA) is a strategic partnership between the Center, NC Chamber Foundation, and AHEC regions aimed at addressing pervasive healthcare worker shortages in North Carolina. The initiative focuses on understanding the regional workforce needs and developing targeted programs to fill identified gaps. The Health Talent Alliance produces an annual report for each AHEC Region that highlights supply and demand workforce gaps across nursing professions, and each AHEC is tasked with setting up an Employer Collaborative to shape strategies to respond to the data. Furthermore, a planning grant awarded by the Appalachian Regional Commission has allowed educational institutions across the southwestern United States, including East Tennessee State University and Appalachian State, to explore inter-institutional partnerships to address workforce challenges. Other efforts across the state include a case study on health workforce challenges conducted by ECU Health, the NC Center on the Workforce for Health and the UNC Sheps Center, which highlighted ongoing efforts to address workforce challenges through community partnerships.

The outcomes of this needs assessment highlight opportunities for stronger collaboration in data collection and workforce research in partnership with local, regional and statewide organizations such as the UNC SHEPS Center and the WNC Health Network.

5. Limitations

Study limitations are due to varying participation rates across WNC counties. This presumably resulted in an underrepresentation of certain counties' needs in the data, as well as the total regional need. For example, the far western counties of Cherokee, Clay and Graham all had a nearly 100% survey completion rate, allowing for an accurate representation of their county's needs. However, other counties known to have significant clinical staffing needs, such as Rutherford, had a low participation rate and a lack of representation in the data. It is possible that the trends in reported vacancies would shift with a more complete regional response rate.

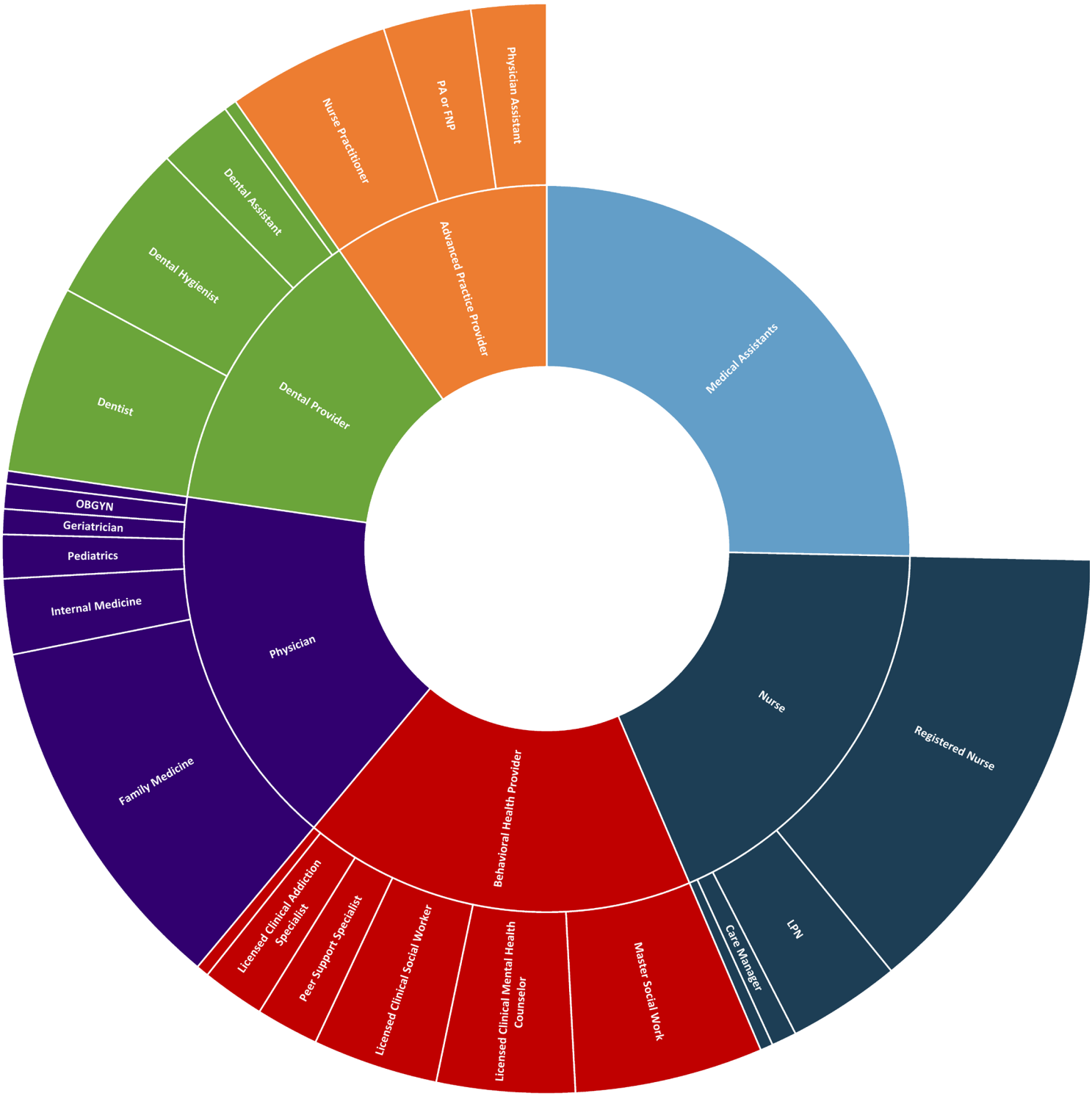
While the survey captured responses from a wide variety of organizations, the survey did not capture hospital-based openings, only outpatient openings within the region's hospital systems. Therefore, hospital-system data is only representative of rural outpatient clinics. There are needs for rural primary care physicians, specialists, APPs, and clinical support staff in inpatient settings that are not represented in this report.

This study was subject to potential human error during the manual data cleaning process. However, multiple rounds of review and the involvement of several team members in both cleaning and analysis helped minimize errors and ensure a high level of accuracy in the reported data

Lastly, this survey was only conducted at a single point in time and may not be representative of historical or long-term trends in hiring needs. A repeat of the study in 3-5 years would illuminate trends in vacancies in addition to areas in which workforce programming improvements have been made.

Appendix

Figure 1. Sunburst plot showing the visual proportion of FTE needs by provider type and subspecialty



Additional Information & Acknowledgements

Established in 1974, the Mountain Area Health Education Center (MAHEC) aims to train and retain healthcare professionals across WNC. Through clinical care, workforce programming, and continuing medical education, MAHEC is committed to training the next generation of healthcare professionals to serve WNC and beyond. MAHEC's pathway programs span from high school to medical school, and from residency training to a post-residency Rural Fellowship. Located in Asheville, MAHEC serves North Carolina's 16 westernmost counties as well as Avery, Watauga and Ashe counties through the expansion of its rural Family Medicine training program in Boone. The report excludes Buncombe and Henderson counties due to their primarily suburban designations. MAHEC's Rural Health Initiative staff members conducted the data collection, analysis and reporting of this needs assessment.

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