

National Rural Health Association

Issue Paper

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Recruitment and Retention of a Quality Health Workforce in Rural Areas

A series of policy papers on The Rural Health Careers Pipeline
Introduction: Defining the Issues and the Principles of Recruitment and Retention

Introduction

One of the most enduring characteristics of the rural health landscape is the uneven distribution and relative shortage of health care professionals.¹ This is not insignificant as nearly 60 million of the United States' populations live in areas considered rural or non metropolitan by various definitions.²

On average, rural populations have relatively more elderly and children, unemployment and underemployment, and poor, uninsured and underinsured residents, and they are more vulnerable to economic downturns because of their economic specialization than are their urban counterparts.³ Problems unique to rural health care delivery systems include long travel distances to obtain health care, low population densities, lack of economies of scale and high rates of fixed overhead per patient revenue.⁴ The nation's rural environment is diverse across its economic, social, environmental, demographic and epidemiological dimensions. Local health care systems, with small numbers of providers and sparse resources are tenuously balanced to meet the needs of residents while providing adequate income and quality of life to providers.⁵

Once local health care delivery systems are dismantled, few rural towns are able to resurrect them. This is the great American health care system paradox: shortages amid surplus. Many rural residents experience a lack of basic health services while the larger society cannot absorb all the health care professionals that are produced.⁶ National policy is largely designed to

solve urban health care delivery problems with rural interests left in the backwash to negotiate policy and regulation patches designed to diminish unintended adverse rural consequences.⁷

Rural areas experience significant problems in recruiting and retaining an adequate and quality trained health care workforce. These issues for rural health care providers are compounded by the disparity in federal and state reimbursement for rural providers and facilities in spite of the fact that these providers clearly serve as the safety net for our rural impoverished communities nationwide. Policies that address the stable economic development of these rural areas and improve reimbursement for health care services are key components that would increase the stability and number of the health care workforce in rural areas.

Providers most likely to serve rural areas come from rural areas. Aspiring healthcare providers need to be well educated in science and math to be competitive in order to achieve admission to advanced health professions schools and programs. Rural schools are usually economically disadvantaged in recruiting such teachers. Strategies that address economic development, workforce education and training throughout the continuum, and education and empowerment of rural community leaders have the greatest chance to impact this continuing problem.

While faced with socio economic difficulties, many of the 60 million people who have chosen to live in rural America do so for significantly positive reasons. These include low-density

population, often a cleaner environment, low crime rates, and a healthy nurturing environment in which to raise a family. Rural people often possess values which are reflected in their commitment to family and community. These values include neighborliness, family solidarity, a sense of beauty, a sense of humor, humility, service to others, pride, patriotism, faith and religion, and equality. While rural people are also self-reliant and value individualism, they also engage readily in collaboration and partnerships to solve problems.

Students and health professionals who live, train, and work in rural areas feel appreciated by the communities in which they serve and that they know they make a difference in people's lives. Information technology resources available in many rural areas provide "virtual" opportunities to reduce problems sometimes associated with professional isolation. Another positive benefit is the willingness of providers to assume the educational expenses of those interested in rural health through scholarships and other financial assistance for those willing to work in underserved areas. Finally, healthcare workforce wages and salaries can be among the highest in the community providing a greater than average standard of living.

The healthcare workforce needs to be broadly defined. The workforce includes, physicians, midlevel providers, registered nurses, licensed practical nurses, pharmacists, pharmacy technicians, certified nursing assistants, radiology technicians, laboratory technicians, emergency medical technicians, paramedics, surgical assistants, dentists, dental hygienists, dental assistants, dietitians, physical therapists, physical therapy assistants, occupational therapists, speech therapists, health care educators, behavioral health/mental health professionals, health care administrators, and public health workers.

Rural health policy makers and leaders concerned with health care workforce supply have come to understand some "truths" about the problematic issue:

- Several strategies should be used to fix the problem.
- Effective strategies have to address the community's ability to recruit and retain health-care providers.

- Pipeline training programs that recruit trainees from rural areas and have rural specific content make a substantial difference.
- Improvements must be made in reimbursement for all rural providers.
- Long term economic development in rural areas can improve the problem over time.

To deal with the problem, the 2001 Institute of Medicine report, *Crossing the Quality Chasm: A New Health system for the 21st Century*, recommended integrating a core set of competencies that included patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics in the education of all health professionals. The committee proposed that all clinicians should possess these competencies irrespective of their discipline.⁸

Some of the factors cited in the literature as being predictors of physician selection of rural practice include 1) having grown up in a rural/underserved area, 2) being a National Health Service Corps (NHSC) scholarship recipient, 3) having a strong interest in rural practice when beginning medical school, 4) being male, 5) choosing a senior year rural family practice preceptorship and 6) being a member of an underserved ethnic/minority group.^{9, 10, 11, 12, 13} It has been further noted that family practice physicians and osteopathic physicians constitute the majority of rural primary care physicians and that they are more likely to distribute themselves in proportion to the population than are other specialists.^{8, 9, 17} In order to address the chronic shortage of rural health care workers, a variety of educational initiatives primarily comprising of rural training experiences for trainees have been devised. Pathman et al. observed that residency rotations, brief preceptorships in rural areas and graduation from an residency program that has an emphasis on rural, underserved area health care have the most promising effect in preparing physicians for rural practice and in lengthening the time that they serve in rural communities.¹⁶

Rabinowitz et al. have mentioned that selectively admitting a small number of medical school applicants who are most likely to become rural family physicians and assisting them to fulfill their professional and personal goals has had a substantial and long-lasting

impact on the source of medical care in traditionally underserved rural areas.¹⁹ It has also been found that community-based training with medically underserved populations and primary care role models living and practicing in underserved communities can reinforce and guide students' interests to serve rural communities.¹⁴ In this respect we have to keep in mind that education policy is a state issue, but both federal and state dollars are used to fund educational programs.

Evaluations of programs that included rural curricula for medical students have often shown success.¹¹ These programs have often utilized a

selective separate rural track for medical students and the effect of the curriculum itself has, therefore, remained unclear. Most studies have had little accounting for pre-existing characteristics and interests and little is known about educational factors affecting career choices.^{13, 16}

The literature indicates that the shortage of physicians is directly related to the educational and career choices of students. Many policy makers and educators, therefore, suggest that major curricular reforms emphasizing primary care^{13, 14} and community based training will prove most effective in bolstering the number of physicians serving in rural areas.¹⁵

The Alaska Center for Rural Health at the University of Alaska Anchorage conducted an extensive and comprehensive literature review in June 2004. It reviewed a wide range of topics directly related to health care workforce recruitment and retention issues. This review categorized and noted four key strategic areas that encompass the issues

1. Community and Organizational Strategies for Health Professional Recruitment

- Empowered communities can work together to make themselves more attractive to health care workers.
- Rural recruitment and retention efforts should take into account the needs of the entire family.
- Organizations can improve recruitment and retention by finding creative ways to provide clinical, professional, and financial support.
- The cost of turnover is large, so recruiting and retaining the right person is important.

2. Health Profession Training Issues

- Rural training programs are successful at recruiting and retaining providers and should be focused at all aspects of the training continuum and integrated into a comprehensive "pipeline" approach.
- Pipeline efforts should start early in the middle/high school years and work to enrich math and science competencies.
- Strategies can be developed to minimize provider concerns regarding rural training tracks and encourage participation.

3. National and state policy issues

- National and state financial incentive programs aimed at encouraging practice in underserved areas are effective but funded too modestly.

4. Health Professional Employment Selection Behaviors

- Healthcare workers who grow up in a rural location are more likely to be recruited to rural practice.
- Many factors affect healthcare workers' decision to practice in a rural location; therefore, training, recruitment and retention efforts should be multi-faceted.

The American Hospital Association (AHA) Commission on Workforce for Hospitals and Health systems is under the impression that hospital leaders – especially boards of trustees and hospital executives -- can play a crucial role in dealing with the shortage of qualified hospital workforce. Thus, in its report "In Our Hands," the AHA has recommended these five ways to solve the workforce crisis in health systems:

- Fostering meaningful work by transforming hospitals into modern day organizations where all aspects of the work are going to be designed around patients and the needs of the hospital staff to care for and support them.
- Improving the workplace partnership by creating a culture in which hospital staff is valued, having a voice in shaping institutional policies, and are appropriately rewarded and recognized for their efforts.
- Broadening the base of health care workers by creating strategies that attract and retain a diverse workforce of men and women, racial and ethnic minorities and immigrants.
- Collaborating with others, hospitals, health care and professional associations, educational institutions, corporations, philanthropic organizations, and government to attract new entrants to the health professions
- Building societal support for the public policies and resources needed to assist recruit and retain a qualified workforce, including adequate payment rates for hospital care and regulatory reform that reduces administrative burden and promotes team approaches to provide quality care.¹⁸

Summary

This paper serves as the introduction to a series of papers on rural health care workforce development through career pipeline programs and outlines the issues endemic to recruitment and retention in rural areas. Regardless of the

discipline, level of health care worker, or location within the nation, these problems are common to all who seek to improve health outcomes by increasing the number of the available workforce. The following papers are:

1. Rural Health Careers Pipeline: Medical School, Residencies, Physicians
2. Rural Health Careers Pipeline: Nurses and Nurse Practitioners
3. Rural Health Careers Pipeline: Pharmacists and Pharmacy technicians
4. Rural Health Careers Pipeline: Dentists and Dental Hygienists
5. Rural Health Careers Pipeline: Behavioral Health/ Mental Health
6. Rural Health Careers Pipeline: Rural Public Health
7. Rural Health Careers Pipeline: K-12 and Pre-College.
8. Rural Health Careers Pipeline: Communities and Academic Partnerships
9. Rural Health Careers Pipeline: Community Practice and Retention
10. Rural Health Careers Pipeline: Healthcare Administration
11. Rural Health Careers Pipeline: Allied Health/Technicians/Technologists
12. Rural Health Careers Pipeline: Physician Assistants
13. Rural Health Careers Pipeline: EMS/EMTs
14. Rural Health Careers Pipeline: Issues of Preserving Rural Professional Quality of Life

End Notes

- 1) Hart, G., Salsberg, E., Phillips, D.M., Lishner, D.M., *Rural Health Care Providers in the United States*, Journal of Rural Health, 2002 Supplement, Vol. 18, No. S 211-231
- 2) Ricketts, T.C. III., Johnson-Webb, K.D., & Taylor, R.K., (1999) *Populations and places in rural America*. In Ricketts, T.C. III., (ed.) *Rural health in the United States* (pp 7-24) New York: Oxford University Press
- 3) Ibid.
- 4) Hassinger, E. W. & Hobbs, D. J. (1992) *Rural society—The environment of rural health care*, In Straub, L.A. and Walser, N. (Eds.), *Rural health care: Innovation in a changing environment* (178-190) Westport, E. T., Praeger
- 5) Hart, G., op.cit., p 212
- 6) Council on Graduate Medical Education (COGME) (1998) *Tenth report: Physician distribution and health care challenges in rural and inner-city areas*. Washington, DC: Government Printing Office.
- 7) Hart, L.G. & Taylor, P. (2001) *The emergence of rural health policy at the federal level in the United States*. In Geyman, J.P. , Norris, T. E. and Hart, L. G. (Eds) *Textbook of rural medicine* (chapter 6) New York: McGraw-Hill.
- 8) Institute of Medicine report, *Crossing the Quality Chasm: A New Health system for the 21st Century*. 2001, National Academies Press.
- 9) Rabinowitz HK, Diamond JJ, Markham FW, Painter, NP. *Critical Factors for Designing Programs to Increase the Supply and Retention of Rural Primary Care Physicians*. JAMA, 2001; 286: 1041-1048.
- 10) Pathman DE, Steiner BD, Jones BD, Konrad TR. *Preparing and Retaining Rural Physicians Through Medical Education*. Academic Medicine. 1999; 74: 810-820.
- 11) Rabinowitz H K, Diamond JJ, Markham F W, Hazelwood CE. *A Program to Increase the Number of Family Physicians in Rural and Underserved Areas: Impact After 22 years*. JAMA, 1999; 281: 255-260.
- 12) Rabinowitz HK, Diamond JJ, Veloski JJ, Gayle JA. *The Impact of Multiple Predictors on Generalist Physicians' Care of Underserved Populations*. American Journal of Public Health. 2000; 90: 1225-1228.
- 13) Campos-Outcalt D, Senf J, Watkins AJ, Bastacky S. *The Effects of Medical School Curricula, Faculty Role Models, and Biomedical Research Support on Choice of Generalist Physician Careers: A Review and Quality Assessment of the Literature*. Academic Medicine. 1995; 70: 611-618.
- 14) Tippetts E, Westpheling, K. *The Health Promotion-Disease Prevention Project: Effect on Medical Students' Attitudes Toward Practice in Medically Underserved Areas*. Family Medicine. 1996; 28: 467-471.
- 15) Pathman DE. *Medical Education and Physicians' Career Choices: Are We Taking Credit Beyond Our Due?* Academic Medicine. 1996; 71: 963-967.
- 16) Pathman DE, Riggins, TA. *Promoting Medical Careers in Underserved Areas Through Training*. Family Medicine. 1996; 28: 508-510.
- 17) Rabinowitz HK, Paynter, NP. *The Rural vs. Urban Practice Decision*. MsJAMA. 2002; 287:113.
- 18) *In Our Hands*. American Hospital Association Commission on Workforce for Hospitals and Health Systems (report)