RURAL HEALTH WORKFORCE: BRIEF OVERVIEW

A quick and easy reference to define rural, retention, and recruitment

For each concept, remember to ask yourself...

- Rural: How do we characterize the location or population?
- Retention: How do we keep health professionals?
- Recruitment: How do we get new health professionals?

Rural Health Statistics

According to the 2010 Census, almost 60 million people, or 19% of the U.S. population, lived in rural areas.

- 64.4% of the total rural population lives east of the Mississippi River
- Only 10% of the total population in the West region live in rural areas
- Nearly half (46.7%) of all people living in rural areas are in the South region
- 704 counties had 100% of their population living in rural areas

In 2014, Rural Americans were more likely to die from five leading causes than urban counterparts, with thousands of potentially preventable deaths:

- 25,000 from heart disease
- 19,000 from cancer
- 12,000 from unintentional injuries
- 11,000 from chronic lower respiratory disease
- 4,000 from stroke

Defining Rural

Many of us may think of "rural" and rural health in different ways, which makes it difficult to define in concrete terms. Similarly, our government agencies and programs use different methods of determine what rural actually means. The following are the some examples of the way prominent government agencies and programs define "rural".

U.S. CENSUS BUREAU

The Bureau focuses on defining urban areas through the use of population density and census block groupings, and defines rural as any population, housing, or territory not in an urban area. Urban areas consist of areas with a population of 50,000 or more or a core census block group with at least 1,000 people per mile with the surrounding blocks having an overall density of at least 500 per square mile. Additionally, in 2000 the Census added urban clusters which have a population of at least 2,500 but less than 50,000. Rural populations are the areas that fall outside these conditions.

OFFICE OF BUSINESS MANAGEMENT

Classifies statistical areas as either metropolitan or micropolitan (metro vs. nonmetro) areas based on high population concentrations and degree of social and economic integration (measured by commute to work). According to the OMB, micropolitan is classified as rural.

ECONOMIC RESOURCE SERVICES

Uses the Rural-Urban Commuting Area Codes (RUCAs) to classify census tracks rather than counties as metropolitan or non-metropolitan. There is a zip code classification in addition to their primary and secondary codes.

Facts about Rural South Carolina

SC was ranked **43rd in health** among all states by *American's Health Rankings 2018 Annual Report*

SC Strengths

Low incidence of pertussis

Low prevalence of excessive drinking

Low levels of air pollution

SC Challenges

High prevalence of diabetes

High premature death rate

Low immunization coverage among children

Changes in Health Data Over Time

In the past 6 years, adult obesity increased 11%

In the past 3 years, occupational fatalities increased 38%

In the past 3 years, premature death increased 7%

In the past 6 years, adult smoking decreased 19%

In the past 4 years, Tdap immunizations increased 24%

In the past 2 years, primary care physicians increased 4%

Find more information and resources at www.ruralhealthsc.com

Information retrieved from U.S. Census Bureau, 2017; CDC, 2017; Economic Resource Service, n.d., Office of Management and Budget, 2010

University of South Carolina College of Social Work

South Carolina Center for Rural and Primary Healthcare

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Retention

How do we keep top performing health professionals in rural practice?

Job Embeddedness

Elements that embed a practitioner to rural practice

- Organizational/Community fit: how well a person is at ease in their surroundings
- Community Links: connections with coworkers and neighbors
- Level of personal sacrifice: how hard it would be to change jobs or move
- Personal fulfillment: level of engagement and ability to make meaning out of role and daily responsibilities

Recruitment

How do we attract new health professionals to rural practice?

Attractiveness Factors

Elements that attract practitioners to rural practice

- Ability to practice a wide scope of skills
- Enjoy nature and being outdoors
- Opportunities to work in both hospital and community settings
- Possibility of continuity of care throughout a patients life
- Previous educational or life experience in a rural location
- Security, privacy and a sense of intimacy
- Community itself—very welcoming, appreciative of the services provided and having community members that respect the workload and responsibilities of a rural practitioner

Extrinsic Incentives

Employment motivators offered by employer

↓

Competitive pay & benefits

Signing bonus

Retirement options

Student loan assistance

Competitive leave package

Intrinsic Incentives

Internalized, personal factors and motivations

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Work environment

Housing

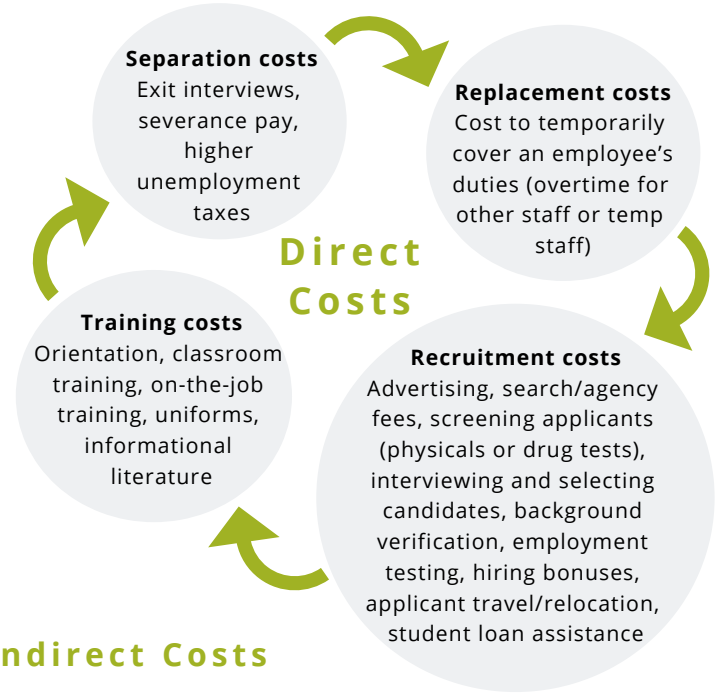
Commute to work

Partner employment

School districts & daycare

Cost of Staff Turnover

Employee turnover is estimated to cost businesses about one-fifth or 20% of a worker's salary to replace that worker, but jobs that are very complex and require higher levels of education or specialized training tend to have even higher turnover costs.



Indirect Costs

- Reduced morale
- Lost clients and lost institutional knowledge
- Lost productivity for departing employee
- Lost productivity due to need to hire temp staff
- Coping with a vacancy or giving additional work to other employees
- Costs incurred as new employee learns his or her job (reduced quality, errors, waste)

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Information retrieved from Asghari et al., 2017; Berndt et al., 2017; Blake et al., 2012; Boushey & Glynn, 2012; Campbell, McAllister & Eley, 2012; Gallup Incorporated, 2017; Lucian Leape Institute, 2013; National Rural Health Association, 2015; University of South Carolina College of Social Work, 2015

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RURAL HEALTH WORKFORCE: CAPACITY-BUILDING STRATEGIES

Categories of Intervention

It is important that we see ourselves as part of the solution and change process when thinking about strategies to improve recruitment and retention. We can all contribute in improving our work environment or supporting one another in our various roles. Although we often tend to think of recruitment and retention to be an issue for administration or we may feel as though it is an issue that is larger than ourselves, we play an important role in our workplace.

Listed below are some categories of intervention strategies we can use to view retention and recruitment efforts. These intervention strategies are not mutually exclusive and can be combined for optimum outcomes.

Selection

Selective interventions focus on criteria used to select students into health professional training programs based on various factors that may increase the likelihood of retaining their services in rural and remote areas once qualified.

Rural origin or background (completing primary and/or secondary education there) has been associated with rural practice and has been shown to be the single factor most strongly associated with rural practice as students with a rural upbringing are more likely to practice in a rural setting. Therefore, efforts need to be made early on to identify students with potential interests and recruit them into health care profession tracks.

Career Intent & Gender have been shown to be strong indicators but there is some dispute in these areas. Some studies have found that students who reported intent to work in rural settings followed through, however, a study of rural physicians reported that they did not intend to enter rural practice. Additionally, men are more likely to enter rural practice than women but there are contributing factors that remain unexplored as to why. More research is needed to determine the full extent of these factors in students' decision-making process regarding rural practice.

Education

Educational interventions focus on strategies that optimize medical training programs (pre and post-vocational) in such a way as to stimulate interest and participation in community-based medicine (including rural practice).

Being exposed to rural settings early and taking part in rural oriented medical curriculum have been shown to contribute to effective recruitment and retention efforts.

Once identified and exposed to rural practice, efforts need to be made to provide training opportunities in rural settings through field placements, summer training programs, or other methods to enhance student exposure, interest and participation in rural practice.

These efforts allow institutions and training programs to capitalize on students' interests and assist to fuel knowledge and skills in rural practice.

In addition, medical educators, deans, editors and other educators may have spent the majority of their lives and practices in urban areas with high physician concentrations and lack knowledge about what happens in rural areas. If educators and other decision makers are unfamiliar with rurality of the unique needs and challenges faced in rural settings, they are less likely to completely understand, communicate or legislate effectively for these areas. It is important that the rural perspective and experience to be incorporated into the curriculum and to do so, we also need to expose and educate urban educators on rurality so they can adequately portray these needs to prospective rural providers.

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Asghari et al., 2017; Berndt et al., 2017; Blake et al., 2012; Campbell, McAllister & Eley, 2012; National Rural Health Association, 2015; Wilson et al., 2009

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Incentives

Incentive interventions focus on the provision of financial incentives or bursary schemes that are linked to rural service agreements.

Influence of Incentives

The role of incentives in the form of loan repayment has been found to improve both recruitment and retention efforts. With student loan debt hovering, providers may be more focused on finding positions with a higher salary or financial compensation measures to cover these costs. Loan forgiveness programs alleviate some of that burden. Another strategy found in the literature discusses the potential of utilizing visa deferment programs and providing opportunities for international students and providers to assist filling positions in shortage areas.

Rural providers—like everyone else—want to feel that their work is appreciated and valued and incentives are one way for employers to show their appreciation. Scholarships and bursaries with rural return of service agreements successfully recruit and retain more rural doctors. Scholarships have been most successful when used in combination with dedicated mentoring and support.

Enforcement Considerations

One thing to consider when establishing or utilizing incentive strategies or service agreements is how to uphold the professionals commitment. Although professionals enter into these service agreements, enforcing rural agreements can be difficult and penalizing professionals for breaching their agreements has been strongly opposed by medical schools and professional organizations.

Financial Challenges

Paying direct financial incentives like rural allowances have shown variable results and as with other financial incentives—local governments or agencies may find it unsustainable. Also, rural agencies and governments may be unable to afford to hire healthcare professionals using high salary incentives. Even given the higher salaries, the response of healthcare professionals is mixed.

Support

Supportive strategies focus on different ways to support rural health professionals in practice.

Supportive strategies bolster intrinsic and extrinsic incentives and address the personal and professional needs of healthcare professionals. If done effectively, supportive strategy interventions through the use of professional development opportunities enhance service delivery and support rural recruitment and retention. It is important to begin utilizing these supportive strategies early throughout the recruitment and retention processes and to set the precedent for professionals as to what support they should expect from their employer.

Enhanced Support

Ex: Job satisfaction, service delivery, and enhanced retention/ recruitment programs

Professional Development

Ex: Improve supervision, distance technologies, and improved rural/urban partnerships

Build Community

Ex: Attachments and friendships, supportive networks, and improved infrastructure

Familial Support

Ex: Identify new opportunities, improve existing opportunities and provisions, emphasize considerations for work-life balance

Coercion

Coercion or coercive strategies focus on the use of authoritarian methods (by medical councils, professional bodies and/or governments) to force health professionals into rural practice

Although coercive strategies address provider shortages in rural areas, they do not positively influence retention and worsen human resources constraints in the long-term.

These measures are controversial and not widely implemented. Coercive strategies ensure that providers enter rural practice but providers often feel that these strategies are unfair as other professionals are rarely required to perform compulsory service. This strategy can build hostility and resentment among students and healthcare professionals due to the fact that they are required to work in a rural setting, rather than practicing there voluntarily. Students may be discouraged from entering medical careers and healthcare professionals may be unable or unwilling to comply with these requirements, which may prevent their entry into practice.

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