Training Needs to Prepare the Healthcare Workforce for Rural Practice

COGME Rural Health Issue Brief #3

INTRODUCTION

Many rural communities in the United States lack of access to timely, effective, high-quality health care. This lack of access to care has contributed to growing health inequities between rural and urban inhabitants, with rural communities having elevated rates of disease and death for many conditions.[1-3] Some of the starkest examples include: an increased incidence of permanent tooth loss linked to a scarcity of dentists,[4] a rise in opioid use and other substance use disorders combined with a shortage of behavioral health providers and treatment facilities,[5] and poorer pregnancy outcomes related to inadequate access to reproductive health care.[6-10] In addition, a 2020 report highlighted difficulties that rural communities face in recruiting and retaining general surgeons, who can perform a wide range of low complexity surgical procedures and provide backup to rural primary care providers, contributing to the quality and financial stability of rural practices and hospitals.[11]

At present, 20% of Americans live in rural areas, but only 9% of physicians live and practice in rural settings.[12] This physician workforce maldistribution deprives rural areas of basic health care resources. And it will worsen without significant intervention – growth of urban residencies has far outpaced that of rural training programs[13] and most physicians ultimately practice close to where they trained.[14]

Multiple government reports have explored this discrepancy and called for change.[15-18] Since graduate medical education (GME), which covers the period of medical training commonly referred to as *residency*, is largely funded through federal programs, Congress has the opportunity to leverage these training funds to reduce some of the health access disparities between urban and rural areas.

This is the third of a three-part series of issue briefs from the Council on Graduate Medical Education (COGME) focused on improving the health of rural communities through strengthening the rural healthcare workforce.

- Issue Brief #1 highlighted disparities in outcomes in rural communities and the importance of ensuring efforts to increase the physician and healthcare workforce that meet the needs of rural communities.
- Issue Brief #2 discussed the role of necessary investments to support a rural healthcare workforce.
- Issue Brief #3 will focus on the current and novel graduate medical education and mid-career training programs required to create an effective and patient-centered rural healthcare workforce.

In recent years, efforts have been made to support the growth of residency training programs in rural areas. The Council on Graduate Medical Education (COGME) supports these efforts, many of which the Council has discussed in previous issue briefs. COGME proposes **modifying the training of residents interested in rural care so that they are better equipped to handle the specific needs of rural populations**. Moreover, COGME proposes further expansion **to include novel sources of funding that extend training to non-physician providers and invest in care teams**.

Key Principles to Promote Rural GME Training

The advancement of rural training coalesces around a key set of principles.

Specific Needs of Rural Communities

The first principle is to recognize that rural communities have a range of specific needs that cover care across the lifespan, and are centered on community-based health care delivery. An assessment of local community and population health needs, developed by working with public and private stakeholders invested in the community, would help to shape the development of tailored training tracks for rural clinicians. Training programs preparing health professionals for practice in rural areas must allow for flexibility and adaptability.

One widely recognized need for improving care in rural communities is the availability of reliable and affordable communications technology, including telephone, video, and internet broadband infrastructure. Building and maintaining this connectivity, and training both clinicians and local residents in its use, would promote community access to accurate health information and the full range of telehealth services.

Team-Based Care

The second principle is an emphasis on interprofessional, team-based care. Rural communities typically have few facilities such as hospitals and clinics, and may have a limited number and range of health professionals in the community. Putting these resource constraints to greatest use will require cooperation and coordination among local providers, working together in teams to complement each other's skills and scopes of practice within flexible models of care.

Training in community care teams can create a more stable local healthcare delivery model and reduce the cost per unit of care, while improving professional satisfaction and meeting the needs of the local population more efficiently. Moreover, effective models of rural team-based care should link office- and hospital-based clinicians with others practicing directly in the community - e.g. community health workers, social workers, case managers, and others. Training in teams would facilitate an understanding of the roles and benefits of other healthcare professionals, and promote cultural competency (especially for trainees coming from outside the community), adaptability, resilience, and an ability to practice in a climate of resource scarcity.

Generalism in Practice

The third principle reflects the need to encourage generalism in rural healthcare practice. The United States has seen a decline in generalist training and practice. However, clinicians preparing for rural practice need to develop and maintain a broad range of skills that they can adapt to meet the specific needs of the local community. For example, behavioral and mental health training could be incorporated into primary care to address such issues as suicide prevention and the opioid crisis. Included within this principle is the need to promote broader, lifelong learning, not just among physicians but among all rural healthcare providers.

Recruitment of Individuals from Rural Communities

The fourth principle recognizes the need to invest in the recruitment and training of individuals from rural communities into the health professions by developing pipeline programs and promoting opportunities for medical and health care professions education. Data suggests that

these individuals would be more likely to remain and work in rural areas. Studies have consistently found that physicians who grow up in rural areas are more likely to practice in rural settings[19] and that counties with providers who have strong ties to the local community usually have better health outcomes.[20] Therefore, scholarships and other incentive programs for those who come from rural communities promise to increase the rural health workforce, and in turn broaden access and improve health outcomes. With the emphasis on and importance of team-based care described above, programs to expand the supply of health care services should capitalize on local resources. For example, primary care capacity can be increased by empowering licensed personnel, such as registered nurses (RNs) and pharmacists, to provide a broader range of services within their scope of practice.

New Sources of Funding

Fulfilling these principles will require developing new sources of funding that support the financial health and sustainability of rural practices, including possible GME funding from state governments and the private sector. Funding is also needed to support the recruitment and training of clinicians in other disciplines, including nurses, physician assistants, social workers, behavioral health providers, and others. New sources of funding should include local, state, and federal initiatives to be sustainable.

Area Health Education Centers

One vital resource already in place in many rural areas of the United States is the Area Health Education Centers (AHEC) program. Based in the Health Resources and Services Administration (HRSA), the AHEC program provides grants to schools of medicine and nursing to develop and enhance education and training networks within communities, academic institutions, and community-based organizations.[21] These networks focus on training programs to improve the supply, distribution, diversity, and quality of healthcare providers, and in turn increase access to health services in rural and other medically underserved areas. A redesign in FY2017 introduced the AHEC Scholars Program, which supports educational and training activities for health professions students in six core areas: inter-professional education, behavioral health integration, social determinants of health, cultural competency, practice transformation, and current and emerging health issues. This program enhances recruitment and training by promoting community-based experiential training in rural areas through field placements and clinical rotations, facilitating continuing education for health professionals already in practice, and developing statewide outcome-focused evaluation methods.

The AHEC program assists educational systems in developing recruitment and retention incentives to attract and retain health care personnel in underserved areas.[22] Thus, AHECs are well suited to advance the principles of rural health care training. However, current funding levels are insufficient to meet the full scope of rural health care needs.

Special Considerations for Rural Training and Practice

To enhance successful practice, programs focused on training clinicians for rural practice must cover aspects of living in and becoming a part of a rural community. There are individuals who would consider moving to a rural community if they could receive some condensed and specific training that would help them transition to a rural practice. This training could take the form of a

funded fellowship for mid-career physicians designed to facilitate this transition. Furthermore, those who complete this training should retain access to the program staff and the expertise of the faculty for ongoing support and advice.

Often the major concern of a rural practitioner is the financial stability of the practice. For physicians and other clinicians relocating to a rural community, funds are needed to establish and secure the practice, to include hiring the necessary ancillary personnel. Other incentives could include student loan forgiveness linked to the years of practice in the rural community, and financial and personnel support to allow the physician can take time off for vacations while maintaining coverage for the community. For long-term practices, a retirement program could be supported by State and Federal funds.

Another potential initiative would be a program to help rural practitioners network with other rural physicians and families, similar to programs in place for physicians and families on mission trips. Building rural networks would allow physicians to have work-based exchanges and consultations, and to develop personal and social interactions to increase job satisfaction. Such a program could offer access to counselling to reduce the risk of burnout and allow for crisis intervention. Rural practitioners also need access to lifelong training to maintain current skills and develop additional skills, expand their network, enhance their careers, and promote satisfaction with their practice. This will require:

- Easy access to local, regional, or national educational institutions,
- Provision for extended time away for training, including the necessary coverage and funds for travel and lodging,
- Ability to take part in remote training through mobile classrooms or tele-education, and
- Long-term access to the program staff and faculty for support and advice.

Family concerns often impact the decision of physicians and other practitioners to relocate to a rural area. New state and local programs are needed to explore career support for the spouse, along with educational support for the children.

Lastly, there is a need to develop and expand the public health workforce for rural communities, with workers recruited from the local community and trained to deal with the local public health needs as well as the more general health issues such as health promotion, cancer prevention, and community outreach. This workforce would play an important role in public health initiatives, such as the current COVID-19 pandemic response and vaccination roll-out, disease surveillance and prevention programs, and the response to natural disasters with the related health challenges. As a potential benefit, many who start out in supportive or paraprofessional public health roles as community health workers may choose to pursue a lifelong career in healthcare.

The Consolidated Appropriations Act of 2021

With passage of the Consolidated Appropriations Act of 2021, aimed to provide relief for the COVID-19 pandemic, there is an opportunity to implement some of the recommendations outlined above. Section 126 will create additional residency positions in rural hospitals, which will expand upon the rural physician workforce and prepare more physicians to provide care in these communities. Further, Section 127 will allow rural training programs more flexibility to

form local partnerships and meet the unique needs of rural communities.[23] Investing and expanding upon the rural healthcare workforce will be critical to creating a more resilient and robust healthcare system in the aftermath of COVID-19.

Conclusion

Given the significant and serious health disparities faced by rural inhabitants across the country, the diverse health care needs of rural communities should be addressed in a flexible manner.[24] In medical education, rural residencies should focus on training physicians who are comfortable in generalist practice, capable of addressing a wide variety of problems, and willing to adapt their practice in a changing healthcare landscape. Furthermore, investments in the training other healthcare professionals and community members are needed to create effective and cohesive care teams. Training programs must reflect the diverse needs of rural communities, prepare health professionals who can address those needs, and emphasize team-based care, generalism, and adaptability. Health professionals in rural areas must care for a broad range of health issues and problems, be adaptable to local conditions, and augment their skills depending on community needs. Finally, strengthening pipeline programs in rural communities would expand opportunities for individuals from these areas to contribute to their own healthcare workforce. Investments from new sources of funding, along with additional support for current programs such as AHEC, hold the promise to expand and improve the rural health workforce, promote rural healthcare access, and improve health outcomes. The strategies outlined in this Issue Brief can serve to leverage community resources and create sustainable solutions to improve clinician training, alleviate provider shortages, and decrease health disparities in rural areas.

COGME Recommendations

Building on these principles, COGME offers the following recommendations:

1. COGME recommends that the U.S. Department of Health and Human Services (HHS) fund a mid-career professional retraining program to help clinicians adapt their existing skills to meet evolving rural health needs.
    a. Offer financing and support for community-based mid-career retraining of generalists to mitigate the gaps in access to care and address the needs of rural populations. Provide ongoing clinical support in specific areas of highest need that include (but are not limited to):
        i. Perinatal and obstetric care (including emergency C-section training), and extended post-partum care,
        ii. Prevention and treatment of substance use disorders,
        iii. Emergency and procedural care, including general surgery, and
        iv. The care of infants, children, and adolescents, and
        v. Behavioral and mental health care.
    b. Support targeted infrastructure investments to facilitate lifelong training for practitioners in rural communities. Specific examples include:
        i. The use and provision of telehealth through dedicated programs.
        ii. Team-based care.
        iii. Advanced technology, including reliable, critical communications infrastructure (e.g. telephone, video conferencing, broadband).
    c. Increase funding for the Area Health Education Center (AHEC) program to develop model(s) to operationalize this recommendation.

2. COGME recommends the promotion and expansion of interprofessional team-based care in training programs funded by HRSA or HHS.
    a. Provide necessary training on team function, team management, leadership, and team business models.
    b. Encourage an understanding of professional scope of practice, including allowing for top-of-education practice at all levels.
    c. Through coordination between HRSA and the Centers for Medicare and Medicaid Services (CMS), consider developing alternative payment models that support team-based, interprofessional training and practice in rural communities, to the extent permitted under current law.

3. COGME recommends that HHS invest in sustainable solutions that focus on building a stable healthcare workforce in rural communities, including:
    a. Additional funds for pipeline programs through scholarships for individuals from rural communities to pursue professional qualifications as well as additional training opportunities for existing licensed personnel in these communities, such as the Health Careers Opportunity Program.

b. A program to support the relocation and resettlement of practitioners and their families to rural locations, including:
    i. Support for the establishment and integration of the practitioner and their family in the community.
    ii. Support for the retention of the practitioner in the community.

c. Specific investment in developing community-based public health assets that advance public and population health.

About COGME

The Council on Graduate Medical Education (COGME) provides an ongoing assessment of physician workforce trends, training issues and financing policies, and recommends appropriate federal and private sector efforts on these issues.

COGME advises and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) and to the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Energy and Commerce.

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