the REPORTER

2-HOUR CME: MEETING THE CHALLENGES FOUND IN RURAL HEALTH CARE

BUILDING A STRONG HEALTH CARE TEAM: A PHYSICIAN'S QUICK GUIDE TO HIRING AND RETENTION

DE-ESCALATION FLASHCARDS

TMLT
Texas Medical Liability Trust

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2-HOUR CME: MEETING THE CHALLENGES FOUND IN RURAL HEALTH CARE

by Jennifer Nelson

OBJECTIVES

Upon completion of this educational activity, the participant should be able to:

1. identify the primary risk factors that affect rural providers and patients;
2. recognize the challenges these providers face and outline solutions;
3. list available frameworks to initiate these solutions; and
4. provide practical advice, risk management strategies, and resources to help rural physicians and their patients.

COURSE AUTHOR

Jennifer Nelson is a health care writer who has also written for WebMD, New York Life, MSNBC, Fox News, and AARP.

DISCLOSURE

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TARGET AUDIENCE

This 2-hour activity is intended for physicians of all specialties who are interested in improving patient care in rural settings.

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RELEASE/REVIEW DATE

This activity is released on November 10, 2024 and will expire on November 10, 2027.

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INTRODUCTION

In the heart of rural America, where winding roads meet rolling hills, today's physicians face a unique set of challenges not seen by their urban counterparts. Identifying areas of potential risk is crucial for physicians practicing in rural settings in order to continue delivering high quality health care to their patients.

About 20 percent of Americans live in rural areas, but only one-tenth of physicians practice there.[1] That is 5.1 physicians per 10,000 rural residents, compared to 8.0 physicians per 10,000 residents in metro or urban areas.[2] Geographic isolation, transportation barriers, and higher patient volume can affect every decision a rural physician makes. Rural health care facilities mostly operate with limited resources, including fewer medical staff members, reduced

access to specialized care, and constrained financial assets.

These limitations can lead to increased risk for both patients and the providers serving them. These restraints complicate health care delivery and increase the risk of errors and burnout. Physicians working in rural areas must be acutely aware of these factors so they can better manage risks in their practices.

One of the more significant risks for patients living in rural areas is limited access to care. Often, patients must travel long distances to reach health care facilities. This can lead to delays in diagnosis and treatment, which can exacerbate conditions and lead to poorer outcomes. Ensuring at-risk patients receive timely care through coordinated referrals, telemedicine, and telepharmacy is a complicated responsibility for rural physicians.

Staffing shortages are common in rural health care facilities, which often leads to overworked, stressed, and exhausted physicians and staff. Risk of errors, increased burnout, and mental health issues plague rural health care providers and may affect their ability to manage patient workflows. Cross-training staff, using locum tenens physicians, incentivizing advanced practice employees to learn additional skills or spend more time with patients, and fostering a more skilled medical team can help mitigate staffing shortages.

Limited financial resources, often the hallmark of a rural facility, can result in outdated equipment, inadequately supplied facilities, a lack of specialized care, and reduced access to continuing education. These risks can increase the likelihood of a malpractice claim. Seeking cost-effective solutions, such as partnering with larger health systems, switching to a Rural Emergency Hospital (REH) designation (more on that later), advocating for equipment and supplies, and seeking grant funding may help to enhance quality of care.

Further, communication barriers can become a factor in areas where patients may have lower health literacy and cultural or language challenges. Using electronic health records (EHRs) and other technologies can help improve communication and information sharing in the rural setting.

Finally, rural health practices may lack emergency preparedness capabilities due to limited resources. Natural disasters, pandemics, or mass casualty events can overwhelm small facilities and rural practices and may impede patient care during such an emergency. Risk management for rural practices should involve regular emergency training; preparation and back-up plans; and coordination between local emergency services and any nearby health care facilities.

IDENTIFYING THE RISKS IN RURAL HEALTH CARE

Clinical risks

Clinical risks in rural health care typically stem from limited access to medical services, including fewer health care providers, specialists, and facilities. Limited access can lead to delayed diagnoses, lower quality of care, and additional challenges when managing patients with chronic conditions.

Additionally, rural areas may face emergency care shortages, resulting in increased mortality and morbidity from conditions that may be more easily treated in urban areas. Advanced technology and comprehensive infrastructure may also be lacking.

Physicians must also contend with risks that fall under their patients' circumstances or control, including financial means to pay for care, lack of insurance, transportation to access services, health and language literacy to communicate with providers, and the trust and confidence that they will receive private, appropriate, and quality care.[3]

Operational risks

Operational risks include workforce shortages, since recruiting and retaining health care professionals in rural areas is challenging. This can lead to a heavier reliance on general practitioners, family medicine, and primary care physicians in place of specialists.

Additionally, rural facilities may struggle to remain viable due to lower patient volumes, lower per-patient reimbursements, higher per-patient costs, and reduced access to funding. These factors all contribute to putting rural health care in financial jeopardy. Challenges related to updating medical equipment and managing supply chains also pose significant operational risks.

Rural hospital closures, declining operating margins, and staff shortages combine to undercut the care of rural patients who are often older, less healthy, and less affluent.[4]

Financial risks
Financial risks are often blamed on lower patient volumes, which reduce revenue streams and may leave rural health care facilities in the "red." Limited access to capital and funding compared to urban areas further diminishes their financial capabilities.

Moreover, dependence on government reimbursement and fluctuating funding creates instability and can threaten the long-term viability of rural health care facilities. Hospitals operating in the "red" increased from 43 percent to 50 percent from 2023 to 2024.[4]

The latest research shows a growing trend of rural health care facilities falling further into the "red," often being forced to close. These closings strongly contribute to communities becoming "care deserts," where population health care needs are unmet partially or totally due to lack of access and insufficient resources.[4]

Physician risks
One of the most evident risks for physicians in rural areas is professional isolation — reduced access to continuing education that includes interaction with colleagues, peer support, and collaboration. Maintaining a broader scope of practice with less specialist support can also lead to decision fatigue and the risk of medical error. Finally, the heavy workload and added on-call demands can strain personal and professional lives, leading to a high rate of turnover and increasing physician shortages.

In an investigation of 25 rural women physicians in 13 states, researchers found that three strategies were critical for successfully navigating rural practice: flexible work hours, clear boundaries between professional and personal life, and establishing supportive relationships.[5]

Legal and regulatory risks
Legal and regulatory risks include maintaining compliance with health care regulations, which may be affected by limited administration resources and expertise. While rural physicians may face a higher risk of legal liability due to resource constraints, staff shortages, and delayed access to specialist services, they must also navigate complicated reimbursement policies and regulatory requirements. These burdensome requirements can lead to financial penalties or lost funding if not managed well. A lack of legal support or health care compliance professionals may also be an issue.

According to an American Hospital Association study, hospitals, clinics, and post-acute care providers spend $39 billion annually on non-clinical regulatory requirements. Yet rural facilities, with their lower patient volumes, have equal or higher regulatory requirements. Receiving relief from these requirements may help to improve patient care.[6]

UNIQUE PROBLEMS/POSSIBLE SOLUTIONS

Geographic, transportation, and infrastructure
Lack of transportation has long been known to be a risk factor for rural residents and a social determinant of health (SDOH). Since patient access to high quality health care is often dependent on transportation, it becomes fundamental to care. Moreover, rural residents who have disabilities, low income, or are seniors, have even greater risk of lack of transportation. Therefore, a lack of reliable transportation affects rural residents' ability to receive regular preventive care and treatment for chronic conditions. Two million rural residents do not have access to a car or public transportation. Medicaid offers one source of transportation for those who qualify, though benefits vary by state.

One study of 1,000 residents in North Carolina found that households with a driver's license had 2.3 times more health visits for chronic conditions and 1.9 times more appointments for preventive care than households without a licensed driver. Geography challenges can include limitations on what insurance will pay for medical transportation, and the necessity of traversing over long distances, water, mountains, or icy or snowy conditions.[7]

Even when there are transportation options, they likely do not include door-to-door services for those who cannot get from door to car and vice versa unassisted. Also, transportation is often a group van or bus where the rural resident must spend the

entire day traveling for a single medical appointment while the vehicle stops at multiple locations across a widespread geographical area.[7]

Potential solutions include:

- using vehicles across organizations (such as a Meals on Wheels shuttle to transport patients to medical appointments or school buses to deliver meals or medications);
- enlisting volunteers to meet transportation needs (modeled on volunteer services like volunteer fire departments and emergency services);
- expanding telemedicine and remote monitoring, lessening the need for travel;
- broadening new transportation technology such as driverless cars, and rural rideshares, modeled on Uber and Lyft;
- sharing new model programs between communities; and
- building partnerships across organizations such as between schools, health care facilities, and faith-based organizations.[7]

Socioeconomic factors affecting patient outcomes

Many socioeconomic factors affecting rural populations include low health literacy, low education, poverty and low income, geographic isolation, insurance status, housing issues, childcare issues, limited access to specialists, and limited job opportunities. Many of these factors are compounded by issues with rural transportation and access to healthy food.[8]

When it comes to improving the health of a rural population, people whose basic living needs (housing, food, income, clean water, etc.) are met can make better health choices, recover more effectively from illness, manage chronic health conditions more efficiently, and take preventive health care steps. By addressing SDOH through human or social services programs, such as food banks, domestic violence shelters, and job training programs, rural communities can reduce health care costs and hospital admissions and improve health care outcomes.

Rural residents may hesitate to ask for help due to stigma or strong self-reliance traditions; however, when social services are implemented into health care facilities, residents benefit from the alignment. Social services can help with coordinating care and providing referrals to mitigate the SDOH that can lead to poor health care outcomes.

Implementation may include co-locating health care facilities near social services or adding a social worker or case manager to a health care practice to help coordinate services. Several examples exist around the country, including the following.

- Humboldt County, California, where a Federally Qualified Health Center (FQHC) is located in the same building as a Family Resource Center. The location shares a front desk and eases rural residents from medical services to social services and vice versa. A white paper on this integration is available online at https://rupri.org/wp-content/uploads/HS_Humboldt_Feb2012.pdf.
- Vermont's Blueprint for Health program includes social workers within a medical team framework that deliver assistance for housing, weather, energy, and domestic violence and child abuse support. Patients can receive both social care and medical care in this scenario. A website describing the blueprint, including reports and articles, is found at https://blueprintforhealth.vermont.gov/.
- The Maine Rural Health Research Center has a paper titled, Integrated Care Management in Rural Communities, that provides additional examples and strategies for implementing these types of integrated care, which may be "funded under Medicaid, and involve coordination or integration with acute care providers under Medicare." The paper is available at https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1006&context=behavioral_health.[9]
- The Healthy Community Collaborative program integrates public and private sector services for rural Texans who experience homelessness, mental illness, and/or substance use disorders through Texas Health and Human Services. Collaboratives are available in Dallas, San Antonio, Austin, Fort Worth, Houston, and New Braunfels. The collaboratives offer skilled providers with a "housing first" approach to programming, meaning their priority is to help residents get secure housing, and who are also versed in

harm reduction, motivational interviewing, employment, and peer support. More information is available at https://www.hhs.texas.gov/providers/behavioral-health-services-providers/healthy-community-collaborative.[10]

Lack of available specialty physicians (diminishing obstetrics, gynecology, and oncology)
In addition to a lack of access to specialists in general, rural areas also face the diminished presence of obstetrics and gynecologists (ob-gyn) and oncologists.

Notably, ob-gyn services disappeared from 152 rural communities between 2011 and 2018 according to a study by The Chartis Group. The study found that 25 percent of rural hospitals stopped providing ob-gyn care altogether.[4]

According to the study, states affected most deeply by dropping their OB services include West Virginia, Florida, Pennsylvania, and New Hampshire. States that lost the greatest number of OB units in rural hospitals include Texas, Minnesota, Iowa, Wisconsin, and Kansas. Only Utah and Wyoming have not lost any of their OB services to date.[4]

Abortion bans and restrictions are thought to play a role in diminishing ob-gyn services. Ob-gyn specialists may be reconsidering working in many of the states that have implemented strict bans or restrictions, such as Alabama, Arkansas, Idaho, Indiana, Mississippi, South Dakota, and Texas. Ob-gyn services and maternal care are expected to further diminish as this issue continues to play out in state and federal legislatures.

The study reported that access to chemotherapy was also becoming more difficult. Between 2014 and 2022, 382 rural hospitals stopped providing chemotherapy services. In Texas, 42 percent of rural hospitals no longer offer these treatments. Alabama, Mississippi, Tennessee, and Florida have the next highest percentages of cuts.[4]

Lack of resources and equipment
Another challenge rural health care facilities and physicians face is a scarcity of equipment and personnel. The federal government predicts a shortage of nearly 20,000 rural primary care physicians by 2025. A lack of specialty and emergency department physicians are also a significant concern as well as a lack of newer technology and equipment.[1]

An increase in costs and lower reimbursement prevent rural facilities from funding capital improvement projects, like new equipment and tech upgrades. Aging hospital infrastructure is also problematic.

Research published in 2021 found that hospitals deferred about 41 percent of their maintenance and would need $243 billion to finance improvements. That number has likely grown. Meanwhile, inflation has driven up the cost of basic supplies, and facilities cannot afford to staff emergency departments or ob-gyn units full-time, while only getting paid when patients use these specialties.[11]

“My hospital is in a community of 900; we are the last city-owned hospital in the state of Nebraska. We don’t have millions in endowments or have private investors or a mother ship; a lot of rural hospitals are a part of hospital systems. We are not. It's just us," says Jared Chaffin, who serves as CEO and CFO of Friend (Neb.) Community Healthcare System, an hour west of Lincoln.[12]

Chaffin said that his hospital used to be a 15-bed critical access hospital that went to an REH (Rural Emergency Hospital) designation in January 2024. REH is a newer government option that pays rural facilities extra Medicare funds to drop their inpatient unit while continuing to offer other health care services.[12]

REHs were signed into law in 2020 to convert closing rural hospitals to new Medicare providers and help provide rural communities greater access to health care. The designation allows hospitals to provide emergency services, observational care, and outpatient services that do not exceed an annual per patient average stay of more than 24 hours. REHs are prohibited from providing typical inpatient services.[13]

“We were literally one to two hours from closing our doors permanently last June,” says Chaffin. “We just could not make payroll.” One of their board members had approached the board after reading an article about the rural program option. “We made a decision at that time and thought REH was the pathway we should go,” said Chaffin.[12]

"We'd been losing money since 2016. This time last year we were at a $1.7 million loss and this year [2024], we're breaking even, so we have been able to drastically turn around the hospital and it's been amazing to pay our bills," Chaffin said.[12]

Difficulty retaining rural physicians

One systematic literature review found that six major factors play a role in retaining rural physicians:

1. financial;
2. professional;
3. working conditions;
4. living conditions;
5. cultural; and
6. personal factors.[14]

For example, rural physicians often cite low compensation and reimbursement rates compared with their urban physician counterparts. Some physicians point to a dearth of educational opportunities, such as CME events or other seminars, and professional development, such as teaching positions. Working condition complaints include the lack of access to certain drugs and surgical equipment, more demanding working conditions, longer hours, and heavier workloads.

Most of the literature shows that older physicians are more likely to serve in rural areas as opposed to younger physicians. Younger physicians may place a higher priority on career development and family and leisure activities, factors that may be lacking in rural health care work.

The lack of amenities, housing, communication services like high-speed internet, and recreation facilities can negatively impact rural physicians' living conditions.

Limited studies have addressed cultural factors. Still, it appears that rural traditions, beliefs, moral values, culture, and language differences can play a role in whether a physician continues to practice in a rural area. These can include rural regional dialect differences and colloquialisms, differences in communication styles like needing more personal space, or a distrust of outsiders. These cultural factors may prevent physicians from creating bilateral relationships with their patients and continually keep them from acclimating fully into a rural culture from which they did not come from initially and are not familiar.[14]

Launching rural residency programs

"Our data across two federally funded programs, Rural Residency Planning and Developing, and Teaching Health Center Graduate Medical Education, show that having enough workforce to train the future workforce is a barrier that is being overcome," says Emily Hawes, Pharm D, BCBS, professor in the Department of Family Medicine at the University of North Carolina, and deputy director of the HRSA-funded Rural Residency and Teaching Health Center Planning and Development Programs.[15]

Hawes says that it is imperative that programs are built in the communities where graduates are encouraged to stay. Research shows that those who train in rural communities are at least twice as likely — some research shows up to five times as likely — to stay in the communities where they train.

Rural residencies provide increased access to care because residents are providing the care.

"Building the residency helped provide new clinical services, like treatment for opioid use disorder and behavioral health services, which is really important in the community I live," says Hawes. "And now, a couple of graduate classes later, seven of eight [graduates] are staying in the community." Across all these programs, about 60 percent stay in the communities where they train.[15]

Hawes also says that the new developing programs are training dentists and physicians to care for those who are underserved by having them reach out into farm worker care, whereby residents go out to farms to provide care for that population. They are also caring for the homeless and those impacted by incarceration, as well as the rest of the rural population.[15]

The federal studies referenced above, both conducted by the U.S. Health Resources & Services Administration, can be found online.

- Rural Residency Planning and Developing: https://www.hrsa.gov/rural-health/grants/rural-health-research-policy
- Teaching Health Center Graduate Medical Education: https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education

APPLICATION OF FRAMEWORKS IN RURAL HEALTH

Rural health care frameworks are strategically designed to address the health care needs of specific communities. These frameworks represent a systemic approach to health care delivery and include several key components.

1. Accessibility and availability
Accessibility and availability frameworks emphasize the importance of making health care accessible to rural populations living in remote areas, far from health care facilities. This involves implementing services like telemedicine, mobile health clinics, and other innovative solutions.

The Centers for Medicare and Medicaid (CMS) Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities focuses on strengthening and supporting health care professionals in Health Professional Shortage Area (HPSA) designations. Strategies include improving efforts to recruit and retain physicians and allied professionals; strengthening rural physician competencies to improve high-quality care; and reducing administrative and financial burdens of rural physicians through funding and reimbursement, including through the new REH designations and increasing Medicare graduate medical education residency slots.[16]

2. Workforce development
Strategies for recruiting, training, and retaining health care workers may include offering incentives like loan repayment programs, loan forgiveness programs, scholarships, and stipends to encourage providers to work in rural settings as well as training them rurally.

The State Loan Repayment Program (SLRP) and the National Health Service Corps (NHSC) are just two such programs that offer loan repayment and scholarships by state. Programs vary by specialty, scholarship, or fund forgiveness, and required time of service. One statistic shows that 86 percent of those who fulfilled their program service commitments between 2012 and 2020 remained in their rural community.[17]

3. Health equity and social determinants of health
Communities working on achieving frameworks for health equity and SDOH often make special efforts to help residents understand how social, political, economic, and environmental factors affect health care. The following framework examples can be reviewed and tailored by rural communities to fit a specific need.

One example is the Aspen Institute's Thrive Rural Framework, available online at https://www.aspencsg.org/thrive-rural-development/#overview. This framework separates its building blocks into three themes: Rural Voice and Power, Equitable Aims and Designs, and Resources for Productive Action. Their goal is to advance health care equity by making it a shared goal between residents and physicians, increasing multi-sector collaboration, and improving a community's ability to shape its health care outcomes.

The CDC offers the Community Strategies for Preventing Chronic Disease framework online at https://www.cdc.gov/dnpao-state-local-programs/media/pdfs/HealthEquityGuide.pdf. The goal of this guide is to "incorporate equity into the public health skills and practices of:

- Building organizational capacity
- Engaging community members
- Developing partnerships and coalitions
- Identifying and analyzing health inequities
- Selecting, designing, and implementing strategies
- Developing effective communication efforts
- Conducting evaluations." [18]

Likewise, more specific frameworks can be applied that reflect a community's "cultural or spiritual preferences," such as the Menominee Indian Tribe framework called Bridges Out of Poverty, located online at https://www.ahaprocess.com/wp-content/uploads/2013/08/Study-Guide-Bridges-Out-of-Poverty.pdf. This workbook-style framework explores the relationship between poverty and the community, family structure, mental attitudes, and resiliency.[18]

4. Integrated care models
To efficiently manage limited resources, health care frameworks often employ integrated care models, where different types of care, such as primary care, mental health care, and substance use services, are coordinated and provided through a single, unified approach.

One such model integrates behavioral health services into primary care. This integration can increase access to behavioral health treatment for mental health conditions, stress management, or substance abuse. Integration also helps to decrease stigma, lessen duplication of services, and maximize resources.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) have developed a framework that focuses on integrating services to coordinate and co-locate care.[19]

Another familiar integration belongs to primary care and substance use disorder services to address the opioid crisis in rural areas. The SAMHSA and HRSA framework is found online at https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56.[19]

Cherokee Health Systems, serving rural Tennessee, is another example of primary care and behavioral services integration. In this program, behavioral health consultants, typically psychologists and clinical social care workers, are embedded into primary care teams. Primary care physicians work hand-in-hand with behavioral consultants to screen patients for mood disorders and substance use disorders. They also access a psychiatrist through telehealth and telephone communications. Learn more at https://www.cherokeehealth.com/about-us/integrated-health-model/.[19]

Another framework example is the Behavioral Health Services of the Shenandoah Valley Medical System in Virginia, which links a rural Federally Qualified Health Center (FQHC) with annual behavioral screenings. A primary care physician refers patients with qualifying scores on their evaluation to a primary behavioral health provider for a same day consult in the same facility, and then follows them if they need further treatment through shared EHR communications. Learn more about this framework example at https://www.ruralhealthinfo.org/assets/4945-22084/ruralbehavioralmanual05312011.pdf.[19]

Finally, The Texas Health Improvement Network (THIN) conducted a 15-month project that explored health care and social care integration in rural Texas. The project conducted six individual case studies to determine the adoption and sustainability of addressing rural Texans' social care needs. Many of the case studies informally identified the challenges, resources, and concerns of rural communities, and then made recommendations covering areas in and around Matagorda, Galveston, Tyler, in Northeast Texas, Houston, and Austin. Information about the project and each case study can be found at https://utsystem.edu/sites/default/files/sites/texas-health-journal/THIN_Healthcare%2BSocial-Care-October2020.pdf.[20]

5. Community engagement

Rural health care frameworks can increase efficacy by involving the local community in planning and decision-making processes. Doing so can help ensure that health care services are tailored to the specific needs and preferences of the population.

Research shows that when community members come together to identify problems and strategize solutions, the programs have better odds of success. Community decision-making not only empowers communities to improve their health but also allows physicians to provide the social support needed to bring change to rural populations.

Frameworks for community engagement may include several key areas, such as:

- focusing on a specific issue, for instance, substance use disorder or diabetes management;
- actively engaging participation from various groups in the community;
- understanding the context and root cause of the problem; and
- providing feedback.[21]

Framework guides that address community engagement include the following online resources.

- The U.S. Department of Health and Human Services provides the *Planned Approach to Community Health (PATCH)* to help communities assess and improve the effectiveness, reach, and sustainability of rural health services. https://www.ruralhealthinfo.org/assets/4945-22084/ruralbehavioralmanual05312011.pdf.
- The National Institutes of Health publication,

Principals of Community Engagement, Second Edition, defines the process and implementation of integrating a community, including why it is necessary, empowering, and crucial to develop community engagement. https://www.ruralhealthinfo.org/assets/4945-22084/ruralbehavioralmanual05312011.pdf.
- The University of Kansas Center for Community Health and Development's website, the Community Toolbox, serves as a practical guide for physician providers to bring change to a community's health care attitudes and access through community engagement. https://ctb.ku.edu/en/table-of-contents/assessment/promotion-strategies/overview/main.[21]

6. Sustainability and funding

Ensuring the financial viability of rural health care is an essential aspect of these frameworks. Financial viability can be achieved in several ways, from securing funding using government sources, grants, or private organizations as well as creating care models that are financially sustainable over the long term. By planning for sustainability, physicians must leverage funding, like grant dollars, early to ensure partners and stakeholders have the appropriate buy-in to implement programs.

Frameworks and guides to help plan for greater sustainability include the following.[22]

- The Georgia Health Policy Center Sustainability Framework is an easy-to-use outline to help identify the necessary components for a successful plan for program sustainability, in addition to community support and engagement. https://www.ruralhealthinfo.org/sustainability/pdf/georgia-health-policy-center-sustainability-framework.pdf.
- The Department of Health and Human Services also offers a framework, *The Dynamics of Sustainability: A Primer for Rural Health Organizations*, which takes rural physicians from grant funding through shared ownership and on to long-term sustainability. https://www.ruralhealthinfo.org/assets/1211-4984/dynamics-of-sustainability.pdf.
- Georgia State University provides the *Sustainability Planning Workbook, Bringing the Future into Focus*, for physicians to plan beyond their grant period. https://www.ruralhealthinfo.org/sustainability/pdf/bringing-the-future-into-focus-sustainability-planning-workbook.pdf.[22]

7. Technology and innovation

People in rural areas often have less access to high-speed internet at home as well as reduced availability of personal smartphones, tablets, or computers. Therefore, frameworks to address this sparsity should focus on expanding the use of medical communication technology, telehealth services covered by CMS, and information technology infrastructure like access to broadband to ensure that rural residents are not left behind due to a lack of access to technology or the services that make it possible.

Medicare is expanding access to telehealth service reimbursement for any location including a rural patient's home. It is also allowing medical services via audio-only technology under certain circumstances. They are also partnering with other federal and local entities to expand broadband access and reduce costs on service and internet-capable devices.

On the provider side, frameworks to adopt, implement, and upgrade hospital and physician practice technology are foremost in demand. Tools and resources include AI-based tools, such as AI-powered scheduling devices and access to EHRs and other technologies that will improve care, outcomes, and physician working conditions.[16]

Some framework examples that focus on technology and telehealth include the following.

- The South Georgia Region Prevention Coalition, a four-county regional network that strives to improve primary and specialty care services via telehealth technology. This model includes both behavioral and oral health. https://www.ruralcenter.org/sites/default/files/South%20Georgia%20Regional%20Prevention%20Coalition%20PDF.pdf;
- The Annie E. Casey Foundation, a charitable foundation dedicated to improving the well-being of American children, has launched a framework called Casebook, a guide that uses social networking and web-based technology to develop a child-centric rural health case management tool. The tool helps physicians and caseworkers collect and share electronic

data across organizations. https://www.aecf.org/blog/casebook-gaining-recognition-as-game-changer-in-child-welfare-technology.[23]

PLANNED INITIATIVES TO IMPROVEMENT

To bridge the health care gap in underserved areas, planned initiatives focus on equipping physicians with the latest skills and resources so that they feel empowered to improve access in their rural communities.

One possible initiative includes mobile health, or "clinics on wheels," which help solve the transportation issue many rural residents face. Since infrastructure costs of mobile health units are significantly lower, costs may be lower for both patients and providers who operate such mobile clinics. One 2020 study found that over half (55 percent) of mobile health care clients were women and racial/ethnic minorities (59 percent).[24]

Telehealth is also usually on the planned initiative list. However, telehealth communications may invoke skepticism regarding privacy and tech literacy. Physicians should be prepared to assure remote patients of the secure use of patient data and to instruct them on how to use and set up remote access tools.

Finally, collaboration with larger health networks is another initiative often proposed during rural health care discussions. One report by the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis found that when rural health care practices collaborate with larger facilities, the benefits include improved technology and services, greater performance, more flexibility in payment models, and larger staff recruitment and retention efforts.[25]

POPULATION CHARACTERISTICS

Rural populations may be older, sicker, poorer, have more chronic health conditions, and, as discussed, have less access to transportation and technology. Rural residents also have higher rates of tobacco use, obesity, and hypertension. They are less likely to pursue active leisure activities and less likely to have health insurance.

Unintentional injuries and deaths are higher rurally than in urban areas. Unintentional drug overdose deaths are increasing and outpacing those in urban areas. Suicide is higher in rural communities than urban ones. And vehicle accidents are also responsible for many rural deaths.[26]

When it comes to cause of death, the U.S. Centers for Disease Control and Protection (CDC) found that rural residents are more likely than urban residents to die from heart disease, cancer, unintentional injuries, chronic lower respiratory disease (CLRD), and stroke.

Because of these risks, the CDC has attempted to reduce preventable rural early deaths with this checklist:

- screening patients for hypertension;
- increasing cancer prevention efforts and early detection screenings;
- encouraging physical exercise and healthy eating;
- promoting smoking cessation;
- promoting motor vehicle safety; and
- treating opioid use disorder.[27]

The CDC offers the following resources on implementing change in rural areas.

- The Leading Causes of Death in Rural American Partner Toolkit provides graphics, messages, talking points, social media messages, and more: https://www.cdc.gov/rural-health/php/about/leading-causes-of-death-toolkit.html.
- The Rural Health Information Hub's webinar, "Mortality in Rural Areas: Insights from National Research and Community-Based Initiatives," highlights work by the National Center for Health Statistics on the differences between urban and rural areas and how to reduce mortality related to substance abuse in rural areas. https://www.ruralhealthinfo.org/webinars/nchs-rural-mortality.
- The CDC's data visualization dashboard on Preventable Early Deaths in the U.S. https://public.tableau.com/app/profile/macarena.garcia4428/viz/PreventableEarlyDeathsintheUnitedStates2010-2022/ss1_mapview_final.[27]

Another health determinant for any community is its economic vitality. Rural communities may contend with increased unemployment, lack of economic equity, and lack of available jobs.

The type of industry found within a community may also be in decline or its economic performance may be variable. For example, agriculture, forestry, fishing, hunting, and mining are important industries in many rural areas. However, typically, it is the service and retail industries, often lacking in rural areas, that have experienced the most job growth in recent decades.

A more robust, economically healthy community is more likely to support and sustain health care systems and recruit and retain health professionals, financially support health care facilities with philanthropic giving, and invest in the infrastructure needed.

Bolstering community resilience

The ability to adapt or recover from a natural disaster, or an economic downswing, is another key to building a more robust rural community that can support health care.

According to a working paper from the University of Arizona Department of Agriculture and Resource Economics, a rural community's resilience is based on such factors as distance to a metropolitan area, percentage of public lands, education, health, and economic diversity. Assessing the financial resilience of a community can be vital to implementing change.

Asset mapping, taking stock of a rural community's assets, such as its individuals, businesses, organizations, institutions, and what it has to offer, is another key to developing a robust rural community economy.

The Southern Rural Development Center offers an asset mapping tool to help communities focus on their positive attributes, better serve their citizens, and improve community-based health. The mapping tool can be found here: https://srdc.msstate.edu/sites/default/files/2023-05/asset_mapping.pdf.

In addition, health care facilities established in rural communities translate into real jobs and are typically among the largest employers in the area. Moreover, bringing health care professionals to live and work in a rural community brings revenue and continues to boost the economy.

One 2017 study found that inpatient health care facilities brought 1.25 million jobs to rural communities. A 2016 assessment found that for every job in a health care facility, another 0.34 jobs are created in other local businesses.[28]

Examples of successful implementations

Physicians may want to review successful rural health programs that have been implemented around the country. Some examples include the following.

- Meeting Essential Health Services And Reimagining Obstetrics In a Rural Community, a case study on implementing a rural Washington state staffing model to retain obstetrics and gynecological care. https://www.aha.org/system/files/media/file/2024/04/rural-case-study-meeting-essential-health-services-and-reimagining-obstetrics-in-a-rural-community-rural-case-study-april-2024.pdf
- Building a Diverse Rural Workforce With Northern Light Health, a case study on recruiting, retaining, and training providers serving rural Maine, where 61 percent of the population resides. https://www.aha.org/system/files/media/file/2024/02/workforce-cs-northern-light.pdf
- Closing the Gap: How a Community Effort Can Improve Rural Maternity Care, a case study detailing a Critical Access Hospital (CAH) that increased patient access to maternal health care in rural North Carolina by opening a maternity care center. https://www.annfammed.org/content/22/1/68
- Assessing the Effectiveness of Policies to Improve Access to Primary Care for Underserved Populations: A Case Study Analysis: Kanawha County, West Virginia. https://www.milbank.org/wp-content/uploads/2023/06/Kanawha_casestudy_Report_6.20_Final.pdf[29]
- The Texas C-Step Project: Cancer Screening, Training, Education and Prevention Program, is a coordinated cancer screening program for rural, uninsured, and under-insured residents in the Bryan-College Station area. The program offers free cancer

screenings by trained residents at on-site or mobile facilities. Colonoscopies, pap tests, mammograms, abdominal CT scans, ultrasound-guided needle biopsies, and LEEPs (Loop Electrosurgical Excision Procedures) are among the screenings offered. In a study from 2012 to 2016, the program was responsible for diagnosing 18 cases of colorectal cancer; identifying precancerous polyps in 25 percent of colonoscopies; diagnosing 18 cases of breast cancer; removing 141 precancerous cervical lesions; and providing thousands of free cancer screenings to rural residents. For more detailed information about the project, see https://www.ruralhealthinfo.org/project-examples/976.[30]

One-size-fits-all implementations often do not apply
When it comes to implementing rural health care programs, it is prudent to remember that one-size-fits-all plans often fall short. Since every community has its own unique challenges and issues, implementing the right plan most often requires a tailored approach. The best strategy for success starts with carefully assessing the problems and needs of each rural community.

Some programs require sponsorships or strategic partnerships with other organizations or larger health care facilities. Some may be ad hoc and informal, while others are more structured and include a task force and sub-committees, a board of directors, coalitions, steering committees, and even elected officials.

Formal partnerships may involve signing a Memorandum of Agreement/Understanding (MOA/MOU), which spells out the goals and details of each member's activities. The CDC provides detailed instructions on how to develop and execute these agreements in a PDF download here https://www.acus.gov/sites/default/files/documents/Appendix%20B%20-%20Sample%20Partnership%20Guidance_0.pdf.

Some rural health alliances may also need to mitigate liability, especially where home health services and a broad spectrum of health care providers are involved. Risk management plans help determine staff training needs such as safety training or travel safety requirements.[31]

USE OF TECHNOLOGY

As discussed, technology plays a crucial role in overcoming barriers in rural health care. Technology solutions can help overcome:

- geographical isolation;
- limited access to specialists;
- resource constraints;
- helping patients manage chronic conditions;
- the sharing of health information between physicians; and
- e-learning and training of physicians.

Telehealth/Telepharmacy
Telehealth can remove barriers related to mobility, transportation, and physical limitations, making it a powerful tool for mental health assessments and therapy for seniors, among other functions. It uses telecommunication technology and other electronic data to supplement health care services.

It can be an effective solution, as was discovered during the COVID-19 pandemic when a reduction in face-to-face contact was warranted. To expand telehealth usage during the pandemic, regulations, laws, reimbursement policies, and insurance coverages were temporarily eased or changed via emergency orders, and many of those orders are still in effect today.

Telehealth and health information technology (HIT) have the power to close existing gaps in access to health care. E-visits and virtual appointments enable rural residents to receive health care without traveling long distances, including care from specialists and services otherwise unavailable in their area, such as cardiology, audiology, dermatology, maternity, and others.

Remote patient monitoring (RPM) can enable physicians to manage and monitor patients for chronic conditions, and mHealth, or mobile health, can help physicians communicate with patients using mobile devices. mHealth can also be used for remote monitoring.

Telecare technology refers to remotely managing elderly or disabled patients in their homes and includes fitness apps and trackers, wearable sensors, fall detection monitors, and medication reminder technology. Telebehavioral health includes caring for patients' mental health.[32]

A helpful resource, T*elehealth for Behavioral Health Care* is a best practice online guide from the U.S. Department of Health and Human Services and can be accessed at https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-behavioral-health.

State laws and regulations that affect Texas physicians can be found in the Texas Administrative Code at https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=22&pt=9&ch=174&sch=A&rl=Y and the Texas Occupations Code at https://statutes.capitol.texas.gov/Docs/OC/htm/OC.111.htm.

In addition, the Texas Medical Association (TMA) offers resources and guidance for Texas physicians using telehealth in their practices at https://www.texmed.org/telemedicine/. Additional information can be found at https://hub.tmlt.org/tmlt-blog/your-guide-to-telemedicine.

Challenges to telehealth use in rural settings

Telehealth implementation is not without its difficulties and limits. Reimbursements have typically been the toughest challenge, as telehealth services are reimbursed at lower rates than in-person care. Not all care associated with telehealth visits is covered by private insurers and Medicare, and state Medicaid programs vary on telehealth reimbursement.

Licensure is another barrier that frequently poses challenges to telehealth treatment. Physicians practicing telehealth must be licensed in each state in which they practice. Currently, efforts are underway to ease licensure barriers, such as offering specific telehealth licenses for out-of-state providers; allowing providers licensed in other states to provide telehealth services; and creating interstate compacts that enable physicians to be licensed in several nearby states simultaneously.

The Interstate Medical Licensure Compact (IMLC), for instance, helps eliminate the need for physicians to manage multiple licensing applications across states in which physicians intend to practice. Texas was the 33rd state to join the 34-state Compact, which alleviates travel barriers and allows locum tenens physicians to practice across multiple rural states. To find out more about the Compact, see https://hub.tmlt.org/tmlt-blog/texas-joins-interstate-medical-licensure-compact.[33]

Finally, broadband, or high-speed internet access, is another challenge, as many remote areas are still without reliable service. Several federal programs are currently responding to rural broadband challenges, including:

- the FCC's Rural Health Care Program, https://www.fcc.gov/general/rural-health-care-program;
- the U.S. Department of Agriculture's (USDAs) investments in rural broadband and e-connectivity, https://www.usda.gov/broadband; and
- The National Telecommunications and Information Administration sponsored Tribal Broadband Connectivity Program at https://www.ruralhealthinfo.org/funding/5275.[32]

Telepharmacy implementation is equally important in rural health care. Between 2003 and 2018, 1,231 rural pharmacies closed, leaving a pharmacy desert and a severe lack of access to medications for 1.5 million rural residents. Telepharmacy services can ease the barrier for patients to access their prescription medications. Yet only about half of the states have passed legislation authorizing telepharmacies to set up services in rural areas.[34, 35]

To date, 23 states currently permit telepharmacy services, and 11 have laws or waivers in place to allow pilot programs to serve rural areas. Telepharmacy services allow a pharmacy technician to be virtually overseen by a pharmacist via telehealth technology.[35]

Pharmacy closures have also increased patient rates of medication non-compliance or adherence. Again, telepharmacy can provide a solution to this problem. One 2020 study found no discernible difference between the quality of patients' medication compliance when using a telepharmacy versus a traditional pharmacy.[36]

Electronic health records

Electronic health records (EHRs) may improve rural health care by allowing physicians to provide accurate, complete, up-to-date information in a patient's file that can be accessed by other providers, pharmacists, and specialists. The use of the EHR has the potential to reduce errors and improve accuracy, help patients avoid the duplication of tests, reduce delays in treatment, and allow physicians to embark on real-time decision-making.

However, while most rural health facilities have converted to EHR use, IT hurdles are compounded when broadband is not adequate and when unaffiliated EHRs have difficulty communicating with one another. The systems may also require costly, ongoing maintenance and repairs or may be prone to tech glitches or downtime. The software also needs updating, and IT vendors may need to implement, maintain, and perform repairs as well as provide training for users. These issues have contributed to rural health care facilities lagging behind urban areas in EHR adoption.

Some solutions to these barriers include programs offered through EHR industry leaders that allow small, rural area facilities to link to larger health systems. Grant programs also exist to help provide funding for the implementation of these systems through the Department of Health and Human Services. And, the USDA's Broadband ReConnect Program was designed to expand access to high-speed internet for more than 300,000 people living in eight Southwestern states. Information on this program is found online at www.usda.gov/reconnect.[37]

Drones

Drones are also helping rural health care through the delivery of medical supplies and emergency response in rural areas. These remote-controlled aerial vehicles can deliver medications, blood, and lab tests and distribute medical necessities to rural physicians and hospitals. Drones can also assist during a medical crisis or rural natural disaster. They are a cost-efficient alternative to road transportation for supplies, tests, medical equipment, and lifesaving medications and treatments. Some of the challenges in using drones in rural health care include:

- they can only carry relatively small or lightweight items rather than heavier medical equipment;
- lack of rural infrastructure can impede drone flight, such as the absence of runway space;
- drones need to be operated by trained staff; and
- significant coordination is needed from the FAA to safely implement rural drone use for health care.

The College of Nursing at The University of Alabama in Huntsville (UAH), along with the UAH

Rotorcraft Systems Engineering and Simulation Center (RSESC), is leading an effort to test whether drones are a viable rural health care delivery service.

A recent simulation included a pregnant woman at risk for preterm labor arriving at a rural hospital. Due to pandemic-related supply chain conditions, the hospital did not have the needed supplies to treat the woman — fetal fibronectin (fFN) and betamethasone. Using a drone, an urban clinic sent the needed supplies.[38]

Researchers from the University of Pennsylvania, using data from Rwanda public hospitals, found an 88 percent reduction in hospital maternal deaths due to postpartum hemorrhage as a result of a blood delivery system by drone. The analysis suggested that the drone delivery system had a "leapfrog effect" by offering a relatively low cost/low-tech solution to replace an outdated method that also produced a reduction in hospital mortality where blood is required for treatment.[39]

Zipline, the world's largest autonomous drone delivery system, is now partnering with the U.S. government and several health care companies to make medical deliveries to rural parts of the U.S. The company's electric-powered drones, called Zips, hold up to three pounds of blood or medication, can fly 300 feet above the ground, are inaudible, and travel 75 miles on a single charge.[40]

Michigan Medicine, the University of Michigan's academic medical center, is among the first organizations to use Zipline to deliver prescriptions by drone to thousands of Washtenaw County residents in 2024.[40]

OhioHealth also announced a partnership with Zipline, integrating drone delivery into OhioHealth's network to deliver medication, lab work, and supplies. The partnership hopes to improve patient experience with faster diagnostic turnaround times and direct-to-home prescription delivery and to reduce carbon emissions.[41]

Artificial intelligence (AI)

Finally, artificial intelligence (AI) has the power to reform rural health care in numerous ways, including:

- improving accuracy;
- enhancing diagnostics;
- aiding in administration tasks;
- analyzing lab and imaging results;
- assisting surgery and robotic care;
- compiling predictive analysis for public health such as disease trends, seasonal illnesses, or health outbreaks;
- creating virtual simulations used in training and education; and
- developing personalized treatment plans based on patients' medical history, lifestyle, genetics, and other data.

AI has varied uses and definitions — from "generative AI," such as the large language models like ChatGPT — to "robotics," which is a middle layer between human and machine learning, reading and interpreting text.

Some AI tools can help physicians document their patient encounters by creating a visit summary. Visual-based AI can help with image processing and be used to read and analyze imagery, such as MRIs, CT scans, and x-rays. It has uses as a screening tool for diabetic retinopathy, and in the diagnostic space, as with ECGs.

In small rural facilities, these technologies assist health care professionals with scheduling appointments, sending patient reminders, generating workflow and revenue processes, and finding and mitigating administrative errors before they become costly.

Two new AI capabilities that may bode well in rural health include tele-ICU, which monitors an ICU patient bed in a rural facility for vital signs, heart rate, and oxygen. This tool can also alert staff of patient incidents, including fall detection, and deliver ICU levels of patient supervision.[42]

ALTERNATIVE MODELS OF CARE IN RURAL PRACTICE

In rural health care, alternative models of care can help with access and cost effectiveness.

Team-based care

Team-based care involves various types of health care professionals and peripheral support figures — physicians, social workers, and community health workers — working together to address patient needs. Challenges for this model can include

a patient's reluctance to see multiple providers; coordinating care from different team members; and reimbursement programs that may not accommodate a model that involves various care professionals.

A 2019 study of a West Virginia clinic's team-based approach to diabetes management resulted in better outcomes for patients than methods that employed a single provider. The team used in the study included a physician, a family medicine resident, a pharmacist, a psychologist, a certified diabetes educator/nutritionist, a case manager, and nursing staff.[43]

Locum tenens services

Locum tenens services, or temporary health care providers, can play a critical role in rural health care, filling the gaps in underserved areas. For rural practices, substitute locum tenens physicians can replace physicians in a wide range of specialties, from primary care to surgery. Locum tenens services can be used for short- or long-term coverage gaps and help stave off physician shortages.[44]

Benefits for physicians working locum tenens include greater earnings potential in regions with low costs of living; a more flexible schedule and better work-life balance; a higher hourly rate than full-time counterparts; and an ability to supplement income while starting a physician practice or paying off medical debt.[45]

Expanding non-physician care with PAs and NPs

Expanding non-physician care by using physician assistants (PAs) and nurse practitioners (NPs) more regularly is another model that can help with health care shortages. By employing advanced practice providers (APPs), rural health systems can meet the growing demand for practice professionals and reduce the burden on overworked physicians. Research shows that NPs, for example, are more likely than their physician counterparts to practice rurally. NPs trained in family medicine are especially well suited to meet rural residents' health care needs because their training covers a wide swath of chronic conditions.

One challenge when employing NPs in rural medicine is that in some states they must enter into an agreement with the supervising physician that can often include proximity requirements to their supervising physician, requiring chart review by a physician, or other regulatory requirements. Some agreements result in the NP paying a fee to the physician for their time and association, which can discourage an NP's desire to practice rurally.

When it comes to physician assistants (known as physician associates in some states), only one in eight works in a rural, underserved area. Texas Tech University Health Sciences Center has a grant program across West Texas focused on PA training in longitudinal rural rotations in hopes that PA students will choose a rural health practice after graduation. Other programs across rural areas do the same.[46]

Supervision in Texas of providers in underserved areas is discussed later in this article.

ENHANCING PATIENT SAFETY WITH QUALITY-OF-CARE SAFETY INITIATIVES

Rural hospitals have historically been compared to larger urban hospitals unfairly when it comes to patient safety and quality of care. For instance, rural hospitals have smaller staff and patient loads and fewer events and outcomes to measure. Also, smaller rural hospitals often do not offer the same number of services that big urban facilities do, and do not have the technology infrastructures that urban hospital systems may take for granted. Likewise, cultural communication needs differ from larger hospitals, creating a need for separate safety initiatives that are more relevant to a rural population.

For example, the Tennessee Rural Hospital Patient Safety Demonstration Project researched and selected several interventions as safety initiatives that were applicable to rural facilities, including implementing a safety culture plan, emergency department protocols, and the use of personal digital assistants (PDAs) such as Apple's Siri, Amazon's Alexa, and Google Assistant to decrease medication errors.

For this project, internal surveys on hospital patient safety culture were used to inform and implement a safety culture plan. The surveys were assessed to find weaknesses and plans were developed to address those weaknesses. For instance, one hospital initiated an error-reporting system through employee suggestions. Another hospital shared the survey results and action plans at an employee fair and

with the local newspaper to engage in an ongoing discussion of changes.

In past years, many rural facilities struggled with medication safety due to a lack of computerized drug interaction systems. So, with a medication error initiative, appropriate staff received a PDA device and training. The PDA contained a drug database, that provided drug interactions, dosing information, a formulary, and pricing data. For some physicians, this was their first foray into clinical support software, and they reported that it took less than one minute to find up-to-date drug information using the device.

With the implementation of emergency department (ED) protocols, hospitals recruited physician "champions" who were instrumental in implementing new ED protocols and overcoming some of the barriers that often prevent facilities from adopting new protocols, such as a resistance to change among staff.

The project found that the ED protocol's implementation jump-started interest among staff to improve systems and had greater odds of success, especially in small hospitals. The protocols helped rural hospitals standardize treatment across shifts in the ED and improved patient flow, hand-offs, and transfers. This Tennessee project showed that implementing safety initiatives is feasible and can be successful in rural hospitals.[47]

Recruitment and retention

Effective physician recruitment and retention efforts in rural communities should not only focus on attracting and retaining physicians but also include strategies to keep those physicians as long-term as possible, minimize turnover, fill vacancies, formulate creative offers, and find the right physician "match" for the position and the community. These efforts should include mitigating a physician's concerns in working rurally, such as workload, call frequency, and isolation.

The USDA Economic Research Service bulletin "Linkages Between Rural Community Capitals and Healthcare Provision: A Survey of Small Rural Towns in Three U.S. Regions" outlines how rural communities can play a role and significantly influence attracting and retaining physicians to rural areas. This publication may be found online at https://www.ers.usda.gov/webdocs/publications/106139/eib-251.pdf.[48]

Scholarship and loan repayment programs

A variety of scholarship programs are available to physicians who are interested in rural practice. The National Health Service Corps (NHSC) offers scholarships to primary care and some specialty physicians for more than 19,000 sites, 35 percent of them rural.

The NHSC scholarships provide financial assistance and loan repayment assistance for primary care students who commit to serving in rural or HSPA urban areas for up to three years. The scholarship is available for students in their last year of medical school and for licensed primary care providers.

Other scholarship programs are available through the HRSA and NHSA including:

- the State Loan Repayment Program at https://nhsc.hrsa.gov/loan-repayment/state-loan-repayment-program;
- the Rural Community Loan Repayment Program at https://nhsc.hrsa.gov/loan-repayment/nhsc-rural-community-loan-repayment-program;
- Substance Use Disorder Workforce Loan Repayment Program at https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program; and
- the Bureau of Health Workforce Pediatric Loan Repayment Program at https://bhw.hrsa.gov/funding/apply-loan-repayment/pediatric-specialty-lrp.

Most scholarship programs exchange medical debt loan repayment for a commitment to practice in a rural health area. These scholarship programs are very successful in recruiting and often retaining physicians in their rural communities even after their commitment has expired. Some studies show that up to 86 percent of physicians remain in their rural community where they served for their scholarship.[17]

Residencies

As mentioned previously, residencies are key to both attracting and retaining physicians.

At the University of North Carolina (UNC), "we have an accelerated program; it's a three-year medical

school with a commitment to an in-state residency program with an additional incentive to practice in-state in a rural or under-resourced area," says Bryan Hodge, DO, a family medicine physician and clinical assistant professor in the Department of Family Medicine at the UNC School of Medicine in Chapel Hill.

"So, there is some level of innovative programming out there, but the dose is just way too small; we're talking five students a year, and that's not going to be nearly enough. We need to quadruple that at least to actually start bridging the gap that continues to widen," Hodge says. He affirms that fewer providers are going to these rural areas, which are becoming more deprived of health care over time. "If any state institution incentivized primary care and rural health clinicians for five years straight, we still wouldn't be caught up, but we would be better off," he says.

UNC administrators reiterate that only two percent of residency training across the nation is in rural areas, so more rural residencies are desperately needed.[49]

LEGAL AND REGULATORY CONSIDERATIONS

Rural health physicians and organizations are faced with complex legal and regulatory requirements. Staying compliant while maintaining access to care is a considerable challenge in such areas as telehealth, workforce regulations, scope of practice, payment and reimbursement policies, EHRs, HIT regulations, value-based care model regulations, and Medicaid and Medicare reimbursement. However, policymaking in rural health care comes down to many players from local, state, and government arenas working together.

When a rural health care issue or problem surfaces, the problem is brought to the attention of a membership organization, a hospital or rural facility, a physician, or any number of lawmakers or advocacy groups, academia, or government organizations interested in taking up the issue. They must then collect data, enact research, chart a course, and implement a program while weighing pros and cons, ethical considerations, as well as political, social, financial, legal, and administrative concerns.

At the federal level, policymakers in the U.S. Senate or U.S. House of Representatives may craft legislation. State-level policy change involves numerous people from the legislative body to state agencies to the governor of the state. Membership organizations such as AARP, American Academy of Family Physicians, American Medical Association, National Rural Health Association, and numerous others may also get involved by developing proposals, sponsoring legislation, holding conferences, and coalescing their members to be involved and connect with local, state, and federal legislators.

At the physician level, change can be implemented by not only corresponding with member organizations and legislators but by writing op-eds in local papers, attending public forums, writing proposals, hosting rural conferences or legislators to the rural area, and showcasing the rural facility, clinic, or practice to those outside the region.

Instructions on how to share individual perspectives when completing government forms so that unique viewpoints can be more clearly understood by federal agencies are available online at www.reginfo.gov/public/jsp/PRA/How_to_comment_on_forms_under_OIRA_review.pdf.[50]

Flexibility of rules in underserved areas

Building in more flexibility in rural health care policy can help physicians and rural facilities overcome some of the challenges related to geographic isolation, limited resources, and reduced physician access. Some of the flexibility in rules and regulations within telehealth is seen in the Telehealth Modernization Act of 2024, a bill modifying Medicare telehealth coverage requirements and extending policies created during the pandemic.[51] Cross-state licensing in telehealth is also a rule many argue needs more flexibility. Flexibility in grant funding for programs like Critical Access Hospital (CAH) initiatives is also on the table for more flexibility.[52, 53]

Exceptions to state board rules when practicing in rural areas

Because of this expected flexibility within some rural considerations, state boards can make exceptions in rural areas. For example, nurse practitioners in Texas and many states received a waiver in the COVID-era relaxed regulations regarding supervision. However, in many states, regulations have returned to their

pre-COVID form. Organizations for APPs continue to advocate for decreased physician oversight for both NPs and PAs.[54]

Supervision in Texas of providers in underserved areas
The Texas Medical Board (TMB) outlines the minimum standards for the supervision of PAs and APRNs by physicians in Texas. "There is no limitation to the number of PAs or APNs a physician may supervise. However, a physician may only delegate prescriptive authority to a maximum of seven PAs or APNs, or their full-time equivalent. The only exception relates to supervision and prescriptive delegation to a medically underserved population or in facility-based practice." [55]

Some rural locations may qualify as medically underserved populations, and physicians practicing in these areas may have flexibility to delegate prescriptive authority to more than seven APPs. This designation is described further at the Texas Health and Human Services site: https://www.dshs.texas.gov/texas-primary-care-office-tpco/health-professional-shortage-area-designations.

The TMB does not authorize the exercise of independent medical judgment by PAs or APRNs. The supervising physician remains responsible for medical acts or treatments performed under the physician's delegated authority.[56]

Physician supervision should conform to what a reasonable, prudent physician would find consistent with sound medical judgment, and may vary given the education and experience of the APP. A physician should provide continuous supervision, but the constant physical presence of the physician is not required. If not on-site, the physician must be easily contacted.[57]

CONCLUSION

Rural health care faces unique challenges, including workforce shortages, limited resources, and geographical isolation. This article covered key topics that may offer solutions to these challenges, such as telehealth implementation, launching rural residencies, REH designations, and others.

One emerging trend may be the rise of the hospital at-home model, where patients who need acute level care receive it in their home rather than at a hospital. While this may present additional challenges for the rural practice, including transitioning diagnostics, treatments, and skilled nursing to the home and payer resistance, the model has shown promise in reducing cost and improving patient outcomes in some countries.[58]

For physicians, staying on top of emerging trends in rural care, engaging with policymakers, advocating for new initiatives, and investing in technology and training will likely result in improved outcomes that will lead the way in shaping the future of rural health care.

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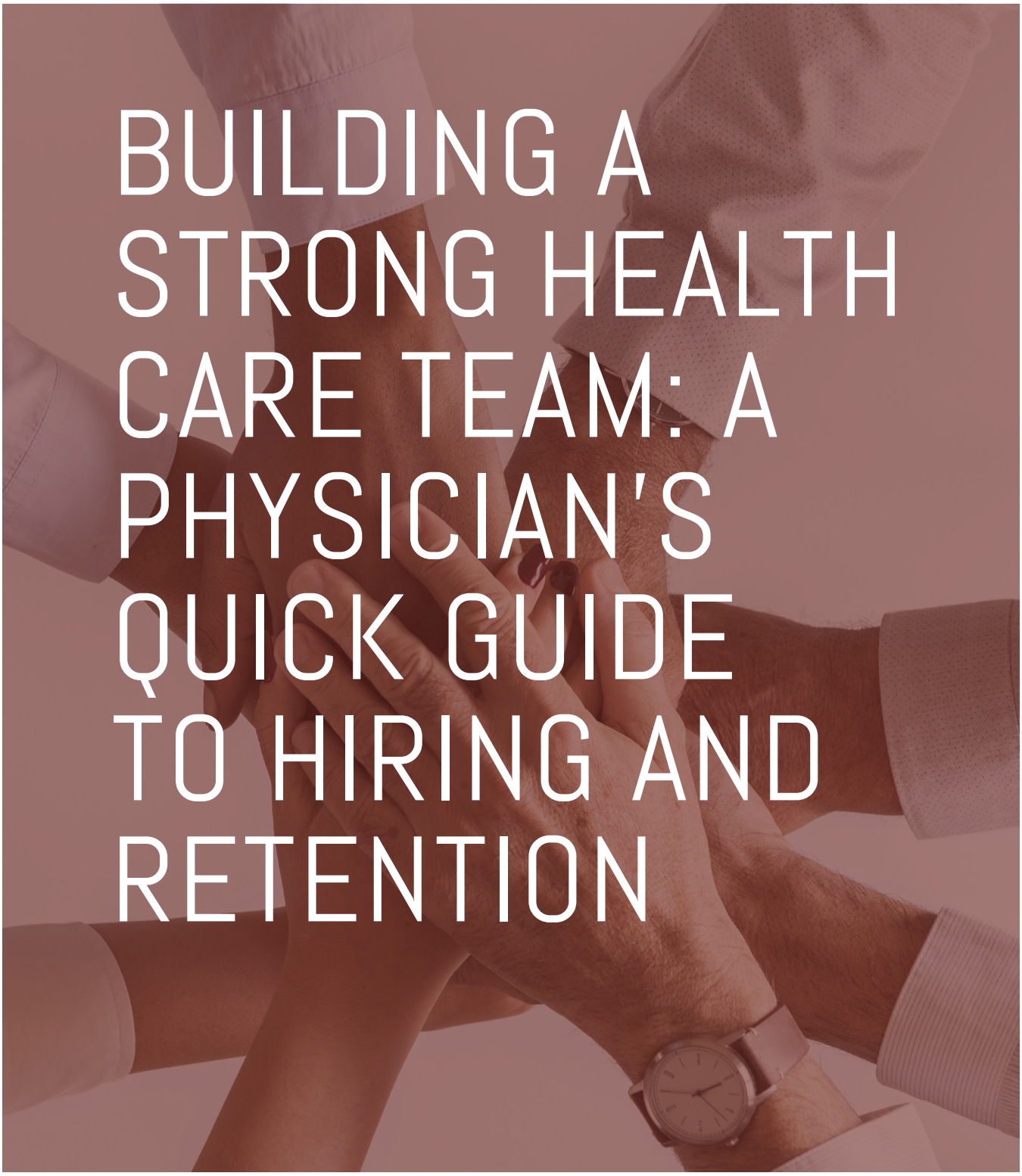

BUILDING A STRONG HEALTH CARE TEAM: A PHYSICIAN'S QUICK GUIDE TO HIRING AND RETENTION

Building and maintaining a strong medical team is crucial for the success of any medical practice. Yet, with increasing competition for talent and rising burnout rates, hiring and retaining skilled medical professionals has become more challenging than ever.

This article provides practical strategies for attracting top talent, implementing effective hiring processes, and fostering a work environment that encourages long-term retention. By focusing on these areas, you can build a cohesive, motivated team that enhances your practice's success and improves patient satisfaction.

ATTRACTING TOP TALENT

Creating an appealing workplace culture is often the foundation for attracting high-quality candidates. This is especially true for attracting millennial and Gen-Y workers, who often put a greater focus on maintaining a healthy work/life balance and working in an environment and culture that shares their values. For example, many nurses enter the profession to make a difference in patients' lives and in their communities; they want to work in a culture that reflects their values and "gives back" in meaningful ways.[1]

To attract top talent, focus on fostering an environment that encourages collaboration with staff; meaningful professional development opportunities; and mutual respect. Highlight your practice's commitment to work-life balance and professional growth during the recruitment process.

Offering competitive compensation and benefits is essential, but to demonstrate your commitment to staff well-being and the work/life balance, you may also consider offering such perks as flexible scheduling, wellness programs, or opportunities for research and publication. These offerings can set your practice apart from others.

Leverage your practice website and social media in your recruitment efforts. Maintain an updated, professional website that showcases your practice's culture and achievements. For example, share your practice's volunteer efforts with website articles and social media posts about staff volunteerism, local good works, and donations.[2]

Also use professional sites and platforms, such as LinkedIn, to network and share academic research, success stories, collaborations, or insights to position yourself as a thought leader in your field. These types of posts will also help you build a brand for your practice.

EFFECTIVE HIRING STRATEGIES

When searching for candidates, create clear, detailed job descriptions that not only outline the required qualifications but also the "soft skills" and cultural fit you are seeking.

Consider including an "about us" paragraph in the listing that describes your practice's work environment and commitment to providing high-quality, patient-centered care within a team environment that supports professional growth and work-life balance. Include details of your practice that are unique to you, your culture, or place in the community.[3]

Use multiple recruitment channels to find the right candidate, including professional networks, medical job boards, and referrals from current staff. Each channel can bring different types of candidates and broaden your talent pool.

CONDUCTING EFFECTIVE INTERVIEWS

When conducting interviews, look beyond assessing clinical skills. Below are some practical tips to help you evaluate a candidate's problem-solving abilities, teamwork, and adaptability.

1. When interviewing, ask a mix of questions such as:

- **Behavioral questions** that ask the candidate to describe how they handled a situation in their past work or life experience using such soft skills as communication, problem solving, and flexibility. These types of questions will also offer insight into how well the candidate may fit into your office culture.
    1. "Tell me about a time you had to deal with a difficult patient. How did you handle the situation?"
    2. "Have you ever disagreed with a colleague's treatment plan? How did you address it?"

3. "Can you provide an example of how you helped develop or improve patient care processes in your previous role?"

- **Situational questions** that provide the candidate with hypothetical situations or problems to solve.
  1. "If a patient's family member became argumentative about the patient's care plan, how would you handle the situation?"
  2. "How would you approach a staff member who consistently arrives late for their shift, affecting patient handover?"
  3. "If you noticed a potential medication error, what steps would you take?"

- **Technical questions**, adapted based on the candidate's specific role, to verify medical knowledge and experience:
  1. "What's your experience with [specific electronic health record system]?"
  2. "How do you stay updated on the latest developments in [relevant medical field]?"
  3. "Can you walk me through your approach to diagnosing [common condition in your practice]?"

- **Traditional, cultural fit, and additional experience questions**, to help you gauge how a candidate thinks and works, and whether they will fit into your office culture:
  1. "What do you like most about working in health care?"
  2. "Why do you want to work here?"
  3. "How do you prefer to communicate with team members?"
  4. "How do you prefer to receive feedback – whether it be positive or negative?"
  5. "What is your idea of effective patient and family education?" [4, 5]

2. Allow sufficient time for candidates to ask questions. The questions a candidate asks you in return can help reveal their level of interest, preparation, and priorities.

3. Consider involving current staff members in the interview process to ensure team fit and to gather different opinions and perspectives.

4. Develop interviewing and hiring methods to combat unconscious bias that may affect hiring decisions. Biases — unconscious or not — can affect a practice's ability to hire and retain strong candidates. Biases may exist based on a candidate's gender, age, race, ethnicity, sexual orientation, or religion. And it's important for a variety of reasons to recognize and remove biases in the workplace.

According to the *Harvard Business Review*, promoting "diversity within organizations fosters better problem-solving, innovation, and thoughtful strategic planning [and] ... studies have shown that talented candidates seek out diverse work environments. Overcoming unconscious bias in your hiring has a ripple effect of building an exceptional team that attracts exceptional candidates." [6]

One way to address unconscious bias in hiring is to standardize the interview process "so that each candidate answers the same questions and performs the same work tests to ensure a fair performance review." Consider adopting a scoring system in which candidates' responses to questions are graded using a consistent standard that ensures objectivity.

5. Compliance considerations: Ensure all interview questions comply with state and federal employment laws. Avoid questions that could be interpreted as discriminatory or unlawful, such as those related to age (unless used to verify legal requirements), race, religion, marital status, gender or sexual orientation, family planning, disability, or alcohol or drug use.

Keep in mind, the interview is a "two-way street." It is not only assessing the candidate's suitability for the role, but it is also an opportunity for you to showcase your practice. Be prepared to answer questions about your work environment, team dynamics, and opportunities for personal and professional growth.

Consider assigning mentors to new team members. This provides them with a go-to person for questions and helps them integrate more quickly into the team. Set clear expectations and goals for the first few months with the new hire and their mentor; schedule regular check-ins to ensure goals are on track and your new employee feels supported.

RETENTION STRATEGIES

A positive work environment is key to employee engagement and retention. Consider adopting the following retention strategies.

- **Encourage open communication by asking for feedback.** Conduct regular staff meetings that provide opportunities for employees to express their thoughts and ideas without fear of judgement or retribution. Also consider calling impromptu meetings after a challenging day or patient encounter to compare notes and share thoughts or concerns.

  Address concerns promptly to demonstrate your commitment to taking staff feedback seriously and to building a team of professionals whose views and opinions are heard and valued.

  Opening channels for feedback creates "a culture of empowerment and continuous improvement ... A robust communication and feedback system fosters collaboration, strengthens teamwork, enhances employee engagement, and ultimately contributes to better patient outcomes and a positive work environment."[7]

- **Recognize staff achievements in meaningful ways**. Public praise, written notes of gratitude, or recognition programs — such as employee of the month/year — can help you show your appreciation for your team members' hard work. "[M]eaningful recognition establishes a culture of appreciation and camaraderie, leading to higher job satisfaction and a reduced likelihood of turnover. As a result, your practice will have an easier time retaining top talent."[7]

- **Offer ongoing professional development opportunities** by supporting attendance at conferences, providing access to online courses, or organizing in-house training sessions. These efforts will help you show your staff your investment in their personal and professional growth.

- **Establish work-life balance initiatives**, such as flexible scheduling options, adequate time off, and policies that respect personal time. Consider offering sabbaticals or extended leave options for long-term employees.

  Several studies point to how effective flexible scheduling can be in reducing stress and burnout, increasing retention, and improving performance. But with these advantages comes a new set of responsibilities. Flexible scheduling can potentially cause confusion or stress among your team. Therefore, physician practices will need to emphasize and focus on clear communication, scheduling, and documentation to track physician coverage/availability and patient progress, tests, and medications.

  It is important for practice leaders to model this behavior for team members.
  - Establish clear boundaries between work and personal life by scheduling personal time on your calendar or avoiding checking work emails or work-related calls during off-hours.
  - Take regular breaks through the day to rest and recharge, even if only for a few minutes.
  - Prioritize and focus on the most critical tasks at work, and delegate or eliminate tasks when possible. This will help you (and your team by example) better manage their workload and reduce stress.[8]

- **Implement strategies to prevent and manage burnout**, such as promoting self-care, providing mental health resources, and ensuring workloads are as manageable as possible.

It is also important to effectively manage interpersonal conflicts. Workplace discord can disrupt team dynamics, create more staff turnover, and even negatively affect patient care. Develop clear conflict resolution processes, such as how to report a conflict, expectations around how and when the conflict will be resolved, and how to keep all processes positive and solution oriented. Consider offering staff training in interpersonal communication or conflict management.

MEDICAL STAFF CHECKLIST

When managing medical, nursing, and support staff, consider the following hiring and retention strategies.

- Conduct thorough background checks and credentialing verification[9]
  - Implement comprehensive background checks

for all new hires.
    - Regularly verify and update staff credentials.
    - Comply with state board regulations on physician and staff licensing.

- Provide ongoing training and education
    - Offer regular training on patient safety protocols.
    - Keep staff updated on changes in state and federal health care laws and regulations.
    - Offer continuing education opportunities to ensure staff maintain competency and to help them meet their professional development goals.

- Establish clear policies and procedures
    - Develop and regularly update employee handbooks and policy manuals.
    - Ensure all staff understand and follow HIPAA compliance measures.[10]
    - Use clear protocols for handling patient complaints and adverse events.

- Promote a culture of safety
    - Encourage open communication among staff members regarding potential risks or safety concerns.
    - Implement a non-punitive reporting system for near-misses and errors.
    - Regularly conduct safety audits and involve staff in improvement initiatives.[11]

- Address burnout as a risk factor
    - Recognize that staff burnout can lead to errors and increased liability.
    - Offer wellness programs and stress management resources for staff. When possible, eliminate barriers to accessing care and identify support services to provide to staff members.
        - Make efforts to remove stigma around mental health care by educating yourself and others. Talk openly about mental health using non-discriminatory language. Normalize treatment for mental health issues, just as you would any other health care treatment.[12]
    - Monitor workloads and ensure adequate staffing levels to prevent fatigue-related errors.

- Documentation and communication
    - Train staff members to properly document all patient care.
    - Foster clear communication channels between all team members. Schedule and maintain regular group and "one-on-one" meetings with staff.
    - Regularly review patient records for accuracy and completeness.

By integrating these management strategies, you not only help to create a more stable and satisfied team, but also significantly reduce your practice's liability exposure.

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