

CAH/FLEX

National
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Project

FINDINGS FROM THE FIELD

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From Arkansas, Georgia, North Carolina, and Texas: Physician Recruitment and Retention

Introduction

All rural hospitals are faced with difficulties in attracting and retaining physicians to provide services in their communities. Challenges include the compatibility of administrative structures, limited exposure of medical students to rural practice, salary competition, and family concerns. Because the problem is multi-faceted, there is no single solution.

Key aspects of health care service delivery in rural areas:

- Rural hospitals struggle to provide access to appropriate primary health care and specialty services for their clients.
- Rural populations are largely underserved.
- Rural hospitals depend on local physicians for their patient volume.
- There is a significant difference in the physician-to-patient ratio in rural areas compared with urban and suburban areas.
- On average, a rural resident must travel 5 to 15 times farther, compared to their suburban counterpart, to get to a provider.

Individual Critical Access Hospitals (CAH) and their states have undertaken a number of initiatives to attract and retain more rural physicians. Some of these strategies and state-level approaches follow.

Previous Findings From The Field

- Vol. 1, No. 9: From Kansas and Idaho: Supporting Quality Assurance/Improvement in Critical Access Hospitals- A Role for Networks and State Agencies
- Vol. 1, No. 8: From Washington: Modeling Economic Changes in Communities and Their Health Systems

Project Website: <http://www.rupri.org/rhfp-track/>

CAH Strategies

1) Ensuring Mutual Benefit: Some CAHs provide office space to physicians or pay for physicians' practice-related expenses in return for emergency room (ER) coverage. Another strategy employed by CAHs is to identify niche services a physician would like to provide and then buy the necessary equipment, help with publicity, and provide other support to the physician expanding into this service. Such arrangements reduce physicians' exposure to practice expenses, while the hospital receives valuable coverage. However, most CAHs do not have the expertise to run a physician practice. ***Thus, while close cooperation between physicians and CAHs is crucial, CAHs should be extremely careful about outright ownership of physician practices.***

2) Relationships with Medical Schools and Residency Programs: Many CAHs actively cultivate formal and informal relationships with medical schools and residency programs that focus on primary care or historically have placed students in rural settings. Some CAHs actively recruit at these schools and residency programs. Others are pursuing telemedicine arrangements with medical centers in an effort to reduce professional isolation and provide continuing education.

In addition, many medical schools and residency programs now require practice time in rural communities and satellite clinics as well as participation in rural health practice fairs. ***There is a need to establish an integrated career pathway of education and training for rural practice. This could start early, in high school career programs, and continue through undergraduate and medical education.***

3) Remuneration Strategies: In many areas, compensation has been raised to reflect the complexity of services and the degree of responsibility taken on by rural physicians who are often in solo practice. A primary strategy used by CAHs is to offer income guarantees for the first few years while a physician's practice is built. Other financial benefits offered include the payment of fees and provision of transportation for continuing education at larger centers, signing bonuses, and bonuses for time in service. Further, CAHs may find a local student who is entering medical school and offer to partially fund their education in exchange for the student returning to practice in the community.

4) Providing Backup Relief: Rural hospitals have worked hard to provide reasonable working conditions, including trying to balance physician workload, the amount of time on-call, and free time. With limited personnel, it is sometimes difficult to provide reliable cross coverage. Relief can be provided through the use of locum tenens positions.

5) Family Considerations: Many rural practitioners move away because of family dissatisfaction related to lifestyle, educational opportunities for their children, and entertainment. Providing a good education for the doctor's children can be difficult and costly. Some CAHs have offered tuition reimbursement for private education in return for years in service to the community, in addition to helping with transportation.

State Strategies

In Texas, the Center for Rural Health Initiatives (CRHI) is a wide-range resource for rural hospital support. CRHI offers a variety of physician recruitment services. One of these, HealthFind, is an annual weekend health care job fair, which brings together medical residents and the administrators of rural hospitals. Another service, Prairie Doc, offers registries to hospitals and physicians for both permanent and locum tenens positions wanted/needed. CRHI also:

- offers technical assistance in a variety of areas;

- provides grant and funding information; and
- administers several rural physician incentive programs, including a loan reimbursement program, a start-up program residency stipend program, and scholarship programs.

Arkansas offers grants that supplement a new physician's income for the first four years in rural practice.

What Has Been Successful?

- Income guarantees, subsidized space from hospitals, and start-up loans to rural practitioners have helped to build the number of rural practices and to maintain the independence of physicians in rural practice.
- The use of locum tenens relief practitioners has served to provide the coverage for off-time, as well as time to attend and participate in continuing education conferences.

How Do The Strategies Work?

The strategies address professional concerns by preserving physician independence and autonomy, and bringing certain features of suburban practice to rural areas. Independence is preserved by supporting affiliated practices that are not administered by the rural hospitals. Replicable aspects of suburban practice include improved financial rewards and bonuses. Rather than productivity bonuses, which are often a part of suburban practice, rural physicians are rewarded for complexity and ultimate responsibility, since they are often in solo practice. Service coverage to allow rural physicians to travel to professional conferences is also important.

Retention of rural doctors may require a broader view. Retention depends greatly on the satisfaction of the physician's spouse and family. CAH administrators should provide resources and information for the spouse and children, as well as the physician, being careful to represent the area accurately to avoid disillusionment and a swift departure.

Where Can I Get More Information?

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About this project: Check our website: <http://www.rupri.org/rhfp-track/>

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BACKGROUND

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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