Finding and Keeping Health Care Providers in Rural Communities:
Culture Change in Recruitment at Rural Health Group

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Transforming rural primary care is possible only when leadership is committed to a core set of competencies. Northeastern North Carolina, not always seen as an attractive locale for health professionals, has been developing a primary care medical home that emphasizes team-based care built upon respect, trust, and professionalism.

I have spent my entire professional career in the field of rural health serving communities of fewer than 15,000 people. These service areas often cover multiple remote counties and have considerable unmet medical, dental, and behavioral health needs. The constant over the last 2 decades has been that rural patients often face high levels of poverty, lack of employment, barriers to health care, and medical issues that are often untreated or poorly controlled. Health care facilities in these areas often have difficulty recruiting medical professionals who desire a rural lifestyle and are willing to take on the challenge of working in under-resourced areas, where patients often face barriers to care and may have limited social support. In my opinion, it takes a special kind of provider to work in a rural setting.

That being said, the worst thing I have done over the years is act out of desperation. When I started recruiting physicians and dentists over 15 years ago, my only criterion for a licensed independent practitioner was the practitioner's willingness to work in a rural clinic. I signed anybody who would sign an employment agreement. My overriding concern was that patients have access to care—any care. I always felt that a vacancy must be filled as soon as possible, so I used nontraditional methods to get a deep and wide applicant pool. I shook every bush to find providers who were willing to work, including cold-calling residents who were within 2 years of completing a family practice residency, attending career days at residency programs, and presenting at residency grand rounds. I was in a seller's market and would accept any willing applicant.

As time passed, the problem with this approach became clear. Providers were dissatisfied with the community, the patients, and the health care system's lack of resources. Patients became accustomed to receiving care from providers who made it clear that this position was a short-term assignment. The revolving door of rural primary care providers began rotating on its vertical axis, with the average provider completing their 2-year tour and then moving on. We were violating a fundamental principle of effective primary care: that there be a continuous healing relationship between the patient and the primary care team. When provider leadership is inconsistent, the patient's care is negatively affected, and the primary care team is less effective in developing relationships with patients and family members.

This was not working—not for the patients, the community, the clinic, or the providers. What did we do? I am currently the chief executive officer (CEO) of Rural Health Group (RHG), a nonprofit, federally qualified health center serving people living in northeastern North Carolina. To address the problem of provider recruitment and retention, RHG embarked on a cultural change over the past 6 years that has transformed our care teams and our provider staffing. First, senior leaders changed our basic assumptions about rural health care and rural providers. Instead of accepting any licensed person who was willing to work, RHG's leadership demanded exceptional providers who embrace our approach to team-based, patient-centered care. Just because we are a rural clinic does not mean we need to be desperate. Rather, we need to be exacting in our recruitment and seek providers who are leaders and who want to practice full-scope family medicine as part of an integrated primary care team. In order to become more selective about our applicants, we first had to stop using access to care as our sole metric. We adopted the stance that it is acceptable to have a provider vacancy if you cannot find the right provider with the core competencies required to work at RHG. We stopped looking at clinical skills and started interviewing for relational, interpersonal, and leadership attributes.

RHG still recruits regionally and nationally, but the screening process for each candidate now takes months. It is

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a team effort requiring staff support and senior leadership's focus. The leaders of RHG found early on that we needed to be better organized if we were going to optimize the selection of the right candidate, so we invested in an online application management system and appointed a staff person to coordinate recruitment and onsite visits. RHG now has a full-time human resource staffer who spends 40% of her time on provider recruitment; her duties include initial screening, arranging phone interviews and onsite visits, and candidate relocation logistics.

The key to RHG's success in finding and recruiting providers rests in our commitment to our core competencies. RHG has developed and seeks to bolster 6 core competencies, which we use both to screen candidates and to retain providers who embrace the RHG way. The 6 core competencies are skill set, judgment, communication, passion, honesty, and responsibility (See Table 1). For providers who embrace these core competencies and view them as central to their way of practicing medicine, RHG is a long-term fit.

TABLE 1.
The 6 Core Competencies of Rural Health Group Practitioners

Skill Set
• You are expected to have a skill set commensurate with your training and experience.
• You are committed to life-long learning.
• You understand the limits of the scope of your position.
• You lead by example and understand that your behavior influences those around you.
Judgment
• You make wise decisions concerning patient and staff interactions.
• You recognize that there is not always a clear solution to a presenting problem.
• You discern what needs to be done well now, and what can be improved later.
• You assess situations quickly but hold assumptions lightly until they are confirmed.
Communication
• You listen well, instead of reacting fast, so you can better understand.
• You are concise and articulate in speech and writing.
• You treat people with respect, independent of their status or disagreement with you.
• You maintain calm poise in stressful situations.
Passion
• You inspire others with your desire for excellence.
• You have a deep commitment to patient care, especially care of the underserved.
• You care intensely about the Rural Health Group's success as a patient-centered medical home.
• You are invested in attaining quality goals.
Honesty
• You are known for respectful candor and directness.
• You only say things about fellow employees that you will say to them directly.
• You are quick to admit mistakes and exhibit self-reflective good humor.
• You are honest with yourself and others about your limitations.
Responsibility
• You are self-motivating, self-disciplined, and self-improving.
• You are also self-aware and understanding, and you respect appropriate boundaries in relationships.
• You take responsibility for your work and complete your tasks in a timely fashion.
• You appreciate the difference between being responsible *to* from being responsible *for*.

To begin the process of applying for a position, candidates must complete an online application that includes behavioral questions that probe how well the provider understands RHG's philosophy of the patient-centered medical home. These responses are reviewed and scored by the recruiter. All active licenses are checked for any professional standard violations. If the provider passes the screening, then he or she is scheduled for a 30-minute informational call with the recruiter. Providers who pass the recruiter's screening are then scheduled for a 30–45 minute phone interview with me, wherein the candidate undergoes a behavioral interview. At this point clinical skills are considered a given. Every duly licensed family practitioner can treat diabetes, but we want to know whether the provider can relate to the patient in a nonjudgmental way that invites the patient into better health. As the current CEO of RHG, I spend my interview probing the provider's soft skills, including judgment, discernment, interests, and demonstrated ability to balance work and home. If the candidate passes this interview, the next phone interview is with RHG's director of integrated care, who is a licensed psychologist. She interviews every provider candidate to gauge the provider's fit with RHG. This part of the interview process is essential because even the best interviewer can become too focused on the hard skills, such as tasks and clinical acumen, and may miss the more essential relationship attributes necessary for an exceptional provider leader. Our psychologist fills this gap by helping the interview team tune into key areas that are often overlooked. Finally, the last phone interview is with the medical director of RHG. Once the 3 phone interviews are completed, I meet with the director of integrated care and the medical director, and we discuss the candidate and decide if an onsite interview is appropriate.

During the past 6 years, less than 20% of the candidates who participated in phone interviews were invited for an onsite interview. During an onsite interview, which lasts 2–3 days, the candidate interviews with each member of the senior team, provider partners, and line staff. Candidates are shown the community, given a real estate tour, and allotted ample free time to see the area. RHG's senior team meets after each onsite interview to decide whether the candidate meets our core competencies.

The culture shift that allowed us to change our recruitment process started with the recognition that the "poor me" mentality in rural health care was only perpetuating the stereotype that rural health jobs were undesirable. When leadership changed its conceptual framework to see rural health care as desirable and deserving of the best providers,

Physicians Providing Leadership for Rural Communities

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Goldsboro Pediatrics provides community leadership by targeting adverse child outcomes such as unplanned pregnancy, chronic mental health disorders, tobacco addiction, child abuse or neglect, school failure or drop out, obesity, and type 2 diabetes. Physicians can address long-term child outcomes during office visits, but we need to collaborate with other groups to assure success. We must provide leadership and form coalitions with like-minded professionals in the community in order to effectively improve child outcomes.

Unplanned Pregnancy

I was on our school board from 1983 to 1991, during which time the issue of student pregnancy became a prominent concern. During that period, the school board hired a health educator, and I served as her supervisor; through this relationship, she became linked with our practice. Pregnancy rates were cut in half after 1 full year of this program.

Today our practice oversees the Wayne Initiative for School Health (WISH), a private, nonprofit corporation that operates 6 school-based health centers in schools with at-risk students. The centers utilize our practice's electronic health record, and enrollees receive services at Goldsboro Pediatrics whenever schools are closed. Pregnancy rates are significantly lower in the WISH schools.

Chronic Mental Health Disorders

Private-sector mental health professionals provide over 5,000 consultations per year in the WISH centers. We have implemented a program in an elementary school that allows at-risk children identified by the school nurse and social worker to receive mental health services onsite from a private-sector mental health professional. We hope to later duplicate this model in other elementary schools. There are 2 mental health professionals at Goldsboro Pediatrics, and the practice arranges telemedicine consultations with the Department of Child Psychiatry at East Carolina University if a patient needs a child psychiatrist.

Tobacco Addiction

Goldsboro Pediatrics participated in an American Academy of Pediatrics program—called Pediatric Research in the Office Setting—to develop a system for educating patients and their families about the dangers of tobacco addiction and for linking smokers with QuitlineNC. To continue this valuable program, the practice is collaborating with Prevention Partners.

Child Abuse and Neglect

In the early 1990s, research began to show that intensive home visiting can reduce early child abuse and neglect. Through a strong partnership with our local Head Start agency, we established Wayne County First Steps, a Healthy Families America intensive home visiting program. Currently, we are in the process of converting to the Nurse Family Partnership model for intensive home visiting.

School Failure and Drop Out

For the past decade, Goldsboro Pediatrics has raised about $40,000 per year to participate in Reach Out and Read, an early literacy program wherein primary care providers give new books to patients aged 6 months to 5 years at all well-child visits. According to 2013 data from the Annie E. Casey Foundation, 66% of 4th-grade students nationally are not reading proficiently [1]. We met with

RHG raised it standards; only then did we see considerable improvement in provider recruitment and retention. Raising the standards also meant paying market salary, covering *all* reasonable moving expenses, paying a signing bonus, providing 2 professional memberships, and allowing for a generous allotment of continuing medical education credit.

In addition to providing our practitioners with financial incentives, we know it is also important to provide a workplace where they will want to stay. In order to promote retention, we support providers in a team-based environment. Hiring an exceptional provider and only giving her one medical assistant is a surefire way to frustrate and burn out even the most dedicated provider. Instead, we believe providers should work as members of a primary care team, with the provider and the patient at the center. Changing to team-based care took time, and this process is ongoing.

To bolster a team-based environment, RHG began the RHG University to train providers, nurses, and operational staff in motivational interviewing, lenses of perception, relational models, and stages of change. Learning opportunities continue with monthly meetings that are facilitated by an expert in person-centered care. These patient-centered medical home meetings, coupled with monthly staff meetings, have created an environment where teams and communication are becoming second nature.

The smaller primary care team has daily huddles with the provider, 2 clinical support staff, and the panel manager; the case manager or behaviorist can also be included when needed. Nursing has changed to become a more integral part of care; it is not just taking vitals. RHG has expanded the function of nursing staff, with clinical assistants now conducting screenings for depression, alcohol and tobacco use,

the administration of our public schools to discuss school readiness. We learned that, despite our Reach Out and Read effort, far too many children enter kindergarten unprepared to learn to read; thus, our community needs to do more to improve the language skills of preschool children. We therefore organized a steering committee of partners—including Smart Start, Head Start, the local health department, the local hospital, public schools, the mayor's office, the public housing authority, the public library system, the Cooperative Extension Service, and Seymour Johnson Air Force Base—and conducted a community forum. Our goal is to work with this coalition to improve the school readiness of kindergarten students.

Childhood Obesity and Type 2 Diabetes

Goldsboro Pediatrics partnered with the health department and Family YMCA to obtain grant funding for the CHANGE for Children program (Commitment to Healthy Attitudes in Nutrition, Growth, and Education). Scholarships are available for youth living in poverty. Enrollees attend wellness sessions at the Family YMCA 2 nights per week for 10 weeks; during these sessions, a dietitian, a fitness expert, and a health professional teach children healthy exercise and eating habits. Goldsboro Pediatrics also joined GoWayneGo, a countywide effort to improve wellness that is being spearheaded by the county commissioner, the local hospital, and the local health department. Our practice is also starting a quality improvement program administered by the American Academy of Pediatrics to improve the outcomes of overweight and obese children.

Conclusion

Goldsboro Pediatrics is a true medical home for the children in our catchment area, and we are integrated with our state's Medicaid model, Community Care of North Carolina (CCNC). Today Goldsboro Pediatrics operates 4 offices where 17 pediatricians, 7 nurse practitioners, 1 physician assistant, 2 mental health professionals, 1 certified lactation consultant, and 2 CCNC care coordinators provide comprehensive health services for pediatric patients. Our practice continues to provide leadership for our community to ensure that more of our children grow up to be responsible, happy, economically independent adults. NCMJ

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and preventive health behaviors, while also following standing orders for all chronic disease conditions to ensure that all necessary lab tests, imaging, and referrals are ordered. Nursing staff also provide patient education using vetted clinical protocols and teach-back techniques that complement the provider-patient education. RHG providers have 1 licensed practical nurse and 1 medical assistant assigned to each provider, and a panel manager (usually a registered nurse) is assigned to every 2–3 providers. The panel manager is responsible for coordinating the care team, arranging the daily team huddles, ensuring that previsit planning occurs for at-risk patients, managing the provider panel's planned visits for preventive care and chronic disease management, and managing quality reports. Panel managers work to ensure that we close the loop (eg, lab orders are received and followed up, abnormal cancer screenings are followed to ensure the patient gets the necessary treatment). The care team has also been extended to include case managers who help patients when they face challenges in accessing services. Case managers connect patients and providers with resources to help ensure that patients are able to access provider-ordered care and services.

RHG has also integrated behavioral health care into all of its practices. Studies show that close to 70% of the patient visits in primary care have no organic cause; most of what we see in primary care is related to the patient's behavior. Understanding behavior is essential, and RHG has continued to spread the integrated model to every clinic and every staff member. With 5 behaviorists on staff, RHG can provide behavioral health services to help patients meet health goals such as diabetes control, smoking cessation, or depression management. In addition, RHG has a pharmacy department whose staff works with providers to find the most appropriate medication therapy and to obtain that medication at a reasonable price.

Undergirding the team approached to care is an investment in information technology and analytics. UpToDate, a clinical decision-support resource, is integrated into our electronic health record system, giving providers a point-of-care clinical knowledge bank as well as clinical decision supports. In addition, quality reports with drill-down capability are provided to care teams on a weekly basis. The reports include medications (with the full prescription), treatment modalities, lab results, and an array of clinical logic.

These analytics have given the senior leadership team the tools they need to focus on challenging areas, such as

prescribing behavior for pain management or hypertensive control. The medical director and director of integrated care have set aside time to meet weekly with a subset of the providers to mentor, listen, and review quality reports. Providers have at least 4 of these sessions with senior clinical leaders per year. These sessions have been an invaluable part of developing open, honest relationships with providers. RHG has carved out time for clinical leaders to meet with providers because the quality of that relationship has a direct correlation with the quality of care provided to the patients at RHG. In addition to these one-on-one meetings, RHG has a "provider day back" at least 3 times per year, during which 6–8 providers meet with the senior clinical team (including myself) to focus on medical education and clinical standards. In addition to furthering learning, these days help providers to develop strong relationships with RHG's leadership.

Investing in people and dedicating time to develop healthy relationships with providers are key parts of RHG's provider retention strategy. Each of the steps—from recruiting providers who embody core competencies to the ongoing commitment to nurturing relationships with providers—is essential to attracting and retaining a staff of dedicated professionals. RHG has seen how an engaged provider workforce supported in a team-based environment can improve care in under-resourced communities. RHG believes that the long view is the only strategy that works: develop meaningful relationships of mutual trust with provider leaders and their teams so that patients and their families have trust in the care and the people providing that care. NCMJ

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