Rural Health Challenges in Retention and Recruitment: How Telehealth can Help.

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INTRODUCTION

In Oregon, rural is defined as, "all geographic areas 10 or more miles from the centroid of a population center of 40,000+" (Oregon, 2014). This literature review will discuss telehealth in general, how it is currently being implemented, and how it can be utilized to solve challenges faced in rural health practice. This review will also look at rural health in types of services provided in a rural setting, why practitioners choose a rural setting for their practice, recruitment and retention challenges, and finally offer solutions to overcome the different barriers for recruiting and keeping practitioners in the rural setting. There are many issues surrounding rural health care which contribute to the recruiting and retention of practitioners. These limitations span the expanse from limited monetary and treatment resources to perceived views of other practitioners.

Services provided

Rural hospitals have seen a dramatic shift from inpatient to outpatient care as technology and practice patterns have changed and specialized inpatient services have remained concentrated in urban areas (American, 2011). Because of this necessity to fly the most complex and complicated cases to places which have greater resources, rural health services are limited and general. In rural Australia, Merritt, Perkins, and Boreland (2013) found the three most common services provided were "home modification assessments, activity of daily living assessments, and equipment provisions" (p. 282).

Why choose a rural practice?

There are a number of reasons why practitioners' choose to practice in a rural health setting. Individuals choose a rural area to practice in because of the benefits of autonomy, the desire for a more diverse practice, relationships, and the desire for broader skills (Mills &

Millsteed, 2002; Roots & Li, 2013). Other reasons include the ability to define their practice based on their values, and a stronger social interaction with clients and colleagues (Lee & Mackenzie, 2003, pg. 37). Mills and Millsteed (2002) found in their research those most likely to seek out work in a rural setting had a rural upbringing or previous rural experience, partners with a rural background, a perceived ideology about a rural lifestyle, or a desire for autonomy or to develop clinical skills.

RETENTION CHALLENGES IN RURAL HEALTH

However, these same reasons which once attracted a therapist to a rural setting can also become the reasons why they desire to leave. Mills and Millsteed, (2002) found there is a distinct difference between why one would choose to work in a rural setting and why one continues to work in a rural setting (pg. 172). These factors between wanting to stay and wanting to go "gave rise to a proposed Model of Retention Equilibrium, which suggests that retention can be improved by addressing the imbalance between incentives to leave and incentives to stay" (Mills & Millsteed, 2002, p. 170).

Before the imbalance of wanting to go and wanting to stay can be improved it is important to know what those incentives to leave are. Incentives to leave are barriers which may include: management not understanding the struggles of being a practitioner in a rural setting, limited access to colleagues and peers for consultant purposes, limited peers not valuing their work experience, continuing education (CE) opportunities, or monetary considerations. Not all rural health practitioners leave because of professional challenges found in rural health settings. Personal reasons for leaving included "the lack of educational opportunities for children, feelings of burnout, and desire of partners to relocate" (Mills & Millsteed, 2002, p. 171).

Professional reasons for leaving

Role variation

There are many different roles practitioners in a rural setting have to fulfil due to lack of available personnel. Literature has shown that frequently occupational therapists practicing in rural settings also took on the roles of secretary, appointment setter, scheduler, filing charts, and making calls to insurance companies and required added skills for communication, resourcefulness, creativity, and management (Johnson, Johnson, Siegel, & Zurawski, 2003; Mills & Millsteed, 2002).

Scope of Practice

In their questionnaire of 10 occupational therapists in Australia, Mills and Millsteed (2002) found all 10 participants of the study "described the scope of rural practice as being wider than in the metropolitan area" (Mills & Millsteed, 2002, p. 174), and many felt their scope of practice was "everything that came in the door and you had to deal with everything" (Mills & Millsteed, 2002, p. 174). The perception represented in the literature suggests one must be a jack of all trades but master of none (Roots & Li, 2013). One interviewees' response was, "My work varies throughout the whole day from anything from pediatrics to working in the nursing home to doing rehab with a sub-acute patient to seeing a critical in-patient down to seeing work injuries, going out into businesses, doing home evaluations, just seeing your basic orthopedic out-patients or neuro patients and it varies continually throughout the whole day" (Johnson, Johnson, Siegel, & Zurawski, 2003, p. 3). Another stated, "I do most of the time feel that I am a jack-of-all-trades/master-of-none, but on the other hand I don't think that is a bad thing. I think it makes me more employable." For some this opportunity to treat everything coming through the door becomes a valuable clinical experience as it expands their exposure to all areas of their practice (Mills & Millsteed, 2002, p. 174).

Traveling between clients

When looking at reasons therapists may not want to practice in rural areas Kohler and Mayberry (1993) said, “distance between service provision bases and clients homes are often vast and require long, hazardous hours of road travel in remote areas” (p. 731). “Providing services in several locations places financial and logistical constraints…not encountered by those based in the city” (Merritt, Perkins, & Boreland, 2013, p. 282).

Professional growth

Professional growth in a rural setting due to limitations on the size of the practice can offer a lack of opportunity to grow. Millsteed (1997) states some of the factors which affect the retention of occupational therapists in rural areas include, “limited opportunities for career progression, terms of employment and salary levels, not feeling valued by city-based peers, difficulties accessing relevant continuing professional development courses and material, and locum of cover” (p. 99).

Peer recognition

In the field of medicine there is a drive for individual practitioners to become specialists. Millsteed said it best in the 1997 Sylvia Docker lecture when she said, “There is a perception across all health professionals that to engage in rural practice will inhibit opportunities to become a specialist practitioner, as defined and valued in city-based practices. This acts as a disincentive for occupational therapists to consider working in rural communities because they believe it will limit career opportunities later on” (Millsteed, 1997, p.101). Mills and Millsteed’s (2002) participants took their concerns to the next level and stated they too had a lack of confidence in rural practitioners and did not see the value of their time in rural practice until after they had left their rural setting for urban employment. In all, the idea of being generalist in practice and not valued as specialists was for some a barrier to retention.

Professional Isolation (PI)

In many ways geography plays a part in creating challenges in retention as rural settings are defined by isolation. Isolation is not only about physical location but can be about the feeling of professional isolation (PI) as well. Williams (2012) says, "inherent in the nature of rural PI is the notion of being distanced from some aspect of the profession, either from peers, technology, larger centers, or education" (p. 8). Williams goes on to say peer support and mentorship are key elements needed to round out one's understanding of their professional role (Williams, 2012). In their research with new graduates who accepted positions in rural areas within the first year of graduating, Lee and Mackenzie (2003) found many of the participants of their studies were not "keen" on the idea of working in a rural setting because of the "perceived lack of professional support" (pg. 39).

In their research, Mills, & Millsteed (2002) found the lack of social privacy can become an issue for some practicing in rural settings as health professionals are more likely to see their clients and colleagues during their off hours and the line between professional and personal life becomes blurred.

Access to continuing education (CE)

When looking at reasons therapists may not want to practice in rural areas Kohler and Mayberry (1993) said, "continuing education courses and graduate studies are essentially inaccessible to rural therapists, who feel they must move to urban areas in states where these courses are available" (p. 731). Literature revealed the lack of employers' willingness to help manage the cost of CE requirements through paid travel time and time off becomes a barrier to retention for some (Kohler & Mayberry, 1993; Mills & Millsteed, 2002).

Monetary limitations

In general there is less money in rural areas, in comparison to urban areas, due to lower income wages which then affect the ability to afford health care and insurance. Less income also

means less discretionary money to pay private practice fees for service (Merritt, Perkins, & Boreland, 2013). When looking at reasons therapists may not want to practice in rural areas Kohler and Mayberry (1993) said, “Rural hospitals and community-based service do not offer competitive salaries” (p.731). Limited resources do not just refer to the monetary resources for salary or continuing education class, but also in the limitation of resources for treatment equipment (Johnson, Johnson, Siegel, & Zurawski, 2003). However, some interviewees felt this limitation of treatment resources forced them to be more creative with their treatments.

Retention Solutions

While all retention barriers cannot be addressed, solutions must come from a wide range of measures, be creative, and satisfy both professional and personal lifestyles. Implementation must be addressed in the job offers to new hires, continued early in their employment, and offered long term to address barriers when practicing in rural health (Mills & Millsteed, 2002). The use of Telehealth is also on the rise as a solution to some of the retention issues.

Telehealth is a general term which refers to the use of telecommunications to provide health services across distances (Esau, 2014). Included under this umbrella term are telemedicine and telerehabilitaion. Heimerl and Rashch define telerehabilitation as the “clinical application of consultative, prevent[ive], diagnostic and therapeutic therapy via two-way interactive audiovisual linkage” (pg. 1).

Peer Recognition

The literature showed that rural occupational therapists feel they are not recognized or valued as highly as those who practice in urban settings. To push back at this stigma, Millsteed says, “perhaps one way that rural practitioners have tried to counter this is by using the power of city language to describe themselves as ‘specialist generalists’…this term…implies that there are

special competencies required to practice effectively in rural settings." (Millsteed, 1997, p. 101-102).

Travel between clients

The issues of accounting for the travel distance between clients can be addressed as Roots and Li (2013) found when, "management offered them flexibility in their work schedule to accommodate distance travelled, or recognized the increased workload that occurred due to the shortage of rehabilitation staff" (p. 8).

Telehealth has the potential to decrease time spent traveling between clients by increasing the opportunity for direct services, increasing frequency of visit for rural patients, and increasing opportunities for peer to peer consultation for better continuum of care (Heimerl & Rasch, 2009; Hoffmann and Cantoni, 2008).

Professional growth

Planning for the lack of opportunity for professional growth by management can increase retention. This path of professional growth and advancement should be a clear professional growth career path which leads to opportunities for progression into senior positions and more authority (Mills & Millsteed, 2002). When there is opportunity for professional advancement retention lengthened up to 5 years instead of the average of 13 - 18 months (Lee & Mackenzie, 2003).

Professional isolation (PI)

For some, the use of other professional/allied health colleagues offers a solution to the feelings of professional isolation (Mills & Millsteed, 2002).

Many of the challenges with retention can be addressed with the use of telehealth as well. Williams (2012) states, "in terms of reducing the ill effects of rural PI, writers often identified communication and information technology as means to reduce PI…" (p. 8). Hoffmann and Cantoni (2008) found, "telehealth has predominantly been used as a support tool for rural

therapists to decrease their sense of isolation and increase the professional support available to them (pg. 240).

Access to continuing education (CE)

Mills and Millsteed (2002) offered a unique suggestion of petitioning the providers of CE courses and asking them to lower the cost of the courses for rural practitioners (Mills & Millsteed, 2002).

CE courses become more accessible with technology. Citing a study by Taylor and Lee (2005), Hoffmann and Cantoni (2008) learned that “rural occupational therapists commonly used videoconferencing for continuing professional development and were more likely to use technology for this purpose than for client service deliver” (as cited in Hoffmann & Cantoni, 2008, pg. 245).

Monetary limitations

In their article, Mills and Millstead (2002) identified ways to overcome compensation barriers and increase rural retention by suggesting the use of a compensation package which included bonuses tied to length of employment, increased monetary reimbursement for CE courses including increased funding for travel to urban areas for CE courses, and increased vacation days (pg. 178).

RECUITMENT IN RURAL HEALTH

Recruitment of rural health practitioners is a challenge for administrators as there is a lack of individuals who desire to work in a rural setting.

Influence of education

One of the greatest assets to push back at the recruitment challenges is educational influence. When looking at reasons therapists may not want to practice in rural areas Kohler and Mayberry (1993) said, “most professional occupational therapy schools do not provide specialized orientations and training for students who could be rural practitioners” (p. 731).

"Students are less likely to choose rural employment without pervious positive exposure through fieldwork placement" (Merritt, Perkins, & Boreland, 2013, p. 284)

Many students are just not exposed to, or educated about; the uniqueness of rural practice and discipline specific schools can address the gap of exposure through their program recruitment strategies, curricula, and practical experience opportunities

It was suggested by Offner (1989) through Kholer and Mayberry that, "people recruited from rural areas are more likely to return to rural areas" (pg. 735). In her 1979 Sylvia Docker lecture, Millsteed suggested occupational therapy be marketed as a career option to rural high school students to overcome the need for more occupational therapists in the rural area,.

Kohler and Mayberry (1993) echo Kohler and Okamoto (1992) and Regan (1982) for educational curricula to focus on the following educational needs, "(a) community based and rural health-care systems, (b) characteristics of the rural culture and life-style, (c) roles that practitioners must play in rural practice (consultant, case manager, administrator, program developer, and direct care provider in schools, home-based services, and nursing homes), (d) skills needed to shift from traditional medical model approaches to that of community health and folk health practices, (e) assessment of the clients' individual culture within the rural life-style, (t) short-and long-range marketing skills, (g) methods of accessing long distance resources, and (h) management of personal issues that arise from long-term isolation" (p. 732).

A review of the literature shows the most needed skills for rural health practice were problem solving, education of others, the ability to consult with others, give standardized tests, develop programs, be professionally independent and self-confident (Kohler & Mayberry, 1993; Lee and Mackenzie, 2003). These are all qualities new graduates do not have because of a lack of experience, but can be enhanced during the educational process.

A new graduate's likeliness to accept a rural health job was based on having a rural background, exposure to rural practice during their educational process, and financial incentives like loan forgiveness (Roots & Li, 2013).

Monetary considerations

A recruitment tool which could be used by rural health administrations would be to address moving expenses in the job offer. Mills and Millsteed (2002) stated, "Generally it was expensive for therapists to take up their country position, with travelling and relocation costs met by the practitioners themselves." (pg. 175).

Telehealth a solution to recruitment

Finally, a non-traditional solution to recruitment is the use of telehealth. If a therapist is not available why not hire an assistant and use telehealth? In his lecture Esau (2014) states the best place to get started with telehealth for direct services is through the use of telehealth for the supervision of assistive personnel (slide. 16).

Conclusion

There are many challenges surrounding rural healthcare. These challenges contribute to the recruiting and retention of practitioners and a better continuum of care for patients and clients. Many of these issues can be overcome creatively with the use of telehealth, and better understanding by administrators in regards to the issues rural health practitioners face when it comes to feelings of isolation, lack of professional value, and lack of monetary incentives. When looking for solutions to the rural health dilemma, the literature suggests there is a role specific medical professional universities and programs can take to help solve the shortage of practitioners to serve in rural health care areas.

Reference

American Hospital Association. (2011). *The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform.* (Trend Watch) Washington, DC.

Brentnall, J., Bulkeley, K., Bundy, A., Dew, A., Gallego, G., Griffiths, S., Lincoln, M., & Veitch, C. (2013). Addressing the barriers to accessing therapy services in rural and remote areas. *Disability and Rehabilitation: An International, multidisciplinary journal,35(18), 1564-1570.*

Cason, J. (2012). Telehealth opportunities in occupational therapy through the affordable care act. *American Journal Of Occupational Therapy*, *66*(2), 131-136.

Esau, T. (2014, April). *Telehealth – The Future is Here*. Paper presented at the meeting of Pacific University School of Occupational Therapy, Hillsboro, OR.

Heimerl, S., & Rasch, N. (2009). Delivering development occupational therapy consultation services through telehealth. *Developmental Disabilities Special Interest Section Quarterly*, *32*(3), 1-4.

Hoffmann, T., & Cantoni, N. (2008). Occupational therapy services for adult neurological clients in Queensland and therapists' use of telehealth to provide services. *Australian Occupational Therapy Journal*, *55*(4), 239-248.

Johnson, A., Johnson, S., Siegel, A., & Zurawski, N., (2003). The experiences of being a rural occupational therapist. *Journal of Undergraduate Research, 6,* 1-8.

Kohler, E., & Mayberry, W. (1993). A comparison of practice issues among occupational therapists in the rural Northwest and the Rocky Mountain regions. *American Journal Of Occupational Therapy*, *47*(8), 731-737.

Lee, S., & Mackenzie, L. (2003). Starting out in rural New South Wales: the experiences of new graduate occupational therapists. *Australian Journal of Rural Health*, *11*(1), 36-43.

MacLeod, G., & Barlow, I. (2004). Tele-occupational therapy. providing seating intervention in a rural setting through tele-health. *Occupational Therapy Now*, *6*(6), 3-5.

Merritt, J., Perkins, D., & Boreland, F. (2013). Regional and remote occupational therapy: A preliminary exploration of private occupational therapy practice. *Australian Occupational Therapy Journal*, *60*(4), 276-287.

Mills, A., & Millsteed, J. (2002). Retention: an unresolved workforce issue affecting rural occupational therapy services. *Australian Occupational Therapy Journal*, *49*(4), 170-181.

Millsteed, J. (1997). 1997 Sylvia Docker Lecture. The contribution of occupational therapy to the fabric of Australian rural and remote communities. *Australian Occupational Therapy Journal*, *44*(3), 95-106.

Oregon Health and Science University. (2014). *Rural definitions*. Retrieved from http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm.

Roots, R., Li, C. (2013). Recruitment and retention of occupational therapists and physiotherapists in rural regions: a meta-synthesis. *BMC Health Service Research* Retrieved from http://biomedcentral.com/1472-6963/13/59.

Williams, M. A. (2012). Rural professional isolation: An integrative review. *Online Journal Of Rural Nursing & Health Care*, *12*(2), 3-10.