Building a Stronger, Integrated Rural Health Workforce

Bottom-Up, Top-Down: Actionable Next Steps

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A Healthier WE - a 501(c)3 non-profit organization dedicated to addressing critical issues in rural health

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Bottom-up, top-down: actionable next steps

The rural health workforce is shrinking. It's not a new problem, which will not go away and it's not going away anytime soon. It's a problem that must be addressed, and it cannot be addressed solely from the top down.

Instead, communities must tackle the situation and rethink issues such as: recruitment, training, and skill development for health workers at all levels; payment structures; licensing standards and work life balance.

Americans are realizing that our "sick care" model is not sustainable. We want and need a "health " model grounded in prevention and better interface between health care and public health.

What follows are some practical ideas our A Healthier WE team has researched and suggests can provide ways communities can get more involved and committed in this needed transformational change.

Moving forward, communities can begin by identifying and nurturing the people in their midst – both young and more mature – who are likely to make good health workers because of their caring personalities.

Leaders both within and outside the health system must talk to each other about what is happening in health and healthcare in the community.

The nation's focus has too often been on the politics, policies and payment for health and healthcare, but we have forgotten what can practically be done in rural communities.

First, we want a health workforce filled by caring people. Health and healthcare are supposed to be about caring for others, but our system has professionalized and often industrialized these models. Instead, start by identifying people who care and are trusted and helping those folks toward a health profession by providing high quality and accessible information to develop their skills. Then, if necessary, provide financial support for the workers to acquire more education and training.

Second, today's system uses licensure as a way to denote skill sets and scope of practice. Too often, though, the license is used to protect jobs and financial models rather than to serve the community. We must review the practice structure to better address prevention and a focus on health instead of just "sick care." The scopes of practice for all professionals must be fully utilized to better meet the needs of those they care for. What skill sets are really the most important as we focus on health and health care? And who should provide that care?

Third, distance is a real issue if you live in a rural area. We are asking citizens in remote areas to drive long distances to find a caring health professional. Health professional training must consider the issues of distance, times, and relationships if they are to live out the caring role that we expect.

We now have digital communication technologies that can allow more training to take place locally, preserving the individuals' bond with their communities. How could we involve local communities to help make this type of educational extension possible and useable? How many pre-professionals could be trained remotely at the same location and time? And how can we better train our citizens in the best way to use and feel comfortable with digital care?

Fourth, generalist or specialist? Our health system today is focused on specialization. In part we believe this has come about because of our demand, as a nation, for perfection. As a result, many prevention and health care services go unmet. We believe specialization has led to a focus mainly on healthcare and its many system/payment models. That system then became top- down oriented because of the goal of perfection.

We believe that for small communities the need for more cross training of everyone involved in providing care is crucial. The distance issue is real. The lack of broadband to expand digital opportunities for training and assessment is real. The way we address these issues will take collaboration and creativity. If you have NO health professional in the community and you need help now, who can help? This problem is real in small, remote places and must be creatively addressed. Could we use EMT's in more ways than allowed right now? What about the other trained citizens in our small communities? Who else do you think could be of help in remote areas?

Terms that have an influence on health workforce discussions
HEALTH: when everything works
COMMUNICATION: the exchange of trusted information and the imparting of knowledge
COMMUNITY: a group of individuals who have agreed to take a risk for each other to a certain degree
BOTTOM UP: an approach by a community to address common issues
TOP DOWN: an approach by an entity outside the community that is working to address community issues
RURAL: a geographic and population identification that includes a set of values and lifestyle choices
URBAN: a geographic and population identification that includes a set of values and lifestyle choices

Fifth, where you are trained and by whom who you are trained by does make a difference. If you have been born in and lived in a rural community for 17-18 or more years and your support system continues to be in that setting, what happens when you are pulled away from that for years of training in an urban setting?

Your idea of community is often changed, and now you have to focus on outside system thinking versus community thinking. For example, you expect people to come to you for help rather than going to them to provide care. Care seems to come in 10-minute increments. Trust comes from a title rather than a relationship that has to be built in small communities.

Those paradigms make it difficult to meet health and healthcare needs in small communities and rural areas. Additional challenges make it even more difficult to recruit a health workforce.

We must now focus on the needed changes to improve our rural health workforce for the best interest of the citizens who live in those communities. We need one and all of us to focus on this issue and then proactively act on those changes. It is too important to wait for a top down approach.

Our Actionable Next Steps:

1. We ask each person to begin thinking about a local person that you would consider to be a model caring community citizen.
2. Identify what key helping/caring values you observe in that person? What relationship skills do they have?
3. Identify what type of support will be needed to ensure that they can get the education they need and want. Try to find a way that they could return to provide local care in whatever profession they choose.
4. Create a group of local citizens who can help you in identifying these types of citizens and the supports needed. The group could include faith leaders, school leaders, volunteer leaders, etc.
5. Work together to identify ways that, collectively, you would like a new system of caring to be developed to better serve the health and healthcare needs of your community.
6. Now advocate for those changes in the state political, educational and health establishments. Where necessary, advocate at the national level because this is a national as well as a local issue.

It is time that we move from a “top-down only” to a “bottom-up also” model. Small communities use that model every day. Encourage one another to put it to use to develop a health workforce to meet the needs of small communities.

"In these times, if 'I' is replaced by 'We', even illness becomes wellness"

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