Lessons Learned from the Cohort Analysis of Rural Health Programs: **Workforce Recruitment and Retention**

Workforce Needs

Health workforce shortages in rural America are well-documented. As of December 2020, **62 percent of all primary care Health Professional Shortage Area (HPSA) designations were in rural areas**. About **63 percent of dental care HPSAs** and **59 percent of mental health HPSAs** were in rural areas.[1]

Federal Office of Rural Health Policy in the Health Resources and Services Administration (FORHP) grant award recipients implement diverse community-focused projects intended to increase access to care, improve quality of care, and improve population health over a three-year grant period. In implementing their programs, many awardees recruit a range of clinical and non-clinical staff. Training new and existing staff is a key capacity building activity for many grant-funded projects. However, many awardees and their partners experience workforce shortages that are common in rural America. The awardees interviewed for this brief have identified successful approaches to recruiting and retaining staff involved with their project implementation.

May 2021

Approaches to Workforce Recruitment and Retention

FORHP awardees recruited new staff, trained existing staff, and/or trained partner site staff. Each approach required different resources to implement.

Recruit new staff. Awardees hired new staff to implement their programs. Some awardees hired project coordinators to manage implementation of grant-funded activities. Several awardees hired and trained Community Health Workers (CHWs). Other awardees hired behavioral health therapists, peer recovery specialists, health coaches, care coordinators, nurses, advance practice providers, or physicians.

Common methods for recruiting for open positions included postings on organization websites, job websites (e.g., Indeed), social media, and local and regional newspapers. Word of mouth was effective in small communities.

Leverage existing staff. Some awardees chose to use existing management, clinical, and non-clinical staff to implement their grant activities. Staff who had sufficient capacity to take on additional duties, participate in new trainings, and implement projects were included in grant activities. For example, clinical quality improvement projects often supported existing clinical staff to implement new processes or workflows.

Train partner site staff. Some awardees focused efforts on training partners to implement evidence-based models. For example, some awardees collaborated with schools, training their leadership and faculty in physical and mental health topics to allow school staff to better support students. Other awardees trained clinical staff at clinics, physician offices, and hospitals in new skills and processes.

Role of Network Partners

Network/consortium partners played an essential role for workforce recruitment and training strategies. Awardees and their network partners together identified workforce needs and gaps. Network partners also served as referral sources for job candidates or staff who would benefit from training.

For example, **one awardee maintained communication with other CHW programs within the state** to identify training opportunities and open CHW positions.

Awardees took time to develop relationships with network/consortium partners prior to and during the grant period. Recognizing the importance of trust with partner sites, one awardee scheduled open time during site visits to allow for providers and staff to meet them and ask questions. The awardee also walked around hospitals and clinics to meet with staff.

Challenges and Barriers

FORHP awardees experienced common challenges to workforce recruitment, retention, and training, including recruitment difficulty, staff turnover, and limited staff capacity.

Recruiting Project Staff. Some awardees experienced challenges hiring staff to lead their project implementation. Potential job candidates were concerned about continued employment following the end of grant funding.

Partner Staff Turnover. Awardees experienced turnover at project partner sites. Awardees spent time developing relationships and building trust with partner organizations. When a primary point of contact left, the awardee had to develop buy-in with new staff that required time. In addition, staff involved in project implementation at partner sites experienced burnout that contributed to turnover.

Lack of Participation from Partners. Awardees implemented projects that required project partners to invest in workforce resources. For example, one awardee provided a peer support specialist to be integrated in a clinic. One of the partners only referred four people to the peer support specialist during the grant period.

Limited Staff Time Available. Awardees providing training to health professionals working in rural health care facilities commented that staff did not have sufficient time to complete trainings, or the facilities did not have additional staff available to fill in gaps while other staff attended trainings.

Certification and Reimbursement for CHWs. Several awardees commented that their states have not yet established CHW certification nor do they provide Medicaid reimbursement for CHW services. Reimbursement was particularly important for sustaining CHW roles in health care settings.

Rural Context. Several awardees commented on challenges related to the rural context. It was important that new hires from outside of the community appreciated the rural lifestyle. It was also important that health professionals understood rural practice, including limited resources and lack of specialized support. One awardee commented on staff turnover in a small town, noting "Rural entities often employ multiple individuals from the same family. If one person from the family leaves the community, the organization may lose additional staff as well."

Facilitators of Success

Awardees described many facilitators of success for their workforce recruitment and retention strategies, including strong and consistent project leadership, relationships with their network/consortiums, and offering support and feedback to employees.

Establish Consistent and Committed Project Leadership. Consistent and committed project leadership were essential for building trust with partners to support workforce projects. One awardee noted that it is important that projects are led with a vision, all planned activities align with the vision, and project leadership have the knowledge and skills to implement the vision. It is important that project leadership communicate the vision to partners, staff, trainees, and potential job candidates. Meaningful work that is connected to a broader goal is important for staff engagement.

Several awardees also commented on the importance of project leadership having relevant experience, sometimes clinical expertise, to anticipate potential issues and implement lessons learned from previous work. A team-based approach to project implementation was also important. Each team member brought different strengths to achieve the project's objectives.

Engage the Network/Consortium. Many awardees found that strong relationships with their networks/consortiums contributed to the success of their workforce recruitment and retention strategies. Partners valued the goals of projects and were invested in the success of projects. They provided input to improve the quality of trainings and recruitment strategies, ensuring they were meaningful for the target audience.

Partners also identified staff members within their organizations or community members to participate in workforce development activities. One awardee provided a CHW training to partners who were responsible for recruiting potential training participants. This firsthand experience allowed them to better describe the training program and required qualities of successful CHWs to potential candidates.

Hire the Right Fit. Awardees commented on the need to hire the right fit for the role, organization, and community to facilitate retention. For example, one awardee hired CHWs who appreciated the racial and ethnic diversity in the community and the struggles of intergenerational poverty among the area's residents. Another awardee hired a consultant who was well-known among community partners due to previous experience providing trainings in the region. The consultant's positive reputation facilitated partner engagement and the project's overall success.

> *With anything, we have to adapt and change courses. I may have sought an individual with overall skillset towards a CHW, but as I matured as a supervisor, I learned in each community it is a very specific community health worker that you are looking for. Some of these communities, you might have an individual more experienced with homeless shelters or homelessness in the school systems. Another one might be more versed in food pantries. It depends on the area...Understanding what fits in one community might not be the most accurate for another, it's a very specific person you are looking for.*
> **–Awardee Project Director**

Awardees recognized that recruitment and hiring the right staff requires more time and effort than is often anticipated.

Invest in Onboarding Processes. Several awardees noted the importance of the onboarding process to ensure that new employees understood their job roles, became familiar with the organization, and connected to the overall vision of the project. One awardee required new employees to meet with the leaders of each department within the first week of employment. New employees then completed a 30-day discussion with their supervisor to ensure that job expectations were clear and to identify any gaps that could be filled with ongoing education.

Support Work/Life Balance. Awardees supported staff to prevent burnout. One awardee helped CHWs set boundaries between work and life to ensure that CHWs spent time with their families. Another awardee commented that recruiting and retaining peer recovery specialists could be difficult as the recovery process can be a non-linear process. The awardee organization developed a supportive culture, including opportunities for open and honest communication, and established policies for paid time off and wellness days to allow time for self-care. This awardee commented on the benefits of their approach for recruiting and retaining peer recovery specialists:

> *But we can weather storms that most other organizations don't let people weather when they experience those types of challenges. We have a deeper level of understanding and flexibility in that… That's really how you're able to recruit people who really come from a place of passion, who may not otherwise be able to do that kind of nine to five work.*
> **–Awardee Project Director**

Implement Timely Performance Feedback. Many awardee organizations conduct periodic—most often annual—performance reviews of employees as a retention tool. One awardee implemented 90-day feedback for all new employees to discuss their performance and goals with their managers or supervisors. Employees received continual feedback and coaching throughout the year and revised their goals six months after hiring and then annually.

Plan for Limited Staff Resources in Rural Areas. Awardees commented on the limited capacity of rural health care staff to take time away from regular duties to participate in trainings. Awardees recognized these limitations and planned accordingly. For example, one awardee provided trainings that aligned with the schedules of registered nurses (RNs) and emergency medical technicians (EMTs) working in rural communities. This required the awardee to adjust the training to allow for a greater number of shorter sessions. Another awardee established a hybrid model training course—half of the training was offered online to be completed independently and the other half of the course was provided in-person during two half-day sessions. For a rural training track program, one awardee provided additional support to rural preceptors.

Travel was a major consideration for most awardees. Awardees ensured that trainings were provided in rural communities, rather than requiring health care professionals to travel to another community. They also leveraged technology, such as telemedicine or videoconferencing, to maintain relationships and offer support.

Cross-train Staff. To support workforce development, one awardee cross-trained non-clinical staff within the organization, including health insurance navigators, CHWs, and other lay health workers. Cross-training facilitated referrals and warm handoffs, or the transfer of care from one member of the care team to another in front of the patient and their family.[2]

Create Opportunities for the Existing Workforce. Rather than recruiting new staff, many awardees sought to build the skills and expertise of the existing w orkforce. Leveraging grant funding to support new certifications (e.g., certified nursing assistant to CHW to licensed practical nurse) contributes to the workforce pipeline and results in greater economic opportunity for rural residents. Given limited resources in rural communities, awardees supported the ability of staff to work at the top of their licenses.

Some awardees employed train-the-trainer models that required participants to progress towards becoming a trainer or master trainer. For an evidence-based chronic disease program, one awardee trained select program completers to be program leaders, and after some time, those program leaders became master trainers who could train and certify program leaders.

Other Strategies. Other successful strategies included:

- A few awardees adjusted job requirements, such as combining two part time positions into one full-time position with benefits or changing minimum qualifications.
- One awardee conducted site visits and fidelity checks to observe trainers.
- One awardee provided training at no cost, which boosted interest in their program.
- One awardee commented on the importance of maintaining a face-to-face relationship with network partners through frequent visits or virtual communications. The awardee also attended statewide meetings with other rural leaders.

Covid-19 Challenges and Adaptations

Some awardees were required to pause workforce recruitment and retention activities when the COVID-19 pandemic began. In-person trainings and travel to sites were no longer feasible.

Some awardees **adapted their trainings to be provided online using virtual platforms (e.g., Zoom, WebEx)**, noting the importance of maintaining interactive and engaging training courses. Trainings were also adapted to new roles during COVID-19.

For example, CHW activities shifted to interventions to support clients at home, such as getting medications and groceries delivered or using telehealth.

One awardee was able to continue providing in-person trainings for medical residents. However, courses were moved to larger spaces and multiple rooms to allow for students and the instructors to social distance; each room was limited to three students and one instructor. As a result, the awardee was required to recruit additional instructors to deliver the training course. The awardee also acquired personal protective equipment (PPE) and implemented thorough cleaning practices.

Awardees employing CHWs stopped providing home visits and conducted telephone visits. One awardee shifted to recruiting and training contact tracers rather than lay health workers to support the state's COVID-19 response.

Evaluation and Monitoring

Evaluation supported continuous performance improvement for workforce recruitment, retention, and training.

Awardees created post-training surveys to improve the quality and effectiveness of training programs. **For example, one awardee asked CHW training participants to evaluate each training module. The results from the participant evaluations were used to add new topics and improve the training.** Another awardee used post-training evaluations to assess improved knowledge and skills and overall satisfaction with the course.

Awardees reviewed training curriculums and student reviews with network members regularly. This process ensured that curriculums were appropriately tailored to the current health care environment and responsive to the emerging needs of network partners.

Other evaluation measures commonly monitored were the numbers of program participants, program completers, and trainers/instructors.

Sustainability

Awardees identified strategies to maintain the workforce that they developed over the duration of their grant program.

The training provided to staff and network partners during the grant period was an investment in the long-term capacity of the organization to meet community health needs and improve quality of care. Train-the-trainer models ensure that organizations have the ability to continue to train staff in evidence-based models of care.

Sustainability for new positions, particularly CHWs, required additional funding. Some awardees sought reimbursement from public and private payers. A growing number of state Medicaid programs provide reimbursement for CHW services. Other awardees sought to integrate CHWs into the clinical staffing models of network partners, suggesting that CHWs improve quality and efficiency of care by reducing unnecessary readmissions and emergency department utilization. This strategy is particularly effective within value-based delivery models, such as Accountable Care Organizations (ACOs).[3]

Cohort Analysis of Rural Health Programs

Section 330A of the Public Health Service Act authorizes grants to improve access to and quality of health care services in rural areas, funding consortiums or networks of three or more partners that come together to implement locally-driven programs. The Federal Office of Rural Health Policy (FORHP) in the Health Resources and Services Administration (HRSA) administers these grant programs, including the Small Health Care Provider Quality Improvement Program (Quality Program), Rural Health Network Development Program (Network Development Program), and Delta States Rural Development Network Grant Program (Delta Program).

The NORC Walsh Center for Rural Health Analysis (NORC), in partnership with the University of Minnesota Rural Health Research Center (UMN), was contracted by FORHP to evaluate the Section 330A grant programs, with a focus on implementation, impact, and sustainability. As a part of the evaluation, NORC and UMN conducted telephone interviews with 12 awardees from the Quality, Network Development, and Delta programs to understand common challenges and solutions awardees have implemented to address barriers to project implementation. This brief presents cross-cutting findings across the three programs related to workforce recruitment and retention.

References

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This report was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under Contract Number HHSH25034002T. The information, conclusions and opinions expressed in this report are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.