

Rural Physicians and Community Leadership: Skills for Building Health Infrastructure in Rural Communities

Steven D. Crane, MD

Few physicians at the beginning stage of their careers are so audacious as to describe themselves as “community health leaders.” Nevertheless, nearly every physician who finds him/herself practicing in a rural community will often be inexorably drawn into discussions about greater health-related needs in the broader community. Once a healthcare professional is able to step back and take a panoramic view of the “health” of the community in which his/her practice is located, he/she often realizes that there are many health needs and barriers to care, and he/she quickly learns that it takes more than individual effort to meet these needs. Whether through the initiative of practicing physicians or others, community-wide initiatives to define existing problems, to plan a range of options for meeting these needs, and the effort to fund and then administer these emerging programs will usually require physician involvement ... and even leadership. This commentary addresses some reasons why rural physicians need to become involved in solving some of these rural health problems, and how they can effectively provide needed clinical leadership even if they haven’t previously thought of themselves in such a role.

The status of rural healthcare in North Carolina can be described as precarious at best. Many rural communities continue to be plagued by shortages of resources to serve the growing needs of a rural population that is increasingly aged and uninsured. The shortage of physicians in rural communities remains a chronic problem.¹ Despite some progress in the last decade in dealing with this maldistribution, significant disparities persist between metropolitan and rural areas.² Although most counties in North Carolina from 1998 to 2003 experienced an increase in the ratio of primary care physicians to 10,000 population, 38 of the state’s 100 counties lost ground. Of the counties with increasing primary care shortages, about half were due to loss of physicians, and about half were due to rapid population

growth that outpaced the supply of physicians.³ Furthermore, in 2003, nearly 20% or 1.4 million North Carolinians under age 65 lacked health insurance coverage, with more than 300,000 having joined the ranks of the uninsured since 2000.⁴ The combination of primary care provider shortages and declining health insurance coverage continues to threaten the healthcare safety net, particularly in rural communities.

The March/April 2005 edition of the *North Carolina Medical Journal* provided a comprehensive view of the various components of this safety net, which includes federally qualified health centers (FQHCs), Area Health Education Center (AHEC) teaching clinics, free clinics, public health departments, rural health centers (RHCs), hospital emergency departments, and efforts to integrate multiple service providers in service to the poor and uninsured.⁵ As rural communities struggle to serve the health needs of their citizens, various combinations of these programs have been developed to address local health

concerns. In all of these programs, physician involvement and leadership are critical components of developing successful safety net services in rural communities, but there are important barriers that prevent effective physician involvement and, perhaps, the successful implementation of vital programs.

The Western Carolina Experience

Henderson, Polk, and Transylvania counties are rural counties in the western, mountain region of North Carolina. The efforts by healthcare providers in these counties to improve access and quality of care for low-income, uninsured patients in their communities have significantly strengthened the local healthcare safety net. These efforts have included:

- The development of one of the first migrant health centers (Blue Ridge Community Health Services, Inc.) funded by

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Steven D. Crane, MD, is the Program Director for the Hendersonville Family Practice Residency Program. He can be reached at Steve.crane@pardeehospital.org or 741 6th Avenue West, Hendersonville, NC 29739. Telephone: 828-696-1255.

the Health Resources and Services Administration (HRSA) as a federally-qualified health center (FQHC).

- An AHEC teaching clinic (the Mountain AHEC Rural Track Family Practice Residency Program).
- A free clinic staffed by family practice residents and private practice physicians in Henderson county.
- An expanded array of primary care and preventive health services by the Henderson County Department of Public Health with AHEC and private physician backup.
- Two additional rural health centers (the George Bond Health Center in Bat Cave and the Saluda Medical Center in Polk county).
- Expanded Community Care Network for managing the chronic illness [asthma, diabetes, depression, and attention deficit hyperactivity disorder (ADHD)] needs of Medicaid patients in the three counties with broad support from the private medical community in the three counties.

Collaboration has helped bring additional resources into the area to deal with the growing challenges, and spreading the risk and burden of uncompensated care has helped individual care providers while offering clients additional choice. Although in retrospect, each of these safety net initiatives has achieved a level of success, none of them would have been undertaken without vision, communication, cooperation, some measure of good fortune, and the intimate involvement of rural physicians. There are many ways physicians may impact the development of a particular program. In general, most involve some combination of advocacy of patients' interests, providing specific health or medical expertise, or serving as the arbitrator between agencies. This arbitration role often flows directly from the physician's role as patient advocate and medical expert, helping agencies set aside what can be competing interests for the common good of patients and the community. These programs also did not appear overnight. Where the region is today can be traced back to efforts that began more than 15 years ago and have progressed with one small step or success at a time.

Although program development in smaller communities can at times be more difficult due to fewer available resources, small size can also work to a community's advantage, as there may be fewer players involved, and problems, if they occur at all, may happen on a smaller scale. Personal relationships between agency representatives are often very important in any setting, but are particularly valuable in rural communities where individuals may serve multiple roles in different organizations.

Importance of Physician Leadership

Physician leadership is a critical factor in developing community programs. Physicians frequently bring unique clinical credibility to a project, knowledge and experience about health matters, access to key decision-makers in healthcare, and are granted the widest scope of practice within healthcare to establish direct patient care programs. Although outside consulting physicians can lend important advice and guidance, involving local physician leaders in health services planning is absolutely necessary for successful community health projects. A serendip-

itous effect of local physician involvement is the simultaneous nurturing of their community health leadership skills, which may be an important factor in retaining physicians in rural practice. Evidence supports that both community leadership preparation and having a sense of "belonging" to a community are determinants of whether physicians stay in or leave rural communities.⁶ Others have also found evidence that underscores the importance of a "sense of place" in rural physician retention.^{7,8} It is likely that physician involvement in these efforts, and the enthusiasm that can come from it, will be infectious and can lead to significant community health action.

Barriers to Physician Leadership: Time and Training

As important as it is for local physicians to be involved in community health leadership, time and lack of training in basic leadership skills can be significant barriers. Most physicians in rural practice have considerable patient care demands that often preclude involvement in planning activities during usual business hours. To include valuable physician input, planning groups may need to meet very early in the morning or after clinic hours, or they may need to structure meeting agendas to include physician partners in key discussions where the physicians' special perspectives are necessary and leave more administrative details to other meeting times. Group practices might be able to help cover a physician leader's clinic time so he/she can participate in an important community health project. Rural hospitals can also help fund physician time as a needed consultant to a developing program. Many rural communities have employed physicians, (e.g., those in academic, community health, or public health agencies), who have some built-in administrative time, which could be re-programmed to assist in developing community health programs. Finally, part-time or semi-retired physicians can be important sources of physician involvement in program development.

Although many physicians will be pushed into leadership roles at some level, most will have no formal instruction in management skills. Many have a limited understanding of how other disciplines, groups, or agencies impact healthcare, or they may have limited contact with other community leaders outside of healthcare. Basic tasks, such as organizing and chairing meetings, understanding general accounting practices, developing business plans, or writing grant proposals are important skills that nearly every community health project needs, but are often in short supply. It is not sufficient to recognize a health need and have an idea that could address it; ideas must be communicated to others. All stakeholders need to be included in planning and implementing a project. Most projects will require monitoring to assure that they are having the desired outcome, and any worthy project will need to be sustained.

For physicians to be effective leaders in their rural communities, there should be ways they can receive these skills either in residency training or as they find themselves in rural practice. Our Rural Track Residency Program includes an explicit curriculum in community leadership that includes a module in public health

evaluation and planning, a direct longitudinal experience providing direct patient care to an underserved population, mentorship with faculty actively engaged in community health activities, and a required hands-on community project that allows residents to put these skills to practical use. Similar curricula could be added to other residency training programs for those planning careers in rural areas.

For practicing physicians, distance learning opportunities or rural leadership training programs could be an important way those interested rural physicians could acquire the skills and contacts that could quickly enhance their ability to serve as a community health leaders. The University of North Carolina

School of Public Health runs a certificate program in Health Care Management, which is a 14-credit-hour program offered primarily on-line that is designed to give course participants basic healthcare management skills.⁹ The North Carolina Office of Research, Demonstrations, and Rural Health Development could develop a program to identify interested rural physician leaders and support their involvement in this certificate program. The Office could also create networking opportunities for rural physician leaders, who are trying to increase their communities' capacity to address local healthcare needs and develop new programs. **NCMedJ**

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