

DEANA MOLINARI
ANGELINE BUSHY

THE RURAL NURSE

TRANSITION TO PRACTICE



The Rural Nurse

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Deana L. Molinari, PhD, RN, CNE

Angeline Bushy, PhD, RN, FAAN, PHCNS-BC

Editors



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vulnerable populations throughout the world.*

CONTENTS

Contributors *xi*

Foreword Charlene A. Winters *xvii*

Foreword Jeri Dunkin *xix*

Preface *xxi*

Acknowledgments *xxv*

I FOUNDATIONS OF RURAL NURSING TRANSITION TO PRACTICE

1. The Rural Context and Nursing Practice 3
Angeline Bushy
2. Rural Nurse Transition-to-Practice Programs 23
Deana L. Molinari
3. Quality of Care and Patient Safety: The Evidence for
Transition-to-Practice Programs 35
Nancy Spector and Josephine H. Silvestre
4. Dual Relationships and Rural Nurse's Transition-to-Practice:
A Canadian Ethnographic Study 47
Kathryn H. Crooks
5. Rural Nurse Perceptions of Organizational Culture and the
Intent to Move 61
Deana L. Molinari, Ashvin R. Jaiswal, and Teri Peterson
6. Women's Health and Nursing Practice in Rural Canada 71
Beverly D. Leipert

II TRANSITION TO PRACTICE: EXEMPLAR MODELS

7. Place-Based Practice: A New Zealand Nursing Education Model 85
Jean Ross
8. Rural Nursing in the Australian Context 95
Karen Louise Francis and Elisabeth R. Jacob

9. University HealthSystem Consortium and American Association of Colleges of Nursing Nurse Residency Program **109**
Debra A. McElroy and Kathy McGuinn
10. National Council of State Boards of Nursing's Transition-to-Practice Regulatory Model **123**
Josephine H. Silvestre and Nancy Spector
11. Northwest Rural Nurse Residency **135**
Deana L. Molinari and Tamara Hollinger-Forrest
12. Vermont Nurses in Partnership Model **147**
Susan A. Boyer
13. North Carolina: Regionally Increasing Baccalaureate Nurses and Evidence-Based Transition-to-Practice Program **159**
Mary P. "Polly" Johnson, Vincent P. Hall, and Joyce W. Roth
14. Washington State: Rural Outreach Nursing Education Program **169**
Helen Hing Kuebel and Karen L. Joiner
15. Alaska Frontier: Statewide Competency Development Initiative **177**
Cynthia J. Roleff, Julie McNulty, and Jill Montague
16. New Mexico: Nurse Residence Collaborative Model **189**
Anna von Dielingen
17. The Oregon N2K Initiative: From Incumbent Worker to Nurse **197**
Gary W. Wappes
18. Rural Preceptors' Concerns with Nursing Student Evaluation **207**
Olive June Yonge, Florence Myrick, Linda Ferguson, and Quinn Grundy
- III PROGRAM DEVELOPMENT, MANAGEMENT, AND EVALUATION
19. Appreciative Inquiry: A Model for Positive Change and Innovation **227**
Kristen Crusoe
20. The Business Case for Rural Transition to Practice **235**
Linda A. Tieman
21. Conversation with a Rural Director of Nurses **247**
Nancy Asay and Deana L. Molinari

22. Professional Clinical Education Model: An Instructional Design 257
Deana L. Molinari
23. To Be or to Do? 273
Deana L. Molinari
24. Rural Distance Education Delivery and Design 293
Jayne Josephsen
25. Simulation in Nursing Continuing Education: The Wherefore's and When-to's 305
Angeline Bushy and Beverly J. Hewett
26. Program Evaluation and Outcome Measurement 323
Deana L. Molinari and Angeline Bushy
27. Specialty Topics: Genetics, Genomics, and Informatics in Rural Nursing 335
Christine F. Mladenka and Deana L. Molinari
- Appendix A: The Perceptive, Affective, Cognitive Critical Thinking Model 341*
- Appendix B: Rural Nurse Role Competencies 345*
- Index 365*

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FOREWORD

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I am pleased to have been invited by Dr. Deana Molinari and Dr. Angeline Bushy to write Foreword comments for *The Rural Nurse: Transition to Practice*. Nurses have been practicing in rural and frontier settings for centuries, yet there is still much that needs to be understood about rural nursing practice. One very important area requiring attention is the transition to practice experienced by new graduates and veteran nurses alike who are new to the rural setting.

To quote one of my favorite authors, “Being rural means being a long way from anywhere and pretty close to nowhere” (Scharff, 2010, p. 251). Few people, distance, geographic and professional isolation, and scarce health care resources are common in rural settings. Rural nurses must be expert generalists when practicing in a critical access hospital, clinic, or community setting. They must demonstrate a wide range of advanced knowledge and skills and the ability to practice proficiently and autonomously across clinical areas. During a single shift, rural hospital-based nurses often care for individuals of all ages with diverse conditions who would have been admitted to a specialty unit had they been in an urban setting. When working in community health, rural nurses often experience extreme professional and geographic isolation. A case in point is the lone community health nurse in a county covering 1,700-plus square miles with one nine-bed hospital, three nurse practitioners, and lacking the services of a physician, dentist, home health care agency, hospice, or assisted living facility (Montana County Health Profiles, 2009). To be able to move seamlessly and confidently across patient populations in rural settings with scarce resources requires an independent spirit, flexibility, creativity, constant adaptability, strong networking and communication skills, and a commitment to ongoing professional development.

Transiting to rural practice can be daunting for both experienced nurses and new graduates who have an urban orientation and are accustomed to specialized practice with abundant health care resources. Since most nursing education programs and practicing nurses are located in urban settings, programs are needed to prepare nurses who

choose rural practice. In their book, Dr. Molinari and Dr. Bushy provide excellent examples of practice models from North America, New Zealand, and Australia with curricula that address transition issues. This text makes a significant contribution to the discussion about how to best prepare nurses for rural practice and will be of interest to administrators, educators, and clinicians.

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FOREWORD

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The Institute of Medicine (IOM) and the Robert Wood Johnson Foundation released a landmark report titled *The Future of Nursing: Leading Change, Advancing Health* in October 2010 that provides a plan for improving health care in the United States. This plan calls for the remodeling of a health care system to achieve high-quality, patient-centered care through the leadership of nurses. This report posits several recommendations in support of nursing's role in remodeling the system and improving health care for all Americans. In order for nurses to be the vanguard in improving health care, we must prepare and enable them to lead change, and health care agencies must build and maintain an infrastructure that ensures opportunities for nurses to engage in lifelong learning.

This recognition of nurses' leadership skills must occur in all types of health care agencies across this country through the development of models, programs, and so on. This will present diverse challenges to the achievement of a system that is relatively low cost, flexible, and replicable in a variety of geographic and cultural settings. To achieve the rapid remodeling of the health care system called for by the IOM report, nurses must be prepared to lead these changes across the spectrum of agency types and settings across the country.

Rural America and rural residents present unique health care challenges that are both cultural and geographic in nature. This book (*The Rural Nurse: Transition to Practice*) presents several models that have been used successfully in rural areas that demonstrate the infrastructure and opportunities for rural nurses to meet the unique challenges of rural America. Both those just beginning their career and those changing the focus of their practice will benefit from the examples of ensuring quality in an improved health care system.

The editors of this book are to be commended for their efforts to assemble basic concepts relative to the transitions in educational and nursing practice that must occur in order to effect nurses' knowledge growth. The presentation of successful rural program examples demonstrates the creativity needed to provide safe quality practice.

PREFACE

This book focuses on national and international nurses' transition to practice and continuing education in rural settings. Medicine, economics and society are changing. The nursing profession is also changing, resulting in modifications in nursing education and practice support strategies. Consequently, nurses are encouraged to obtain knowledge through professional development programs as well as with advanced academic degrees (IOM, 2010). The purpose of the text is to provide conceptual and practical information that can be used by nurses and leaders in rural settings to develop, implement, and evaluate innovative programs designed to meet local needs and preferences.

The importance of new graduates, initial work experiences and their retention in the profession cannot be overstated. Both novice nurses and expert nurses who transfer into a new specialty area of practice adopt their leaders' attitudes about ongoing professional development. Administrators and clinical educators in a health care facility set the tone for employees with respect to development of a competent caregiver. In other words, nurses need support to develop and maintain professionalism and lifelong learning.

Recent nurse graduates usually believe the career they have chosen to be important, complex, and exciting. Those in leadership roles may inadvertently squelch an individual's motivation for self-improvement. Nourishing passion and competence requires attention to organizational and peer support and education content.

Program outcomes depend on leaders' values and the fit with an institutional culture. The rural nursing "specialty" meets the needs of rural communities. Most nursing leaders have not been exposed to rural health information or culture, and are not familiar with the nuances of rural practice. Thus, successful urban models lacking essential cultural components can be "transplanted" in small facilities or communities. Likewise, the act of creating something new is not necessarily the act of creating something successful, especially if the approach does not fit the local culture.

Historically, new rural nurses learned "to survive" in spite of what their leaders believed or did. Consequently, horizontal violence among

employees coupled with the lack of administrative support challenged the novice to endure in a particular workplace. Supportive evidence proves that ignoring the learning and professional development needs of new employees contributes to high employee turnover, as well as impacting on the quality of care that is provided for patients. Motivated leaders can address these professional challenges with creativity, passion, and evidence-based principles. Thus, there is a need for information from experts about successful nurse transition-to-practice (TTP) models to guide future leaders in supporting and motivating employees, and thereby improving retention rates and addressing the quality of rendered care.

The text compiles the insights and experience of early transition-to-practice program adopters for the benefit of others who realize the importance of not needing to reinvent the wheel. By using principles of quality and safety, rural-based nurse administrators can improve on the work of the text contributors and increase patient care quality and thus the nursing profession. Rural nursing as a specialty area of practice emphasizes identification and efficient use of scarce resources, collaborative interprofessional relationships, autonomy, and accountability. These characteristics also are the core of successful TTP programs. The book includes chapters that describe both small and larger complex programs. Most involve partnerships that were supported by national and state governments, private enterprises, professional organizations, advocacy groups, health care facilities, or academic institutions.

Learning theories and educational principles such as learning through interactive experiences, building on existing knowledge, and measuring competence are noted throughout the book. Strategies for changing education and rural nursing practice are described. Creative approaches from national as well as international experts demonstrate that there is more than one way to increasing nurse knowledge, skills, or attitude. However, there are several common elements among the models presented that address the rural context among others, identifying a specific TTP need, asking why there is a status quo, and dreaming of more successful strategies are common themes. Program creators tend to first examine patients' and organizational needs and then proceed to develop and refine programs to address those priorities. This form of program development begins with the end in mind. Outcomes are delineated; goals and objectives are identified and strategies are refined that take into consideration system strength and resources. In determining effectiveness, cost and benefit analyses are undertaken,

and findings are disseminated to target audiences. In other words, nurses apply a nursing process in an effort to design a program that nurtures and supports nurses, and can ultimately improve the patient quality of care. The book provides the rationale for transition-to-practice, recent research about rural nursing, examples of TTP, and suggestions for creating and maintaining programs. The authors of the various chapters present studies describing novice and expert rural nurses. Others highlight educational challenges and continuing education requirements for successful rural practice and workforce retention. The book features new-employee needs and offers insights into the practice and development of rural nurse generalists. This information can be useful to students, nurse educators, researchers, scholars, clinicians, administrators, and policy developers. Professional organizations such as the Rural Nurse Organization, academic and clinical educators, and researchers are poised to advocate for nurses in rural health care. Each of these entities is in a position to disseminate relevant evidence, as well as promote nursing standards and competencies.

In even the smallest community, a health care institution can become a center for excellence by nourishing its nurses. History provides examples of outcomes associated with doing little for the profession, as evidenced by an expectation that new nurses will learn naturally with time. Some refer to this as the “sink or swim” mentality for retaining survivors. Novice nurses are dared to succeed by learning the “hard way” what it is they need to know for practice and then by seeking out their own learning resources. This costly approach to nursing education leads to a high turnover rate among new employees. Agencies struggle to recruit and retain new nurses, and yet without changing transition-to-practice strategies, few agencies develop the loyalty needed for retention.

The need for overcoming the rural nurse shortage through improved recruitment and retention strategies is another theme running through the text. Several chapters address issues such as the global nurse shortage, turnover, job satisfaction, and personal practice perceptions. Research and program development reforms impact on administrators’ interviewing and new-employee support strategies (Allen, Fiorini, & Dickey, 2010). Most rural administrators support residencies for two reasons: Retention and patient care (Holloway, Baker, & Lumby, 2009). The chapters indicate administrators need to do more than develop good reasons to create successful nursing organizations. Research indicates transition-to-practice requires administrators to create supportive staff cultures, design education delivery

methods, provide preceptor and resident support, reserve participation time, and recognize educational accomplishments. Authors posit administrators' leadership impacts job satisfaction, personal practice perceptions, and patient safety (Baernholdt, Jennings, Merwin, & Thornlow, 2010; Molinari & Monserud, 2008; Wieck, Dols, & Landrum, 2010). Although the transition-to-practice challenge is colossal, the cost of ignoring new nurses is greater. Rural nurses can serve communities by collaborating on new TTP programming. Future rural nurse leaders will change the profession by producing new models of nurse support based on disseminated best practices.

Usually publishing a text indicates a culmination of topic knowledge. This book's purpose is to call rural nurses to the transition-to-practice debate, to encourage future studies, and to disseminate findings from dedicated rural nurses around the world. Experiment with the innovations described in the text, and share findings in professional venues. The future of rural nursing is in our focus—the care for rural populations is in our hands.

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A textbook requires the dedication and innovation of many people. We are deeply grateful to contributors for their rural nurse research and program development. Rural nurses' scholarly work improves health care. This text would be impossible without their daily efforts.

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I

Foundations of Rural Nursing Transition to Practice

The information in Section One presents an overview of nursing practice and its rural context. The first chapter by Bushy highlights characteristics of life in a small community where most people are familiar with one another. Rural is defined and features of rural nursing practice are examined. Chapter two, by Molinari, discusses current trends and the benefits and challenges of implementing new employee support programs. This is followed with a chapter by Spector and Silvestre who review evidence for the need to transition new graduates into competent and safe nurses.

Crooks offers an international perspective by presenting findings from a Canadian qualitative study exploring the phenomenon of dual interconnecting relationships in a small rural community. Another study by Molinari, Jaiswal and Peterson discusses nurses' perceptions of rural organizational cultures and the intent to leave. Since nursing is a predominately female profession, research focusing on women may provide insights about nurses and nursing practice. The section concludes with a chapter by Leipert examining the meaning of being both female and a nurse in a rural context.

1

The Rural Context and Nursing Practice

Angeline Bushy

Although nursing is probably similar across settings and populations, there are some unusual features associated with practice in a geographically remote area and small towns where most people are familiar with one another. This chapter establishes a foundation for the information provided in this textbook; beginning an historic overview of “formal” rural nursing; followed by common definitions for rural. An overview of rural populations’ health status is presented along with barriers experienced in obtaining a continuum of health care services. Given the rural context and the health status of people who live there, nursing practice issues are examined that should be addressed in rural nurse transition-to-practice programs.

— Bigbee & Crowder, 1985; Bushy, 2011

HISTORICAL PERSPECTIVES

Formal rural nursing originated with the Red Cross Rural Nursing Service, which was organized in November 1912. The Committee on Rural Nursing was under the direction of Mabel Boardman (chair), Jane Delano (vice-chair), and Annie Goodrich along with other Red Cross leaders and philanthropists (Bigbee & Crowder, 1985). Before the formation of the Red Cross Rural Nursing Service, care of the sick in a small community was provided by informal social support systems. When self-care and family care were not effective in bringing about healing, this task was assigned to healers, who often were women who lived in the local community. Historically, the health needs of rural Americans have been numerous, and although not necessarily unique, they are different from those of urban populations. Consistent problems of maldistribution of health professionals, poverty, limited access to services, ignorance, and social isolation have plagued

some rural communities for generations. Overtime, the Red Cross Rural Nursing Service shows a consistent movement away from its initial rural focus, as demonstrated by its frequent name changes. Unfortunately, concern for rural health is similarly often temporary and replaced by other areas of greater need.

Defining Rural

Everyone has an idea as to what constitutes rural as opposed to urban residence. However, the two cannot be viewed as opposing entities. Moreover, with the increased degree of urban influence on rural communities, the differences are no longer as distinct as they may have been even a decade ago (Bureau of the Census Bureau, 2009; Gamm et al., 2003; U.S. Department of Agriculture [USDA], 2005, 2006, 2008a, 2008b). In general, rural is defined in terms of the geographic location and population density, or it may be described in terms of the distance from (e.g., 20 miles) or the time (e.g., 30 min) needed to commute to an urban center.

Both urban and rural communities are highly diverse and vary in terms of their demographic, environmental, economic, and social characteristics. In turn, these characteristics influence the magnitude and types of health problems that communities face. Urban counties, however, tend to have a greater supply of health care providers in relation to population, and residents of more rural counties often live farther from health care resources (CDC, 2010; Cromartie, 2008; Mead et al., 2008).

Some equate “rural” with farm residency and urban with nonfarm residency while others consider rural to be a “state of mind.” For the more affluent, rural may bring to mind a recreational, retirement, or resort community located in the mountains or in lake country, where one can relax and participate in outdoor activities such as skiing, fishing, hiking, or hunting. For the less affluent, the term can impose grim scenes. For example, some people may think of an impoverished Indian reservation as comparable to an underdeveloped country, or it may bring to mind images of a migrant labor camp with several families living in a one-room shanty with no access to safe drinking water or adequate sanitation. Just as each city has its own unique features, it is also difficult to describe a “typical rural town” because of the wide population and geographic diversity. Furthermore, there can be vast differences between rural areas within one state. Still, descriptions and definitions for rural tend to be more subjective and relative in nature than those for urban. For example, “small” communities with populations of more than 20,000 have some features that one may

expect to find in a city. Then again, residents who live in a community with a population of less than 2,000 may consider a community with a population of 5,000 or 10,000 to be a city. Although some communities may seem geographically remote on a map, the residents who live there may not feel isolated. Those residents believe they are within easy reach of services through telecommunication and dependable transportation; although extensive shopping facilities may be 50–100 miles from the family home, and obstetric care may be 150 miles away.

Often-used definitions to describe rural and urban are offered by several federal agencies. The definitions, which in many cases are dichotomous in nature, fail to take into account the relative nature of ruralness. Rural and urban residencies are not opposing lifestyles. Rather, they must be seen as a rural–urban continuum ranging from living on a remote farm, to a village or small town, to a larger town or city, to a large metropolitan area (Exhibit 1.1).

Several federal agencies classify counties according to population density, specifically, metropolitan area (1,090 U.S. counties), micropolitan area (674 U.S. counties), and noncore area (1,378 U.S. counties) (USDA, 2006). The terms metropolitan and micropolitan statistical

EXHIBIT 1.1 Terms and definitions

Farm residency: Residency outside area zoned as “city limits”; usually infers involvement in agriculture

Frontier: Regions having fewer than six persons per square mile

Large central: Counties in large (1 million or more population) metro areas that contain all or part of the largest central city

Large fringe: Remaining counties in large (1 million or more population) metro areas

Metropolitan county: Regions with a central city of at least 50,000 residents

Nonfarm residency: Residence within area zoned as “city limits”

Micropolitan county: Counties that do not meet SMSA criteria

Rural: Communities having less than 20,000 residents or fewer than 99 persons per square mile

Small: Counties in metro areas with less than 1 million people

Suburban: Area adjacent to a highly populated city

Urban: Geographic areas described as nonrural and having a higher population density; more than 99 persons per square mile; cities contain an urban core of at least 10,000 (but less than 50,000) population

areas (metro and micro areas) refers to geographic entities primarily used for collecting, tabulating, and publishing Federal statistics. Core-Based Statistical Area (CBSA) is a collective term for both metro and micro areas. A metro area contains a core urban area of 50,000 or more population. A micro area contains an urban core of at least 10,000 (but less than 50,000) population. Each metro or micro area consists of one or more counties containing the core urban area. Likewise, adjacent counties have a high degree of social and economic integration (as measured by commuting to work) with their urban core (Cromartie, 2008). Demographically, micro areas contain about 60% of the total nonmetro population. According to Bureau of the Census estimates (2009) about 25% of all U.S. residents live in rural settings.

In general, lack of an urban core and low overall population density may place these counties at a disadvantage in efforts to expand and diversify their economic base. The designation of micro areas is an important step in recognizing nonmetro diversity. The term also provides a framework to understand population growth and economic restructuring in small towns and cities that have received less attention than metro areas. Nationally and regionally, many measures of health, health care use, and health care resources among rural populations vary by the level of urban influence in a particular region. Micro areas embody a widely shared residential preference for a small-town lifestyle—an ideal compromise between large highly populated urban cities and sparsely populated rural settings.

Population Characteristics

Adding to the confusion about what constitutes rural versus urban residency are the special needs of the numerous underrepresented groups (minorities, subgroups) who reside in the United States. In general, there are a higher proportion of whites in rural areas than in urban areas. There are, however, regional variations, and some rural counties have a significant number of minorities. Little is documented on the needs and health status of special rural populations (Meade et al., 2008; USDHHS, 2010b, 2010c). Anthropologists are quick to report that, within a group, there often exists a wide range of lifestyles. Consequently, even in the smallest or most remote town or village, a subgroup may behave differently and have different values regarding health, illness, and patterns of accessing health care. Also, their lifestyle may be associated with health problems that are different from those of the predominant cultural group in a given community.

Demographically, rural communities include a higher proportion of younger and older residents. Consequently, a nurse who works in a

rural health care facility can expect to encounter more residents under the age of 18 and over 65 years of age. Rural residents 18 years of age and older are more likely to be, or to have been, married than urban counterparts. As a group, rural adults are more likely to be widowed and have fewer years of formal education than do urban adults (Cromartie, 2008; USDA, 2008a, 2008b).

Although there are regional variations, rural families in general tend to be poorer than their urban counterparts. Comparing annual incomes with the standardized index established, more than one fourth of rural Americans live in or near poverty and nearly 40% of all rural children are impoverished (Gamm et al., 2003; Rand Corporation, 2010a, 2010b). Consequently, rural families are less likely to have private insurance and more likely to have public assistance or to be uninsured. Working poor in rural areas are particularly at risk for being underinsured or uninsured. In working poor families, one or more of the adults are employed but still cannot afford private health insurance. Furthermore, their annual income is such that it disqualifies the family from obtaining public insurance. A number of reasons are cited to explain why this phenomenon occurs more often in rural settings.

For example, a high proportion of residents are self-employed in a family business, such as ranching or farming, or they work in small enterprises, such as a service station, restaurant, or grocery store. Also, an individual may be employed in part-time or in seasonal occupations, such as farm laborer and construction, in which health insurance often is not an employee benefit. In other situations, a family member may have a preexisting health condition that makes the cost of insurance prohibitive, if it is even available to them. A few rural families fall through the cracks and are unable to access any type of public assistance because of other deterrents, such as language barriers, compromised physical status, the geographic location of an agency, lack of transportation, or undocumented-worker status. Insurance, or the lack of it, has serious implications for the overall health status of rural residents and the nurses who provide services to them (Agency for Health Care Policy and Research [AHCPR], 2009; Bennett, Olatosi, & Probst, 2008; Nelson & Stover-Gingerich, 2010; USDHHS, 2010c).

Health Status of Rural Residents

Even though rural communities constitute about one-fourth of the total population, the health problems and the health behaviors of the residents in them are not fully understood. Based on data from national health surveys, the overall health status of rural adults leaves much to

be desired. This is attributed to a number of factors, including impaired access to health care providers and services, coupled with other rural factors. Thus, nurses in rural practice settings have an important role in coordinating a continuum of care to clients living in these underserved areas (Nelson et al., 2009). (Exhibit 1.2).

When the use of health care services is measured, the evidence shows that more than three-fourths of adults in rural areas received medical care on at least one occasion during a year. Despite their overall poorer health status and higher incidence of chronic health conditions, rural adults seek medical care less often than urban adults. In part, this discrepancy can be attributed to scarce resources and lack of providers in rural areas. Also, recruiting and retaining qualified health professionals in general and nurses in particular can be a challenge in rural communities, especially in more sparsely populated regions (AHCPR, 2009; BHPR, 2007; Cromartie, 2008; IOM, 2004; NACRHHS, 2008).

The ability of a person to identify a usual source of care is considered a favorable indicator of access to health care and a person's overall health status. Essentially, a person who has a usual source of care is more likely to seek care when ill and adhere to prescribed regimens. Having the same provider of care can enhance continuity of care, as well as a client's perceived perception of the quality of that

EXHIBIT 1.2 Characteristics of rural life

- More space; greater distances between residents and services
- Cyclic/seasonal work and leisure activities
- Informal social and professional interactions
- Access to extended kinship systems
- Residents who are related or acquainted
- Lack of anonymity
- Challenges in maintaining confidentiality stemming from familiarity among residents
- Small (often family) enterprises; fewer large industries
- Economic orientation to land and nature with industries that are extractive in nature (e.g., agriculture, mining, lumbering, marine-related, outdoor recreational activities)
- More high-risk occupations
- Town as the center of trade
- Churches and schools as socialization centers
- Preference for interacting with locals (insiders)
- Mistrust of newcomers to the community (outsiders)

care. Rural adults are more likely than urban adults to identify a particular medical provider as their usual source of care. As for the type of provider who delivers the care, general practitioners and advanced practice registered nurses (APRNs) increasingly are seen by rural adults, whereas urban adults are more likely to seek care from a medical specialist. However, this trend may be changing with health care reform, which emphasizes the importance of primary care (Bureau of Health Professions [BHRP], 2007, 2009; USDHHS, 2010a, 2010c).

Another measure of access to care is traveling time and/or distance to ambulatory care services. Rural persons who seek ambulatory care are more likely to travel more than 30 minutes to reach their usual source of care. Extended commuting time may also be a factor for residents in highly populated urban areas and those who must rely on public transportation. On arriving at the clinic or physician's office, however, no differences between rural and urban residents have been found in the waiting time to see the provider.

Measures of usual place and usual provider suggest that rural residents are at least as well-off as urban residents with regard to access to care (Woolston, 2010). However, caution must be used when making this generalization, because one out of 17 rural counties is reported to have no physician. Among rural respondents on national surveys, the ability to identify a usual site of care or a particular provider often stems from a community or county having only one or two physicians or nurse practitioners (Gamm et al., 2003; IOM, 2004). This finding may be attributable to the reality that it is not unusual for a rural health professional to live and practice in a particular community for decades.

Moreover, in a health professional shortage area (HPSA), a physician, a nurse practitioner, or a nurse often provides services to residents who live in several counties. Consequently, rural physicians and nurses frequently report, "I provide care to individuals and families with all kinds of conditions, in all stages of life, and across several generations" (J. A. Yost, personal communication); thus, it is no surprise that rural respondents who participate in national surveys are able to identify a usual source and a usual provider of health care (BHPR, 2009; NCHS, 2010).

Essentially, one cannot generalize about the health status of rural Americans associated with the diversity coupled with conflicting definitions of what differentiates rural from urban residences. Many vulnerable individuals and families live in rural communities across the United States, but little is known about most of them. This information deficit therefore is a potential area of research for nurses who practice in rural environments.

Barriers to Health Care

Although each rural community is unique, the experience of living in a rural area has several common characteristics (AHCPR, 2009; Bushy, 2008; USDA, 2008a, 2008b). Barriers to health care may include whether or not services and professionals are available, affordable, accessible, or acceptable to the rural consumer (Exhibit 1.3).

Availability implies the existence of health services as well as the necessary personnel to provide essential services. Sparseness of population limits the number and array of health care services in a given geographic region. Lacking a critical mass, the cost of providing special services to a few people often is prohibitive, particularly in frontier states where there are an insufficient number of physicians, nurses, and other types of health care providers. Consequently, where services and personnel are scarce, these must be wisely allocated. Accessibility implies that a person has logistical access to, as well as the ability to purchase, needed services. Affordability is associated with both availability and accessibility of care. It infers that services are of reasonable cost and that a family has sufficient resources to purchase these when needed. Acceptability of care means that a particular service is appropriate and offered in a manner that is congruent with the values of a target population, and unhampered by a client's cultural preference or the urban orientation of health professions (NACRHHS, 2008).

EXHIBIT 1.3 Barriers to health care in rural areas

- Lack of health care providers and services
- Great distances to obtain services
- Lack of personal transportation
- Unavailable public transportation
- Lack of telephone services
- Unavailable outreach services
- Inequitable reimbursement policies for providers
- Unpredictable weather and/or travel conditions
- Inability to pay for care/lack of health insurance
- Lack of "know-how" to procure publicly funded entitlements and services
- Inadequate provider attitudes and understanding about rural populations
- Language barriers (caregivers not linguistically competent)
- Care and services not culturally and linguistically appropriate

The past decade has seen the closure of many small hospitals over two decades. Of those that remain, many report financial problems that could lead to closure (NACRHHS, 2008; USDA, 2006). A shortage or the absence of even one provider, most often a physician or nurse, could mean that a small hospital must close its doors. Closure of the hospital has a ripple effect on the health of local residents, other health care services, and recruiting and retaining health professionals, as well as on economic development efforts in a small community (USDA, 2008a, 2008b).

Likewise, health care providers', in particular nurses', attitudes, insights, and knowledge about rural populations also are important. A patronizing or demeaning attitude, lack of accurate knowledge about rural populations, or insensitivity about the rural lifestyle on the part of a nurse can perpetuate difficulties in relating to those clients. Moreover, insensitivity perpetuates mistrust, resulting in rural clients' perceiving professionals as outsiders to the community. Some nurses in rural practice settings express feelings of professional isolation and community nonacceptance. To address disparate views, nursing faculty members should expose students to the rural environment and the people who live there. Clinical experiences must include opportunities to provide care to clients in their natural (e.g., rural) setting to gain accurate insight about a particular community and the local health care facilities.

Nursing Theory, Research, and Practice

Over the past two decades, the body of literature about nursing practice in small towns and rural environments has grown, and several themes have been noted (Exhibit 1.4).

The work of researchers from the University of Montana is widely accepted. They contend that existing theories do not fully explain rural nursing practice (Long & Weinert, 1989; Winters & Lee, 2009) (Exhibit 1.5).

Montana researchers examined the four concepts pertinent to a nursing theory (health, person, environment, and nursing/caring) and proposed relational statements that are relevant to clients and nurses in rural environments. Since the focus of their research was populations living in the Rocky Mountain area, care must be taken about generalizing those findings to other geographic regions and minorities. They propose that rural residents often judge their health by their ability to work. They consider themselves healthy, even though they may suffer from several chronic illnesses, as long as they are able to continue working. For them, being healthy is the ability to be productive.

EXHIBIT 1.4 Characteristics of nursing practice in rural environments

- Variety/diversity in clinical experiences
- Broader/expanding scope of practice
- Generalist skills with specialty knowledge of crises assessment and management across disciplines/specialties
- Flexibility/creativity in delivering care
- Sparse resources (e.g., materials, professionals, equipment, fiscal)
- Professional/personal isolation
- Greater independence/autonomy
- Role overlap with other disciplines
- Slower pace
- Lack of anonymity
- Increased opportunity for informal interactions with clients/coworkers
- Opportunity for client follow-up on discharge in informal community settings
- Discharge planning allowing for integration of formal and informal resources
- Care for clients across the lifespan
- Exposure to clients with a full range of conditions/diagnoses
- Status in the community (viewed as prestigious)
- Viewed as a professional role model
- Opportunity for community involvement and informal health education

Source: Bushy (2008), Hurme (2009), Nelson (2009), and Winters and Lee (2010).

Chronically ill people emphasize emotional and spiritual well-being rather than physical wellness.

Distance, isolation, and sparse resources characterize rural life and are seen in residents' independent and innovative coping strategies. Self-reliance and independence are demonstrated through their self-care practices and preference for family and community support. Community networks provide support but still allow for each person's and family's independence. Ruralites prefer and usually seek help through their informal networks, such as neighbors, extended family, church, and civic clubs, rather than seeking a professional's care in the formal system of health care, including services such as those provided by a mental health clinic, social service agency, or

EXHIBIT 1.5 Emerging conceptual framework for rural nursing

Nurse researchers at Montana State University proposed the following theoretical concepts and dimensions of rural nursing (Long & Weinert, 1999; Winters & Lee, 2010):

- **Health:** Defined by rural residents as the ability to work. Work and health beliefs are closely related.
- **Environment:** Distance and isolation are particularly important for rural dwellers. Those who live long distances from health care providers neither perceive themselves as isolated nor perceive health care services as inaccessible. Often there is suspicion of outsiders and “government” authorities who the community perceives as historically providing short-term resources without an understanding of the rural way of life.
- **Nursing:** Lack of anonymity, outsider versus insider, old-timer versus newcomer. Lack of anonymity is a common theme among rural nurses who report knowing most people for whom they care, not only in the nurse–client relationship but also in a variety of social roles, such as family member, friend, or neighbor. Acceptance as a health care provider in the community is closely linked to the outsider/insider and newcomer/old-timer phenomena. Gaining trust and acceptance of local people is identified as a unique challenge that must be successfully negotiated by nurses before they can begin to function as effective health care providers. Nurses often feel increased accountability for friends and neighbors.
- **Person:** Self-reliance and independence in relationship to health care are strong characteristics of rural individuals. They prefer to have people they know care for them (informal services) as opposed to an outsider in a formal agency.

health department. Although nursing is generally similar across settings and populations, there are some unique features associated with practice in a geographically remote area or in small towns where most people are familiar with one another. The next few paragraphs highlight a few of the variations that nurses in rural practice report (Hurme, 2009; Molinari & Monserud, 2008; Nelson, 2009; Skillman, Palazzo, Hart, & Butterfield, 2007).

A nurse’s professional and personal boundaries often overlap and are diffuse. It is not unusual for a nurse to have more than one work-related role in the community. For example, a nurse may work at the

local hospital or in a physician's office and may also be actively involved in managing the family farm, a local grocery store, or the pharmacy. For nurses, this means that many patients they encounter are personally known as neighbors, as friends of an immediate family member, or perhaps as part of one's extended family. Associated with social informality is a corresponding lack of anonymity in a small town. Some rural nurses say, "I never really feel like I am off duty because everybody in the county knows me through my work" (L. King, personal communication). In part, this report can be attributed to nurses being highly esteemed in their community and viewed by local people as experts on health and illness. It is not unusual for residents to informally ask a nurse's advice before seeing a physician for a health problem. Moreover, health-related questions are asked by residents when they encounter a local nurse in a grocery store, at a service station, during a basketball game, or at church functions.

Nurses in rural practice must make decisions about the care of individuals of all ages and with a variety of health conditions. They assume many roles because of the range of services that must be provided in a rural health care facility, given the scarcity of nursing and other health professionals. Stemming from rural residents' expectations of the health care delivery system, need to display nurses in rural practice technical and clinical competency, self-confidence, leadership, adaptability, flexibility, sound decision making, and interest in continuing education, together with skills in handling emergencies, teaching, and public relations. The nurse administrator, too, may be expected to be a jack-of-all-trades (i.e., a generalist) and to demonstrate competence in several clinical specialties in addition to managing and organizing staff within the facility for which he or she is responsible. Administrators often perform patient care in addition to their leadership and management responsibilities.

There are challenges, opportunities, and rewards in rural nursing practice. The manner in which each factor is perceived depends on individual preferences and the situation in a given community. Challenges of rural practice sometimes are listed as professional isolation, limited opportunities for continuing education, lack of other kinds of health personnel or professionals with whom one can interact, heavy workloads, an ability to function well in several clinical areas, lack of anonymity, and, for some, a restricted social life (Nelson, 2009; Roberge, 2009).

Of the many opportunities and rewards in rural nursing practice, those most commonly cited include close relationships with clients and coworkers, diverse clinical experiences that evolve from caring for clients of all ages who have a variety of health problems, caring

for clients for long periods of time (in some cases, across several generations), opportunities for professional development, and greater autonomy. Many nurses value the solitude and quality of life found in a rural community, both personally and for their families. Others thrive on the outdoor recreational activities. Still others thoroughly enjoy the informal, face-to-face interactions coupled with the public recognition and status associated with living and working as a nurse in a small community.

Nursing in the Community

Although most of the publications about rural health care and nursing focus on hospital practice, much of that information is applicable to both community-oriented agencies and community-focused nursing (Davis & Drees, 1993; Molinari & Monserud, 2008; Skillman et al., 2007). The work-related stressors of community-focused nursing have received some attention in the literature. Early on, Case (1991) identified stressful experiences of nurses working in rural Oklahoma health departments including the following: political or bureaucratic problems, and inter-professional collaborations and interpersonal conflicts associated with inadequate communication; unsatisfactory work environment and understaffing; difficult or unpleasant nurse–client encounters, such as with relatives who refuse to deliver needed care to clients, and with clients who are hostile, apathetic, dependent, or of low intelligence; fear for personal safety; difficulty locating clients, and clients falling through the cracks of the health care system. (Decades later, similar stressors are cited by nurses who work in urban as well as rural public health agencies.) Anecdotal reports describe specific stressors associated with geographic distance, isolation, sparse resources, and other environmental factors that characterize rurality. Nursing in rural practice settings is characterized by physical isolation that may lend itself to any one of the following: professional isolation; scarce financial, human, and health care resources; and a broad scope of practice.

Anecdotally, this author has heard reports from nurses describing the lack of civility among nurses and other staff members in small health care facilities. Such behaviors may be related to low staff numbers who are employed in the facility who have day-to-day encounters. Sometimes the interpersonal conflicts that exist in the hospital or long-term care facility become common knowledge among community residents, and the targeted individuals are unable to “get away from it.” Subsequently, the individuals may leave the facility or the community, and sometimes the profession. This dimension of

retention of nurses in rural settings needs further study to identify risk factors and potential interventions to prevent the described outcomes (K. L., L. U., S. S. et al., personal communication).

Associated with personal familiarity with local residents, nurses often possess in-depth knowledge about clients and their families. Along with the acknowledged benefits, informal (face-to-face) interactions can significantly reduce a nurse's anonymity in the community and at times be a barrier to completing an objective assessment on a client. Like urban practice, rural community nursing takes place in a variety of locations, including homes, clinics, schools, occupational settings, and correctional facilities, and at community events such as county fairs, rodeos, civic and church-sponsored functions, and school athletic events.

Nursing Practice

Nurses in rural practice must have broad knowledge about nursing theory. Topics important in this practice environment include health promotion, primary prevention, rehabilitation, obstetrics, medical-surgical specialties, pediatrics, planning and implementing community assessments, and understanding the public health risks and needs for emergency preparedness in a particular state. A community's demographic profile and its principal industry(ies) can provide a snapshot of some of its social, political, and health risks. From this kind of information, a nurse can anticipate the particular nursing skills that will be needed to care for clients in a catchment area (U.S.A. Center for Rural Health Preparedness, n.d.).

Refer to Exhibit 1.6 for the health-related priorities for rural communities.

EXHIBIT 1.6 Health service priorities of rural communities

- Access to care
- Cancer (screening, early intervention, oncology services)
- Diabetes (prevention, screening, tertiary care)
- Maternal/Infant and children services
- Mental Illness and behavioral health services
- Nutrition/obesity
- Drugs, Alcohol, and Substance abuse
- Use of tobacco products
- Education and an array of community-based programs

Public health infrastructures
Immunizations and infectious diseases
Injury and violence prevention
Family planning
Environmental and occupational health
Emergency medical services infrastructures
Long-term care/assistive living facilities
Other—that will vary by community based on predominate industry(ies) and age cohorts

Source: Bennett et al. (2008) and Gamm et al. (2003).

Nursing Research

Empirical data about rural family systems are sparse in terms of their health beliefs, values, perceptions of illness, and health care-seeking behaviors, as well as what is deemed to be appropriate nursing care. Therefore, nurse scholars must assume a more active role in implementing research on the needs of rural populations for nursing services to expand the profession's theoretical base and subsequently implement community-sensitive, evidence-based clinical interventions (Bushy, 2009; Graves, 2009; Merwin, 2008). Specific research topics that are of importance to nursing practice in rural environments include the following, among others.

- Most nurses indicate that they enjoy practicing in rural areas and are proud of what they do. They believe, however, that their work deserves more recognition by professional nursing organizations. Furthermore, the retention rate of nurses in some practice settings is poor. The perspective of nurses who are dissatisfied with rural nursing is necessary to provide a more complete picture of the rural experience. This information can be useful to a variety of people: Other nurses who are considering rural practice; nurse managers in need of better screening tools to assess the fit between the nurse and the environment when interviewing applicants; planners of continuing nursing education programs; and faculty members who teach undergraduate and graduate students.
- More information is needed about the stressors and rewards of rural practice. These data could lead to the development of stress management techniques to be used by nurses and their supervisors to retain nurses and improve the quality of their workplace environment.

- With the increasing number of rural residents in all regions of the United States, empirical data are needed on the particular nursing needs of rural–client systems, especially underrepresented groups, minorities, and other at-risk populations that vary by region and state.
- There also is a need for the international perspective on the health of rural populations, and on nursing practice within the rural community. Nurse scholars from Australian, New Zealand, and Canada have provided some insights into rural practice in these nations. Information is needed from less-industrialized nations as well as from those that are highly industrialized.
- Technology increasingly is used in health care and seems to hold great potential in improving access to health care in rural and underserved areas. However, research is needed to determine the most efficient and effective way to meet the needs and preferences of rural clients, and to assure quality.
- Communication technology increasingly is used by institutions of higher learning to deliver educational programs to nurses who live and work some distance from campus. Empirical studies are needed to measure the most effective modalities to achieve desired learning outcomes and the impact on recruitment and retention of nurses in rural settings.
- Rural–urban disparities in health status and health behaviors need closer examination from the nursing perspective. Evidence-based practice nursing guidelines are needed that take into consideration the rural context and preferences of residents who obtain health care in these settings.

In summary, preparing nurses to practice in rural environments demands creative and innovative nursing educational opportunities, such as nurse transition to practice and extended residency programs. Communication technology and the internet hold great potential to link nurses in rural practice with nurse educators and researchers in urban-based academic settings. Collaboration and partnerships must be established to design and implement innovative learning experiences that include educators, rural nurses, and administrators of health care facilities in rural settings. To meet the demands and expectations of practice in that setting, nursing faculty members must expose students to the rural environment, facilitate the development and appreciation of generalist skills, and enhance the ability to function in several roles—that is, as expert generalists. The short supply and increasing demand for primary care providers in general, and nurses in particular, will continue for some time. In an effort to effectively

respond to this opportunity, nurses must be creative to ensure delivery of appropriate and acceptable services to at-risk and vulnerable populations who live in rural and underserved regions. Nurses must be sensitive to the health beliefs of clients, and then plan and provide nursing interventions that mesh with the community's cultural values and preferences.

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