

OREGON'S ECONOMIC CRISIS AND THE NATIONAL NURSING SHORTAGE: A TRANSFORMATIONAL OPPORTUNITY FOR RURAL AREAS

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ABSTRACT

Oregon's drastic budget cuts and the national nursing shortage pose severe barriers for consumers and providers of human services and health care in rural areas. Because of the unique culture, demographics and a deficit of human service and health care providers, metropolitan based decision and policy making aimed at improving human service and health care delivery, may actually cause harm in rural areas. This time of crisis must be viewed as a transformational opportunity for nurses. Creative alternatives must be explored to decrease the higher rates of human service and health-related disparities for individuals, families, and communities in rural areas compared to those in metropolitan areas. In addition, nurses must invest in furthering the development of the field of nursing to reverse the nursing shortage and prevent shortages in the future. This paper will explore the effect of Oregon's economic crisis and the national nursing shortage on human service and healthcare delivery and economic development in rural areas. In addition, the effects of the unique culture of rural areas and metropolitan-based decision and policy making on recruitment and retention of nurses in rural areas will be explored. Finally, solutions will be explored to reverse the nursing shortage, prevent future nursing shortages and further the field of nursing.

ECONOMIC CRISIS

Oregon is in a severe economic crisis. Unemployment rates are at an all-time high, college tuition and fees are increasing while faculty and programs are being cut, and healthcare costs are forcing revisions in the quality and quantity of services available.

The Oregon Center for Public Policy revealed, in an analysis of census data for 1998 to 2000, that 7.2 percent of rural Oregonians live in homes with hunger compared to Oregon's overall hunger rate of 6.2 percent. Oregon's rural counties had an unemployment rate that exceeds national rural areas and the rate of employment fluctuates more. On the Oregon coast, after adjusting for inflation, in 2000 the earnings were 19 percent lower than they were in 1979 (Leachman, 2002).

Cuts to the Oregon University System are reducing, and in some cases, eliminating technical and human service education programs, exacerbating the economic crisis in the long run. Restructuring the delivery and implementation of state funding (e.g., Oregon Health Plan, Oregon Medical Assistance Program, Department of Human Services) for human services and health care, while increasing the number of individuals eligible to receive services, actually reduces the amount of coverage for each individual. More individuals and families will have coverage; however, the necessary human services and health care may not be covered. Further, consolidating services and

establishing premiums and co-pays for Medicaid may force individuals and families to relinquish coverage altogether.

In rural areas, other compounding factors exist. Reimbursement rates and the methods of how reimbursements are managed for human service and health care providers are affected by geographical location. First, Medicare reimbursement rates are lower for human service and health care providers in rural areas than they are for providers in metropolitan areas. Second, the distribution of funding at the state level (e.g., Medicaid) varies in a number of ways. In some counties, funding is paid out as a fee-for-service to health care providers. Other counties may select existing insurance organizations to manage Medicaid monies (e.g., Blue Cross/Blue Shield). Finally, funding may be distributed to health care networks which further disperse the money to clinics in a capitation payment system. This structure operates much like that of a managed care organization.

The idea behind the managed care approach is to prevent the duplication of services so unnecessary costs are avoided. In metropolitan areas, where an abundance of human service and health care providers exist, the managed care philosophy is certainly with merit. However, for many rural areas, where there is already a deficit of human service and health care providers, the managed care approach is inappropriate (Rosman, M. & Van Hook, M, 1998). State budget cuts negatively impact human services and health care in rural areas drastically.

The negative impact of budget cuts to human services and health care in rural areas often extends beyond the deficit of services available for consumers. In rural areas with human services and health care available, these industries provide a consistent structure of economic stability and employment for the community. State level budget cuts result in higher rates of unemployment for individuals with higher levels of education and higher levels of income. With fewer job opportunities, highly educated individuals relocate to metropolitan areas, taking expertise and economic contributions with them.

RURAL CULTURE, HUMAN SERVICES, AND HEALTH CARE

Despite the heterogeneity of culture in rural areas, research conducted by the Rural Health Task Force of the Federal Office of Rural Health (HHS Rural Task Force, 2002) revealed that human service and health care program structure and delivery closely resembled that of metropolitan areas. Whether this similarity is the result of the effect of metropolitan decision and policy making or an evolution of efficacious service delivery and implementation in rural areas remains unclear. The relationship between the culture of rural areas (in all of their heterogeneity), human service and health care delivery and implementation, and metropolitan based policy and decision making remains to be examined. A closer look at the construct of rural culture will clarify the ambiguity of the issue.

Rural areas vary vastly in regards to culture because of the primary economic industries. For example, a southern agricultural community is similar to that of a rural coastal community in the seasonal nature of fluctuations of the economy (related to production, weather, tourism); however, strong differences also exist. Demographic composition, impact of weather (e.g., droughts in agricultural areas versus torrential rain

in coastal regions), proximity to metropolitan areas, impact of primary industry on statewide economy, etc., influence the beliefs, values and attitudes of communities.

History plays a strong role in rural culture, as well. Many individuals and families in rural areas have roots in specific geographic locales dating back for generations. Historically, rural individuals and families migrated into unexplored territories in pursuit of financial, religious, and intellectual freedom. Long and Weinert (1989) described independence and self reliance as key concepts in relation to understanding rural health needs and rural nursing practice. The ability to be independent and self reliant is often entrenched in being able to provide and care for oneself and family. Financial resources and the ability to work are a pivotal point in relation to human service and health care delivery and implementation in rural areas. "Health is assessed by rural people in relation to work role and work activities, and health needs are usually secondary to work needs," (Long & Weinert, 1989). Thus, human service and health care delivery is strongly affected by the high value placed on independence and self reliance by rural individuals and families.

Because independence, self reliance, and the ability to work govern decision making, human service and health care needs are typically acute and often critical when rural individuals and families present for assistance. The challenge of obtaining necessary assistance is compounded by multiple factors. First, the availability of human services and health care in rural areas, as mentioned before, is limited. Proximity to human service and health care providers where assistance may be obtained may also present obstacles. For example, poverty may prevent rural individuals and families from traveling to sites where assistance may be accessed, whether they lack a vehicle or funds to pay for fuel. Public transportation systems are often non-existent. Geographical isolation may also inhibit rural individuals' and families' awareness of preventative and supportive services. Thus, there is a national movement to utilize information technology to increase accessibility to human services and health care.

Advances in technology have expanded the ability to access human services and health care for many rural individuals and families. Information can be found on the internet in abundance. Videoconferencing has increased opportunities for rural individuals and families to access human service and health care providers in metropolitan areas. Human service and health care providers are able to access educational resources and metropolitan based providers for consultation, mentoring, and support.

Although technology has demonstrated the potential to expand resources and decrease isolation for consumers and providers, few rural areas are equipped to implement and utilize such resources. Availability of the internet and information technology resources and staff are often limited, too expensive or non-existent. Reimbursement protocols for services received utilizing videoconferencing require further development and clarity (Ormond, Wallin, & Goldenson, 2000). Resistance to access metropolitan resources may be a factor, as well. Long and Weinert (1989) described the tendency for rural individuals and families to access informal versus formal systems (local versus regional or national) and "insider" as opposed to "outsider" support. A familiar human service and health care general provider is far more likely to be sought for assistance than an unfamiliar specialist. Providers often find themselves in unfamiliar territory acting as mediators, advisors, spiritual counselors, negotiators,

educators, mentors, evaluators, brokers, liaisons, advocates, coordinators, collaborators, facilitators, and researchers (Stanton & Packa, 2001). The role of rural human service and health care providers is challenging due to the diversity of hats worn and the responsibility attributed to the role.

INTERDEPENDENCE OF HUMAN SERVICES, HEALTH CARE, AND ECONOMIC DEVELOPMENT

In 2001, the U.S. Department of Health and Human Services created the Rural Task Force under the leadership of the Health Resources and Service's Administration's Office of Rural Health Policy and the Department Office of Intergovernmental Affairs. The Rural Task Force was established to examine program investment, regulatory policy, and barriers to providing human services and health care in rural America. The report generated by the Rural Task Force revealed that rural residents experience poorer health and social welfare outcomes than urban residents. The greatest health related disparities for rural residents were in the areas of mental health, substance abuse, oral health, and public health outcomes. The greatest human service disparities included higher levels of poverty and unemployment.

The Rural Task Force pointed out in the report that there is a distinct interdependence of health care, human services and economic development. "To be healthy, a community needs not only health care, but a thriving economy, low levels of poverty and reliable social service networks" (HHS Rural Task Force, 2002). Inadequate insurance coverage, limited provider availability and accessibility, regulatory barriers, inappropriate dispersal and utilization of federal and state level funding, and naivete` of metropolitan based decision and policy makers of the unique heterogeneity of rural culture were some of the reasons for the existing disparities in human service and health care outcomes between rural and urban residents. "Possibly the most important factor in fragmentation and lack of coordination in rural areas is the continuing conceptual and practical separation among primary health care, behavioral health care and social services. Although health and social welfare are strongly associated with one another, in many cases federal, state, and local planning efforts continue to address them separately," (HHS Rural Task Force, 2002, p. 10).

The Rural Health Task Force established five goals to direct Health and Human Services in driving the movement to integrate human services, health care and economic development and reduce disparities for rural individuals, families and communities. The five goals are:

1. Improve rural communities' access to quality health and human services;
2. Strengthen rural families;
3. Strengthen rural communities and support economic development;
4. Partner with state, local, and tribal governments to support rural communities; and
5. Support rural policy and decision-making and ensure a rural voice in the consultative process.

A detailed description of the themes of each goal can be found in the HHS Rural Task Force Report to the Secretary at the website www.ruralhealth.hrsa.gov/PublicReport.htm.

The five goals are broad and complex. In order to achieve the aims of the goals, individuals with a vast knowledge base in health care, human services, and economic development must be utilized. Therefore, nursing is an ideal profession to enlist in the venture.

The knowledge base of nurses is holistic, integrating multiple facets of individuals, families and communities. Training for nurses enrolled in accredited BSN programs entails health care, social services and economic development for individuals, families, and communities. Educational and clinical experiences for nurses incorporate assessing primary care, mental health and substance abuse across age, gender and ethnic barriers and teaching illness prevention and health promotion strategies. Quality assurance, health policy, leadership, role development, and management are incorporated into the curriculum and experiential learning of accredited MSN training programs. Many bachelor's, master's and doctoral level degree nurses are involved in decision and policy making at local, state and national levels. The nursing profession is well equipped to address the complex task of integrating human services, health care, and economic development in an attempt to reduce the health disparities encountered by rural individuals, families and communities.

Because nurses are a valuable commodity in rural areas, particular attention should be turned towards the recruitment and retention of nurses. The economic crisis in Oregon poses a threat to the number of human service and health care providers, including nurses. Compounding the current state of affairs, a national shortage of nurses exists and the statistics are projected to worsen.

EFFECTS OF THE NURSING SHORTAGE ON RURAL AREAS

The nursing shortage nation wide has created obstacles in recruiting and retaining nurses in all venues of health care and human services. Because rural areas experience a deficit in health care and human service providers, the obstacles posed in recruitment and retention of nurses are even more detrimental to rural individuals, families, and communities than those in metropolitan areas. Recent statistics have shown that nurses in rural areas have the largest percentage of older nurses (MacPhee, 2002) and the rate of individuals under the age of 30 entering the field of nursing declined by 25.1% between 1980 and 2000 (Engen, 2002). Filling nurse vacancies in rural health care facilities has taken up to 60% longer than filling those in a metropolitan area (Tone, 1999). Tone (1999) reported a recruitment period of 150 days for advanced practice nurses in rural areas as opposed to 90 days for metropolitan areas. While the nursing shortage continues towards the projected peak in 2010, fewer young individuals enroll in nursing (Engen, 2002) and increasing quantities of older nurses retire, negatively affecting rural individuals, families and communities.

CHALLENGES SPECIFIC TO NURSING IN RURAL AREAS

MacPhee (2002) stated three distinct barriers exist to recruiting new nurses to rural areas, including nursing-related barriers, community-related barriers, and

professional interaction barriers. Clark (2002) described multiple nursing-related barriers that contribute to the national nursing shortage, including economic changes affecting health care, lower wages and reimbursement rates than those in metropolitan areas for services rendered, an increasing shift to outpatient health care services, ineffective recruitment, and inadequate application of nursing knowledge, educational preparation and educational systems for nurses. Factors unique to rural areas complicate matters further.

Long and Weinert (1989) and Tone (1999) reported that community-related barriers such as lack of anonymity, limited social opportunities for single nurses, lack of employment options for spouses of nurses, and inadequate access to academia or continuing education opportunities exacerbate the nursing shortage in rural areas. The multifaceted role of the rural nurse and the complex needs of rural human service and health care consumers (who often present in acute or critical need) were also intimidating and taxing (Tone, 1999). Community involvement, personal acceptance and extended periods of time are required for rural areas to accept the presence of nurses entering rural areas (Long & Weinert, 1989; Baldwin, Sisk, Watts, McCubbin, Brockschmidt, & Marion, 1998). Social support affected the satisfaction and retention of nurses (MacPhee, 2002) and while there was the expectation of personal and professional investment, there was a delay in acceptance for nurses new to rural areas. Baldwin et al. (1998) suggested that because many rural communities lack prior exposure to advanced practice nurses, public education on the qualifications and roles is necessary to increase the likelihood of their acceptance. Tone (1999) and MacPhee (2002) revealed that even though many rural physicians accept and accommodate advanced practice nurses, the poor quality of relationships with physicians continued to pose significant professional interaction barriers. Nurses must be critical thinkers, steadfast, patient, skillful, and knowledgeable to endure the nursing role and provide quality health care services in a rural area.

NEEDS SPECIFIC TO NURSING IN RURAL AREAS

Degney (2002) identified two primary categories important to nurses staying in rural practice: 1) issues related to the rural context of practice and 2) professional issues. Issues related to the rural context of practice centered on rural lifestyle and the sense of belonging to a community, including personal security and social support. The category of professional issues addressed teamwork, skill acquisition and maintenance, and organizational structures. Clearly, rural nursing needs are complex.

The needs of nurses in practice in rural areas can be stratified into three levels: 1) the personal level, 2) the community level, and 3) the professional level. On the personal level, the lifestyle and pace of the rural dweller, a sense of reciprocity between the nurse and the community, and a social support network for the nurse and the nurses' family are critical elements for the rural nurse in practice. Employment opportunities must exist for spouses, adequate childcare and education for children, and opportunities to develop social contacts with similar interests for all family members.

Second, on the community level, the rural nurse must have an understanding of the culture of the community and the culture of the health care and human service environment within the community. Awareness of the economic trends of the primary industries of the community and the effects of decision and policy making affect the

nurse's ability to influence resource utilization to the maximum benefit of the community. Further, increased community involvement and awareness enables the rural nurse to establish, communicate, clarify, and improve the roles and responsibilities of nurses at all levels of practice.

Third, on the professional level, access to affordable and up to date continuing education is imperative for ensuring quality practice. Opportunities must be created to network with community human service and health care providers to establish communication and improve continuity of care. Opportunities must also be created to network with human service and health care providers from metropolitan areas to enable rural nurses to exchange innovative ideas for improving the quality of practice they provide.

STRATEGIES TO INCREASE RECRUITMENT AND RETENTION OF NURSES IN RURAL AREAS

Meeting the complex human service and health care needs of rural areas with a deficit of providers and a multitude of challenges facing those that are present, is no small task. Numerous strategies have been implemented to increase the recruitment and retention of nurses in rural areas. Tone (1999) reported that rural recruiters have attempted to hire traveling nurses, foreign nurses, temporary nurses and new grads. Affiliations with nursing schools and state loan repayment and scholarship programs have been established to recruit nurses to rural areas and to attract rural natives back to their communities (MacPhee, 2002; Tone, 1999). Preceptorship programs and rural nursing courses have been implemented to introduce students and new graduates into nursing practice in rural areas (Baird-Crooks, Graham, and Bushy, 1998; Tone, 1999). Baird-Crooks et al. (1998) stated that to be successful as a nurse in a rural area, there is a need to expose nurses as students to the rural environment. After implementing a rural nursing course aimed at immersing students fully into the rural environment, Baird-Crooks (1998) concurred that a rural practicum is a logical transition from more institutionally based experiences. The investigators reported that the course increased students' rural cultural competence while inspiring them to consider rural employment following graduation.

Recognizing the unmet human service and health care needs in rural areas, faculty at Oregon Health Sciences University established the innovative "Rural Frontier Delivery Program." The program consists of rural health clinics aimed at training baccalaureate level nursing students in rural areas while providing health care for an underserved rural population. The training utilizes distance learning modalities while forming partnerships with local health care hospitals and agencies. Students are able to increase their cultural competence for nursing and achieve professional nursing degrees while residing in rural areas. Thus, the likelihood that students will remain in the community after graduation increases. More information about the programs can be found at the website <http://www.ohsu.edu/son-clinical/clinical.html>.

Creative options to expand the nurse workforce are at the forefront of human service and health care education, delivery and decision and policy making. Rural and metropolitan human service and health care providers continue to seek alternatives to increase recruitment and retention of nurses, while attempting to make accessible,

affordable, appropriate, adequate, acceptable health care available. Thus, alternative approaches to providing human services and health care are being considered. “Instead of perceiving the current situational crisis with fear and trepidation, the nursing shortage should be viewed as a transformational opportunity to reformulate and recreate postmodern nursing as the most caring respected and unified of the health care professions,” (Clark, 2002). The Oregon Nursing Leadership Council composed the “ONLC Strategic Plan, Solutions to Oregon’s Nursing Shortage,” detailing five specific goals aimed at transforming nursing education, delivery and decision and policy making. The five goals are:

1. Double the enrollment of Oregon nursing programs by 2004;
2. Develop, implement, and evaluate staffing models that make the best use of the available nursing workforce;
3. Redesign nursing education to meet more directly the changing health care needs of Oregonians;
4. Recruit and retain nurses into the profession; and
5. Create the Oregon Center for Nursing that will coordinate implementation and ongoing evaluation of this plan.

The full version of this report, detailing the strategies to implement each goal, can be located on the Oregon State Board of Nursing’s website at <http://www.osbn.state.or.us/shortage.htm>.

Legislation at the federal level has supported solutions enabling nurses to provide human services and health care to underserved and rural areas, reversing the nursing shortage and ensuring adequate nursing educational preparation and systems exist. The Nurse Reinvestment Act, PL 107- 205, signed into law by the President on August 1, 2002, amended Title VIII of the Public Health Service Act. The Nurse Reinvestment Act has required the Division of Nursing (at the Health Resources and Services Administration which is part of the U.S. Department of Health and Human Services) to develop a funding allocation methodology accounting for its education and practice programs. The funding methodology is required to account for the health care needs of the US population (including those of minorities, and of those residing in medically underserved areas and in rural areas) and workforce needs (including its current composition, geographic distribution, and capacity to meet the changing needs of the US health care delivery system over time) (Center for Health Policy Research and Ethics, http://www.gmu.edu/departments/chpre/DONfunding/home_DONfunding.html).

McKeon (2002) explained that the new law has expanded authority for existing federal programs, while creating a number of new provisions. The new law has granted the authority for the following:

1. Expanding loan repayments and establishing scholarships for nursing students who commit to working in a health care facility deemed to have a critical shortage of nurses;

2. Establishing a nursing loan cancellation program for master's and doctoral students who commit to working as full-time faculty after completing their degree;
3. Establishing a career ladder program to create partnerships between health care facilities and schools of nursing to support nurses and nurses aides who wish to advance within the profession, and to reestablish preentry programs for nursing students;
4. Establishing geriatric training grants to support educators and nursing students who provide care to the elderly;
5. Establishing grants for public service announcements to educate the public regarding nursing to promote student aide programs. State nurses associations are eligible to receive some of these grants;
6. Establishing "Nurse Retention and Patient Safety Enhancement Grants" based upon criteria of the Magnet Recognition Program, administered by the ANA's subsidiary, the American Nurses Credentialing Center. These competitive grants encourage health care facilities to increase collaboration between nurses and other health care professionals and to promote nurse involvement in the governance of the facility with the ultimate goal of increasing nurse retention and improving patient care.

Updates on The Nurse Reinvestment Act are available on the Department of Human and Health Services website at <http://bhpr.hrsa.gov/nursing>, (McKeon, 2002).

The new legislation is aimed at improving nursing practice, increasing the quantity of nurses, advanced practice nurses and nursing educators and encouraging the participation of nurses in decision and policy making. Tone (1999) reported that the average age of current nursing school faculty is about 53 years old. Nurses must be encouraged to aspire to higher levels of education to reverse the current nursing shortage while preventing shortages in the future. Participation in decision and policy making at state and federal levels is imperative for nurses to expose issues affecting nursing practice and educational preparation and systems, which influence the recruitment and retention of nurses.

The new legislation is particularly important for nurses in rural areas. As demonstrated by Baird-Crooks (1998) and OHSU faculty, educational preparation and educational systems specifically designed to integrate rural culture into the curriculum increase the probability of recruitment and retention of nurses in rural areas. Incentives (such as loan repayments) aimed at encouraging master's and doctoral level prepared nurses to commit to full time faculty positions, particularly if they are invested in human service and health care delivery in rural areas, increase the probability of reversing the nursing shortage while preventing a similar crisis in the future. Encouraging participation in decision and policy making ensures that the voices of rural human service and health care providers and consumers (individuals, families, and communities) are heard. Revealing the detrimental effects of metropolitan-based decision and policy making on rural areas serves to enlighten metropolitan-based decision and policy makers. Therefore, the likelihood that the effects of metropolitan based decision and policy making on rural human service and health care providers and consumers are considered in the legislative process increases.

CONCLUSIONS

With recent and impending drastic budget cuts, Oregon's human service and health care industries and economic development is hindered with rural areas encountering the most severe impact. Rural areas experience higher rates of human service and health related disparities than metropolitan areas, and a deficit of human service and health care providers poses challenges for rural areas. Oregon's economic crisis, the unique culture of rural areas, metropolitan based decision and policy making and the national nursing shortage exacerbate the barriers for human service and health care providers and consumers. To implement the five goals of the Rural Health Task Force, culturally sensitive and economically conscious strategies must be devised for rural areas specifically.

Because nurses' training is holistic, they are well suited for human service and health care delivery and economic development in rural areas. Utilizing nurses maximizes their intrinsic knowledge base while integrating human services, health care, and economic development in an attempt to reduce the health disparities encountered by rural individuals, families and communities. Although a national shortage of nurses poses further challenges in providing human services and health care to individuals, families, and communities in rural areas, creative solutions to reverse the nursing shortage enable culturally sensitive and economically conscious alternatives. Oregon's economic crisis and the national nursing shortage should be viewed as a transformational opportunity to develop efficacious strategies for recruiting and retaining nurses in rural areas.

The Nurse Reinvestment Act provides a vehicle for reversing the nursing shortage and preventing future nursing shortages. Authorities included in the act support incentives for entering nursing, further education aimed at teaching and conducting research, and involvement in decision and policy making. The Nurse Reinvestment act enables advancement of field of nursing. In addition, human service and health care providers and individuals, families and communities in rural areas will also benefit from the act.

Nurses must recognize the value of their contributions to rural areas while encouraging the development of the field of nursing. Developing culturally sensitive and economically conscious models of human service and health care delivery for rural areas benefits consumers and providers. Achieving higher levels of education with the intent of teaching and conducting research and supporting other nurses in doing so contributes the reversing the nursing shortage and preventing a shortage in the future. Involvement in decision and policy making ensures that the voice of human service and health care providers and consumers in rural areas is heard. Nurses, as advocates, are responsible for individuals, families and communities in rural areas and further development of the field of nursing.

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