RURAL NURSE ADMINISTRATORS: ESSENTIALS FOR PRACTICE

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ABSTRACT

The rural practice setting has unique nursing and health care needs that significantly impact the role of rural nurse executives. This article describes aspects of the rural environment pertinent to rural nursing and helps identify the special competencies needed by nurses who work as managers and executives in rural settings.

INTRODUCTION

There is growing recognition that the roles and functions of nurse managers and executives vary according to the setting. Studies of health care administration practices indicate that management responsibilities differ by state, size of facility, and practice location (Purnell, 1999). The rural environment in particular has several unique characteristics that affect how nurses and nurse administrators function. By exploring the qualities that distinguish rural health care from its urban counterpart we can define some of the implications for nurse executives.

CHARACTERISTICS OF THE RURAL HEALTH CARE ENVIRONMENT

Health Factors

Certain aspects of rural life have significant implications for health care providers, such as the higher risk factors and proportionally older and poorer compositions of rural populations as compared to urban. Tables 1 and 2, representing data from the National Center for Health Statistics (Eberhardt et al. 2001), indicate a greater percentage of people age 65 and older living in rural areas than urban, with higher numbers of uninsured rural residents and more who exist on incomes below the poverty line. A larger proportion of rural inhabitants engage in high-risk health behaviors such as cigarette smoking, more are obese, and more consume five or more alcoholic drinks per day. Hospitalization percentages and death rates are higher in all age brackets. Although the homicide death rate is lower in rural areas, deaths due to both suicide and unintentional injuries occur more frequently. Other studies have found that women in rural areas compose 25% of reported AIDS cases, compared to a national rate of 15%. Approximately 1 in every 16 women with AIDS lives in a rural area, 1 in 10 in the rural south (Voelker, 1998).

Table 1
Selected Data on Urban and Rural Health: United States, 1996-1999

	Nonmetropolitan Counties (Rural)		Metropolitan Counties		
Selected data	No city ≥10,000	City ≥10,000	Small	Large Fringe	Large Central
% Total Population ≥ Age 65	**15.3%**	13.7%	13.0%	11.8%	11.8%
Cigarette Smoking: Teenagers	**18.9%**	15.2%	16.1%	15.9%	11.0%
Adult Men	**30.6%**	28.4%	27.1%	23.6%	25.4%
Adult Women	**26.5%**	24.0%	23.7%	19.5%	20.0%
Obesity: Men	**22.0%**	20.1%	19.6%	19.0%	17.9%
Women	**23.3%**	21.0%	19.9%	16.3%	20.2%
Alcohol ≥ 5 drinks/day	24.8%	**29.6%**	27.2%	29.5%	24.8%
Infant Deaths per 1,000 Births	**7.7**	**7.7**	7.5	6.1	7.5
Deaths per 100,000: Ages 1-24	**58.5**	46.2	41.7	35.4	44.5
Ages 25-64	**421.5**	399.8	384.9	319.1	419.6
Age 65 and Over	5,407.4	**5,428.4**	5,227.1	5,111.4	5,063.8
Due to Ischemic Heart Disease	**269.2**	256.0	239.6	245.9	259.1
Due to COPD	61.5	**64.0**	61.1	54.7	52.9
Due to Unintentional Injuries	**54.1**	44.6	36.5	29.1	31.2
Due to Homicide	5.4	5.2	6.4	3.9	**11.5**
Due to Suicide	**18.0**	16.5	15.2	12.6	13.2
Births per 1,000 Female Adolescents Aged 15-19	57.9	54.6	53.6	36.1	**59.6**
Limitation in Activity Due to Chronic Health Conditions	**18.2%**	17.6%	15.8%	13.0%	14.0%
Total Tooth Loss among Persons Aged 65 and Over	**37.6%**	33.5%	29.9%	25.7%	26.8%

Provider Shortage

Many rural areas fall far short of having sufficient numbers of health care providers. Only 10% of physicians practice in rural communities, even though 20% of the nation's people live in rural areas. Over 20 million nonmetropolitan residents live in

Table 2
Frequency Counts and Percentages of Demographic Variables (n=30) with Depression

	Nonmetropolitan Counties (Rural)		Metropolitan Counties		
Demographic variable	No city ≥10,000	City ≥10,000	Small	Large Fringe	Large Central
Population in Poverty	**16.1%**	14.6%	13.2%	8.0%	15.6%
Uninsured	**21.0%**	18.1%	16.1%	12.2%	19.6%
Physicians per 100,000 Population	**80.0**	147.2	227.7	223.5	308.5
Hospital discharges per 1,000 population	**92.6**	70.8	65.0	67.5	72.9

areas with shortages of primary care physicians (North Carolina Rural Health Research Program, 1997). Forty-five percent of rural health care administrators report a very limited supply of nurses in their region, versus 10% of urban administrators. Sixteen percent of rural administrators note significant difficulty in recruiting nurses, as opposed to 7% of urban (LaSala, 2000).

Health Care Facilities

The majority of rural hospitals are small, averaging 74 beds, with nearly half having 50 or fewer beds. In contrast, urban hospitals average 231 beds. Hospitals with fewer than 25 beds constitute 10% of rural hospitals and only 2% of urban hospitals. While two-thirds of urban hospitals belong to a multihospital chain, only one-third of rural hospitals are similarly affiliated, their smaller size making them acutely vulnerable to changes in payment systems (Mohr, 1999).

CHARACTERISTICS OF RURAL NURSING

Rural nurses are generalists and must be comfortable functioning with significant autonomy, increased responsibility for action and decision-making, and self-sufficiency in practice. Exceptional assessment and technical skills and a broad base of knowledge are essential, along with creativity and resourcefulness. Rural nurses rank flexibility and multiple skills as their most important attributes (Crosby et al. 2000), as they must handle a multitude of widely varied duties with limited support from peers and other personnel. They may be required to be on call at all times. It is not uncommon for rural nurses to work in three or more departments on a daily basis, going from the emergency room to labor and delivery to the operating room in a single shift (Cook, Hoas, & Joyner, 2001).

Equipment and supplies are sometimes limited or outdated. Nurses often spend more time with rural clients, since low-income clients with poor health status require additional teaching and help with accessing resources. In one study, rural home health patients required a total of 150 minutes more RN direct care time than urban patients (Adams, Michel, DeFrates, & Corbett, 2001). One of the most prominent characteristics of rural nursing is the lack of privacy and confidentiality afforded both the nurse and the health care client. Nurses who work and reside in a small community do not have the anonymity of nurses who live and work in urban settings (Bushy, 1999). This compounds some of the ethical dilemmas faced by rural nurses, yet 41% say they are uncomfortable with the subject of ethics and do not know who is supposed to make decisions when ethical issues arise (Cook et al. 2001). Nurses in rural areas are, on average, older and less educated than those in urban areas. Rural hospitals have lower ratios of registered nurses to licensed practical/vocational nurses, and fewer of the registered nurses possess a bachelor's degree. For example, only 21.8% of the registered nurses in rural Brown County in Texas hold baccalaureate or higher degrees, while in nearby metropolitan Dallas County 55.2% of the registered nurses hold baccalaureate or higher degrees (Board of Nurse Examiners State of Texas, 2001).

ESSENTIAL COMPETENCIES FOR RURAL NURSING ADMINISTRATIVE PRACTICE

#1 Financial Management

The ability to plan and implement creative strategies for financial survival in the rural environment. Rural hospitals with well developed strategic planning have higher profits, higher operating margins, greater planning effectiveness, lower costs, and higher patient revenues per patient day (Smith, Piland, & Funk, 1992). Knowledge of critical access hospital designation requirements, strategies for keeping rural hospitals open, the ability to seek and obtain government grants, and familiarity with various federal and state programs are essential tools in the rural nurse administrator's portfolio.

#2 Leadership

The ability to communicate a comprehensive, integrated vision and lead a rural organization to achieve its goals as a unified team. The difficulties that plague health care in general tend to be intensified in rural areas, making progressive, visionary leadership an important component of the administrative role (Carpenter, 2001). Executive nurses from both urban and rural hospitals list leadership as their most important role (Murray et al. 1998). Building a team that works toward a common goal is a challenge in any environment, easier to say than it is to do. Fitzpatrick (2001) emphasized that successful leadership begins with trust, including leading by example, maintaining integrity, establishing clear, open, honest communication (overcommunicating if necessary), being available, visible and direct, and thriving on relationships. Elements of leadership such as these transcend community settings. Another aspect of rural leadership is the role that healthcare facilities and their executives play in the community. Hospitals and their administrators are often highly visible to the

community. Rural nurse executives should expect to take an active role in community and civic organizations and in healthcare leadership throughout the area.

#3 Workforce Management

The ability to develop and manage a rural workforce. Nurse executives in rural areas must be able to organize the nursing delivery system to capitalize on the strengths and abilities of the available workforce while responding to volume and reimbursement issues. Successful strategies for recruiting and retaining nurses in rural areas include paying relocation expenses, waiving benefit eligibility periods, giving educational reimbursement, offering finder's fees for recruiting full-time nurses, providing refresher courses for nurses desiring to reenter the job market, and increasing paid time off benefits. With a shortage of physicians as well as nurses, the use of nurse practitioners to provide primary care in rural areas is growing, and has been shown to increase revenues, increase and improve service offerings, and reduce the costs of recruiting physicians (Bergeron, Neuman, & Kinsey, 1999). Rural nurses have significant educational needs, partly because most of them have only the minimum nursing education required for licensure and partly because their work requires broad generalist knowledge. Access to continuing education programs, however, is usually limited in a rural community. Rural nurse executives and managers need to provide opportunities for continuing education in their facilities, encourage interaction between rural nurses and urban peers, form educational partnerships to tap into the resources of urban agencies, and allow for precepted experiences. Continuing education offerings should focus on the generalist perspective. Citing isolation, lack of information, and inadequate support as their greatest concerns, rural nurses often request activities that allow them to discuss health care issues with other nurses (Cook, Hoas, & Guttmannova, 2000). Nurse executives can help by creating electronic mail groups, listservs or chat sites, issuing newsletters, arranging for satellite or online access to university courses, encouraging staff to join professional nursing organizations, and finding other creative ways to support rural practice. Educational development may need to include programs that assist nurses in obtaining baccalaureate or advanced degrees. Cooperative agreements with local colleges or universities may assist in degree advancement as well as continuing education. Growing numbers of schools are offering nursing degrees on the Internet, and many organizations provide continuing education hours online. Arranging for access to computers with Internet connections can facilitate both continuing education and degree acquisition. Nurse managers should be encouraged to take advantage of online master's degree programs, perhaps by arranging for a flexible schedule or time off. Rural health care agencies can help their nurses by providing information about the many grants, tuition reimbursement opportunities, and loan forgiveness options available for nurses that work in underserved areas.

#4 Cross-Disciplinary Management

The ability to manage the delivery of all types of client care, nursing and non-nursing, inpatient and outpatient, in a rural setting of broad-based generalist care. A survey of department heads in a variety of practice settings found that respondents from facilities with less than 300 beds were more likely to be responsible for additional departments, along with nursing, making cross-disciplinary management skills essential for rural nurse executives. Nurse administrators in smaller facilities spend more time on marketing activities, community events, and direct patient care than urban managers (Purnell, 1999). Rural nurse executives are involved in every aspect of operations across a comprehensive continuum of care, from primary to acute to long-term. Such integrated organizations are more financially viable and more successful in meeting community needs. Case management programs can be efficient care delivery systems in rural areas. Case management in the rural community is unique, with a broad, diverse scope of practice that blends individual case management with disease management activities and community interventions (Stanton & Packa, 2001). Nurse executives must be prepared to work closely with interdisciplinary services to ensure prompt discharge processes in both inpatient and outpatient settings. Ongoing education of nurses is required to maintain consistent application of case management principles at every stage of service.

#5 Integration of Need-Based Community Services

The ability to understand rural environmental conditions and effectively organize health care operations to meet the needs of a rural community. Nurse executives should know how to assess and profile health and risk issues of targeted populations within communities. They must understand the political workings of a rural community and be able to facilitate interagency collaboration and organizational relationships to improve health care programs and decrease costs. Since rural residents have less political power than urban dwellers, government attention to rural problems is often slow and solutions imperfect. Healthcare administrators who understand rural health issues can develop local strategies to meet the community's needs. Recognition of high-risk health behaviors inherent in many rural populations should lead nurse executives to shift the health care emphasis to prevention and health education within their communities. Collaborative relationships with community agencies such as local or state health departments and senior citizen's centers may offer outreach opportunities to high-risk populations that can ultimately improve health and potentially reduce the need for inpatient hospitalizations.

#6 Maximizing Resources

The ability to use advanced communication and information technology to enhance client care and maximize resources in rural settings. Synchronous communication technology is available that allows two-way, audiovisual interaction between clients, rural health care providers, and urban specialists located in different geographical areas without requiring physical proximity (Fishman, 1997; Miller & Carlton, 1998). By 1997, nearly 30% of rural hospitals were using some kind of telemedicine technology, and that percentage continues to increase. Telecommunication

and videoconferencing can be used to give information and support to rural residents with chronic illnesses who cannot easily come to health care facilities for follow-up, providing a method for identifying developing problems and intervening early. Linking central systems to portable notebook or laptop computers can assist nurses in providing efficient and knowledgeable care to rural clients. Nurse executives should lead the development of telehealth resources, capitalizing on the potential savings and advantages to improve rural health care and provide at least a partial solution to the problems of poor access in underserved areas. While knowledge of technology is important to nurses in any setting, the nurse administrator who is competent in acquiring and implementing this technology can help overcome rural provider undersupply.

AREAS FOR FUTURE STUDY

It is our desire that this review of the rural practice setting may assist readers to understand the uniqueness of rural health care and its administration. Moreover, we hope that the process of identifying essential competencies for nursing administrators will help direct ongoing studies into the special abilities required for leading rural systems. Studies of rural nurse administration could take many forms. Issues of nurse recruitment and retention in rural areas could be contrasted with urban settings, as could effects of gender and ethnic bias on healthcare. Examination of decision-making responsibility and control among nurse managers in rural agencies may guide nurse executives as they lead rural facilities. Outcome studies such as community partnering and its impact on population health would assist rural nurse executives in making financial decisions about where to invest limited resources. Suggestions such as these are only the tip of the iceberg, but we are confident that these processes will significantly contribute to the practice of nursing administration in all healthcare settings, whether urban or rural.

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