

# Retaining Rural Nurses:

## **Midwestern Summit on Retaining and Making Best use of the Older More Experienced Rural Registered Nurse**

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# TABLE of CONTENTS

Acknowledgements	5
Executive Summary	8
Introduction	11
A Rural Nursing Summit	13
Recommendations	23
References	27



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# Executive Summary

*I hear much about recruitment of new nurses, which I understand is necessary; however, retention and career advancement of experienced nurses needs to be addressed.*—Respondent to Iowa's 2003 Retirement Survey of RNs and LPNs

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In rural and frontier areas, the registered nurse (RN) workforce is aging. In rural Minnesota the median age in 2006 was 49 years old and 29 percent were age 55 and older. Bordering states face similar demographics. The nursing shortage in rural areas is compounded by the fact that fewer younger nurses are available and those who are often choose to practice in metropolitan areas.

The purpose of this Summit was to gather rural nursing leaders and experts from the upper Midwest to discuss ways to retain and make best use of older, more experienced nurses. Research and national work in this area has concentrated on metro and urban areas. Given the gap of information pertaining to rural nurses, discussion focused on the unique rural challenges, the opportunities inherent in the rural health care system and innovations currently in place.

In a one-day session, 25 nurse-leaders from Iowa, Minnesota, North Dakota and South Dakota engaged in a series of roundtable discussions on the future of older nurses in rural communities. They represented rural hospitals, long term care, public health, home care, hospice, nursing education and nursing boards. The group also included two retired nurses and a student nurse.

## Themes

A number of themes emerged from the discussion. To retain and make best use of the older more experienced rural nurse:

- Health care organizations must support rural nursing practice through recognition of the complexity of practice and through the development of collaborative care models of management.
- Education is essential and can be a benefit in keeping nurses in the workforce by providing continuing education opportunities, training younger nurses and using mature nurses as preceptors, educators and mentors.
- Salary and benefits must speak to the unique needs of the experienced rural nurse.

- Scheduling needs to be flexible and include innovations such as job sharing, seasonal work arrangements and availability of part-time work.
- Care delivery models should be tailored to the needs of the rural setting.
- The physical workplace should be redesigned in a way that supports the older nurse through modified lift procedures, better lighting, less walking.
- Technology, such as electronic health records, telehealth services, and other innovations should be incorporated into the health care workplace.

## Recommendations

Recommendations were based on these themes. The top recommendations included:

- Seek examples of innovative rural care models. Develop a framework for creating pilot delivery projects that include input from regulators, providers, nurses and patients.
- Develop Rural Nurse Certification, which recognizes the uniqueness and complexity of rural nursing practice.
- Create a new employee benefit group for registered nurses who are 59 years and older that would include pro-rated benefits, flexible hours, phased retirement options and other benefits appealing to the older rural nurse workforce.
- Foster a health care organizational structure and environment that supports nurse engagement in decision-making, leadership development for nurses and succession planning.
- Develop a rural nursing education model that uses mature rural registered nurses as faculty and preceptors.
- Develop community assessments that examine the rural nursing workforce needs, and that collect data on what the older nurse requires in order to stay in the workforce.
- Create continuing nursing education programs that are accessible and relevant to nurses in rural settings including “traveling programs” and online opportunities.

The participants emphasized the need to keep the current workforce healthy especially the large numbers of RNs who are in their 40s and 50s. Additionally, they identified a crucial need to find ways to recruit newer, younger nurses into the workforce.



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# Introduction

*I've worked in my long term care facility for 20 years and I'm still one of the youngest nurses. What are we going to do when people retire?—RN rural Iowa*

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In the next 10 years, many rural and frontier health care providers will be facing the retirement of a large segment of the registered nurse (RN) workforce. In Minnesota the median age of a rural RN is 49 (compared with 47 statewide) and 29 percent are age 55 and older (compared with 24 percent statewide). Bordering states face similar demographics. In rural North Dakota, the average age of an RN is 46, compared to 44 statewide. The nursing shortage in rural areas is compounded by the fact that fewer younger nurses are available (in 2004 only 8 percent were under the age of 30) and those who are, often choose to practice in metropolitan areas.

The Rural Nursing Summit was conducted in order to explore ways to retain and make best use of the older rural RN. Twenty-five nurse-leaders from Iowa, Minnesota, North Dakota and South Dakota participated. They represented rural hospitals, long term care, public health, home care, hospice, nursing education and nursing boards. The group also included two retired nurses and a student nurse.

Using the *Wisdom at Work* (Hatcher, 2006) report from the Robert Wood Johnson Foundation as a framework on how to look at the older, rural nursing workforce, the Summit participants discussed the trends in their communities and workplaces, the barriers to retaining older nurses in the workforce and the innovations that are already in place. From this discussion, a number of themes emerged and from these themes, the group crafted a number of broad recommendations.



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# A Rural Nursing Summit

*When you've seen one rural health care setting, you've seen ONE rural health care setting. We're all different.*—Hospital nursing director

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## National Outlook

Registered nurses (RN) make up the largest segment of the health care workforce. The shortage is expected to increase from 6 percent to 29 percent by 2020 (*Projected Supply, Demand and Shortages of Registered Nurses: 2000-2010*, 2002). The number of nursing jobs available in the long term care field is expected to increase 45 percent between now and 2010. The declining rates of graduating nurses combined with young nurses going to urban areas and the aging of an existing RN workforce are all contributing to the rural nurse shortage.

The average age of working RNs will continue to increase rising to 45.4 years by 2010 (Buerhaus, 2000). Today the median age of RNs has reached 45 years of age, the oldest yet. Half of nurses practicing today will be entering the average retirement age of 60 years in the next 10 to 15 years (Cyr, 2005).

### Quick Facts:

- RNs' labor participation is among the highest of any labor group: 83 percent of licensees work as nurses, 5 percent work in other fields.
- The most frequently mentioned reasons for unemployment among RNs are: 1) retirement 2) disability and 3) child or elder care.
- More than half of nonworking RNs are 60 years and older.
- Demand for nurses remains high. Only 1.4 percent of all RNs report looking for employment.
- Sixty percent of employed nurses work in hospitals, the younger the nurses the more likely they are to work in hospitals.
- As nurses age, they spend less of their employed hours in providing direct patient care.

Source: Minnick, Ann 2000. Retirement, the Nursing Workforce, and the Year 2005. *Nursing Outlook*. 48:211-17

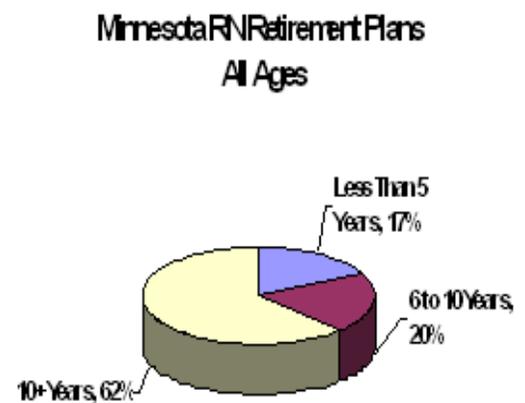
The effect of retirement is likely to have lasting impact. The number of RNs 50 years and over grew at a rate of 4.1 percent per year until 2001, when their numbers increased to 15.8 percent (Norman, 2005). The Health Resources and Services Administration (HRSA) suggests that delaying retirement by an average of four years would increase the FTE RN supply by nearly 158,000 (9 percent) in 2020, easing the impact of an expected nursing shortage. Delaying the retirement of nurses during a time of increasing demand has caught the attention of both national and state policymakers, largely because a shortage of health care providers contributes substantially to rising health care costs (*Rescuing the Health Workforce: Options for State Action*, 2004). Delays in average retirement age might occur as a result of:

- Government policies delaying eligibility for Social Security and Medicare
- A healthier population able to remain longer in the workforce
- Improvements to RN working conditions that increase the likelihood that nurses will remain active in the workforce.

Changes to the work environment that may influence a nurse's decision to delay retirement include, increased pay scales, part-time or seasonal work, tuition reimbursement or use of assistive devices. Many of these incentives have focused on nurses in large acute care settings, where a shortage of nurses is predicted to have the greatest impact. It is unknown if applying the same retention strategies will work in smaller, rural communities.

## Retirement Plans

Many states are starting to identify options for keeping older, experienced nurses in the workforce. A North Dakota survey of nurses found that about one-quarter of the state's nurses planned to retire within the next 10 years (Hanson, 2006). The same survey reports factors such as increased pay, flexible scheduling and retention of benefits while working part time would encourage older nurses to work for more years (Hanson, 2006). Workforce surveys in South Dakota reveal that 51 percent of RNs are now over age 46 and may retire in the next 10 to 20 years.



Source: Office of Rural Health and Primary Care survey response from July 2006 to January 2007

An Iowa nursing survey found a majority of the older nurses intend to continue working over the next three years (*2006 IONL Registered Nurse Practice Survey Findings*, 2007). The same Iowa survey also identified work flexibility as being most important after salary among the 56-60 year age group (*2006 IONL Registered Nurse Practice Survey Findings*, 2007). A survey of Minnesota's RN workforce found that 17 percent planned to retire in the next five years (*Office of Rural Health and Primary Care Monthly Update Newsletter*, April 2007). However, of the active 50-54-year-old RNs, only 7 percent said they expect to retire in the next five years.

## Retaining Experienced RNs

Nationally, the reasons nurses most often give for leaving the workforce are retirement, disability, and child or elder care. Increased wages and work flexibility are often mentioned by experienced nurses as areas that may influence their retirement decisions (Cyr, 2005).

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***In 2006, RNs in rural North Dakota reported an average income that was 12 percent lower than the salaries of urban RNs.*** – UND Center for Rural Health

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Other incentives include opportunities for part-time work, retention of benefits, shorter shifts, adequate staffing, and ergonomic improvements. Iowa has taken steps to find out what would keep experienced nurses working longer and what employers are doing to retain more experienced nurses.

Salary is cited by employed RNs as the most important aspect of the work environment that would keep them working (*2003 Retirement Survey of Iowa's RNs and LPNs*, 2004). For unemployed RNs, ages 51-55 and 56-60, in Iowa, control of schedule is the most important work element that would attract them to nursing again (*2003 Retirement Survey of Iowa's RNs and LPNs*, 2004).

Some health care organizations in Iowa are seeing the importance of providing experienced nurses with options. For example, 25 percent report using unique strategies to retain RNs in the 50+ age group and 13 percent are employing incentives to encourage re-entry of RNs (*2006 IONL Registered Nurse Practice Survey Findings*, 2007). Flexible scheduling tops the list of strategies.

North Dakota has been conducting a Nursing Needs Study since 2003, which is designed to capture an accurate picture of nursing trends in rural and urban areas of North Dakota. Data collected from October-December 2006 found that fewer RNs than in previous years are willing to postpone retirement. Still, the survey found salary increases (55 percent) and flexible scheduling (51 percent) remain the most popular workplace changes that would delay retirement (Hanson, 2006).

**Strategies to Retain 50+ Age Group**

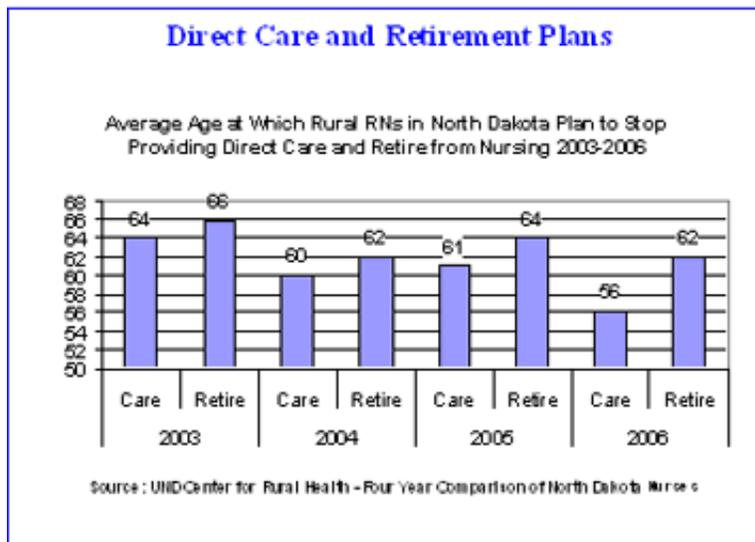
<u>Strategy</u>	<u>Response Total</u>	<u>Percentage</u>
Flexible Scheduling	13	93%
Professional Growth		
Opportunities/Education	10	71%
Ergonomic Adjustment to		
Work Environment	6	43%
Lighter Patient Load	1	7%
Other (PRN, Flex hours)	1	7%

**Strategies to Recruit 50+ Age Group**

<u>Strategy</u>	<u>Response Total</u>	<u>Percentage</u>
Flexible Scheduling	7	100%
Professional Growth		
Opportunities/Education	6	86%
Ergonomic Adjustment to		
Work Environment	3	43%
Lighter Patient Load	0	0%
Other (PRN, Flex hours)	1	14%

Source: 2006 IONL Registered Nurse Practice Survey

Research indicates that direct patient care declines as nurses age (Norman, 2005). The Nursing Needs Study reports that the average age at which RNs in North Dakota plan to stop providing direct care is 57 years (Hanson, 2006). Most striking is the estimated age at which rural RNs planned to stop providing direct care. This decreased significantly from 64 years in 2003 to 56 years in 2005, yet their estimated retirement age decreased only slightly from 66 years in 2003 to 62 years in 2006. The study concludes that experienced rural nurses wish to remain employed, but not provide direct care (Hanson, 2006).



Stakeholders are beginning to recognize the advantages of retaining experienced nurses as a way of minimizing health care workforce shortages. Retaining nurses can be a win-win for health care organizations wanting to serve their patients' needs and older nurses looking for more organizational support and recognition.

What remains to be determined is whether the same strategies will work for older nurses working in rural areas, and whether rural models already exist. With a few exceptions in some states, little attention has been paid to the characteristics of the rural RN workforce. Creating greater awareness and understanding of the rural nursing environment is necessary to ensure that strategies for retaining an older and more experienced workforce are successful in rural communities.

## Uniqueness of Rural Health Care Delivery

In 2005, the Institute of Medicine issued a report on rural health care in the United States entitled *Quality Through Collaboration, The Future of Rural Health*. The report noted that differences existed between the rural and the urban areas regarding the delivery of health care. Some of the differences included:

- Aging population along with an out-migration of the younger population
- Increasing chronic care needs due to the aging population
- Lower levels of income and education
- Higher rates of uninsured and a greater need for health care safety net providers
- Longer distances to health care providers.

*“For most rural communities, retaining workforce capacity and health care services—whether primary care, emergency, hospital care, long term care, mental health and substance abuse, oral health or public health—has been a continuing challenge.”*

Yet, the report also notes that rural areas have a strong sense of community responsibility and the ability to collaborate.

*“As a result, they are adept at devising unique and creative ways to build social and physical infrastructures needed to provide services that urban areas take for granted.”*

Summit participants were quick to point out that all rural health care settings are not identical. Some rural cities are able to provide sophisticated and complex care in their hospitals. Yet, many rural health care providers—hospitals, nursing homes, home care/hospice, clinics and public health—are located in small and sparsely populated areas with limited resources.

The group generally agreed that no matter the setting, rural nursing practice has a uniqueness of its own. Rural nurses are often working without the backup of staff that a larger system might be able to provide. For example, many small critical access hospitals have one RN and one aide on the night shift. The RN is responsible for all the inpatients as well as staffing the emergency room. As several nurses described, the rural nurse has to be a sophisticated generalist with

the ability to handle typical medical surgical nursing, emergency care, trauma care, obstetrics and mental health emergencies.

## **Wisdom at Work: A Framework for Discussion**

In 2006, the Robert Wood Johnson Foundation issued a report on the importance of the older and experienced nurse in the workplace entitled *Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace*. The report included a thorough review of the research and literature on the older workforce along with interviews with nursing experts. The findings of this report became the framework for the Nursing Summit discussion.

### **Myths About Older Workers**

Summit participants discussed stereotypes about older workers identified from the literature in the *Wisdom at Work* report (Hatcher, 2006). They noted that some of the stereotypes are found where they work, but they also provided examples contradicting the stereotype.

**Myth:** Older workers are not agile or quick, so they're of little value.

**Reality:** Some mature workers do have physical limitations, but their accumulated knowledge, experience and strong interpersonal skills often far outweigh physical limitations.

Several participants commented that while older nurses might have some physical limitations, staff valued them for their expertise and often teamed with them to help with the physical part of the job. A rural hospital nursing director described one of her older nurses, "Because of her arthritis, she uses a scooter to get around. She is a highly valued member of the nursing team."

**Myth:** Older workers are unwilling to learn new technology.

**Reality:** A study by Louisiana State University found that older workers in a state agency were more willing than their younger counterparts to learn new technology.

Contrary to the idea that older workers cannot learn new technology, many noted that nurses in their settings were willing to learn and understood the value of technological advances such as electronic health records. A hospice and home care director related, "We have to recognize that older nurses need to be taught in different ways. They need the time to try things out on their own."

**Myth:** Older workers are more expensive to employ.

**Reality:** The costs of more vacation time and pensions are often outweighed by the low turnover among older workers. Higher turnover among younger workers means recruiting, hiring and training expenses.

While older nurses might have higher pay than their younger counterparts, several participants noted that the wage differences were not significant. In fact, in some rural settings, in order to attract newer nurses, younger nurses were paid almost on the same scale. Because of this, some of the long time employees were not receiving wage increases that matched their years of experience. “We need to bridge that gap if we want to keep our older nurses.”

*Wisdom at Work* identified four areas in the workplace environment that could enhance the retention and best use of the older, experienced nurse. These four areas framed the Summit discussion:

- Organizational features or environment including flexibility, competent management, respect for the older nurse, team work and inclusion of nurses in decision-making
- Promising avenues for creating innovative senior nurse positions
- Work design and ergonomic features that reduce the physical burden of the work
- Human resource benefits such as flexible hours, health insurance for part-time workers or pensions.

Summit participants were asked to look at this framework from the rural workplace perspective. Several cautionary themes developed specifically addressing the rural workplace.

- With limited financial resources, many rural health care organizations might have difficulty providing enhanced benefits such as health insurance for part-time/casual employees or employer sponsored pension plans.
- Limited financial resources force rural facilities to choose between investments that bring in revenue over costly infrastructure and ergonomic enhancements. As one nurse noted, “Do we buy lifts to help the nurses with the patients, or do we buy a CT scanner? We know the lifts are a good investment, but we also know that a CT scanner will produce revenue.”
- Small health care organizations have limited capacity to create and support “senior nurse” positions such as those noted in the *Wisdom at Work* report. A hospital nursing director said, “Those are overhead positions. We don’t have the overhead!”

## Barriers to Addressing the Needs of the Older Nurse in Rural Health Care Settings

Summit participants presented a variety of examples of the types of barriers they see in their settings that make change difficult.

### Lack of Resources

Lack of resources was noted as a significant barrier to innovation, including financial, educational and professional.

Fragile financial resources affected the ability to provide competitive salary and benefits, technology that could assist the older nurse in the provision of care, redesign of older buildings and access to education. As a long term care nurse reported, “We don’t have the financial resources to cover tuition costs and time off work for someone to go back to school.”

Education resources are scarce in many rural areas. Opportunities for continuing education and professional growth are unavailable or require long-distance travel to obtain. Furthermore, it’s difficult to attract nursing faculty to rural schools of nursing. As a faculty recruiter from North Dakota noted, “It is so difficult to recruit qualified doctoral faculty to a rural state. Yet we cannot educate nurses without qualified faculty.”

Rural health care environments often do not have an array of professional resources to help guide patient care. For example, the rural nurse in a small critical access hospital might have to attend to a regular medical surgical patient load while also supervising the emergency room. Often, in the smallest hospitals, only two nurses are on duty at one time.

*We live in a sparsely populated community. Without our already aging nursing workforce—health care services might not be sustainable.*—Nursing director, South Dakota

### Regulatory

Complying with the regulatory burden is a two-fold challenge for rural facilities. First, in the rural setting, one or perhaps two nurse leaders fill the roles of director of nursing, infection control, quality coordinator and several others. To keep abreast of all the requirements is an enormous challenge. Added to this, they often work on the floor during peak times. Second, who will want that job in the future? As older nurses retire, will the younger nurse leader want to work 50 to 60 hours per week? One attendee pointed out that a director of nursing position in a rural South Dakota Critical Access Hospital has been posted for six months. Added to this are regulatory requirements that don’t “fit” the rural environment. As one participant pointed out, “Many of the regulations and other expectations were developed for urban settings. We have difficulty complying with guidelines on certain types of diagnoses because we so rarely see them.”

### **Union rules**

Some of rural health systems have unionized nurses. Union contracts typically do not allow for more routine flexible scheduling including short shifts and varied weekend work rotations. Participants also noted in the past the union hasn't been open to negotiating this. "Some of our older nurses can't or don't want to work eight- or 12-hour shifts and every second or third weekend." This potentially leads to older nurses leaving the workforce earlier.

### **Generation gap**

Discussion around the issue of generation gaps between older and younger nurses was particularly robust. Some pointed out that younger nurses felt they weren't being treated fairly if they had to assume the burden of the heavy physical work or the less desirable shift or weekend rotations. Some nurse leaders in attendance felt they couldn't offer flexible weekend or shift rotations given the small numbers of nursing staff they currently had. Others disagreed. In their experience, younger nurses have been very respectful of that generation gap. The younger nurses were eager to have the older nurse work short shifts and only occasional weekends. They felt like the older nurse had "earned" these more desirable hours.

## **Innovations**

While barriers to change exist, it was clear from the discussion that rural settings can be an incubator for innovation. Participants were able to provide a number of examples of changes they instituted in their health care setting.

### **Staff safety and wellness**

Several rural health care settings were developing wellness programs aimed at keeping nurses healthy. Additionally, because home care, hospice and public health nurses travel to see patients, one rural organization provides occupational therapy consults to the staff to help them stay healthy in their work environment. "Not only are our nurses carrying equipment to and from their cars, but they are using laptop computers. We provide ergonomic evaluation to make sure they don't injure themselves."

### **Flexible Scheduling**

Some rural hospitals are already offering work flexibility with nursing staff who are in their 60s and 70s. In a small Minnesota critical access hospital, a 72-year-old RN works 14-16 hours a week. "She does a great job of filling in during high use times and also for staff who need to be away for a number of hours." Another hospital in North Dakota employs several retired nurses who come back to the community in the summer from their retirement homes in the south. "They cover so our regular staff can take summer vacations."

## Workplace Redesign

Summit participants reported on projects intended to redesign the workplace to make it more inviting and more efficient, even with limited funding. Facilities are adding lifts and new equipment to help move patients. In one of the larger rural hospitals, staff carry walkie talkies so they can contact other staff while they are working with patients. “We thought the patients might object to this, but we found they liked knowing that staff were talking with each other.”

## Areas of Greatest Interest and Possibility for Change

A number of themes emerged from the discussion to retain and make best use of the older more experienced rural nurse:

- Health care organizations must support rural nursing practice through recognition of the complexity of practice and the development of collaborative care models of management.
- Education is essential and can be a benefit in keeping nurses in the workforce by providing continuing education opportunities, training younger nurses and using mature nurses as preceptors, educators and mentors.
- Salary and benefits must speak to the needs of the experienced rural nurse
- Scheduling needs to be flexible and include innovations such as job sharing, seasonal work arrangements and availability of part-time work.
- Care delivery models should be tailored to the unique needs of the rural setting.
- The physical workplace should be redesigned in a way that supports the older nurse through modified lift procedures, better lighting, less walking.
- Technology such as electronic health records, telehealth services and other innovations should be incorporated into the health care workplace.

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# Recommendations

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Using the themes that emerged the Summit participants developed a number of high-level recommendations for action. Participants ranked the recommendations based on interests and needs.

- 1. Seek examples of innovative rural care models and develop a framework for creating pilot delivery projects that includes input from regulators, providers, nurses and patients.**

Discussion on ways to make best use of the mature or senior nurse included a call to change care delivery models. Often care, particularly in a hospital or nursing facility, follows rigid boundaries where collaboration and team work are not supported. As one nurse pointed out, “Many of the care delivery models we use were developed in large institutions. They don’t work in rural areas where we have staff limitations and need to work as a team.”

Participants were particularly interested in supporting the creation of pilot care delivery projects. An example used in the discussion was the model used in Watertown, South Dakota at the Prairie Lakes Hospital. Called “Self Organized Agile Teams,” patient care is organized around teams and the concept that “every nurse touches a patient.” Positions such as charge nurses have been eliminated and the teams have the responsibility for all activities regarding their patients.

- 2. Develop Rural Nurse Certification that recognizes the uniqueness and complexity of rural nursing practice.**

Rural nurses need to be skilled generalists. Rural nurse certification would be one way to recognize and support the complexity of care expected from the nurse. Several nurses pointed out that the importance of this recommendation was not in the certification itself but in the recognition that rural nursing is a specialty in the same way family practice is a specialty for rural physicians.

- 3. Create a new employee benefit group for those registered nurses who are 59 and over that would include pro-rated benefits, flexible hours, phased retirement options and other benefits appealing to the older rural nurse workforce.**

Because the needs of the older nurse might not fit under current benefit packages for full-time or part-time work, participants discussed development of a separate category that might fit the scheduling and benefit package needs of older nurses who want to continue working but need flexibility and deserve recognition for their skills.

- 4. Foster a health care organizational structure and environment that supports nurse engagement in decision-making, leadership development for nurses and succession planning.**

A strong theme emerged that in order to keep older nurses in the workforce, they need to feel valued and engaged in decision-making. An organizational structure that supports nurse engagement is an environment that will also attract and retain younger nurses. Participants felt strongly that older nurses remain dedicated to their profession and want to see their positions filled by nurses who will carry on their philosophy of caring.

- 5. Develop a rural nursing education model that uses mature rural registered nurses as faculty and preceptors.**

Mature nurses can make excellent clinical teachers and mentors. Summit participants emphasized the important role mature nurses can play in attracting student nurses to work in the rural environment. A number of barriers exist that keep older nurses from becoming teachers and mentors including salary differences between the schools of nursing and the health care facility, and oversight of clinical teaching staff by faculty with advanced degrees. As one nurse said, "I have a lot to share with students and being a part of a nursing school would increase the variety of my work and my job satisfaction."

**6. Develop community assessments that look at the rural nursing workforce needs and that collect data on what the older nurse requires in order to stay in the workforce.**

Community assessments looking at where the shortages exist could assist in planning where to add incentives to attract younger nurses to the areas of greatest need. Comparing the collected data against expected standards would be a step to redesigning internal workforce policies for retaining older nurses.

**7. Create continuing nursing education programs that are accessible and relevant to nurses in rural settings including “traveling programs” and online opportunities.**

The Summit participants identified education as an important component of job satisfaction and an important component in keeping nurses in the workforce. They noted that especially for a nurse who works limited hours, it’s hard to keep up with new technology, standards and procedures. Traveling programs and online opportunities would bridge some of that gap.

### **Other**

Although the Summit group did not make a specific recommendation on health and wellness of the nursing workforce, they emphasized the need to keep the current workforce healthy, especially the large numbers of RNs who are in their 40s and 50s. Additionally, they identified a crucial need to find ways to recruit newer, younger nurses into the workforce.

### **Conclusion**

The aging of the RN workforce is a significant problem in rural areas and affects all health care settings. Retaining and making best use of the older more experienced nurse will be critical in the next decade to sustaining rural health care services.

Recommendations from this Summit will be used by participants in their own health care settings. This report will also be shared with public and private educators, policymakers and funding organizations.



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# References

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- Projected Supply, Demand and Shortages of Registered Nurses: 2000-2010.* (2002). Washington, D.C.: United States Department of Human Services.
- 2003 Retirement Survey of Iowa's RNs and LPNs.* (2004). Des Moines: Iowa Department of Public Health - Center for Workforce Planning.
- Rescuing the Health Workforce: Options for State Action.* (2004). Washington, D.C.: National Governors Association - Health Policy Studies Division.
- Quality Through Collaboration: The Future of Rural Health.* (2005). Retrieved May 2007 from <http://www.nap.edu/openbook.php?isbn=0309094399>.
- 2006 IONL Registered Nurse Practice Survey Findings.* (2007) Des Moines: Iowa Organization of Nurse Leaders 2007.
- Buerhaus, P. I.; Staiger, Douglas O.; Auerbachm, David I. (2000). Policy Responses to an Aging Registered Nurse Workforce. *Nursing Economics*, 18(6), 278-303.
- Cyr, J. P. (2005). Retaining Older Hospital Nurses and Delaying Their Retirement. *JONA*, 35(12), 563-567.
- Hanson, B. L.; Moulton, Patricia L. (2006). *Four Year Comparison of North Dakota Nurses: Results and Implications.* Grand Forks: University of North Dakota - Center for Rural Health.
- Hatcher, B. J.; Bleich, Michael R.; Connolly, Charlene; Davis, Kathleen; O'Neill Hewlett, Peggy, et al. (2006). *Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace* (White Paper): Robert Wood Johnson Foundation.
- Norman, L. D.; Donelan, Karen; Burehaus, I. Peter; Willis, Georgianna; Williams, Mamie, et. al. (2005). The Older Nurse in the Workplace: Does Age Matter? *Nursing Economics*, 23(6), 282-289.

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