A Model to Develop Nurse Leaders for Rural Practice

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Rural health disparities are due in part to access barriers to health care providers. Nursing education has been extended into rural areas, yet a limited rural research and practice literature informs the content and delivery of these educational programs. The University Of Virginia School of Nursing through a grant from the Health Resources and Services Administration developed the Nursing Leadership in Rural Health Care (NLRHC) Program. The transformational nursing leadership in rural health care (TNLRHC) model guided the development of NLRHC program content and teaching methods. This article describes the TNLRHC model and how it has steered the integration of rural content into advanced practice nursing (APN) education. The capacity of the TNLRHC model for promoting innovation in APN education is described. Recommendations regarding the future development of APN education are presented. (Index words: Advance practice nursing; Rural nursing; Rural health systems model; Nursing education) J Prof Nurs 30:463–473, 2014.

IN RESPONSE TO workforce and regional rural access disparities, an increasing number of undergraduate and graduate nursing programs are extending their educational programs into rural areas or offering advance practice and research degrees with a focus in rural nursing (Cramer, Duncan, Megel, & Pitkin, 2009; Horns et al., 2007; Ligekkis-Clayton, 2007). Extending nursing education to reach rural nurses who do not have access to advanced nursing education is significant, yet much work is needed to establish a sufficient educational and practice research base to guide curriculum development for rural nursing (C. Chipp et al., 2011; Pierce, 2007; Priest, 2004). In 2009, the University of Virginia School of Nursing (UVASON) received a grant from the Health Resources and Services Administration (HRSA) to revise the curricula within its master of science in nursing (MSN) and doctor of nursing practice (DNP) programs to prepare advanced practice nurses (APNs) for leadership and practice in rural settings. The authors were guided in curriculum revision and integration of rural content by the transformational nursing leadership in rural health care (TNLRHC) model, a descriptive rural health systems utilization model that had been developed by investigators in two federally funded rural research centers at UVASON. In this article, we provide a brief review of the literature describing the health challenges of rural populations and the rural health care delivery system; describe the TNLRHC model, its historical development and primary constructs, and how it is informed by extant literature; and discuss our use of the model to integrate rural content and leadership skills into APN nursing education. The capacity of the TNLRHC model to promote innovation in APN education is addressed, and recommendations are made regarding the future development of APN education to prepare nurses for rural practice.

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The Need for Nursing Expertise in Rural Places

Rurality Defined

About 50 million people in the United States are considered rural dwellers, but no one definition of

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rurality captures the diversity of rural people and places (Lichter & Brown, 2011). Rural places are often characterized along certain dimensions including demographic indicators (e.g., population density or rural percentage), distance from urban centers, topographical features, land-based economies, and culture (Hart, Larson, & Lishner, 2005). For policy and research purposes, rural is often defined using census tract or county codes that use such dimensions as commuting patterns to obtain work, size of urban core, or distance to urban centers as parameters for aggregating rural types (Hart et al., 2005; United States Department of Agriculture, 2013). There is evidence, however, that significant differences are obtained when varying codes are used to characterize rural health and health systems (Berke, West, Wallace, & Weeks, 2009; Stern et al., 2010). Rurality may be better understood in the context of local demographic, topographical, economic, and social characteristics and symbolic and cultural boundaries than more traditional spatial definitions (Lichter & Brown, 2011). Portraying rurality as local circumstance, however, presents challenges for designing APN education for rural leadership and practice.

Rural Health Disparities

It is widely recognized that rural residents receive less health care than do urban dwellers. Rural residents are less likely to obtain preventive health screenings, (Bennett, Bellinger, & Probst, 2010; Benuzillo et al., 2009; M. C. Jackson et al., 2009), early treatment when a health problem arises (Colleran, Richards, & Shafer, 2007; Paquette, Zuckerman, & Finlayson, 2011), or specialty treatment when serious illness occurs (Denham, Wood, & Remsberg, 2010; Hauenstein et al., 2007; Pesek et al., 2010; Vanasse, Courteau, Cohen, Orzanco, & Drouin, 2010). Further, environmental health practices that promote healthy living and work spaces are less available in rural areas than in urban sites (Franche et al., 2010; Hendryx, Fedorko, & Halverson, 2010). As a result of these preventative and health care disparities, rural residents are more likely to have higher morbidity and mortality rates for numerous health and mental health problems when compared to urban residents (Baade, Youlden, Coory, Gardiner, & Chambers, 2011; Dobson, McLaughlin, Vagenas, & Wong, 2010; Franche et al., 2010; Pesek et al., 2010; Rost, Adams, Xu, & Dong, 2007; Simmons & Havens, 2007; Singh & Siahpush, 2002). Health disparities are especially prevalent among members of ethnic minority groups or non-English-speaking rural residents (Bennett et al., 2010; Cordasco, Ponce, Gatchell, Traudt, & Escarce, 2011; Onega, Duell, Shi, Demidenko, & Goodman, 2010; Paquette et al., 2011). While urban–rural health inequalities are widespread even in developed countries, it is important to note that disparities do not exist for all rural residents on all health indicators (e.g., homicide, infant mortality; psychological distress; Dhingra, Strine, Holt, Berry, & Mokdad, 2009; Eberhardt & Pamuk, 2004).

Barriers to Health Care in Rural Settings

Both patient and health care system level factors contribute to inequities in health experienced by rural residents. At the patient level, rural residents value self-reliance and may view help seeking as a weakness (Edwards, 2004; Egede et al., 2011; Leipert & George, 2008; Price & Evans, 2005). As a result, they may be unwilling to seek informal help from others or delay seeking formal health care. Rural residents expect difficult life circumstances and may be stoic in the face of health challenges (Judd et al., 2006). Religious practices in some rural communities may further discourage early help seeking especially with regard to health problems perceived to be associated with behavioral or social failings (Blank, Mahmood, Fox, & Guterbock, 2002; Price & Evans, 2005). Even when a rural resident identifies a health problem and wants to obtain treatment, challenges of the rural physical (e.g., mountains, limited roads, weather/travel conditions) and social (e.g., privacy issues) environment may prevent help seeking (Freydberg, Strain, Tsuyuki, McAlister, & Clark, 2010; Leipert & George, 2008; Popay et al., 2003; Rost, Fortney, Fischer, & Smith, 2002; Sherman, 2009).

At the health systems level, rural residents have few options for health care. While many studies document that rural dwellers often can identify a usual source of care, many factors reduce their ability to obtain health care when they need it (Devoe, Krois, & Stenger, 2009; Everett, Schumacher, Wright, & Smith, 2009; Litaker, Koroukian, & Love, 2005; Shin & Kim, 2010; Simmons, Anderson, & Braun, 2008). There are fewer health care facilities in rural places, so rural residents may have to travel long distances to obtain care (Campbell, Merwin, & Yan, 2009; Grzybowski, Stoll, & Kornelsen, 2011; Liu, Bellamy, Barnet, & Weng, 2008; Merwin, Snyder, & Katz, 2006; Peek-Asa et al., 2011). The number and types of providers are limited in rural areas restricting rural residents' choice of providers; this may be especially difficult for women, members of nondominant cultures, or those who do not speak English. Services such as emergency treatment and specialty care may be particularly difficult to obtain (Jukkala & Kirby, 2009; MacDowell, Glasser, Fitts, Fratzke, & Peters, 2009; Schneider et al., 2010; K. C. Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Nurses and informal providers often fill these gaps in health care and may do so without desired educational or experiential preparation (Fiandt, Doeschot, Lanning, & Latzke, 2010; MacKinnon, 2011; Purroy et al., 2011; Webb, 2011; Yates, Usher, & Kelly, 2011).

This brief review of challenges in rural health and health care delivery highlights the need for APNs in rural practice who have specific knowledge of rural people and places. Nurses in underserved rural communities often work with individuals who delay seeking health care, waiting until they are seriously ill before trying to find appropriate but often unavailable health care. It is evident that rural communities would benefit from expert APNs