

The Rural Nursing Shortage

The pandemic has worsened a long-standing national shortage of nurses. Rural communities face the greatest challenges.



Danielle Good, RN, outside Page Memorial Hospital, the 25-bed critical access hospital in Luray, Va., where she works.

During the pandemic, policymakers and reporters have focused on the number of available hospital beds as a measure of the health system's capacity to deal with COVID-19 infections. But those beds don't matter very much without medical staff — doctors, nurses, and other trained specialists — to treat the patients in them. And after nearly two years on the front lines of the pandemic, health care workers are stretched thin.

Nationwide, hospitals employ 105,000 fewer workers today than in February 2020, a loss of about 2 percent. According to the Bureau of Labor Statistics' Job Openings and Labor Turnover Survey (JOLTS), almost 600,000 health care and social assistance workers quit in November 2021, amounting to 3 percent of the total, and the highest number on record since the survey began in 2000. (See chart.) Many attribute these resignations, at least in part, to health care workers' mounting emotional and physical fatigue.

"Everybody is just tired," says Danielle Good, a registered nurse at Page Memorial Hospital, a 25-bed facility in Luray, Va. "A lot of nurses feel that they can't provide the care that their patients deserve because they have to keep moving. A 12-hour shift sounds like a lot, but it's not enough time when you are short-staffed and doing the jobs of several people."

As recurring surges of COVID-19 tax the health care system, the availability of registered nurses has become a major concern for hospital administrators. Nurses are critical to the assessment and treatment of patients, and numerous studies show that having more nurses improves patient

outcomes. In the context of the current health crisis, a working paper by William Padula of the University of Southern California and Patricia Davidson of Johns Hopkins University's School of Nursing looked at data across 172 countries and found that having more nurses per patient was associated with a decrease in COVID-19 mortality.

Yet many hospitals have reported increased difficulties hiring and retaining nurses. This problem is particularly acute in rural settings. In a November 2021 survey of 130 rural hospital leaders by the Chartis Group, a health care advisory firm, nearly all respondents said they were having trouble filling nursing positions. That is limiting the care some of those hospitals can provide. Nearly half of the survey respondents said they had been forced to turn away patients due to a lack of nurses, and 27 percent reported that they had suspended offering some hospital services altogether for the same reason.

"When we talk to rural hospital leaders, nine times out of 10, their number one concern is staffing," says Michael Topchik, national leader for the Chartis Center for Rural Health. "It is really tough to get nurses in rural America."

A GROWING PROBLEM

This shortage of nurses isn't new. A patient in a Cleveland hospital over 100 years ago wrote a letter to the *American Journal of Nursing* commenting on the "present shortage of nurses." The patient observed that the short-handed nurses

in the hospital were “like machines driven at high speed to perform their daily tasks” and seemed always exhausted.

Those words could have just as easily been written today. Burnout has always been a top challenge for health care workers, and the pandemic has dramatically increased stress levels in hospitals. A 2020 survey of health care workers by Mental Health America found that three in four were overwhelmed and experiencing burnout. And according to a 2021 survey of 1,000 health care workers by Morning Consult, 19 percent of those who had worked since February 2020 were considering quitting and leaving the health care industry entirely.

This comes on top of a wave of nurse retirements that has been building for years. According to the 2018 National Sample Survey of Registered Nurses, the average age for a registered nurse was 50. Many will retire soon, if they haven’t already. At the same time, the graying of America is increasing demand for health care services, as more baby boomers age into their 60s and 70s. Before the pandemic, the Bureau of Labor Statistics predicted that the United States would need nearly 200,000 new registered nurses each year to keep up with retirements and rising demand for health care over the next decade. Given the elevated quits rate for nurses and other health care workers in recent months, that number is only likely to increase.

These problems are magnified at rural hospitals and clinics, which serve populations that tend to be older and sicker on average. Even without the looming challenge of older nurses retiring, rural areas have long struggled to recruit and retain enough medical personnel. The Health Resources and Services Administration designates counties as health professional shortage areas (HPSAs) based on criteria such as their population-to-provider ratio and the average travel time to the nearest site for care. For primary care providers, nearly two-thirds of HPSAs are in rural or partially rural areas. In the Fifth District, nearly all nonmetro (rural) counties are either partial or full HPSAs for primary care. (See chart.) For nurses specifically, in 2020, there were nearly 30 more registered nurses per 10,000 people in metro counties than in nonmetro counties.

Moreover, as with some other occupations, it can be difficult to attract doctors and nurses to work in rural areas if they are not already from there. “Unless you grew up in a

rural community, it’s hard to make the move to one,” says John Gale, a senior research associate and rural health expert at the University of Southern Maine.

Good’s decision to work at Page Memorial Hospital after finishing her nursing degree at James Madison University was driven in large part by a desire to stay close to where she grew up.

“This is my home,” she says. “I love living here. I like being close to my family. I like taking care of my own community.”

Health Care Workers Call It Quits

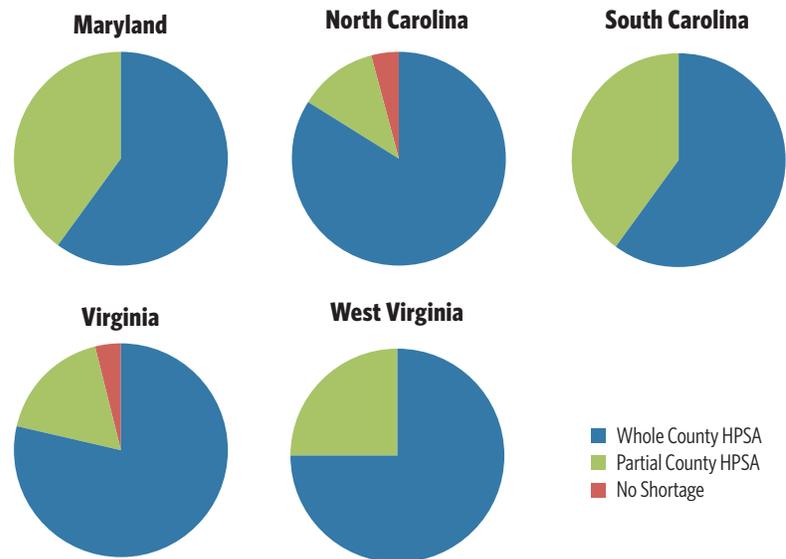
Number of quits (in thousands) for health care and social assistance workers



SOURCE: U.S. Bureau of Labor Statistics’ Job Openings and Labor Turnover Survey

Most Rural Counties in the Fifth District Face Health Workforce Shortages

Share of nonmetro counties with health professional shortages for primary care as of January 2022



NOTE: “HPSA” stands for Health Professional Shortage Area, as designated by the Health Resources and Services Administration.
SOURCE: Health Resources and Services Administration

But while Page Memorial has mostly managed to stay adequately staffed through the pandemic, not all rural hospitals have been so lucky. To fill in the gaps, rural hospitals have historically turned to travel nurse agencies, which send nurses to facilities across the country on temporary contracts. But as COVID-19 caseloads spiked, demand for travel nurses increased, bidding up their salaries substantially. According to some reports, travel nurses have been able to earn more than \$5,000 a week during the pandemic, while the median salary for a rural hospital nurse is \$1,200 a week. This has both inflated the labor costs for rural hospitals relying on travel nurses and made it harder to retain permanent nursing staff when they can earn more doing the same job elsewhere.

Most rural hospitals lack the funds to compete with larger urban hospital systems for personnel in terms of salary. Indeed, they have increasingly struggled just to stay open. Since 2010, 138 rural hospitals have closed, and another 453 are vulnerable to closure. A 2021 Chartis Group report found that nearly half of rural hospitals were operating in the red, and the median hospital had only 33 days cash on hand. (See “Rural Hospital Closures and the Fifth District,” *Econ Focus*, First Quarter 2019.) By all indications, the COVID-19 pandemic has only worsened these financial difficulties. Rural hospitals rely heavily on outpatient services for revenue, and those have been scaled back during the pandemic.

EXPANDING THE PIPELINE

To a large extent, the growing shortage of nurses is itself a symptom of another shortage: nursing instructors. In the midst of a major health crisis and surging demand for nurses, the American Association of Colleges of Nurses reported that more than 80,000 qualified applicants to nursing programs were turned away in 2020 due to a lack of clinical sites, faculty, and other resources.

This problem also predates the pandemic. The National Advisory Council on Nurse Education and Practice (NACNEP) published a report in 2010 warning of an inadequate supply of nursing faculty. In an update published December 2020, NACNEP noted that while some federal and state investments had been made to address the issue, they weren't enough. There is still a shortage of both academic nurse faculty and clinical preceptors — practicing nurses who provide hands-on clinical training for students.

Some of the root causes of this instructor shortage are similar to the ones behind the practicing nurse shortage. Like nurses in general, nursing teachers are getting older: Nearly one-third of faculty members who were active in 2015 will reach retirement age by 2025. Already, more than 50 percent of nursing schools report having vacant full-time faculty positions. Finding new instructors to fill those vacancies has proven difficult. Most nurse faculty positions require at least a master's degree, narrowing the pool of trained nurses who might apply. Less than 2 percent of nurses hold a doctorate, but more than half of the teaching vacancies require one.

Another reason schools struggle to find instructors is that salaries for faculty have long lagged behind what nurses

with an advanced degree could earn by practicing in the field. According to NACNEP's 2020 report, salaries for nursing instructors range from \$57,454 for those with a master's degree to \$120,377 for those with a doctorate. In contrast, most practicing nurses with a master's degree earn more than \$100,000 per year, while those with a doctorate can earn more than \$200,000.

“For a nurse to teach, it often means taking a pay cut,” says Topchik.

As with pay for hospital nurses, faculty salary shortfalls are often the result of lack of funding, something that federal, state, and private nonprofit entities have attempted to address. At the federal level, the Health Resources and Services Administration oversees the Faculty Loan Repayment Program to assist health professional faculty with loan repayment in exchange for teaching at institutions that train health care professionals. The program isn't specific to nurses, but from 2010 to 2019, it has made over 20 awards totaling more than \$1 million to nurse faculty.

An example of state-based support is Maryland's Nurse Support Program II, created in 2005 specifically to support nursing faculty and expand nursing program capacity in Maryland. By 2013, the program was responsible for helping train nearly 6,000 new undergraduate nurses. For the fiscal year 2021, the program awarded 29 grants to state nursing schools worth \$29.3 million.

For rural hospital administrators, developing local education and training opportunities for nursing candidates could be one way to help address staff shortfalls in the long run. Nurses who train in a rural setting may be more likely to stay there and practice when they graduate. Tabitha Fox, chief nursing officer at the Robert C. Byrd Clinic in Lewisburg, W.Va., also serves on the advisory council for the Greenbrier School of Practical Nursing just a few miles down the road.

“We try to get students into our clinic to do rotations and start the recruiting process early so when they graduate, they know we have jobs and would love to have them,” she says.

Another solution might be to expand apprenticeship programs for nurse training, where nursing students learn on the job in hospitals and clinics. When nursing schools began in the United States, this model of training was typical, and both private and public entities have latched onto apprenticeships as one solution to health care worker shortages. Virginia Health Services graduated its first class of nursing assistants in April 2021 through a partnership with the Healthcare Apprenticeship Extension Program.

“If we can't train enough nurses in traditional academic programs, yet there are people who want to become nurses, that says to me that we need to think about doing things a bit differently,” says Gale.

PATCHING THE LEAKS

Expanding the number of new nurses entering the workforce is only part of the solution. As the pandemic has highlighted, many hospitals also struggle to retain qualified nurses. Some seek new health care work in other locations,

while others choose to leave the profession entirely.

According to the National Sample Survey of Registered Nurses, there were nearly 4 million licensed registered nurses in the United States in 2017, but only about 83 percent of them were working in a nursing-related job. In a 2005 article in the *Labor Studies Journal*, Gordon Lafer of the University of Oregon highlighted survey evidence suggesting that many of the qualified individuals not working as nurses would return to the profession if salaries and work conditions at hospitals improved.

“There is no shortage of qualified personnel—there is simply a shortage of nurses willing to work under the current conditions created by hospital managers,” Lafer wrote.

It isn’t always just a question of money. In a 2004 article in the *Economic Journal*, Michael Shields of Monash University reviewed econometric studies of nurse wages and labor supply starting in 1970. Most of these studies used data from the United States. Shields concluded that very large wage increases would be needed to generate a moderate increase in the supply of nurses, pointing to the importance of nonpecuniary aspects of the job.

One common complaint of nurses is the ratio of patients to staff is too high, inhibiting their ability to properly administer care and adding to their feelings of burnout. Numerous studies have suggested that limiting the number of patients per nurse results in better health outcomes, but so far only California has adopted a nurse-to-patient cap.

To be sure, capping the number of patients per nurse in the midst of a staff shortage and major health crisis isn’t really feasible in the short run. But some rural hospitals are exploring other nonpecuniary incentives to entice nurses to stay. Carilion Clinic, a health care organization based in Roanoke, Va., recently became the first health system in the state and the 13th in the country to be certified by the Forum for Shared Governance. That organization promotes empowering nurses to be more involved in decision-making, arguing that collaboration between hospital staff, managers, and patients results in better health outcomes. As a result of these and other efforts to empower nurses, Carilion says it has lowered its turnover rate below the national average.

“As much as we’re talking about recruitment, retaining our talented and dedicated employees is our top priority,” says Alicia Bales, senior director for Carilion Tazewell Community Hospital.

At the Byrd Clinic, Fox says they have reexamined the tasks nurses were being asked to do in order to redistribute

workloads. They created a position to handle medication refills and asked receptionists to handle more of the phone calls to patients. They also hired nursing assistants, which they hadn’t previously employed, to handle tasks like taking patients’ vital signs and cleaning examination rooms, freeing up other nurses to focus more on patient care. When she started at the clinic in November 2020, Fox says, there were six to seven openings on the nursing staff. That number climbed to 12 at one point but has since come down to just two.

“We’re trying to give our nurses more opportunities to give us solutions,” says Fox. “They’re the ones in the trenches daily with the patients. We want them to know that their voices are heard. So far, I think it’s working. We have three or four nurses in orientation right now, and once they are on board, I think we will all breathe a little sigh of relief.”

FACING THE FUTURE

Ultimately, there is no single solution to the nursing recruitment and retention challenges that rural communities face.

“We’ve been talking about recruiting enough nurses, primary care physicians, and mental health staff to rural communities for more than 30 years, and we’re not much farther along,” says Gale.

While federal support in response to the pandemic has helped stem the bleeding at some rural facilities, Topchik sees the same problems now reemerging at an accelerated rate.

“The system is in absolute crisis,” he says. “If nothing is done, we will continue to see a negative spiral in terms of hospital margins and closures once the federal support has worked its way through, because nothing has really changed.”

For now, most hospitals and clinics are taking things day by day and trying to make the most of the staff and equipment they have. But looking ahead, Scot Mitchell, CEO of the Byrd Clinic in Lewisburg, thinks the pandemic will have a lasting effect on health care staffing.

“I think you’re going to see more people leave health care, just because it’s less stressful somewhere else,” he says. “Health care providers and organizations are really going to have to change how we think about recruitment and retention. None of us know yet what will happen, but I think having more flexibility in terms of staffing, shifts, work-life balance, and providing staff with more opportunities to get additional education and responsibilities are all going to be much more important in the coming years.” **EF**

READINGS

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