Leading Rural Nurse Academic Progression

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LEADING RURAL NURSE ACADEMIC PROGRESSION

by

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ABSTRACT
LEADING RURAL NURSE ACADEMIC PROGRESSION

Cynthia J. Larsen, B.S.N., M.S.N.
Marquette University, 2020

Higher levels of nurse education have been associated with improved patient outcomes and lower healthcare costs. Members of rural populations are vulnerable, having poorer outcomes than urban inhabitants on a number of health indicators. Rural nurses are more likely than urban nurses to enter practice with associates degrees. Hence, academic progression is important for rural nurses and for the health of rural patients and communities. Rural nurse leaders work to promote the academic progression of rural nurses. Grounded theory methodology was used in this study to describe the concerns of and the actions taken by nurse leaders in the promotion of rural nurse academic progression. Data were derived from semi-structured interviews with 14 rural nurse leaders who practiced in a variety of nursing educational, organizational, and policy roles in a Midwestern state. The theory of leading through distance emerged from these data. The theory states leaders of rural nurses promote rural nurse academic progression by reconciling resource distance, bridging social distance, working through cultural distance, and lessening profession distance; all through the perspective of their professional practice of delivering rural nursing. Members of all populations should have access to high quality nursing care. Rural nurse academic progression promotes health equity for rural populations. The findings of this study suggest leadership of rural nurse academic progression may be enhanced through minimization of the effects of nurse workforce shortages in rural settings, through resource allocation to rural nurse academic
progression, by helping rural nurses to navigate social and cultural challenges related to academic progression, and through strengthening the iterative bonds between rural nurses and the greater nursing profession.

*Keywords*: academic progression, education, equity, leadership, nursing, rural
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Cynthia J. Larsen, B.S.N., M.S.N.

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CHAPTER 1
Overview of Research

A robust and healthy rural population is a perspective rarely challenged, though the data describe a far different story – a rural population which experiences significant health disparities when contrasted with urban populations (Catlin et al., 2016; Yaemsiri et al., 2019). A well-led (Adams et al., 2018) and well-educated nursing workforce is an essential tool in promoting positive population health outcomes. This research explored the concerns faced by and the processes used by nursing profession leaders as they worked to promote the educational progression of rural nurses.

Description of the Research Topic

Rural nursing occurs when nurses provide professional care for persons who live in sparsely inhabited areas (Long & Weinert, 2013). Rural nurses provide critical health support for the 18% of people who live in the 65% of United States (U.S.) counties designated as rural by the federal government (Agency for Healthcare Research and Quality, 2015). The practice of rural nursing aims to promote health and minimize health disparities (American Nurses Association, 2015).

The profession of nursing recognizes health as a universal right (American Nurses’ Association, 2015), yet residents of rural areas live shorter and less healthful lives than do urban residents (Catlin et al., 2016). They are more likely to be poor and to have poorer health outcomes (Lutfiyya et al., 2013; Yaemsiri et al., 2019). Rural residents are more likely than urban residents to have shorter lives resulting from accidents and hazards related to their occupations (Anderson et al., 2015; Givens et al., 2017; Moy et al., 2017). The people who live in rural areas are, on average, older, less affluent, and less
well-educated than members of urban and suburban populations. This disparity is widening (Singh & Siahpush, 2013). Rural persons are among our nation’s most vulnerable (Robert Wood Johnson Foundation, 2016).

**Defining Rural**

Rurality is not a unitary concept (Anderson et al., 2015; Nichols, 1989). Definitions of rural vary from Long and Weinert’s (2013, pp.114) “sparsely populated area” to highly specified policy formulas. The U.S. Census Bureau identified Urbanized Areas as those that comprised 50,000 or more persons and Urban Clusters as those that comprised between 2,500 and 50,000 persons. All areas not designated as Urbanized Areas or Urban Clusters under this scheme were identified as Rural. Using the Census Bureau definition, 19% of the U.S. population and 95% of the land area were classified as rural according to the 2010 Federal Census (United States Census Bureau, 2015).

Alternately, the U.S. Department of Agriculture used ten-year U.S. Census data to identify counties as metropolitan, having an urban area with at least 50,000 people; micropolitan with at least 10,000 inhabitants; or rural. Additionally, large tracts of sparsely populated land within metropolitan counties were also designated as rural. The Department of Agriculture definition identified 15% of the population and 72% of the U.S. land area as rural, based on 2010 Census data (U.S. Department of Agriculture, 2019).

The Federal Office of Rural Health Policy (2018) used more precise methodologies to bridge the gaps between the Census and U.S. Department of Agriculture statistics. They estimated the rural population to number approximately 57 million (18%) with 84% of the U.S. land area designated as rural. This hybrid definition
was used for this research, because of the enhanced precision inherent in the methodology.

Theoretical perspectives regarding the concept of rurality are primarily place-based or socio-cultural in nature. Place-based perspectives are grounded in quantitative measures such as population density and distance while socio-cultural theories rely more heavily on qualitative measures which addressed cognitive structures and social representations (Koziol et al., 2015). A place-based perspective was used predominantly in this research due to the current nature of nursing as a primarily place-based profession, grounded in a physically present relationship between the nurse and patient.

**Social Determinates of Rural Health**

There is no single profile of rural population health. Experiences of the social determinates of health including economic stability, access to education, health and healthcare, physical environmental factors, and community support (HealthyPeople, 2020) vary widely within and between rural populations.

Rurality as a social determinant of health is one aspect of a causal pathway, a multifactorial phenomenon comprising more variables than simply distance from healthcare resources (Lutfiyya et al., 2012). Limited choices for employment, education, and socioeconomic support are among the factors which expose rural populations to higher levels of economic uncertainty than those experienced by urban populations (Anderson et al., 2015; Brown and Schafft, 2019; Burton et al., 2013). The health challenges faced by rural populations are complex and are mediated by multiple interacting factors. The interplay of the social conditions in which one grows, develops, and lives affects health and has a disproportionately negative impact on the health of rural
residents (Phelan et al., 2010; Singh & Siapush, 2013). The profession of nursing has a responsibility to assess the effects of the social determinants of the health on rural populations and to advocate for individual- and population-level policies designed to minimize the negative effects of the social determinants of health (Mahony & Jones, 2013).

**Healthcare Access**

Having health insurance promotes access to healthcare. Meit et al. (2014) found that twenty-seven percent of non-elderly rural residents lacked health insurance, the highest rate when compared with non-elderly residents of metropolitan and suburban areas.

Disparities between urban and rural health and resource access existed in the areas of mental health (Anderson et al., 2013), adult smoking, adult obesity (Warren et al., 2019), teen births, increased rates of children living in poverty (Schaefer et al., 2016), and higher rates of unemployment (Catlin et al., 2016). Distance to healthcare was a barrier to treatment, impacting both preventative and acute care (Hart et al., 2005). Exposure to nursing and to nursing care for rural residents was limited by an underrepresentation of nurses in the rural population as compared with overrepresentation in urban populations (Bureau of Health Professions, 2013).

Rurality presents unique challenges related to distance and needed support (Arcury et al., 2005; Bacsu et al., 2012). Experiencing a myocardial infarction in a rural area, 40 miles from the nearest hospital presents a different level of risk from that same emergency in an urban area where the intensive treatment is available within a 10-minute drive. Impoverished rural residents have fewer resources with which to advocate for
themselves on personal or community levels (Anderson et al., 2015; Singh & Siahpush, 2013). Well-organized systems for the promotion of public health in urban areas give way to less-structured and informal rural public health systems (Bellamy et al., 2011).

**Rural Nursing**

Rural nursing is semi-visible, not yet well-represented or reported in the professional literature. Despite the prediction that more nurses will be needed to care for rural populations, (“The U.S. Nursing Workforce in 2018 and Beyond”, 2018) the literature does not consistently capture the demographics of the rural nurse workforce, even when zip code-level employment location data were available (Smiley et al., 2018). Interestingly, demographic cohorts with smaller representational proportion including nurses who identified as male gender were consistently surveyed and reported upon. A relative lack of representation of rural nurses in the nursing literature may obscure the presence of the large and impactful nursing cohort.

Rural nurses are a subset of the vulnerable rural population. In addition to the impact of a rural environment on the health of these nurses, resource limitations and cultural constraints (Metcalf & Neubrander, 2016) impact their access to and success with educational experiences (Koricich, 2013). The nature of rural existence may stall or prevent rural nurses’ journeys toward self-care, a necessary precursor to the ability to care for others (Perron, 2013).

**Rural Nurse Academic Progression**

Rural nurse academic progression is important because the rural healthcare workforce is a relatively place-bound population (Kovner et al., 2011; MacQueen et al., 2017,) and because the educational level of nurses may impact rural patient health
outcomes (Jones et al., 2019). Rural residents including rural nurses, were less likely to have a baccalaureate degree as their highest level of education preparation than were urban residents (Jones et al., 2019; Pittman et al., 2013; Ramos et al., 2014; Bureau of Health Professions, 2013). Jones et al. (2019) reported that 11.1% (N=11,163) of Texas nurses practicing in 2008 had academically progressed by 2014, with those in rural areas less likely (OR 0.86) to have progressed than were members of an urban cohort. Fifty-eight percent of urban nurses met the baccalaureate or graduate degree standard while only 40.7 percent of rural nurses were similarly prepared (Bureau of Health Professions, 2013).

Constraints related to economy, distance, and culture may result in nursing students perceiving the local community college as their best or only access point to a professional education (Fishman, et al., 2017; Harbour & Wolgemuth, 2013; Hlinka et al., 2015). Competencies essential to a baccalaureate nursing education are not universally situated in associate degree nursing education programs, resulting in educational competency gaps between associate-prepared and baccalaureate-prepared nurses (Kumm et al., 2014). The knowledge missed within this gap relates, in part, to principles of equity and outcomes thinking. This discrepancy in educational outcomes may negatively impact associate degree nurse progression decisions.

The creation of nursing knowledge is the work of a well-educated nursing professorate. Lower levels of nursing educational attainment in rural areas translate to lower rates of created nursing knowledge embedded in the vulnerable rural perspective.

Improved patient outcomes have been correlated with higher levels of nursing education (Aiken et al., 2003; Aiken et al., 2011; Chang & Mark, 2011; Harrison et al.,
It is possible that lower levels of nursing education in rural areas could contribute to the poorer health outcomes noted in rural populations (Jones et al., 2019).

**Nursing Profession Leaders and Rural Nurse Academic Progression**

Rural populations are vulnerable populations and well-educated nurses are important to the promotion of health in rural populations (Gorski, 2011). Nursing profession leaders who practice in the areas of nursing education, nursing organizational leadership, and nursing policy leadership have the ability to exert influence over the education of rural nurses, individually and collectively (Bednash, 2015; Burman & Fahrenwald, 2018; Tri-Council for Nursing, 2010b; Williams et al., 2016). Nursing profession leaders are accountable for the establishment of nursing educational goals, and for the promotion of rural nurse educational attainment.

Nursing education at the baccalaureate level as an evidence-based standard for patient safety is the dominant discourse within the nursing scholarly community (American Association of Colleges of Nursing, 2019a; Institute of Medicine [IOM], 2011; Tri-council for Nursing, 2010a). The necessity of academic progression for associate degree nurses is not yet the dominant discourse in the larger U.S. society. This research was undertaken to determine what was happening as nursing leaders promoted the academic progression of rural nurses (Glaser, 1999).

Many collaborative and independent initiatives exist for the purpose of promoting nurse academic progression (Gorski et al., 2015). Nursing profession leaders are accountable for the establishment of nursing educational goals, and the promotion of rural nurse educational attainment. Despite the large percentage of nurses who live and practice in rural areas with vulnerable rural populations, little nursing knowledge exists
regarding the processes used by nursing leaders to promote rural nurse academic progression.

**Purpose and Rationales of the Study**

Persons who live in rural areas need and deserve high-quality nursing care. The social determinates of health weigh heavily on rural populations, whose health outcomes are poor, and worsening on multiple measures when compared with those of urban residents (Anderson et al., 2015; Yaemsiri et al., 2019). Promoting the educational progression of rural registered nurses and thereby promoting the highest possible quality of nursing care are important strategies for advancing health outcomes and minimizing health disparities for vulnerable rural residents. It is essential that current processes employed to promote educational advancement for rural nurses are conceptualized and illuminated.

Nursing leadership impacts patient outcomes (Adams et al., 2018). Nursing leaders establish priorities for the profession. They target resources and define the parameters of safe and effective nursing practice. They are pivotal in assuring the delivery of the highest quality of nursing care to members of vulnerable populations. Nursing profession leaders are essential in promoting the progression of nursing education (IOM, 2011).

The purpose of this research is to identify, describe, explain, and provide a theoretical analysis regarding the concerns of nursing profession leaders as they enact processes to promote rural nursing educational advancement. The aim of the research is to develop theory that explains the concerns of nursing profession leaders which arise as they work to promote the health of vulnerable rural populations through the promotion of
the educational advancement of rural nurses (Starks & Trinidad, 2007). The rationales for this research are to promote the health of rural populations and to promote progress toward the Institute of Medicine’s nursing educational goal of 80% of registered nurses earning a baccalaureate or graduate degree. These aims and rationales will be pursued through the generation of nursing theory which explains nursing profession leader promotion of educational advancement for rural nurses (Glaser, 1999).

**Documentation of Need for the Study**

Rural persons, who constitute 18% of the U.S. population, are collectively less healthy than are urban residents. They are dying at younger ages and these disparities are worsening on a number of indicators (Catlin et al., 2016; Yaemsiri et al., 2019). Rural nurses are a subpopulation of the larger vulnerable rural population, representing 16% of all U.S. RNs. Based on 2010 census data, 40.7% of rural nurses, contrasted with 58% of their urban colleagues held a baccalaureate or graduate degree as their highest nursing degree (Bureau of Health Professions, 2013). According to the Wisconsin 2018 RN Workforce Survey, 48.4% ($n=6,871$) of the State’s rural nurses held an associate’s degree as their highest nursing degree. This is contrasted with 31.7% ($n=14,588$) of urban nurses (Zahner et al., 2019).

Nursing profession leaders are accountable for the establishment of nursing educational goals. They share responsibility with the individual rural nurse for the promotion of rural nurses’ educational attainment. Understanding how nursing leaders promote the advancement of rural nurse education can help nurse leaders to further promote rural nurse academic progression. The implications of understanding the promotion of rural nurse education are personal and profound for the hundreds of
The current nursing literature addresses the IOM goal of fashioning a nursing workforce that is prepared to the 80% baccalaureate or graduate educational level. Research regarding the promotion of this goal in the rural nursing workforce by nursing profession leaders is not yet prevalent. The literature reveals a piecemeal approach to achieving this nursing workforce goal in the rural setting (Anderson et al., 2017). The Campaign for Action dashboard (2019, July 9), was designed to track progress toward the IOM goal. It features data related to gender, race, and ethnicity, but not related to rurality. Interventions are largely local or state-based and few, if any, are targeted toward the rural nurse population. A population-based approach to promoting rural nurse education, grounded in systematic assessment and analysis of the current processes undergirding rural nursing educational advancement is not yet evident.

The challenge of building a nursing workforce educated at a minimum of 80% baccalaureate or graduate-degree level has been accepted by nursing leaders in educational, organizational, and policy-level settings (American Association of Colleges of Nursing, 2019a). Rural nurses represent approximately 16% of the nurse population (Bureau of Health Professions, 2013) and promotion of rural nurse educational advancement is critical in making progress toward the IOM nursing educational goal. Understanding of the processes used by nursing profession leaders to promote rural nurse education provides a foundation upon which evidence-based educational, organizational, and policy-based initiatives designed to promote rural nursing educational advancement may be constructed.
Significance of the Problem to Nursing

Nursing is a profession which continues to evolve. Though progress was made, the IOM goal of 80% of the nursing workforce holding a baccalaureate or graduate degree by 2020 was not met (Campaign for Action, 2019, July 9). Sixteen percent of nurses practice in rural areas and these nurses are more likely to enter practice at an associate’s degree than are non-rural nurses (Bureau of Health Professions, 2013). Failure to promote rural nurse academic progress slows the progression of nursing as a profession. Efforts to achieve nursing profession educational goals will be challenged until the issue of rural nurse academic progression is systematically addressed.

The call for nursing to work to decrease health disparities has been made (American Nurses Association, 2010; American Nurses Association, 2015). Health disparities between urban and rural populations are well-documented and worsening (Anderson et al., 2015; Yamsiri et al., 2019). The promotion of equality and social justice are important nursing profession goals (Meleis & Glickman, 2014). Nursing has a history of advocacy for vulnerable populations and opportunities abound for nurses to work to minimize and eliminate urban-rural health inequities.

The American Nurses Association Code of Ethics (2015) specifies that nursing serves individuals, families, communities and populations. Likewise, nursing subsumes the whole of all nurses and the health of the whole. The ability of the whole to serve the patient is affected by the health of the particular nurse and the health of the large population of rural nurses. Rural nurses are impacted by factors which manifest as vulnerability risks. In designing nursing research, it was imperative to consider ethical
ways of knowing in order to produce nursing knowledge which promotes “what is good, what ought to be desired and what is right” (Carper, 1978).

The nursing metaparadigm comprises the four major concepts of person, health, environment, and nursing. Rural nurses constitute 16% of the total nursing population, a significant proportion. Opportunities exist for the nursing profession to improve patient outcomes related to the high rates of associate degree nursing educational preparation in the absence of academic progression. Realities within this nursing cohort’s environment threaten the realization of full health for these rural nurses and for the patients and groups for whom they care. In order for nursing to reach its potential as a profession, Focault’s concept of care of the self (1985) should be applied on both personal and professional levels (Perron, 2013). The health of the nursing profession and the health of the rural populations who receive nursing care from rural nurses are dependent upon all major systems of the whole being healthy and being provided with an environment that promotes growth and full human flourishing.

**Organization of the Study**

Chapter one has comprised descriptions of rural nursing and rural health. It presented the purpose and rationales of the study, descriptions of the need for the study, and highlighted the significance of rural nurse educational progression to the profession of nursing. Chapter two contains the review of the literature and research related to rural health, the vulnerable rural nursing population, curriculum theory, and nursing professional leadership. Methodology and procedures used in carrying out the research are presented in chapter three. The study findings are described in chapter four and
Chapter five contains the interpretation of the findings and recommendations for future research.
CHAPTER 2

Review of the Literature

In chapter two, I provide a review of literature pertinent to the leadership of rural nurse academic progression. The literature review was guided by Watson’s theory of human caring, focusing on human connections and on the transcendent power of human becoming (Fawcett, 2013; Fawcett & Desanto-Madeya, 2013; Watson, 2008).

Literature germane to key concepts including vulnerability, symbolic interactionism, rural health, the vulnerable rural nursing population, curriculum theory, and nursing educational progression were explored. The literature regarding professional nursing leadership and rural nurse educational progression was also explored. At the conclusion of the chapter, the study assumptions, research questions, and a summary of how this work addressed the current research gaps are offered.

Conceptual Framework

Vulnerability

Cutter et al., (2000) explored the interaction between social and geographic variables and vulnerability. Within their model, risk and mitigation interact to produce hazard risk, which is moderated by the social fabric and by geographical context. The concept of place vulnerability is a product of the interaction of the model variables and is relevant to the vulnerable rural population and to the rural nurse population.

Luna (2009) conceptualized vulnerability as a layered model, in contrast to a necessary and sufficient model in which persons are labeled as vulnerable or not vulnerable. In this layered vulnerability model, conditions which could include rurality, poverty, low levels of education, gender, and lack of exposure to opportunity and
inspiration act as layers of vulnerability, which interact to complicate mitigating efforts and to suppress human flourishing. This model informed this research as it stimulated the consideration of the multifactorial nature of vulnerability of place.

Urbanormativity (Thomas et al., 2011) is reflected in the propensity for popular culture to radiate from cities; and from the dominant urban perception of rural areas as simple and wild. Within an urbanormative conceptual framework, the rural nurse is framed as ‘other’ within the society of professional nursing. Within this model, structure, space, and culture interact to create uniquely rural vulnerabilities.

Structural urbanism contributes to rural health inequities through an urbanormative healthcare delivery structure. Structural urbanism describes a market-driven healthcare system which focuses on service delivery to individuals rather than on population-based service strategies. The current system, which focuses on scale and efficiency directs resources disproportionately to large and concentrated populations and away from residents of sparsely populated rural areas (Probst et al., 2019).

**Symbolic Interactionism**

Grounded theory methodology is used to create theoretical knowledge which emerges from the data. The grounded theory researcher must be watchful to assure findings are grounded in the data and are not influenced by a preexisting theoretical or conceptual framework (Glaser & Strauss, 1967; Glaser, 1978).

The theory of symbolic interactionism undergirds the process of grounded theory methodology. A symbolic interactionist framework indicates people act towards concepts and toward others based on the meaning those concepts or those people have for the subject (Blumer, 1969). Meaning is socially constructed and, as such, meaning is
established, deconstructed, and reconstructed continually based on the manner in which the individual interprets the meaning of social interactions (Denzin, 1992). In a seminal work, Parry (1998) identified symbolic interactionism as a useful tool for examining contextualized leadership phenomenon. The social construction of concepts surrounding effective nursing educational preparation, nursing profession leadership, and the role of the nursing profession in promoting health undergird the processes used by nursing professional leaders as they work to promote the advancement of rural nurse education.

Symbolic interactionism is particularly cogent to the study of complex group behavior (Blumer, 1969) such as nursing profession leaders’ approaches toward promoting rural nursing educational advancement. Its critical and feminist underpinnings (Denzin, 1992) are useful in exploring the profession of nursing, with its majority female constituency and the ongoing efforts of nursing leaders to achieve societal acceptance as a fully formed profession (Buresh & Gordon, 2013).

During the course of the research, I explored the participants’ designation of their own identities and social roles including those of nurse, rural nurse, and nursing profession leader (Blumer, 1969). I gave attention to affective factors related to designations and definitions, with a goal of constructing layered substantive theory. I attended to rationales and to cognitive attributions, as well as to the non-rationale attributions which contributed to meaning-making (Ashcroft et al., 2013).

The participants’ designation of objects was examined within a symbolic interactionist framework. The symbolic meanings of objects including the nursing profession, nursing education, and the IOM’s nursing education goal were explored.
Processes of meaning-modifying interactions were examined, including the context in which these processes took place (Blumer, 1969).

I acknowledge the use of a post-colonial feminist perspective in conducting this research. A post-colonial perspective was useful in exploring intra-professional and inter-professional marginalizing (Reimer-Kirkham & Anderson, 2010) and legitimizing forces. The profession’s efforts to define legitimacy for entry into practice, professional space, and professional margins with relation to the more dominant and patriarchal medical profession were also germane to this research and were explored through a post-colonial lens. The long-standing nature of these efforts underscored the relevancy of this perspective to the research (Abbott, 1988; Abbott & Meerabeau, 1998; Ashcroft et al., 2013).

**Conceptual and Philosophical Underpinnings**

**Key Concepts**

I maintained mindfulness of grounded theory methodology and the need for theory to arise from the data while conducting the research. While maintaining this perspective, I performed preliminary literature searches of key concepts related to the research, including the concepts of rural health, curriculum theory, concepts surrounding inclusion and marginalization, and individual versus structural approaches to change. This review of key concepts provided important insights that guided this research.

**Rural health**

Rurality is a risk factor for poor health (Brown & Schafft, 2019). Rural populations, in general, are older and have poorer health outcomes than than do urban populations (Foutz et al., 2017; Hart et al., 2005). Rural residents are more likely than
urban residents to smoke, to use alcohol to excess (James et al., 2017), and to experience childhood obesity and premature birth. Inactivity and diets lower in fruits and vegetables are also more common for rural residents. Urban populations, since the 1990s, have experienced decreased levels of premature death while the premature death rate in rural populations is increasing (Robert Wood Johnson Foundation, 2016). Rates of suicide, diabetes, and childhood mental health and behavioral alterations are also more prevalent in rural than in urban settings (Anderson et al., 2015; Robert Wood Johnson Foundation, 2016). Higher hospitalization rates for preventable conditions are noted and scores related to health behaviors, morbidity factors, and clinical care are less favorable in residents of rural U.S. counties (Anderson et al., 2015; U.S. Department of Agriculture. Economic Research Service, 2020).

Access to health-related services and to health insurance are often limited in rural areas due to financial factors and shortages of healthcare professionals. The percentage of medical specialists and dental providers available to rural populations is limited by number and distance to services (Hart et al., 2005). Access to nursing care is impacted by rurality. Sixteen percent of U.S. RNs live in rural areas, where they are underrepresented in the rural population when contrasted with nursing representation in urban areas (Bureau of Health Professions, 2013).

Life expectancy for metropolitan populations is greater than for non-metropolitan populations. County-level data indicated this disparity widened from 0.4 years in 1969-1971 to 2 years in the 2005-2009 with increased rurality associated with increased mortality (Singh & Siahpush, 2013). Findings from the 2017 County Health study, which included data from 2008-2015, indicated the highest rates of premature death occurred in
rural areas, defined as non-urban rural counties with less than 50,000 inhabitants. Death related to suicide and unintentional injuries were also highest in this cohort when compared with large urban metro, large suburban metro, and smaller metro populations (Robert Wood Johnson Foundation, 2017). Embedded within the concept of rurality, geography and distance exert influence over health. Factors such as living without a driver’s license, and increasing distance from home to primary care were significantly negatively correlated with receipt of health care (Arcury et al., 2005).

**The Vulnerable Rural Nursing Population**

Urbanormativity situates the rural nurse as ‘other’ within the larger nurse population (Thomas et al., 2011). The rural population is less diverse than urban populations (U.S. Department of Agriculture, 2020). The relative homogeneity of race and ethnicity in rural populations may lead persons who hold an urbanormative perspective to believe progression behavior of rural nurses is relatively unaffected by equity and is moderated by distance considerations, alone.

Differences in rural and urban nursing are not defined completely by space and distance, but also through social and cultural variables (Long & Weinert, 2013; Harris, 2014). Concepts related to rural nursing practice include work and health beliefs, the influences of isolation and distance, self-reliance, absence of anonymity, and dichotomous concepts of outsider versus insider and old-timer versus newcomer. The abilities to function and to be productive are integral to the perception of health for rural persons (Long & Weinert, 2013). Rural populations control less social and financial capital than their urban counterparts and these disparities affect the way rural students, including nursing students, approach and participate in education (Owens, 2012; Sutton,
Poverty is a persistent challenge affecting rural populations.

Community colleges may be the only perceived option for rural persons who aspire to enter the nursing education pathway (Gillon, 2015; Koricich, 2013, Owens, 2012; Petges & Sabio, 2020). Impoverished rural families are less likely to have the resources needed to support their children’s college goals. Associate degree nursing students are more likely to be paying their own way through their pre-licensure program and they are more likely to be working full-time while enrolled in the pre-licensure degree program than are nursing students who are enrolled in baccalaureate pre-licensure nursing education (Feeg & Mancino, 2014).

Nurses who enter the profession with an associate’s degree are less likely than those who enter with a baccalaureate degree to academically progress to graduate degree status (Cleary et al., 2009; Health Resources and Services Administration, 2010). Rural nurse academic progression to the graduate level is critical in rural areas in order to provide the faculty members needed by rural schools of nursing. Without these minimally masters-prepared nurses, it is not possible to continue the ‘grow our own’ strategy critical to maintaining the rural nurse workforce.

The nursing profession represents a large, complex system of persons who constitute a political community (Dussel, 2008). Nursing is a profession in evolution, one that is currently performing the work of professional closure – the contentious work of identifying a single pathway to professional standing (Harrits, 2014; Witz, 1990). Including the rural nurse population as full members of the profession is critical to maintaining the integrity and strength of this largest cohort of health professionals.
Abbot (1998), in his seminal work, noted that power and privilege are secured and maintained within all complex systems. Behaviors of marginalization from more powerful to less powerful subgroups are noted within the nursing profession (Smith, 2014). Nursing knowledge and nursing language is created within the academies by members of the scholar academic communities. The disparate levels of nursing education between urban and rural nursing population results in a system in which rural nurses are often underrepresented and largely unseen. Claims that all nurses are solely accountable for their own educational progression (Zittel et al., 2016), while important, may assume a level of autonomy and resource access not yet available to many rural nurses. For example, urban acute care organizations offer financial support for nurse academic progression. Such support cannot be taken for granted for rural nurses. The percentage of regional rural acute care organizations which provide unconditioned tuition support was estimated to be approximately 50% by one of this study’s participants.

Rural and other vulnerable nursing student populations share constraining cultural themes regarding educational success. These include the need to be cared for versus the need for independence; family members who simultaneously encourage, yet depend on students for financial support; and the desire to leave the rural community versus remaining in it (Hlinka et al., 2015; Metcalfe & Neubrander, 2016).

Margins are constructed at all social levels, between legitimate agency and bare existence (Georges, 2011). Distinctions between rural and urban (Thomas et al., 2011) and between the associate-prepared and the baccalaureate- or graduate-prepared nurse represent hierarchical systems through which marginalization and legitimization are constructed within the profession of nursing. Such constructions maintain relations of
power and privilege and create biopolitical spaces which may foster a lack of compassion for marginalized nurses (Georges, 2011), including rural nurses. A perspective of inclusion and advocacy for rural nurses and their continuing education, while avoiding an ‘othering’ perspective decreases the risk of further marginalizing this vulnerable population (Browne & Reimer-Kirkham, 2014; Cloyes, 2010).

Review of the literature provides insight into nursing student choice regarding associate-degree pre-licensure nursing programs and how those students regard potential future baccalaureate enrollment. Petges and Sabio (2020) conducted focus group interviews with 19 A.D.N. students from three non-urban Midwestern community colleges regarding their choice of enrolling in an A.D.N. versus a B.S.N. pre-licensure nursing program. Participants identified time, financial constraints, and physical proximity as the three most important reasons for selecting an associate-degree over a baccalaureate-degree pre-licensure program. Pre-existing debt or the avoidance of debt and lack of financial reserves were offered as specific reasons for seeking an associate’s degree. Participants’ responses were indicative of perceived forced choices associated with marginalized persons including fear of competition related to acceptance to B.S.N. program, concerns with ability to pay high tuition prices, and concerns related to transportation costs. Though participants voiced the importance of a B.S.N. degree, the theme of ‘Yes (it is important), but…’ emerged (p. 28). The study was pertinent to this research because the participants were rurally located in a Midwestern state and may share characteristics and perspectives with current rural associate degree nurses. The small sample size and self-selection recruitment process limited generalizability of the research findings.
J.M. Taylor (2016) interviewed 9 rural associate degree nurses to determine how they described academic progression and how they perceived the role of the nurse in the 21st century. This phenomenological study revealed themes of a nurse’s need for a B.S.N., challenges related to earning the B.S.N., motivators associated with entering into academic progression, and needed support. The participants were recruited from one community hospital, limiting participant perspective and generalizability of findings.

**Curriculum Theory**

Nursing comprises the largest professional group in the U.S (Health Resources and Services Administration, 2010; U.S. Bureau of Labor Statistics, 2019). Multiple educational pathways allow entry to this profession. Despite the use of a unitary examination as the gateway to licensure, the learning outcomes between various types of pre-licensure nursing education pathways vary, with baccalaureate and graduate pre-licensure curricula addressing many outcomes not included in associate degree curricula (American Association of Colleges of Nursing, 2008; Kumm et al., 2014)

The Commission on Collegiate Nursing Education (CCNE), the accrediting body for the American Association of Colleges of Nursing, provides accreditation services for over 700 baccalaureate and graduate nursing programs. Nursing students enrolled in CCNE-accredited nursing colleges learn social citizenship content as an essential aspect of their nursing pre-licensure education. The concept of social justice is explicitly addressed six times within the Essentials of Baccalaureate Education for Professional Nursing Practice (CCNE, 2008).

The National League for Nursing and its associated accrediting bodies, the Commission for Nursing Education Accreditation (CNEA) and the Accreditation
Commission for Education in Nursing (ACEN) offer accreditation for all levels of nursing education, including associate degree nursing programs. The CNEA and ACEN criteria have not yet explicitly called for the inclusion of social citizenship curricular content within their nursing education accreditation guidelines (Kagan, et al., 2014; National League for Nursing Commission for Nursing Education, 2016; ACEN, 2019). Therefore, the rural nursing student population, comprised by the larger vulnerable rural population, is less likely to be exposed to social citizenship concepts and to frameworks designed to mitigate the effects of socioeconomic status on individual and population health.

Rural nurses are more likely to be socioeconomically disadvantaged and to be educated within associate degree nursing programs than are urban nurses. Individuals hailing from vulnerable populations have been found to attribute their own socioeconomic disadvantage to personal decisions and choices rather than to sociocultural constructions which limit socioeconomic mobility (Rondini, 2015). Explicit reference to social justice language within nursing education accreditation standards has the potential for revealing the concept to members of vulnerable populations and for granting permission for the discussion and exploration of the topic within classrooms where such concepts may be culturally taboo. Such exploration has potential implications for rural nurses and for the vulnerable populations for which they provide nursing care.

Higher levels of nursing educational attainment are associated with improved patient health outcomes (Aiken et al., 2003; Aiken et al., 2011; Chang & Mark, 2011; Harrison et al., 2019). In response to these findings, recommendations for entry into nursing practice at the baccalaureate level or rapid progression of RNs to the
baccalaureate or graduate educational levels are widespread (AACN, 2000; IOM, 2011; Tri-council for Nursing, 2010a; The National Academies of Sciences, Engineering, and Medicine, 2016; Zittel et al., 2019). For the purposes of this research, nursing educational progression refers to RNs enrolling in and completing formal nursing education programs leading to attainment of a baccalaureate or graduate degree in nursing.

In 2019, approximately 49.5% of nurses earning initial licensure in the U.S. entered practice at the associate degree level. In that same year, 49.2% of nurse entered practice at the baccalaureate level (National Council State Boards of Nursing, 2020). Because the majority of pre-licensure nursing education occurs at the associate degree level, efforts to achieve nursing educational goals using a laddered system of advancing nursing education are common.

Conflicting perspectives regarding the role of nursing in society are one challenge to achievement of the IOM goal. Nursing education curriculum models differ in perspective according to degree type. Contemplation of the existence of disparate approaches to nursing education and of the power structures inherent in each is integral to developing meaningful research into the processes used by nursing profession leaders in minimizing rural health disparities through the promotion of rural nursing education.

A social efficiency ideology informs the development of many associate degree nursing curricula. The goal of nursing educational preparation according to the social efficiency curriculum model is to serve the needs of society or particular social agents by producing nurses who are well-equipped to perform needed nursing skills. Designers of social efficiency curriculum derive direction from the demands of the consumer market.
or other powerful interests, and focus on preparing graduates to perform the functions assigned to a nurse (Schiro, 2013).

Baccalaureate and graduate-level pre-licensure nursing programs are more likely to utilize a scholar academic curricular model. This model’s outcome is the enculturation of students into the role of the professional nurse. Within this model, educators focus on the development of graduates who think like members of the nursing profession. This curricular model emphasizes the quest for professional knowledge and truth and features a nursing education evolution which moves the student from being an initial learner of knowledge to a teacher of knowledge to becoming the creator of knowledge (Schiro, 2013).

The disparate social efficiency and scholar academic nursing education perspectives present challenges regarding the development of either a unitary approach to nursing education or an integrated educational progression curriculum. The existence of the two primary perspectives has profound implications for the education of nurses, for the profession’s self-regulation (Chiarella & White, 2013), and for the role of nursing in society. These disparate perspectives are rooted not only in curriculum choices made by educational leaders, but also in the beliefs and values of the persons and organizations which support these approaches and which utilize the labor of the nursing graduates (Schiro, 2013).

Rural nurses educated at the associate degree level, within the social efficiency model, are at risk for experiencing dislocation as they move into an often unfamiliar scholar academic model of nursing education (Ashcroft et al., 2013). Such dislocation may present as resentment when associate degree nursing students or nurses are
encouraged or obligated to enroll in a baccalaureate or graduate program of education without understanding or valuing the benefits of such education to the nurse, to their clients, and to their communities (Sportsman, 2011). Dislocation may be further aggravated through unsupportive behaviors exhibited by RN colleagues toward educational advancement (Doering, 2012).

**Societal Challenges to Nursing Educational Progression**

Minimization of socioeconomic disparities in the pursuit of population health requires political acumen and is foundational to the practice of nursing (White, 2014). Nursing leadership has embraced the IOM goal of developing a nursing workforce of whom at least 80% hold a baccalaureate or graduate degree (Benner et al., 2010). Strong societal forces are in play which challenge the achievement of this goal.

Limited expenditure and delivery policies act within higher education to funnel resources from working-class populations toward students from middle- and upper-class backgrounds (Harbour & Wolgemuth, 2013), further challenging the educational aspirations of rural nursing students and worsening urban and rural health and nursing disparities. Public opinion regarding the value of associate-degree-granting institutions, often the only practical option for a nursing education for rural persons, has risen concurrently with changes in policy which shift the cost of higher education from the public sector to the individual user (Fishman, et al., 2017; Gillon, 2015). This is important because student nurses reported reputation of the school as the primary criterion for selection of their school of nursing (Feeg & Mancino, 2014).

A large number of nurses are required to provide essential services in the modern state. Therefore, a financial impetus exists to create and maintain systems in which
groups of persons with required skill sets are produced in a cost-efficient manner. This may be accomplished by diverting these persons to low-cost educational options and then implementing policies which promote a ‘cooling off’ period and educational stall as a member of the essential workforce, prepared at the minimal educational level (Brint & Karabel, 1989; Harbour & Wolgemuth, 2013).

Such cooling-off forces may act upon nurses who enter the nursing profession with an associate’s degree. Policies which promote nursing educational cooling include a lack of wage differential between associate-prepared and baccalaureate-prepared nurses and frequent opportunities for RNs to advance vertically through organizations without consistently achieving standard nursing education milestones (Munkvold et al., 2012; Orsolini-Hain, 2012; Owens, 2012; Sportsman, 2011).

This educational cooling-off is further enhanced when RNs educated in an associate degree social efficiency model contemplate entry into a baccalaureate or graduate-level nursing education program featuring the unfamiliar scholar academic curricular model. Munkvold et al., (2012) surveyed 208 RN associate degree graduates of the Oregon Consortium for Nursing Education (ONOSE) model who had not yet chosen to enroll in baccalaureate courses. Respondents identified the requirement for non-nursing coursework and a sense of disconnection from university faculty as reasons for lack of enrollment. These participants were originally enrolled in and enculturated to the ONSE system, with an expectation of their enrolling in advancing nursing education. Therefore, it is likely such factors, which are integral to the dissonance between social efficiency and scholar academic curricular models, could be of even greater concern for
RNs who are not affiliated with a coalition such as OCNE during their pre-licensure associate degree education.

Fear of failure may be partially rooted in the move from the social efficiency-based associate degree to the scholar academic-based baccalaureate or graduate curricular models (Dweck, 2007) and has been cited as a reason for non-continuance with nursing education. Adorno (2010) used a phenomenological approach with RN to baccalaureate student participants and elicited themes of fear of failure and cost as barriers to continuing nursing education.

Students acculturated in a social efficiency curriculum may initially consider aspects of the baccalaureate or graduate scholar academic model such as elective courses to be superfluous (Munkvold et al., 2012). They may resist the move into a scholar academic model of education if they believe the scholar academic system dominates nursing education and contributes to oppression of the associate degree-prepared RN community (Dussel, 2008; Salas, 2013; Smith, 2014).

**Individual Versus Structural Approach to Nursing Educational Policy**

Social structures can promote or discourage behavior, including behaviors surrounding education. Interventions designed to promote continuing nursing education may be undertaken at the individual level, the structural level, or with some combination of individual and structural approaches. The decision to intervene at an individual or structural level should include consideration of the prevalence of the behavior. Cohen et al. (2000) defined “common behaviors” as those which occurred at rates within two standard deviations from the mean rate of occurrence. With approximately half of nurses entering the nursing workforce with an associate’s degree and hence a directive to pursue
advancing nursing education, entering the nursing workforce with a need to continue
nursing education is a common state best addressed with structural-level, rather than
individual-level interventions.

Despite the fact that entering the nursing workforce as an associate degree
prepared nurse is a common behavior, and the promotion of progression to baccalaureate
or graduate enrollment is therefore best approached with structural-level interventions,
current interventions are primarily focused on individual-level interventions (Duffy et al.,
2014; Metcalfe & Neubrander, 2016; Munkvold et al., 2012; Pittman et al., 2013; Rosa,
2009; Sarver et al., 2015).

**Nursing Professional Leadership**

Nursing leadership as it relates to rural nursing education progression is well
examined through a sociological lens. Professions have been defined using a trait
approach, through the examination of a set of criteria including unique knowledge and
specialized skills, competent application of these skills, a unique guiding code of ethics,
and a perspective of service to others. In their seminal works, Abbott (1988) and Goode
(1960) noted that professionalization is a process in which a unique practice is
established and protected.

Parry (1998) identified leadership as a social influence process. Leadership
assumes power which allows influence over others. Leadership is an intrinsically political
professional practice (Weber, 2011). Leadership and understanding of health policy are
among the many competencies required of all nurses, regardless of educational
professional entry point (National League for Nursing, 2011). Attention to the self-
perceived limits and boundaries of professional power (Ceci, 2013) was examined within
this research, as were the manner in which participants constituted themselves and rural nurses as sociopolitical actors and categories (Cloyes, 2010).

The nursing profession does not recognize one overarching theory of leadership. The theory of transformational leadership (Burns, 1978), is commonly used by nursing leaders to motivate and inspire followers (Matson, 2014). This theory addresses the importance of strong interpersonal leadership skills.

For the sake of this research, nursing profession leaders will include those who have considerable influence over the profession of nursing, including on the manner in which groups of nurses are educated; on the manner in which groups of nurses are employed, retained, and reimbursed; and on the manner in which the work of nurses is valued and utilized within the workforce and society (American Nurses Association, 2010).

Nursing profession leaders with influence regarding the manner in which rural nurses are educated include nursing leaders at all levels of pre-licensure and graduate nursing education. This group comprises nursing faculty, deans of nursing programs and colleges, and academic provosts and officers.

Nursing organizational leaders, for the purposes of this research, are those who have influence over the manner in which nurses’ professional work is utilized and over how nurses are situated in employment settings. These leaders include nursing, clinical, and executive officers; and members of healthcare organization governing boards.

Nursing education is highly influenced by health policy. Policy arises from organizational, public, and professional sources (Taft & Nanna, 2008). Nursing policy leaders include those who have influence over health policy functions within
organizations that represent nurses or members of the public who care for nurses; leaders who hold public elected or appointed political offices, and those who influence the manner in which nursing work is utilized and valued. These leaders may have influence upon a wide range of nursing-related factors including educational standards assigned to particular nursing roles or upon the manner in which nurses’ work is reimbursed. Such influences critically impact the perceived value of nurses and nursing care in society (Scott et al, 2014).

Nursing policy leaders are those who have influence over the scope of nurses’ work and of nurses’ value in society including those who maintain the standards of the practice for the nursing profession. This group comprises those leaders who maintain the overarching professional and ethical standards of the profession and who maintain and exert the professional boundaries of nursing practice.

Nursing leaders may act in multiple leadership capacities. For the purposes of this research, the primary nature of the work being done by the nursing profession leader with respect to the promotion of rural nursing education will guide the designation of the various participants as primarily nursing educational, organizational, or policy leaders.

Outline of the Literature

The literature regarding nursing leadership in educational, policy, and organizational settings with respect to the promotion of rural nursing education was examined. The Cumulative Index to Nursing and Allied Health Literature Database (CINAHL), Cochrane, ERIC, Medline, PubMed, Science Direct, and Google Scholar databases were searched. Inclusion criteria included peer-reviewed materials from 2008 to present, as well as seminal works. These dates were chosen because of the relatively
small amount of literature addressing nursing professional leadership of rural nurse educational progression and because economic factors in the U.S. since 2008 have had profound effects on rural economies. Literature which did not explicitly address rural nursing, but which could contribute to the research were included, as were seminal and historically pertinent sources of literature.

**Review of the Literature**

**Rural Nurse Education Progression**

Warshawsky, Brandford, et al. (2015) used an electronic survey, distributed to all practicing Kentucky RNs to examine the educational status and plans of Kentucky’s RN workforce. A 3% response rate impacted the generalizability of these findings and introduced potential for response bias. Rural-Urban Continuum Codes (United States Department of Agriculture, 2019) were used to dichotomize the sample into rural and non-rural residence. The non-rural nurses were statistically more likely to be attending school full-time ($\chi^2 = 4.39, p = .036$). Non-rural nurses were more likely to report receiving tuition reimbursement from their employer ($\chi^2 = 7.76, p = .005$). There were no significant differences in educational aspiration between rural and non-rural nurses. Lack of skill with or access to technologies that facilitate distance education were not identified as significant barriers to continuing education and were cited at low levels with near equal frequency in both rural and non-rural cohorts.

Harris and Burman (2016) used survey methodology, structural equation modeling, and confirmatory factor analysis to examine the impact of motivators and inhibitors on Wyoming nurses’ intent to academically progress. They engaged 796 Wyoming nurses as survey respondents, 15.2% of all nurses employed in Wyoming in
2014, at the time of the survey. Harris and Burman’s findings were pertinent to this current research because the state is largely rural and remote. Job satisfaction (-.29), professional motivation (-.98), and employer discouragement (-.62) were negatively correlated with academic progression. Perceived time constraints (.20) and personal motivation (2.04) were positively correlated with academic progression. The generalizability of the findings to this research was limited because the population was not specific to associate degree nurses. Applicability to this study is further limited because Harris and Burman removed potential participants from their study if the participants indicated they did not know if they would academically progress in the future. Self-selection bias may also have impacted findings as the average age of respondent was 46.4 years.

**Nursing Professional Education Leadership and Rural Nurse Academic Progression**

Sportsman (2011) used survey methodology to explore the perceptions of Texas associate degree nursing students, associate degree nursing faculty, and chief nursing officers regarding RN educational progression. Interestingly, 50% of the nurse administrators responding had chosen to remain at the associate degree level of educational preparation. Responses from educational leaders and from organizational leaders regarding the importance of RN educational progression were similar. While associate degree nursing students identified time limitations and family obligations as their greatest barriers to pursuing baccalaureate or graduate degrees, associate degree nursing faculty and nurse organizational leaders predicted family obligations would be the greatest barrier to educational advancement by students. Simple statistics were
offered and response rates were not reported, limiting the ability to draw conclusions regarding the rigor and the generalizability of the findings.

Associate degree nursing faculty were identified as a source of educational progression motivation for associate degree nursing students. Rosa (2009) used mixed methods, including a researcher-designed instrument, personal interviews, and examination of program documents, to study factors which influenced the advisement of nursing students by associate degree nursing faculty regarding baccalaureate nursing education. A 67% participation rate was achieved with 57 associate degree nursing faculty completing the online survey. Findings included a faculty perception of a moral obligation to advise students to matriculate at a baccalaureate program level. Faculty members reported a belief that many students would need a break in their studies to allow the RN to rest and accrue resources prior to baccalaureate program enrollment. Quantitative findings were minimally reported, with nine attitudinal factors influencing student advisement and one subjective normative finding that faculty should promote continuing nursing education for associate degree graduates. Attitudinal factors included a sense of responsibility to advise associate degree nursing students of the importance of advancing to baccalaureate or graduate education and a perspective that most students would be successful with nursing education at advancing levels. This research was specific to the associate degree nursing population, but not to the rural RN population.

**Nursing Policy Leadership and Academic Progression**

Gorski et al. (2015) described four nursing educational progression models identified by nursing profession leaders from The Center to Champion Nursing. These include a baccalaureate degree offering in the community college setting, a competency
or outcomes-based curriculum administered through either the community college or university, an accelerated associate degree to master of science in nursing model, and a collaborative regional or statewide curriculum. Such models could be useful in promoting educational advancement in rural areas, where a predominance of community college-based nursing education exist.

M.R.S. Taylor (2016) explored the state of nursing political advocacy with nursing policy leaders, through the lens of Bandura’s Social Cognitive Theory. The author used a mixed-methods approach with survey methodology and a small sample size \((n=20)\) of executive leaders from professional nursing organizations. A focus group was convened to further explore themes which emerged from the survey findings. Key findings associated with nursing leader policy engagement were a deeply meaningful cause and camaraderie with other nursing professional leaders surrounding a common cause. The lack of monitoring of the advocacy skills of professional nursing organization members was cited by participants as a barrier to affecting change at the professional level. The research was not specific to the promotion of rural nursing education progression.

Travers et al., (2015), studied the longitudinal racial composition of enrolled nursing students in seven states, three years after the enactment of legislation designed to increase the numbers of Black and Hispanic nursing students. Significant increases in the number of Black students were noted in three states, Arkansas \((13.8\%-24.5\%, p<.001)\), Michigan \((8.0\%-10.0\%, p=.01)\), and California \((3.3\%-5.4\%, p<.001)\), while the number of Hispanic students increased significantly in two states, Florida \((11.8\%-15.4\%, p=.001)\) and Texas \((11.2\%-13.9\%, p=.001)\) during the post-legislation enactment period. To
control for longitudinal changes in race and ethnicity enrollment in schools of nursing, each state examined was paired with another state with similar demographic variables. This methodology enhanced the rigor and generalizability of the findings. Legislation that provided reimbursement, encouragement, and funding were strongly associated with significant increases in Black and Hispanic enrollment versus legislation associated only with workforce enrichment.

Cramer et al. (2013) described the conceptual models used in creating a state-level action coalition for the purpose, in part, of promoting the IOM goal of increasing the percentage of baccalaureate prepared nurses. The authors cited the need to develop and maintain a shared sense of social vision, establishing goals based upon the improvement of healthcare rather than on the self-interests of the nursing profession. Curriculum goals were focused on adequacy of course seats, efficient transfer criteria, and distance education option.

In December of 2017, New York’s Governor Cuomo signed into law legislation requiring registered nurses to have earned a minimum of a baccalaureate degree within 10 years of initial RN licensure. A coalition of New York nursing educational, policy, and organizational leaders, working over a 15-year period, successfully promoted the passage of this legislation. Strategies associated with successful passage of this legislation included retaining a lobbyist, identifying the legislation in a neutral and effective manner, developing collaboration and support, and thoroughly understanding the perspective of those who opposed the legislation (Zittel, 2018).
Nursing Organizational Leadership and Academic Progression

Gerardi (2015) described the unfolding results of the Academic Progression in Nursing (APIN) initiative, coordinated by the American Organization of Nurse Executives (AONE) through the Tri-Council for Nursing (2010a). The nine states participating in the initiative all made progress with action plans designed to promote achievement of the IOM’s goal of 80% of nurses holding a baccalaureate or graduate degree by 2020. Specific goals for this initiative included the development of competency-based curriculum, shared state or regional curriculum, creation of RN to baccalaureate or master programs, and establishment of community college nursing programs conferring a baccalaureate degree.

Pietrocola (2015) interviewed the chief nursing officers at eight critical access hospitals in Kansas to identify perceptions of nurse organizational leaders regarding barriers to and facilitators of RN educational advancement. Perceived barriers included finances, life responsibilities, a lack of perceived value, professional stagnation, and challenges unique to the rural setting. Perceived facilitators included increased funding for advancing the education of RNs, mandates with time limits for earning a baccalaureate or nursing graduate degree, mentoring and role-modeling programs, and the availability of a variety of baccalaureate education delivery models. Featured quotations from the nurse executives indicated a lack of perceived control over the facilitators and barriers. At least one respondent indicated some knowledge of governmental assistance available to nurses for continuing their educations. No indication that nurse executives had dedicated resources to exploring such assistance for their nurses was apparent. No apparent alignment between the stated value of promoting RN
educational progression and budgetary support for such initiatives was offered. A mismatch between the stated value of a baccalaureate versus an associate degree and the organizational value as reflected in nurse reimbursement was noted. The findings did not indicate a sense of agency on the part of the nurse executives regarding nurse academic progression. Accountability for creating a financial system which rewarded attainment of the baccalaureate degree was subsumed by the organization and presented as fiscally impossible, rather than owned or partly owned by the nurse executives.

Jeffs and Brown (2014) described the development of an academic nursing education role in an urban hospital within a rural state, for the purpose of advancing the educational status of the organization’s nursing workforce. Strategic hiring of baccalaureate-prepared nurses and promotion of nursing education for current RN team members were reported interventions. Outcomes reported as associated with the new educational focus and initiatives included an organizational increase in nurses holding a baccalaureate from 45% to 59% and an increase in nurse directors who held a baccalaureate or higher degree from 60% to 100%. The report was descriptive and it was not possible to determine if the interventions impacted the dependent variable of academic progression, or if the increased prevalence of progression was mediated or moderated by other unnamed variables internal or external to the organization.

Pittman et al. (2013) distributed surveys to one nurse executive from each of the AONE-represented organizations in the U.S. regarding employers’ nurse education policies. A 17.8% response rate was obtained from emailed surveys, limiting generalizability and introducing the risk of response bias. The availability of organizational tuition reimbursement for nurses was reported by 97.3% of nurse
executives. These data were not consistent with those reported by nurses in other settings regarding their own organization’s tuition reimbursement policies (Adorno, 2010; Sarver et al., 2015; Warshawsky, Brandford, et al., 2015). This discrepancy may indicate response bias, differences between organizations led by an AONE member, or need for communication to nurses regarding available tuition reimbursement. Alternately, tuition reimbursement policies may differ between unit and leadership levels within organizations. It is also possible that nurse executives consider scholarships to be tuition reimbursement while unit-level nurses view scholarships differently from systematic tuition reimbursement.

Pittman et al. (2015), examined survey data provided by rural organizational nurse leaders from 47 rural hospitals. They noted the percentage of rural nurse executives who indicated they preferred or required a baccalaureate degree for RN prospects increased from 2.1% to 5.3% from 2011 to 2013. Differentiation between rural and urban hospitals was determined by zip code and core-based statistical area coding (Federal Office of Rural Health Policy, 2018). The authors accepted non-nursing baccalaureate degrees as meeting the criteria for a nurse to hold a baccalaureate degree, confounding attempts to draw comparisons with research findings which recognize only nursing baccalaureate degrees. The total response rate of 336 respondents and a 19.6% response rate increased the risk of response bias and limited generalizability of findings.

Kataoka-Yahiro et al. (2011) conducted a qualitative study examining distance learning needs for rural nurses. Demographic data and focus group information were derived from 37 nurses, including seven nurse administrators from rural Hawaiian hospitals. Data were not reported distinctly between organizational nurse leaders and staff
nurses, though a theme of offering advancing nursing education as a benefit of employment was cited in three of six selected quotes offered by nurse administrators within the author’s published work. The qualitative nature of this research and the unique rural setting of the Hawaiian Islands limited generalizability of findings.

Warshawsky, Wiggins, et al. (2015) surveyed chief nursing executives using an electronic survey sent to 120 Kentucky healthcare organizations. A 40% response rate (N=52) was achieved. Rural-urban continuum codes were used to classify organizations as urban or rural. Sixty percent of respondents represented rural hospitals. The majority of organizations did not have a preference for hiring baccalaureate-prepared nurses. Associate degree nurse educational plans were in place at 75.5% of the responding organizations. Tuition reimbursement was the most frequently cited intervention and was reported by 97% of respondents. Thirty-five percent reported having requirements for nurse career advancement. A marginal association (p= 0.63) was noted between the educational level of the chief nurse officer and that of the organization’s nursing workforce. Twenty-six percent of the nurse executive respondents planned to achieve the 80% baccalaureate goal by 2020 and 38% had not established an organizational goal for advancing the educational levels of their nurses.

Alonzo (2009) used a focus group approach with inductive content analysis to identify motivational factors for RNs who entered B.S.N. completion programs. In four of four focus groups, RNs identified their employers as important motivators to their academic progression decisions. The study comprised 19 students from four Midwestern schools of nursing. The qualitative methodology limited generalizability of the findings.
Statement of the Assumptions of the Study

This research was based on five assumptions:

- Nursing profession leaders promote the educational advancement of rural nurses.
- Rural populations have unique health needs from those of urban populations. Nursing profession models developed for urban residents may not function effectively in promoting rural health (Long & Weinert, 2013).
- Rural populations are vulnerable populations and well-educated nurses are important to the promotion of the health of rural populations (Gorski, 2011).
- Rural nurses are a subset of the vulnerable rural population. The majority of rural associate degree nurses are educated outside nursing’s colonizing scholar academic nurse community. Marginalizing intra-professional forces may contribute to challenges in promoting rural nurse educational advancement (Georges, 2011).
- Nursing leaders formulate their individual agency and sphere of influence, constructed through analysis of contemporary discourses and personal reflection (Perron, 2013; Weber, 2011).

Research Questions

The research questions explored through this work were:

- What were the central concerns of nursing profession leaders as they worked to promote rural nursing educational advancement? and
- What did they do to resolve these concerns?
Literature Gaps and how the Study Addressed Those Gaps

Through this research, I examined how nursing profession leaders practicing in the areas of nursing education, nursing organization leadership, and nursing policy leadership interacted with and promoted the educational advancement of rural nurses. I examined how the leaders conceptualized the challenges of rural health disparities and of rural nursing education advancement. I explored how nurse leaders situated the rural associate degree nurse within the nursing profession and how they conceptualized the challenge of rural nursing educational progression. I sought to create nursing knowledge regarding how nursing leaders conceptualized and promoted solutions to the IOM nursing educational goals. I sought to create nursing knowledge regarding leaders’ approaches to the advancement of rural nurse education at the individual nurse level and at the social policy level. I sought to identify potential socially structured fictions, often the first step to incremental social change.

The development of substantive theory regarding nursing professional leadership and its role in promoting rural nurse educational advancement may promote dialogue between the three realms of academic, organizational, and policy-based nursing leadership. Through this research, I sought to conceptualize the process of nursing leader-led rural nurse educational progression, to promote rural health, and to decrease marginalization of the rural nursing workforce through the development of nursing theory.

Maintaining momentum toward the IOM’s goal of 80% of the nursing workforce being prepared at the baccalaureate or graduate level requires a thorough understanding of the state of nursing leadership promotion of rural RN educational progression. I offer
this knowledge in the form of substantive theory. This theory was developed by
examining what was happening, including the associated challenges and currently
proposed and enacted solutions, as viewed from the perspectives of nursing leaders
within educational, organizational, and policy leadership. Proposed future research based
on the developed theory may include theory testing or the development of a participatory
framework resulting in praxis which promotes the educational progression of members of
vulnerable rural populations, including rural nurses, and which strengthens the profession
of nursing for the future (Lincoln et al., 2011).
CHAPTER 3

Research Design and Methods

This research was conducted using grounded theory methods to obtain rich description (Denzin & Lincoln, 2011) of the perspectives of nursing profession leaders regarding the concerns of and the processes used by leaders of rural nurses in promoting rural nurse educational advancement. I used Glaserian grounded theory methods to create nursing knowledge through systemic examination of emerging core categories and social processes (Artinian, et al., 2009) used by nursing profession leaders as they work to promote the educational progression of nurses who practice in rural areas. The substantive theory generated may be used to enable prediction of behavior, for practical use in promoting rural nursing educational advancement, and to provide perspective regarding the nature of nursing leadership as it pertains to rural nurse educational progression (Glaser & Strauss, 1967).

This research was conducted using a partial framework of local concepts, rather than a guiding theoretical framework. The use of a preconceived formal guiding theoretical framework is inconsistent with the theoretical sensitivity required for the development of grounded theory (Glaser & Strauss, 1967). Throughout the research process, I cultivated theoretical sensitivity in order to conceptualize and formulate a theory grounded in the data examined. Local concepts important to early work in this research included rural health, nursing education in the rural setting, rural nursing education advancement, patient outcomes, social determinates of health, and nursing profession leadership.
This research constituted a study of human group life and conduct. The theory of symbolic interactionism has important meaning for the study of group life and conduct and is foundational in the use of grounded theory methodology. The theory of symbolic interactionism indicates that people act toward things on the basis of the meaning those things have for them. The meanings persons hold regarding nurses, rural nurses, and vulnerable nurse populations affect the manner in which these people approach, interact with, and respond to the challenge of rural nurse educational progression. Social meaning, a social product, is considered pivotal to understanding and interpreting behavior according to symbolic interactionism (Blumer, 1969).

The problem of multiple avenues for entry into nursing practice is a complex one, influenced by myriad societal and professional forces. The generative nature of grounded theory research (Glaser, 1978) invites the open-mindedness and creativity required to develop effective approaches within such a complex system.

The purpose of this research was to identify, describe, explain, and provide a theoretical analysis of the concerns of nursing profession leaders as they enacted processes to promote rural nursing educational advancement (Glaser, 1992; Starks & Trinidad, 2007). The aim of the research was to develop theory which explained the concerns of nursing profession leaders which arose as they worked to promote the health of vulnerable rural populations through the promotion of the educational advancement of rural nurses (Jones et al., 2019; Starks & Trinidad, 2007).

Rationales for the study included the need to promote nursing education in order to minimize health disparities between rural and urban populations, as well as the promotion of the achievement of the IOM’s goal of attaining a nursing workforce of
whom at least 80% are educated at the baccalaureate or graduate level (IOM, 2011). The present relatively low level of rural B.S.N. attainment (Jones et al., 2019) presents a persistent challenge to achievement of this national goal.

**Study Design**

The rationale for the design of this proposed research was based on metaphysical considerations of ontology, epistemology, and methodology. These metaphysical concepts are intertwined and interdependent with ontological factors guiding epistemology and epistemological factors guiding the choice of the methodology used in developing nursing knowledge (Guba & Lincoln, 1994; Carter & Little, 2007).

Ontologically, the post-positivist or critical realist paradigm posits that objective reality exists and can be known but that the imperfect nature of human senses and comprehension make critical interpretive processes necessary in meaningfully researching, understanding, and identifying the nature of that reality. Within this paradigm, the true nature of reality can never be perfectly known with singularity, despite the use of a critical and comprehensive examination of the nature of the information gathered. Reality can be known only probabilistically and imperfectly (Guba & Lincoln, 1994).

The process of educating nurses in the U.S. is an objective reality, a reality that can be studied and known. The processes by which nursing leaders promote the advancement of rural nurse education are composed of both objective and subjective aspects. These can be objectively and systematically studied, but the reality of such leadership processes may be approximated only. Hence, study of this phenomenon was well situated in a post-positivist paradigm (Guba & Lincoln, 1994).
The dualistic nature of the researcher as an independent and entirely objective observer of the phenomenon under study, as situated in a positivist paradigm, cannot hold with perfect certainty in a post-positivist view. Epistemologically, I acknowledged the impossibility of maintaining strict dualism and strove to utilize an objective lens regarding the nature of reality, while critically appraising the information derived from participants, each who brought their own perceptive and perceptual limitations to the proposed research. My own perspective and perceptive limitations were constantly and reflexively examined in order to minimize the effect of these on the emerging theory (Guba & Lincoln, 1994).

Aims of research situated in a post-positivist paradigm include explanation and prediction. Through this research, I aimed to explain and predict the behavior of nursing educational, organizational, and policy leaders in promoting rural nursing education. Classic grounded theory is a methodology well suited to the post positivist paradigm (Anells, 1996; Glaser, 2007). This inquiry occurred largely in naturalist settings and findings were grounded in the emic view of the researched, producing knowledge which reflected the reality and grounded perspectives of the participants (Guba & Lincoln, 1994).

Grounded theory emerged from the discipline of sociology (Glaser & Strauss, 1967). In this research, grounded theory methods were used to conceptually explain behavior used to address the core concern and to name a social pattern which emerged from the systemically obtained empirical data (Glaser & Strauss, 1967; Glaser, 2002). The issues surrounding the behavior of nursing leaders in the promotion of rural nurses’
education involved complex sociological concepts including patient outcomes, economic factors, and social determinates of health.

I acknowledged the intrinsically political and structural societal nature of the challenge of rural nurse educational advancement. It is my hope that the theory generated and used for explanation and prediction will serve as a building block for future action-based research and policy development which promotes the advancement of rural nurse education. It is because of a desire for empirical theory development on which future policy change may be based, that a post-positivist paradigm with classic grounded theory methodology was selected for this research versus a more intrapersonal critical paradigm and constructivist grounded theory methodology (Morse et al., 2009).

I strove to maintain the modified dualistic epistemology associated with the post-positivist paradigm as I reflexively monitored my own postcolonial feminist perspective with regard to the research. The filters through which I designed the research, engaged the participants, and analyzed the findings were all potentially subject to my personal perspective (Guba & Lincoln, 1994). I worked to remain alert to the possibility that my perspectives could have been informed by membership in the predominantly female rural nursing workforce and by my submersion in a profession with a history of subjugation by the dominant and largely patriarchal medical model which influences the nursing profession and the socialization of nurses. Grounded theory was an appropriate method for the generation of theory surrounding such social influence processes (Glaser, 1998; Parry, 1998; Artinian et al., 2009).

The socially defined process that gave meaning to these nursing leader participants’ work to promote rural nurse academic progression was not previously
widely examined in the nursing literature. Data obtained from these participants was used to promote comparative analysis leading to the development of substantive grounded theory (Glaser & Strauss, 1967).

**Selection of Sample Participants**

This research was grounded in the emic view of nursing profession leaders (Guba & Lincoln, 1994). Nursing leaders are called upon to direct and guide the education, acculturation, and regulation of the practice of nurses, including those who live and practice in rural areas. Abbott (1988) noted, in his seminal work, that jurisdiction of professional practice is maintained, in part through its academic knowledge. Therefore, nursing leaders from academic institutions which educate both pre-licensure nurses in rural associate degree nursing education units and RNs in baccalaureate degree completion programs were included as participants because they have personal knowledge regarding education and educational advancement of rural nurses.

Nurses who practice in leadership roles within healthcare organizations also exert influence over the professions, including over education and production of professional membership (Chiarella & White, 2013). These organizational nursing leaders were included as participants because their degree of support for a wide variety of employment policies influences the rate at which many nurses seek nursing academic progression (Pittman et al., 2013).

Nursing professional leadership is practiced in policy-based settings. Professions claim self-regulatory control over educational and behavioral standards of members (Abbott & Meerabeau, 1998; American Nurses Association, 2015; National Council State Boards of Nursing, 2007), as well as control over public protection related to professional
practice (Abbott, 1988; National Council State Boards of Nursing, 2007). The view from nursing policy leadership and related healthcare consumer protection was addressed in this research through the inclusion of nursing professional organizational leaders and nursing policy leaders from regulatory organizations.

Because of the theoretical relevance of their work and perspectives (Ma et al., 2018), nursing profession leaders from academic, healthcare organizational, and professional and regulatory nursing organizations were purposively selected for initial interviews. My initial plan was to interview ten participants from a Midwestern U.S. state. I recognized that, due to the nature of grounded theory research, it would not be possible to predict the precise number of participants that would need to be sampled beyond the initial collection of data (Glaser & Strauss, 1967). Theoretical sampling and theoretical saturation guided the final sample size. Institutional Review Board authorization for twenty participants was initially sought in order to account for anticipated theoretical sampling and for attrition (Morse 2015a). The final sample size was guided by analytical strategies comprising theoretical sampling and theoretical saturation (Glaser & Strauss, 1967; Morse, 2000; Morse, 2015a).

The recruitment and retention of participants was guided by Peplau’s theory of interpersonal relations (1997). Participants were nursing leaders who practiced within complex frameworks influenced by personal nursing experience, professional nursing practice, and metaprofessional forces. Dissonant forces may create anxiety for participants. Serving the needs of the participant through maintenance of a listening mode promoted trust, caring, respect, and valuing between the researcher and participants as the
participant-researcher relationship progressed through orientation, working, and termination phases of grounded theory research (Peplau, 1997; Penckofer et al., 2013).

**Data Collection Methods**

Data were derived from a variety of sources (Glaser, 2004) including nursing professional leader interviews, published reports and documents, and my own memos. Memos were constructed to identify the source of data contained and to avoid any potential confusion between participants’ data and my conceptualizations (Glaser, 1978).

Development of the semi-structured interview guide included consideration of the antifoundational perspective, which considers the legitimacy of foundational standards or truth, based on the belief that these are a social construction of participating groups, rather than unquestionable universal truths (Lincoln et al., 2011).

Semi-structured interviews were used to give license to participants to share their perspectives regarding nursing leader promotion of rural nurse education advancement. I then was able to compare and contrast interview data for the purposes of identifying similarities and differences across data. A balance was sought between loose guiding to maintain focus on the research question without directing or leading the participants away from their own concerns and perspectives, hence minimizing the effect of my own biases on the data. I utilized reflection for the purpose of clarifying needed interview data and member checking with my supervising researcher to promote reflexivity and to enhance rigor (Engward & Davis, 2015).

I am a rural native, a rural associate degree nurse educator, a former nursing administrator, and a healthcare organizational leader who entered into nursing practice with a baccalaureate degree. As a member of the rural nursing population, I worked to
exercise reflexivity regarding binaries, contradictions, and paradoxes within the research and with the participants on a continuous basis (Lincoln et al., 2011). Because of my experiences, I was able to use anecdotal comparison as another data source while maintaining reflexivity (Glaser & Strauss, 1967).

**Procedures and Promotion of Trustworthiness of Findings**

This research commenced with purposive sampling and semi-structured interviews with concurrent initial coding and ongoing memoing, including the creation and maintenance of an audit trail. Constant comparative analysis was employed as interviews proceeded and initial concepts begin to emerge (Glaser & Strauss, 1967). Incidents were compared with incidents, emerging concepts were compared with new incidents, and then concepts were compared with concepts. As categories began to emerge, these were compared with concepts, and then categories with categories. I utilized the criteria of fit, relevance, work, modifiability, and refit (Glaser, 1978) in ensuring methodological rigor and trustworthiness of the grounded theory research.

Memoing was conducted continuously as I become theoretically sensitive during the process of coding. Theoretical sampling occurred based on concepts derived from raw data and constant comparative analysis. Theoretical sampling continued until saturation was reached with respect to properties and connections with codes. Theoretical coding was used to conceptualize the relationship between codes (Glaser, 1978). Ultimately, a core variable and five categories emerged and theoretical saturation was reached (Birks & Mills, 2012).
Fit

Theory generated from grounded methodology should evidence fit, as one measure of objectivity. Fit was evidenced by the development of clear, descriptive categories that worked theoretically for the purposes of prediction, explanation, interpretation, and application. Fit was promoted through the selection of participants who shared their emic perspectives of rich insider knowledge of the processes under study. I assessed for and continuously monitored for fit by clarifying evolving concepts with participants to assure those were consistent with current knowledge regarding rural nursing educational advancement (Guba & Lincoln, 1994).

To further promote fit, I continuously strove to maintain a reflexive, consciously self-aware perspective, assuring that the grounded theory arose from the data, free from preconceived theories or frameworks. Simultaneous coding and analysis were performed throughout the research process, grounding me in the view from the data (Engward & Davis, 2015; Finlay, 2002; & Glaser, 1978).

Concepts were allowed to emerge, without forcing. Constant comparative analysis was employed with a focus on conceptualization, rather than description. I remained alert to and tolerant of the existence of conceptual confusion, and regression that are inherent in constant comparative analysis (Glaser, 1999).

A focus on the development of substantive theory prior to any effort to identify formal theory minimized the risk of forcing. This promoted fit by allowing a focus on the emerging data and on objectivity rather than on theoretical guidance, which can cause forcing of conceptualizations (Glaser & Strauss, 1967).
I am a novice to the generation of nursing knowledge. The participants were nursing leaders, many of whom were highly-qualified nursing experts. I was mindful of power differentials between myself and the participants to best assure power differentials did not unduly privilege the weight of data received from participants, many of whom hold positions of power and influence within the profession and the geographic region.

**Relevance**

Relevance is integral to discovering grounded theory that works. Relevance is promoted when core problems and processes emerge from the data and when the data is free from preconceived frameworks and from any personal researcher biases or interests (Glaser, 1978). I used an actively reflexive stance throughout the conduct of the research in order to promote relevance. I did this by clarifying and focusing the research lens on the data and the emerging concepts and categories.

I conducted this research through my perspective as a first-generation college student and a rural nurse who prepared for nursing practice in a private university setting which utilized a scholar academic curricular model. I have practiced as a nursing organizational leader and a nurse educator in a rural associate degree nursing program, resided in a rural area, and studied nursing philosophy in a metropolitan-based university. I have encountered issues related to rural population health and rural health disparities regularly in my professional practice. These experiences have contributed to my perspective regarding rural RN educational advancement, including my perspective regarding the value of a nursing-profession-led, population-based approach to promoting rural nurse educational advancement (Engward & Davis, 2015). In order to promote relevance and reflexivity, a constant state of attention to self awareness was maintained...
through memoing in order to assure findings which arose from the data were not unduly influenced by my own perspective.

**Modifiability**

Grounded theory emerges from the data at a given time and place in a given social setting. As such, the validity of findings gain vigor and tractability when modifiability is considered and embraced (Glaser, 1978). A substantive grounded theory has only partial closure because new ideas and more data can modify the theory. Modifiability is a continuous process and all grounded therapy studies have potential for further development” (Artinian, 2009, p. 51, Glaser, 1987). During the research process, I strove to allow emergence and to resist temptations to modify the emerging conceptualizations in order to appeal to a broader audience or to fit a preconceived hypothesis.

**Work**

Grounded theory findings work when these can be used to explain, predict, and interpret what is happening with nursing profession leaders as they work to promote rural nurse educational advancement. I allowed for emergence and worked to achieve theoretical sensitivity in conducting this research in the interest of promoting the ability of the grounded theory to work (Glaser, 2004).

**Refit**

Refit was promoted by constant comparative analysis and conscious attention to the effect of successive data on the emerging categories. Refit was also promoted through maintaining reflexivity without adherence to a category that had changed due to the introduction of successive data. Emergent fit was promoted by carefully fitting existing
categories with the emerging theory during the theoretical coding phase of the research (Glaser, 1978).

**Qualitative Rigor**

The conceptual framework used to describe qualitative research rigor has vacillated through the decades. Quantitative concepts including reliability, validity, and generalizability were initially used to evaluate the rigor of qualitative research. Guba and Lincoln (1994) influenced a move to a general qualitative evaluative conceptual framework which includes dependability, credibility, and transferability, all in the service of the promotion of trustworthiness as an indicator of qualitative research goodness (Denzin & Lincoln, 2011). Morse (2015b) has increasingly called for a return to the use of evaluative concepts associated with quantitative research including rigor, reliability, validity, and generalizability. Hence, conceptual shift and evolution contribute to any discussion of qualitative research trustworthiness and rigor.

In order to promote general qualitative research rigor, credibility, and trustworthiness, an audit trail detailing decisions related to the research was maintained. Memoing, as a priority activity (Glaser, 1978), was continuously conducted in order to promote conceptualization from the data and to provide an audit trail of activities, emerging conceptualizations, and to promote communication.

**Validity**

Questions of authenticity and trustworthiness undergird the concept of validity, which is used cautiously in qualitative research (Lincoln et al., 2011). Whittemore et al. (2001) included credibility, authenticity, criticality, and integrity as primary criteria of
validity; with explicitness, vividness, creativity, thoroughness, congruence, and sensitivity as secondary criteria.

I promoted valid conceptualizations of the data by gathering sufficient data and utilizing constant comparative techniques until saturation was reached, no further categories emerged, and the patterns noted emerged repeatedly (Glaser, 1978). Validity was further promoted by allowing time for the participants to become familiar with me prior to beginning the semi-structured interviews (Morse, 2015a).

Validity of concepts was promoted through the inclusion of nursing profession leaders and their emic view of the processes under study. The use of nursing leaders as participants was a strength of the study related to their educations, experiences, and their abilities to conceptualize and to verbalize these conceptualizations.

The nursing profession comprises the largest number of healthcare professionals in the U.S. (Bureau of Health Professions, 2013). It is inevitable, in such a large group, that subcultures are present and interacting. Individuals within these subcultures, including nursing leaders, hold cultural preconceptions regarding their subculture and those of other groups. These normative preconceptions, particularly when held by dominant subcultures, are well examined by grounded theory, which examines what is happening, minimizing the effect of preconceptions and leading to the emergence of theory that is relevant, which has fit, and which works (Glaser, 1999).

**Understandability.** Trustworthiness was enhanced by the promotion of understandability. During this research, I strove for the development of clear and accessible conceptualizations and theory which is accessible to both researchers and to non-researchers (Glaser & Strauss, 1967).
**Generalizability.** I worked to develop substantive theory which is generalizable in that it is usable for other research and theorizing within the subject area. The substantive theory created may be used to facilitate some degree of control over the processes under study through time and in similar situations (Glaser & Strauss, 1967). Grounded theory methodology, as a qualitative method, preserves the rich contextual reality of the researched reality, promoting applicability and generalizability (Guba & Lincoln, 1994).

**Choice of Setting**

As often as possible, participants were interviewed in the setting associated with their nursing leadership role. This choice of setting promoted authenticity, vividness, and an embedded perspective with rich and thick description by participants.

**Description of Data Analyses Procedures**

**Plan for Analysis**

Analysis began with the collection of data from each member of the purposive sample of initial participants. I analyzed the data received, coded these data, and created case-based and conceptual memos based on these data. Memo writing was used to assist in code and category generation throughout the process (Saldaña, 2013).

Grounded theory methodology does not require the practice of tape recording interviews. Field notes are the preferred method of recording participants’ data (Glaser, 2004). In part because I am a novice researcher, audio recordings of interviews were conducted in order to assure the participants’ communications were gathered explicitly (Artinian, 2009). Field notes were taken concurrently. Recordings were transcribed following each interview to best allow for concurrent data gathering and analyses.
(Engward & Davis, 2015). Consistent with and supporting grounded theory methodology, the use of a symbolic interactionist framework and exploratory inquiry allowed me to take a broad approach to what constituted data and to use a purposive data-driven approach to exploring concepts within the context of use (Blumer, 1969). I vacillated between inductive and deductive reasoning as concepts arose from the data, were verified through memoing and through constant comparison, and through analysis of and between further data obtained (Glaser, 1978). As core categories began to emerge, theoretical sampling was employed.

The acknowledgement of the presence of multiple participant perceptual realities, reflexive examination of claims of truth, and acknowledgment of the role of power in shaping an ever-changing reality were used in exploring this complex social phenomenon. The acknowledgement of the presence of multiple realities (Denzin & Lincoln, 2011) according to perspective was useful in exploring this complex social phenomenon. I reflected on my own post-colonial feminist perspective reflexively throughout the study of the processes used by nursing profession leaders to address rural nurse education progression.

**Description of Types of Coding and/or Statistical Procedures**

Open coding, interviewing, and analytic memo writing occurred simultaneously during this research. Comparisons were made between data and between codes. In vivo coding, noting words and phrases from the participant’s actual language (Saldaña, 2013) was conducted, sentence by sentence, with comparison of incident with incident. Coding evolved into comparison of incident with codes and then codes with codes. Attention was given to identifying the argot of nursing profession leaders regarding rural nursing
educational progression (Saldaña, 2013). NVivo 12© software (2016) was used as one tool to assist in the data management process.

Data were examined line-by-line and coded, using open coding, in as many abstractions as were conceivable (Glaser & Strauss, 1967). Instances were coded in maximal pertinent categories. Constant comparative analysis, which contributed to perceptual empowerment and a transcending perspective (Glaser, 1999) was employed. Interviewing, coding, and analytical memo writing occurred in simultaneous timeframes (Glaser & Strauss, 1967). Open coding was used to reduce and refine the number of codes. Data newly gathered were compared with existing codes (Glaser, 1978).

Following identification of a tentative core variable, theoretical sampling of participant groups was guided by theoretical purpose and relevance in order to develop emerging categories. Codes were considered for possible use as both categories and dimensions of categories (Glaser, 1978). I continuously interacted with participants, data, codes, and categories (Glaser, 1992).

Group identification and sampling continued until properties of the categories were no longer developing and theoretical saturation was achieved. Theoretical coding with sorting, theorizing, examination of the literature, and checking with nursing profession leaders for theory fit, work, and relevance occurred as the basic social process and the core variable emerged from the inter-related theoretical categories (Glaser & Strauss, 1967).

**Rationale for Choice of Analysis**

Methodology drives method (Carter & Little, 2007). Open, selective, and theoretical coding, performed simultaneously with constant comparative and theoretical
memoing are the analytical tools of classic Glaserian Grounded theory. These methods helped me to move from the empirical data to higher level of theorization by breaking down the data, conceptualizing it, and simultaneously exploring and discovering theoretical relationships between the emerging concepts (Glaser, 1978).

**Provision for the Protection of Human Rights**

Provision for the protection of human rights was assured through Marquette University’s Institutional Review Board. Participants in this research were nursing profession leaders. Confidentiality of participants was maintained by assigning numerical identifications to participants and by storing the key which links participants with their identification number in the locked file cabinet in the researcher’s locked office. Physical interview notes, memos, and interview transcriptions, identifiable only by code, were stored in the researcher’s locked home file cabinet. Digital files including transcriptions, memos, and analyses, identifiable only by code, were stored on the researcher’s password-protected computer.

The audio files were destroyed immediately after transcription. The key linking participants’ identities to the transcripts will be destroyed at the conclusion of the research. The de-identified transcripts will be maintained for ten years following the conclusion of the research, on an encrypted drive in the researcher’s locked home file cabinet.

I did not supervise or control resources related to any of the participants. It was not anticipated that participation in this research placed the participants at risk for undue psychological distress. The probability that participation in this research placed
participants at occupational, professional, or personal risk was judged to be low. The magnitude of potential harm related to such risk was judged to be low, as well.

**Limitations**

Limitations regarding this research were present with respect to the researcher and to the research design. The novice status of the primary researcher is a noteworthy limitation of this research. Theory generated as a result of this research was the work of a novice researcher. This was my first experience developing theoretical sensitivity within a grounded theory study, so this research likely required a longer period of time in order to achieve such sensitivity (Morse, 2015a). Fourteen participant interviews were conducted in the course of the research, not an extensive number, though their perspectives were broad and drawn from deep experience as leaders of rural nurses.

Participants’ perspectives were informed by the experiences of promoting rural Midwestern nursing educational progression. The study was conducted with participants from one Midwestern state. Therefore, the findings fit and work in this Midwestern state, but may have less fit in other rural regions. The perspectives of rural associate degree nurses were not solicited and did not inform the resulting theory.
CHAPTER 4

Results

In chapter four, I will discuss the findings from fourteen in-depth interviews and other related data sources.

The Journey to Meaning Making

I conducted this research to create knowledge regarding the work of nursing leaders in the promotion of rural nurse academic progression. Grounded theory methodology does not include an extensive initial literature review, as such a review has the potential to interfere with the researcher’s theorizing and, ultimately, with the developing theory. An initial review surrounding key variables was conducted and included review of the literature with regard to rural health, rural nurse academic progression, and leadership of rural nurse academic progression.

It was important that I recognized my own biases and preconceptions while conducting the work. I grew up in a rural area, was a first-generation college student, and entered practice with a B.S.N. I benefitted from privileges not afforded many persons who enter rural nursing practice with an associate’s degree. My perspective was informed by rurality and a hard-working, comfortable, and supportive childhood. I earned my B.S.N. as a traditional college student from a small private college. I was an outsider in this academic setting, having no close role models from my family or our social groups who had experienced higher education. I attended a private college at a time in history when social policy allowed a rural high school graduate from a working-class family to borrow the money needed to obtain a baccalaureate degree, and to earn a degree with minimal debt related to college loans. I am a rural nurse and I reflexively examined the
biases and preconceptions associated with my perspective continuously while conducting this research to minimize the effects of these on the emerging theory.

I conducted in-depth semi-structured interviews with 14 nurse leaders centered around nurse leader concerns and strategies regarding rural nurse academic progression. Semi-structured interviews were held in a location selected by the participants. I assumed particular strategies and interventions for the promotion of rural nurse academic progression would emerge from the data, and these certainly did. However, from the first semi-structured interview, it was apparent that the work of promoting academic progression is complex and that leaders navigate many ‘distances’, in addition to the apparent rural physical distances, in promoting B.S.N. and graduate degree attainment by rural RNs.

The work of coding and analyzing the data derived from the participants began with the first interview. Constant comparative analysis was used to compare data with data. As subsequent interviews were conducted, codes from these interviews were compared continuously with previous codes. Concepts emerged from these codes and these were compared with new codes and concepts with concepts. Categories began to emerge from these concepts. These emerging categories were compared with concepts. After category to category comparison, the core variable of Leading Through Distance emerged. Leading Through Distance is the process used by rural nurse leaders to promote academic progression through myriad resource, vocational, social, cultural, and professional factors all of which may constitute distance between rural nurses and their achievement of academic progression.
The purpose of this research was the development of substantive theory which explained the concerns experienced and processes used by leaders of rural nurses to promote rural nurse academic progression. Through analysis of the data, the substantive theory of leading through distance emerged.

The first research question was, ‘What are the central concerns of nursing profession leaders as they work to promote rural nursing educational advancement?’ The second research question was: ‘What do they do to resolve these concerns?’

Leading through distance is central to rural nurse academic progression. Leading rural nurse academic progression is conceptualized and navigated by participants through the intersection of a variety of vocational, resource-based, social, cultural, and professional factors. Through this work I integrated these into a substantive theory which can be used as a guide for future research and to develop interventions that promote rural nurse academic progression.

The theory of leading through distance states leaders of rural nurses promote rural nurse academic progression by reconciling resource distance, bridging social distance, working through cultural distance, and lessening profession distance; all through the perspective of their own professional practice imperative of delivering rural nursing. The theory examines the interplay of nurse leader concerns and strategies and how these interact to explain the leadership of rural nurse academic progression. In this chapter, the categories will be described, through the voices of the participants.

**Participant Demographic Characteristics**

I conducted semi-structured interviews with 14 nurse leaders who practiced in nursing academic, organizational, and policy leadership roles. The criteria used to
attribute an area of nursing leadership practice to an individual was more than one year of formal service in a given practice area of nursing leadership. Several participants had extensive expertise in more than one category of nursing leadership. Primary practice area attribution was based on primary employment setting. Participant education and practice characteristics are featured in Table 1. Aggregate participant education and practice characteristic data are featured in Table 2.

Table 1

Participant Education and Practice Characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Degree at Entry to RN Practice</th>
<th>Highest Nursing Degree</th>
<th>Highest Non-Nursing Degree</th>
<th>Primary Practice Area</th>
<th>Secondary Practice Area</th>
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Table 2

Aggregate Participant Education and Practice Characteristics

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<td>7 (50%)</td>
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The Findings

In the following section, I will explore, in detail, the five categories which compose the substantive theory of leading rural nurse academic progression.

Delivering Rural Nursing

Delivering rural nursing was the main concern of participants as they worked to promote rural nurse academic progression. Leaders of rural nurses promoted rural nurse academic progression through the perspective of their professional practice of delivering rural nursing.

At approximately the mid-point of the research, I was challenged by a rural acute care leader, Joyce, who questioned the idea of rural nursing and rural nurse progression being different from the same experiences for urban nurses:
So, um, I have a little bit of a, I don't know exactly what to call it. I have a little bit of concern when I hear people pull out rural nurses as a group that has to get special treatment or whatever, because, I think that part of the um, part of the myth is that rural nursing is different in some way. So, I struggle with that a little bit. I know it's maybe a little bit more challenging but in today's world with everything that's online, the, you know, the flexibility that we have in scheduling, I don't really know that being a nurse in a rural setting puts a person at a disadvantage in terms of rural progression.

I shared the Joyce’s comments because there are certainly readers with the same thought, especially as Joyce was a leader of rural nurses and other readers may have less contact with rural nurses than does Joyce. During the course of this dissertation, I hope the data and interpretations will convince readers that the academic progression decision for rural nurses is often a complex and multifactorial one with aspects unique to the rural experience. In response to Joyce’s comments, I offer the comments of Stephanie, rural policy leader, who shared her experience of applying an urban lens to a continuing education offering for rural nurses:

One thing that we learned really early was that we had to stay rural focused. Because we had speakers coming in from the city, and you know, and the rural nurses got that nixed, right away. They said, “That urban nurse presenter talked about all of these resources - well, in rural nursing, it's me and the doc, so, that's not really working for me.”

So, we just revamped our whole program, based on that, to be sure it's rural-focused - that it is reality for the nurse who's choosing to work rural.
The delivery of nursing care in the rural setting is a central concern for leaders. Their occupational role success, whether as an educational, organizational, or policy leader is predicated on their ability to deliver high quality nursing care to populations through the maintenance of a capable and stable nurse workforce. Jackie, organizational leader, described the challenge of providing nursing care in her rural acute care organization:

Well, the biggest challenge is access to nurses, in general, because we are sort of remote, being an hour commute, either way, to a larger city. We are in a rural community. There isn't a lot to draw younger people to the community or to entice them to stay. So, access to nurses in general, or, in a broader capacity, actually, a lot of healthcare professionals is challenged where we live.

Shelli, academic and policy leader, shared the effects of distance and of an urbanormative perspective (Thomas et al., 2011) on nursing profession awareness of delivering rural nursing.

People don't realize, they are so used to the metropolitan areas and they are not thinking about the rural areas. ‘Cause if we didn't have the associate degree programs throughout the state, we wouldn't have the rural nurses.

Marie, academic and organizational leader described the difficulties faced in tuning legislative attention to the workforce and resource needs of rural areas, “There's an assumption, that healthcare in this area is just always going to be. I think it makes it difficult. Sometimes, those legislative conversations are extremely difficult.”

These leaders’ comments are supported by the findings of Kovner et al. (2011) who noted the U.S. nursing workforce is not a mobile one. Participants report their belief
that, to secure an adequate number of nurses to provide care to rural communities, nurses must be ‘grown’ from the existing rural population. The necessity to ‘grow our own’ was identified by many of the study participants as key to maintaining a rural nurse workforce.

**Academic Concerns in Delivering Rural Nursing and Academic Progression.**

Associate-degree nursing programs located in rural locations provide an academic on-ramp to nursing education and practice for local persons including members of vulnerable rural populations. However, the existence of these programs perpetuates the problem of low rates of nurse progression to baccalaureate or graduate degrees.

Associate-degree educational and organizational leader, Marie, shared her perspective regarding delivering rural nursing:

One of the things that we have really struggled with is maintaining that infrastructure of rural health. I've kind of come to realize it in the educational component, that we really do need to grow our own. To have people who want to have the rural experience come from more urban areas - they have the experience and then they go back to the urban area. So, being able to educate nurses and really, all facets of healthcare and be able to have them come back and commit and contribute to the rural areas is hugely important and it's something that I think that we need to focus more on.

Organizational and policy leader, Sue, expressed concerns regarding the use of successful completion of the National Council Licensure Examination (NCLEX©) as a marker of nurse competency. Her comments are particularly relevant in rural nursing care, where large percentages of the nurse workforce practice with an associate’s degree:
The associate degree schools, it's not that they don't care about knowledge, they do. But they are held accountable, to a greater degree, for their NCLEX© passing scores. So, I do think there is a trend. There is a presence of focusing on how do I get my students to pass NCLEX©? NCLEX© passing is not, in my mind, competent.

Rural healthcare organizational leaders reported their reliance on nursing education programs which serve the local population. Jackie, organizational leader, has proximity to two nursing programs, both associate-degree, in her geographic area. She explained:

So, in many situations, we are very grateful for the fact that we are blessed with the A.D.N. programs being in our service area and that we have the opportunity to support nurses' learning in the rural community, and actually starting to feel the tug of the care that's provided in the rural setting.

This reliance of rural healthcare organizations on local associate degree nursing programs highlights the importance of academic progression messages embedded in rural associate degree nursing programs.

**Organizational Concerns in Delivering Rural Nursing and Academic Progression.** In order to deliver rural nursing, leaders must recruit nurses, help them to prepare for rural nursing practice, and align incentives with progression behavior. Organizational leaders shared concerns in all of these realms. Gail, policy leader, shared her perspective regarding recruiting non-rural nurse leaders to provide nursing care in rural areas: “I know that to try and recruit nurses who are not from the rural areas, who
want to come and oversee care and direct care and be that nurse leader, I just don't know what brings them.”

Acute care leader Tammie discussed the challenges related to delivering rural nursing care through a rural generalist approach:

Well, some things I see are maybe the fact that you're more specialized in a tertiary center. You know you're an orthopedic nurse or you're a cardiac nurse. I see, in our rural areas, um, you're much more diverse. You learn lots of things.

Organizational and policy leader, Sue, who practices on a geographic margin between a rural and a semi-urban setting, voiced her support for academic progression for rural nurses, citing the high levels of nursing practice required in rural healthcare organizations.

I believe that rural nurses are, in many ways, needing to have a higher level of critical thinking, autonomy, and independence than are urban nurses, because they generally are generalists, versus specialists, and that requires a different skill set. I believe the rural nurse, from a practice and a process perspective, has to be way more developed, not less.

Organizational policies, including reimbursement policies, send a powerful message to employed nurses regarding the value of academic progression. Educational and organizational leader Marie discussed the importance of rural healthcare organizations contributing resources to support their workers’ nursing educations, “Healthcare employers want to have workers, but I think they need to get a little skin in the game.”
Policy leader, Stephanie described the damping effect on progression behavior when acute care organizations do not provide a system of tuition support for nurses. She shared nurses’ attribution for their non-progression decisions to their employing organizations’ lack of tuition funding, “Obviously, some of the RNs comments are, ‘You know, our organization doesn't reimburse us.’” Stephanie actively supported progression and voiced her support for delivering high quality nursing care for rural persons through the use of graduated salaries for A.D.N.s and B.S.N.s:

You have higher level thinkers as B.S.N.s, you know, and the evidence is that they improve patient outcomes. So, when you think about your global snapshot, it's worth investing um, more money per hour in the B.S.N. than, you know, the A.D.N..

Acute care organizational leader, Joyce was working to prepare her A.D.N. primary care nurses for delivering rural nursing in the future by encouraging those nurses to progress. Joyce’s concerns regarding future increased needs for B.S.N.s in primary care settings are supported by Bauer and Bodenheimer (2017). Joyce shared:

One of the things we really need to have an RN do in the clinic setting is care coordination. And, of course, the national associations are saying, guess what? - Need to have a bachelor's degree to do care coordination, which I think is absolutely correct. But, where does that leave our nurses in the rural clinic - these experienced nurses who have all this great clinical background, but don't have a bachelor's degree? So, I think that's where the challenge comes in – helping them developing an appreciation that the world is not stagnant. And the world is
changing and we need to change with it if you want to stay where you are. That has been, probably, the biggest challenge.

One unanticipated concern of increasing the rates of academic progression in rural acute care settings is the production of an organizational surplus of nurses prepared at the master of science in nursing (M.S.N.) level. Both Tammie and Joyce discussed concerns related to this phenomenon. Tammy spoke of a desire to move these M.S.N.-prepared nurses from the medical-surgical unit to other organizational opportunities as soon as those opportunities manifested. Joyce discussed a plan for shared M.S.N. nurse appointment with a local school of nursing:

The challenge is keeping them engaged and really helping them use that degree in a rural setting. That can be challenging. So, we've tried to, and not just do it in a management role, because that's not what some of them want to do - and - good for them. So, we've tried to use a couple of them as faculty. But, what they really want to do, I mean, the clinical piece, I think is good, but what some of our master's prepared nurses want to do is, they want to teach. They want to do the didactic part, too. And, my experience has been that the schools of nursing are less willing to let them do that. They need the clinical support in the facility, but, as far as letting them be full-fledged faculty member, it's like the schools want to hang on to that other piece.

**Policy Concerns in Delivering Rural Nursing and Academic Progression.**

Marie educational and organizational leader, expressed her concern for any proposed “all or nothing” policy in which the B.S.N. was required for entry to practice. She advocated for a continued system of both associate-degree and baccalaureate-degree pre-registration
nursing programs, with funds being dedicated to encourage and educate the nursing workforce regarding academic progression.

**Occupational Inequities**

The distance between academic progression support offered in many rural acute care organizations contrasts starkly with the lack of formal progression support available from stand-alone long-term-care organizations. Rural long-term care leaders not affiliated with acute care systems reported little to no resource availability to support nurse academic progression.

Academic progression for rural long-term care nurses is important because a greater percentage of the rural nurse population practices in long-term care organizations than does the urban nurse population (Bureau of Health Professions, 2013). Effective nursing knowledge and skills are important for long-term care nurses and their patients, as nurse leader Sarah, stated, “Symptomatology in the elder is more obscure, so, really, nurses who practice in long-term care have to be sharp.”

Margaret, long-term care leader, explained the nominal tuition reimbursement scheme used in her long-term care organization, “The nurses had to pay out of pocket, successfully complete, and then they got reimbursed for a portion. That was one of the very poor benefits that we had. I think it was, like, $500 or $1,000.”

Long-term care leader, Elizabeth, explained the challenge with the value proposition for her rural RNs: progression would not result in higher wages for the nurses who academically progressed:

I think, in rural areas we have fewer resources in the facilities in which you might be working to provide financial support to those individuals. Also, I don't see a
great financial advantage here. I think there are a lot of advantages for our registered nurses to continue their education, certainly. But, financially, there's very little opportunity, in my facility for them to earn a lot more if they gain that bachelor’s or master's degree.

Elizabeth’s comments are supported by rural long-term care funding realities. Rural long-term care facilities have high Medicaid utilization rates (Rural Health Information Hub, 2018) and state Medicaid reimbursement schemes often utilize tiered payment systems with lower reimbursement rates for rural long-term care organizations (Division of Medicaid Services, 2018).

Despite these fiscal realities, Elizabeth found other ways of supporting her nurses who academically progressed. She shared stories of assisting her nursing team members which reflected her pride in these nurses and their accomplishments. Some stories were tinged with sadness when the nurses left the long-term care organization for other aspirational roles, following supported, successful progression:

I think of a couple of nurses that have continued their education and then have moved on and you know, there's a little part of you that thinks, “Gosh, after all the encouragement, and all of the support, and the schedule changes, and the last minute calls because they have a test tomorrow and they can't come in to work because they have to study. And then, they leave you, anyway.”

Experienced RN to B.S.N. educational leader Nicole spoke from her extensive experience with acute care healthcare organizations that funded RN to B.S.N. tuition for nurse employees, and with policies which require progression to a baccalaureate degree within a prescribed number of years following hire in order to maintain employment. In
her following comment, she addressed her unfamiliarity with such policies within long-term care organizations:

You know, I've not investigated that, really and I've not heard about long-term care requiring progression. I'm pretty certain they might be offering some tuition reimbursement, but I've not heard of any policy from long-term care where they've required nurses to academically progress.

Nicole’s reflections regarding a lack of condition of continued employment policies in long-term care are rationale considering long-term care leader participants’ experiences with long-term care RNs who academically progress. Under the current incentive structure, strategies to help long-term care RNs earn their B.S.N. often result in the new B.S.N. leaving the long-term care organization for a different nursing role – challenging the long-term care leader’s ability to deliver rural nursing for vulnerable residents.

**Delivering Rural Nursing and Academic Progression**

Employers Delivering Rural Nursing Progression. Sarah, policy leader, described the potential of nursing organizational leaders to influence progression behavior, particularly on the individual level.

I think the fact that affects progression is your employer. Is there a leader in your workplace that values this, that encourages you, that tells you how you can make it happen, how it's doable? Is there a leader that brings people in, that offers scholarships, I think that's the factor that makes the difference?

**Investing in Learning.** Organizational leaders deliver rural nursing and promote academic progression by investing in and sparking motivation for continued learning for
their nursing team members. Tammie, acute care organizational and policy leader, promoted both academic progression and preparation for the high levels of rural nursing practice through funding nurse residency experiences for all novice nurses hired into her organization:

We send all of our new grads through a year long nurse residency course. This functions as a bridge to practice from when they first graduated…I think that's what really makes a lot of our nurses, from my perspective, want to want more. They want to continue on their education.

Acute care organizational leader, Joyce, also funded nurse residency experiences for every newly hired novice nurse. She explained, “we worked really hard to engage those nurses that first year. So, we sent them through a year-long nurse residency program, and, simultaneously, we work hard to engage them in the work that’s happening on the unit.”

**Bringing B.S.N. Students to Rural Organizations.** Leaders shared their strategies to deliver rural nursing and promote academic progression by welcoming baccalaureate nursing students from urban schools of nursing for clinical experiences in the rural acute care facilities. Tammie’s rural acute care organization facilitates pre-licensure clinical experiences for both rural A.D.N. and urban B.S.N. students. Joyce, rural acute care leader, implemented a similar strategy and was preparing for her organization’s first cohort of B.S.N. clinical students. She described her desire for more organizational interaction with B.S.N. students:

I think the one thing the rural nursing setting struggles with is having access to bachelor's degree students, in terms of clinical courses. That is something that we
have struggled with. We get them, usually one at a time. They want to do a capstone project, or something. I think it would really help our nurses if we could have B.S.N. students here for longer-time clinical experiences.

**Preferential Hiring Practices.** Jackie, acute care organizational leader, uses preferential hiring and promotional practices to promote academic progression. She successfully led consistent nurse academic progression behavior despite limited access to baccalaureate schools of nursing and without a policy requiring baccalaureate degree completion within a prescribed time limit in order to maintain employment. She shared her experience regarding the progression plans of associate degree nurses entering her organization:

Somewhere around 75% of our staff initially come onboard as associate degree nurses, but, every single one that we've hired within the last couple of years comes on board with a plan. They are doing the completion. Some have already applied and they're ready to roll right into that program as soon as they've passed boards and some, by the next semester, have already begun those programs.

**Progression as a Requirement of Continued Employment.** The policies and behaviors of rural acute care leaders influence the educational behaviors of nurses who work both inside and outside of their rural acute care setting. Urban and some rural acute care organizations have increased their percentage of B.S.N.-prepared nurses through preferential hiring for B.S.N.s and through policies requiring academic progression within a designated time period. Organizational and policy leader, Sue, when asked what has worked to promote academic progression in her acute care organization stated, “When we made it a requirement.”
Condition of continued employment policies were utilized by three of the four participant acute care organizational leaders. These policies affect the academic progression value proposition by allowing the RN to maintain their current employment position upon academic progression. Tammie’s rural acute care organization required attainment of the B.S.N. within five years of initial employment while financially supporting progression with tuition reimbursement. Tammie reported strong success related to this policy:

Yes. Within five years, that they are either enrolled or completed. And, the majority are just right in it. I mean, they're, maybe a year, you know. They want to get their, you know, their feet on the ground here. But then, most of them are either taking classes or fully enrolled in a B.S.N. program.

Nurse organizational leader, Joyce, instituted a B.S.N. requirement in order to hold a management position within her organization. She strongly supported this decision as an overall benefit to the organization, though it did result in one nurse electing to leave the organization, rather than obtain the B.S.N.:

We actually had a supervisor that, when we told the supervisors they had to get their bachelor's, we actually had a supervisor who left and went to work in a skilled nursing facility because she did not want to get her bachelor's degree. That was not something that was in her plan and that's where she is today and she's doing really well there.

These policy adoptions in acute care settings have far reaching effects. More long-term care nurses are entering academic progression as a strategy to prepare themselves to move their practice from long-term care to acute care. Nicole, RN to
B.S.N. nurse educator described a substantial shift in the occupational demographics of RN to B.S.N. program enrollees. She estimated that sixty to seventy percent of the nurses enrolling in the most recent years were currently practicing in long-term care at the time of enrollment, “We're seeing more and more long-term care nurses- where it used to be more acute care nurses.” She explained the forces impacting many of these nurses’ enrollment behavior:

Part of the reason is that many of these nurses who are recent graduates from an associate degree school, if they’ve not been in an acute care system, worked as a certified nursing assistant (C.N.A.) and worked their way up, they are maybe not getting the acute care position they want. And so they're having to work long-term care first to get experience, and to go back and start that degree before they can be considered for an acute care position.

**Delivery Rural Nursing Through Policy Work**

Policy leader Sarah discussed the importance of standardizing the associate degree nursing curriculum in promoting academic progression:

Standardizing the A.D.N. curriculum across the region made is easier for graduates to transfer credits and to academically progress. Previously, that was a barrier, as it was very hard to get your credits to transfer, and every school transferred them differently and it was just very hard to start your way into baccalaureate education.

Sarah worked with rural hospital and nursing programs to promote the delivery of clinical experiences in rural hospitals. This work helped rural nurses to appreciate the experiences to be gained in the rural setting and decreased travel costs for the rural
nurses. Sarah helped rural hospitals and nursing homes to grow their own nurses and helped keep them in the rural areas, as well as promoting clinical experiences for B.S.N. students in rural areas.

**Academic Progression to Advanced Practice**

Marie shared the imperative to take a future-facing view toward educating nurses from the current rural population. She envisioned progression as an important strategy in both addressing the rural physician shortage and advancing nursing practice. Tammie’s acute care organization facilitated the provision of scholarships from local benefactors for the purposes of promoting B.S.N. enrollment in M.S.N. education, particularly in preparation for advanced practice nursing roles. Many rural advanced practice nurses initially enter the nursing professional pathway as A.D.N.s. Feeg and Mancino (2018) noted an increase in the percentage of A.D.N. graduates who aspired to a doctoral role in nursing practice, supporting Marie’s and Tammie’s visions.

Nurse leaders worked to promote academic progression through the lens of delivering rural nursing through educational, organizational, and policy-based strategies. Academic progression can be further promoted when the resource distance between rural nurses and their progression goal is reconciled.

**Reconciling Rural Resource Distance**

So, I always had this urge or whatever it may be, to learn. But the accessibility just wasn't there and we just didn't have the finances, and had three kids and, um, life was extremely busy.

—Laura, rural native and educational leader
The category of Reconciling Rural Resource Distance comprises the concerns expressed by and the work being done by leaders of rural nurses to promote rural nurse academic progression by recognizing and minimizing costs and identifying and maximizing benefits of progression for rural nurses.

The decision to academically progress involves a value proposition. The nurse considers the benefits of progression and the potential recipients of that value. The nurse also considers the costs of progression, both financial and social; as well as any available resources to mitigate those costs. Through the analysis of benefits and costs, the nurse determines a value proposition for academic progression.

Rural resource distance is the space - physical, psychological, emotional, or social which tips the value proposition toward or away from enrollment in academic progression. Rural resource distance is minimized when the costs associated with rural nurse academic progression are decreased and when the benefits of academic progression are maximized. In the next section, I will explore the nurse leaders’ concerns and actions regarding the resource distance separating rural nurses from academic progression.

Costs

Participants described concerns regarding financial, employment, and social costs of rural nurse academic progression. Each of these areas are next detailed.

Financial Costs. Nurse leaders spoke of the high cost of returning to school. All study participants, particularly those who entered the profession as associate-degree nurses strongly stressed the role of cost in academic progression decisions. When asked to identify obstacles to rural nurse academic progression, organizational leader Tammie responded, “I think cost. OK, we all know it's very expensive now. I don't know there's a
lot that will happen to change that.” Organizational policy leader, Stephanie stated, “The
money. Totally the money - it's all I hear. It's not about, 'I don't want to go back to
school' or 'That's not for me'. It's always about the fiscal responsibility that they carry.”

Stephanie shared her own earlier experience of academic stall related to financial
costs and of the life-changing effect of a one-time organizational policy which supported
LPNs academically progressing to A.D.N. degrees:

I just get goosebumps thinking about it. Because, I would not have been able to
go back to school, because I was out on my own and I had to pay for myself, and I
wasn't going to take a loan.

Acute care leader Tammie spoke with concern about the position of some rural
acute care organizations toward nurse academic progression. Tammie’s own organization
had a strong system of tuition support. When asked if her colleagues in other
organizations felt the same level of organizational support for nurse academic
progression experienced by Tammie, she replied:

Umm. Not all of them. I think there's a lot of budget constraints out there now,
especially in small, rural hospitals, that, that's not always their priority. I mean,
I'm sure they're still encouraging. Well, I'm thinking they're still encouraging.

Stephanie, organizational policy leader identified the release of the IOM report
with the height of rural acute care organizational support for nurse academic progression.
She estimated that about half of all rural hospitals currently provide some type of formal
tuition reimbursement, in addition to selective scholarships.
The participants described rural resource inequities with respect to resource access, tuition support, and community financial support. Laura, education and policy leader, shared her concerns and delivered a call to action:

We need to accommodate the challenges and the issues associated with poverty and rural area geography - lack of broadband, lack of social support, and lack of many of the determinants of health that really affect our rural environments and our rural students, way more so than urban environments.

Physical distance creates costs for rural persons. Elizabeth, long-term care leader explained, “one of the largest barriers would be… the financial burden, the distance to school because we are removed from those a little way …from any school within our small center here.” The rural nurse incurs distance expenses related to gasoline, automobile maintenance, and insurance and these costs accrue as the nurse travels between home, work, school, and family. Transportation in rural areas requires an automobile and the associated costs including gasoline, insurance, and repairs. Marie, organizational and educational leader explained, “living in rural areas, we don't have any mass transportation.”

Laura, educational and policy leader discussed the need for increased support for rural nurses – a recommendation for additional resources that could alter the value proposition and shorten the distance between rural nurses and academic progression.

I would say, that we need to provide more financial support for nurses who would like to go on because, oftentimes, in rural environments, nurses, we typically are the breadwinners of the family and so the loss of an income or benefits, perhaps, can be unsettling for one's family. And there just isn't financial depth for many
rural families. I look at my own family and my husband's family. Neither one of us had financial depth to support our educational journeys.

**Employment-related Costs.** Associate degree academic leader, Shelli, discussed the effect of cost and vocational variables on academic progression:

It's money. Money is huge, you know. And insurance, because they need the money to support their family. But even if they had that, if they could, the insurance is huge, so a lot of them have to work to get the insurance and usually, it's 50% of full time hours that you have to work to get the insurance. So, that's a huge thing. Insurance is big and so, that's the main thing we hear about. So, people have to work and they try to work and go to school full time, while they are working and that's a nightmare. You know, plus, they have kids in between and, I mean, there's just a multitude of issues.

Physical distance can result in lower income when potential work time is lost to transportation time. For rural nurses who enroll in academic progression, time spent in transportation, in academic progression courses, and in study compounds the cost of academic progression by decreasing the time available for paid employment. Elizabeth, long-term care leader explained:

I don't very often see an individual that can just come in and say 'I'm going to quit my job and go back to school'. I don't think the majority of individuals, probably, residing in this area, aside from kids right out of high school, can do that.

**Social Costs.** Social costs impact the academic progression value proposition. These costs were described extensively by participants. Costs related to distance and family obligations were limiting factors for Tammie, organizational and policy leader.
She discussed her own transition from working in an administrative position in a primary clinic to earning her associate’s degree in nursing, explained she was able to achieve this milestone “only because there was a technical college in the area and I was able to still, you know, with my family - my young family, able to join that program there.” The presence of the associate degree program in her rural area partially ameliorated the resource challenges of distance and role responsibilities, though it drove her choice to enter practice with an associate’s degree.

Laura, educational and policy leader spoke of the intersection between the rural economy and available social support for nurse academic progression:

We're working alongside families that work very hard as farmers, loggers, machinists, manufacturing, um, construction, which brings another whole set of issues because, many times if you have family support, parts of that family support may be gone for weeks on end as they are over-the-road truck drivers. Or they are gone for service because many of our rural people have joined the service because there aren't any decent paying jobs.

So, they're gone for months of the year. So that whole social support, financial support, lack of other socioeconomic resources - just in the nature of occupations are not in a rural environment to support nursing students going on to school.

Stephanie, healthcare policy leader, spoke with rural nurses from across the region. She shared their collective story of social costs which interfere with academic progression:
It’s the commitment that they have for their family. It's still, you know, “I've got kids in soccer and sports” and, you know, “maybe ten years from now.” Right? But it's, it's really the personal obligations that they have.

Role pressures on rural women are high and this can impact the academic progression value proposition (Burton et al., 2013). Sarah worked with rural nurses who had been out of the workforce and were contemplating a return to active nursing practice. She shared her experiences of assisting these rural nurses and of the role pressures they experienced when they contemplated new professional endeavors:

They would say things like, "My husband left a note on the refrigerator saying, 'Where were you today? I needed something and you weren't here.” Oh, well, now she has to pick between how things are going at home and and going back to work or to her career.

**Technology-Mediated Distance**

In addition to financial and social costs, technology affects the academic value proposition for many rural nurses. Technology is associated with connectivity, but participants also attributed factors related to technology with progression barriers and increased distance between rural nurses and academic progression behavior.

**Broadband Access.** Laura, educational and policy leader lived in a remote rural region. She explained the impact of access to technology on rural persons:

I know it's expensive but I think we've got to do things differently and better for rural environments. We spend all kinds of funding to provide access in urban environments and yet, in our rural environments, where we are decimated, we lack broadband, and all these other things, um, because we have less numbers of
people, we're not seen as needing as much. Which, if you think about it from a health inequities lens, um, it really should be the opposite way.

**Technology Skills.** Participants shared stories of technology-related skill deficits that increased distance between nurses and academic progression. Sue, organizational and policy leader summarized her perspective regarding the technology skills of many of the more seasoned nurses – “those individuals who are in their 40s and 50s and have had second careers - they’re not very tech savvy.”

Joyce, acute care organizational leader, spoke of technology challenges and the fear felt by nurses related to the use of new technologies required for academic progression:

Honestly, I think a lot of reluctance to academically progress is related to fear, especially, if RNs don't see themselves as particularly computer literate - although I can't understand how any nurse practicing today could not see themselves as computer literate.

We had an eye opener when we had one group of nurses who went through a B.S.N. completion course on campus here. This was a cohort of experienced nurses and they wanted a face-to-face course delivery model. So we brought in one of the colleges and did classes on site. And that group of nurses, it was really quite eye-opening because even though they were fine with using the electronic health record - Word, PowerPoint, Excel - not so much. So, they really almost had to have remedial skills training in those three applications before they could begin to participate in the coursework. And that was even in an onsite course.
Margaret, long-term care organizational and policy leader, who abandoned her own academic progression attempt, shared her story of technology challenges related to academic progression.

Well, I just ran into barrier after barrier for myself. I went through the state university system’s online RN to B.S.N. program. But, right off the bat I got into trouble because I'm not tech savvy. There were multiple electronic systems that weren't compatible. When I would call for assistance, people were very good and very helpful, but only in their little arena. None of them seemed to understand how the components integrated.

**Online Curriculum Delivery.** Online educational delivery options have created opportunities for rural nurse educational progression. For some rural acute care nurses, however, the move to online course delivery has shifted the burden of time needed for achieving academic progression from the employing organization to the individual rural nurse. Nicole, educational leader, discussed recent trends in B.S.N. completion curriculum delivery. She explained that, in past years, nurses employed in many rural acute care organizations received one day of release time per week to attend academic progression classes. Organizational leaders Tammy and Joyce both discussed similar models that had been used in their organizations. Nicole explained that her employing RN to B.S.N. academic program has noted a steady shift from on-site to online delivery in recent years.

Laura explained the transition from face-to-face academic progression delivery in the employing organization to online delivery has decreased costs for nurses related to travel but simultaneously shifted the burden of academic progression time management
from the employer to the individual nurse. Policy leader Stephanie shared a perspective in which the nurse’s life time is construed as ‘someone else’s time’, rather than their own limited resource.

There's a lot of online options now and I think that's helping because the nurse doesn’t have to travel. They don't need to take another day away from work and can do it on their own time and not someone else's time. They can still work.

This shifting of the time resource burden from organization to nurse can help the nurse to maintain income and benefit levels. However, when the nurse enrolls in progression education while maintaining current employment levels, a new cost is placed upon the vulnerable rural nurse. This shift requires the nurse to prioritize current life obligations with fewer time resources. High levels of stress may then be added to an already stressful situation. RN to B.S.N. educational leader Nicole interacts weekly with progressing rural nurses and shared her perspectives regarding best practices for supporting these nurses.

Many nurses are jumping to online programs versus what we used to have - face-to-face, one day a week. We've tried to provide hybrid options where they just come to a physical classroom 3 times in a seven-week period. The nurses are not getting those days off as easily as they used to. So getting that time off has become much more difficult than it used to be. I think just really truly supporting their nurses by allowing them time to be students is the best way leaders can support their nurses who are contemplating going back to school.
Reconciling Rural Resource Distance

Leaders of rural nurses identified and brought forth resources to promote nurse academic progression, by lessening the costs associated with progression.

Closing Tuition Cost Distance. Rural acute care nurse leaders have led the provision of financial resources for rural nurse academic progression. Stephanie, policy leader reported approximately half of the state’s rural hospitals provide programs of tuition reimbursement and scholarship support for nurse academic progression.

Joyce, acute care leader, reported her organization provides “full tuition reimbursement.” Tammie, organizational and policy leader described her acute care organization’s philosophy regarding financial support for nurse academic progression:

Nurses who academically progress qualify for up to $12,000 per year in tuition reimbursement. There is no payback to us, just a forgiveness of a dollar amount per hour for every hour they work for us after that.

Jackie, acute care leader, described her organization’s programs for decreasing the cost of nurse academic progression:

We have both a tuition assistance and a scholarship program for people wishing to further their education and it's particularly beneficial for nursing staff because the dollar amount awarded is, is a very solid dollar amount. They can continue to access that every semester the entire course of their completion program.

We talk about funding, creative options, tuition reimbursement, all of the time - about, how do we maximize the education of our nurses, who are the foundation of our hospitals? Um, so, you know, people are coming up with creative ideas all of the time.
Tammie reported her perception that offering paid progression courses had correlated with a high degree of employment satisfaction and retention. She reported nurses completed their B.S.N. and many continued on to achieve M.S.N. degrees and nurse practitioner roles. Tammie spoke proudly of that organization’s commitment to every nurse, stating, “We never hold anyone back.”

Academic and policy leader, Shelli, shared her graduates’ experiences with financial support available from some large acute care health systems, mostly available to those rural nurses who practice in acute care at the edges of suburban areas.

We do see a lot of support, especially from large hospital systems, where our alumni, especially the ones who have gone on, got their masters they will say that they didn't pay for the bachelors or for their master's degree - the hospital did. And so, a lot of them are calling it Degree Up or something - there's different names for this. That is what I'm seeing. So, I think we're having a multi-faceted approach towards this, and that's how we're going to make this happen.

**Closing Resource Distance Through Future Reimbursement.** Differential reimbursement based on nursing degree is used as a tool to promote progression in Tammie’s acute care organization. Though this differentiation is a long-term incentive, it alters the value proposition, potentially lessening the resource distance for rural nurses. Nurses from a wide range of academic preparation backgrounds participated in the creation and management of the organization’s nurse career ladder through service on the nurse education committee. The career ladder incentivized both academic progression and certification. The organization’s career ladder required either a baccalaureate degree
or certification related to the nursing practice area in order for nurses to assume a leadership position. Tammie explained the philosophy underpinning the career ladder:

We have a bridge for nurses to, like if you, the more you train, I mean, they're compensated. I don't want to sound like it's all about the money, but the more departments that you become trained in, and the more, and the higher degree, and the education that you do, that's all, somehow fit into a compensation structure, so that they're, you know, we value them, and they know that we value them, and we value their continuing education.

**Closing Physical Resource Distance.** Both Joyce’s and Tammie’s rural acute care organizations lessened nurses’ costs of progression by holding progression courses at the employing healthcare organization. Tammie elaborated: “We actually have another B.S.N. program coming in in the Fall and we currently have 11 of our nurses enrolled, and it's probably about the last 11 signed up to continue on to their B.S.N. degree here.”

Joyce’s acute care organization decreased resource distance with regard to both distance and technological concerns when they responded to nurses’ requests for onsite progression courses. Joyce explained: “They wanted face to face courses, so we brought in one of the colleges to hold courses onsite.”

**Minimizing Resource Distance Related to Employment.** Leaders report assisting nurses with work schedules in order to minimize the effects of academic progression enrollment on the nurses’ ability to maintain their employment. Margaret shared the teamwork involved in helping progressing nurses maintain their employment, “We always ‘wheeled and dealed.’ Or a manager would work the floor.” Elizabeth, long-
term care leader, shared the pride she experienced, assisting one of her organization’s nurses to academically progress, and to become an influential policy leader:

I couldn't give her a nickel. I mean, we didn't have that, but, again, it was just the support that I think she received from me and from my administrator at the time in both encouragement and flexibility of schedule, that she was able to do that.  

So, I had, and I'm so proud when I see her. I think, "Gosh, you know I knew she had all of that skill and capability and I'm glad that, in some small way, that I could help. 

Nurse leaders promote nurse academic progression by reconciling resource distance. In the next section, we will explore the ways in which nurse leaders promote academic progression by bridging nurse social distance.

**Bridging Nursing Social Distance**

The category of Bridging Nursing Social Distance comprises the concerns expressed by and the work being done by leaders of rural nurses to promote rural nurse academic progression. Leaders recognized and minimized nursing social barriers to progression for A.D.N.s.

Rural associate degree educational leaders identified associate degree nursing programs as an accessible on-ramp to a nursing educational pathway for rural persons. Many nursing leaders referred to the associate-degree graduate as a technical bedside nurse. This group identity as a technical expert was proudly claimed by rural associate-degree nurses.

Leaders of rural nurses sought to realize the full potential of rural A.D.N.s., encompassing, but not exclusive to the technical expert role. Rural nurses have strong
technical bedside skills but many have not yet fully benefitted from the knowledge, skills, attitudes, and resources needed to realize their full potential as nurses – to develop into nurses who are prepared to maximize health outcomes for the persons, families, and communities they serve.

Organizational policy leader, Sarah, earned her B.S.N. through an urban university in the 1960s and entered practice in a rural hospital. She shared her experiences of learning from and appreciating the technical expertise of rural nurses:

Following B.S.N. graduation, we went immediately to a very small hospital in a neighboring state where I was practicing because my partner was in graduate school and this was a place that I could find work. And it was really kind of interesting to find out that nurses with baccalaureate degrees weren't respected at all. It was pretty much, "Oh, too bad, we got a baccalaureate graduate. They don't know anything. This will be hard to swallow."

So, it was a really, um, it was a very interesting change for me to go from clinical courses in a large urban hospital to begin practice in this small rural hospital. I would say things worked out well. I enjoyed my two years there. I learned a lot there. It was one of those places that had a 12-bed medical unit and a 12-bed surgical unit - so it was a tiny hospital and I learned to do everything. I mean I really learned to do everything - got a good experience in a rural hospital.

In the next section, I’ll explore the concerns of the leader participants working to promote progression of rural associate degree nurses across social distance, beginning with the experiences of nurse leaders.
The Traditional Society of Nurses

The profession of nursing is rooted in the values of middle-class European women (Choperena & Fairman, 2018). This value set is more consistent with that of the leaders of rural A.D.N.s than with the rural A.D.N. population. Participants who entered practice through baccalaureate schools of nursing during the 1960s and 1970s shared many characteristics with this historical middle-class European female perspective.

Shelli, educational leader described her pride in being a first generation baccalaureate student in the 1960s. She shared insights into the academic choices available to women during that period in time:

So, I wanted to go to college - that was the big key. And so, when I got to college, it was more like – “Do you want to be a nurse, a social worker, or a teacher?” So, I chose nursing, which I’ve never regretted. I’ve loved it.

In 1970, 8.2% of U.S. women had completed a baccalaureate degree (National Center for Education Statistics, 2018). The percentage was most certainly lower in rural areas of the Midwest. Shelli’s baccalaureate degree achievement was the first step of her educational progression. Regarding further progress to a graduate degree, she explained, “I was always going to go back.” She subsequently earned her M.S.N. on schedule, according to her life plan.

Gail, policy leader, entered practice with a baccalaureate degree in the 1970s. She progressed to an M.S.N. program approximately three years after completion of her B.S.N., Joyce, organizational nurse leader, entered practice with a B.S.N. in the 1970s and completed her master’s degree in the 1980s.
Nurse organizational policy leader Sarah entered practice with a baccalaureate degree in the late 1960s. She explained, “Women of that era were not offered very many options. My parents were pretty clear - I could be a teacher or a nurse.” Sarah and her spouse had pledged that they would take turns earning their graduate degrees following their baccalaureate graduations. She explained the signal to academically progress after the baccalaureate was strong from her large, research-intensive alma mater.

I kind of came out of my bachelor's program thinking that was my obligation. You know, we sort of got that beaten into us in our bachelor's program, that we really, to be a clinical leader, either a clinical leader or an administrative leader, we needed to do that.

Nurse leaders are a relatively affluent group when contrasted with rural RNs. Louise, who entered practice in the 1980s, discussed the strong support she experienced for higher education participation from her parent:

I remember talking with my Dad and thinking, “I've got to go down that nursing path because I want to be a nurse and work with people.” And I thought, “Well, maybe I'll just go to an associate degree program.” And I remember my Dad saying, “No, just apply to university, get your four-year degree.” And I'm so glad I did. You know, sometimes, when you're young like that, you're just thinking, “Oh, I just want to get done and get working and make money and do that.”

These leaders’ perspectives align more closely with the middle-class European perspective rooted in historical nursing profession practice than do the perspectives of many members of the rural RN population they lead. Leaders of rural nurses may be more likely to practice from a position of relative privilege than are rural associate degree
nurses and this can impact how they perceive, speak about, and approach the challenge of rural nurse academic progression. Gail, policy leader, who entered practice with a bachelor’s degree and rapidly attained a graduate degree, attributed time as a key barrier in rural A.D.N. progression behavior.

So, I advocate for the bachelor's being the minimal sort of degree that you want to attain, and support that associate degree nurse who has the skills, and when they get the time, I encourage them to progress. And I know the organizations that they get their B.S.N. completed in so many years. I think, we support all of those sort of activities.

Organizational leader Joyce, who entered practice as a B.S.N., employed a similar unimodal approach to rural A.D.N. progression promotion when she identified online access as key to progression behavior.

I know it's maybe a little bit more challenging but in today's world with everything that's online, the, you know, the flexibility that we have in scheduling, I don't really know that being a nurse in a rural setting puts a person at a disadvantage in terms of rural progression.

Joyce’s professional perspective is that of an acute care leader who practices in an organization that provides strong tuition support for progressing nurses. In this organization, nurses are required to academically progress in order to maintain employment and baccalaureate degrees are required in order to attain a supervisory role.

In the full scope of rural nursing, both her own nursing educational journey and the resource and workforce realities of those she leads are privileged with respect to the majority of rural nurses.
A Change in the Progression Message

A change in the historical nursing progression message was reported by leaders who entered practice in the 1980s. Louise, organizational nurse leader, entered practice with a baccalaureate degree from a research-intensive university in the 1980s that was very similar to that described by Sarah. Louise, entering practice two decades following Sarah, spoke of the absence of a progression message to graduates. She stated that she felt, ‘No pressure, at all’ to academically progress.

My own experience, entering practice in 1987 with a baccalaureate degree was similar to Louise’s, but with an additional element– An attorney from the local healthcare organization came to our school of nursing with a direct message of academic cooling off to our graduating cohort. He recommended that we take at least a year or two away from academia, in order to practice before returning for graduate study. The reason for this cooling off message was not made clear. No shortage of nurses was occurring at the time, so nurses lost from the bedside to academia were not an immediate concern for healthcare organizations or the greater nursing profession.

Is it possible that the presence of an attorney from an affiliated health organization taking the time and resources to speak to our graduating class was indicative of an increased level of healthcare organizational influence over the nursing profession emerging during the 1980s? An interesting question is: Would the baccalaureate academic leaders of the 1960s and 1970s have welcomed or permitted such a message to be delivered to a cohort of graduating B.S.N.s in the 1960s or 1970s?

During 1970s and 1980s, a large number of associate-degree nurses began to enter the profession (Shaker-Field, 1991). This change created more opportunity for rural
people and those from other vulnerable populations to access the nursing profession. Simultaneously, opportunities for careers were expanding for women, well beyond those available to Shelli and Sarah. Suddenly, wealthy women had opportunities far beyond nursing, social work, and teaching. The social fabric of the profession was changing with a much bigger social ‘tent’ and increased social distance between nurses who were joining the profession and the experienced nurses who entered practice with diplomas or B.S.N. degrees.

Educational leader, Shelli, mused regarding the social changes which have occurred in the nursing profession since she entered practice, “And how many wealthy women are going to go into nursing these days? They'll go into medicine, law, engineering, you know.” Nurse policy leader, Sarah, who entered practice in the 1960s, discussed her thoughts regarding generational changes in nursing leadership which occurred in the 1980s and 1990s:

I think there is kind of a space, um, where the people who ended up being in nursing were people who um didn't have that the academic skills that their predecessors had. It was partly, who went into nursing and I think that has resulted in a leadership vacuum. I do think there is a space in the middle where, um, women proposedly missed nursing. And I think that has been a problem and I think it has been a struggle for the nurse leaders from my generation.

Sarah identified generational gaps in nursing academic skills. It is possible that this variable represents a gap between the social and cultural homogeneity of the earlier nurse population and the new social order which emerged as associate degree nurses entered the profession and wealthy women chose other newly opened professional fields.
The participants in the study are not a random sample of nursing leaders but do represent a broad range of leaders of rural nurses. These leaders practiced in the areas of educational, organizational, and policy work. Nine of the 14 participants entered practice with a baccalaureate degree. This fact, alone, represents a difference in perspectives between the participants and the rural A.D.N.s they seek to lead to and through academic progression. In the following section, I’ll explore more of the leader’s concerns as these relate to their work of helping rural associate degree nurses to flourish from across a nursing professional social distance.

**Bridging Social Distance to Promote Progression**

Laura explained the importance of the growth that occurs when nursing social space is minimized and nurses academically progress from A.D.N. to B.S.N. status.

It’s not to negate the value of an associate degree nurse by any means, but they've got to continue because when you are so focused in the technical aspects of nursing, you are excellent in those procedures in that getting the job done. But, what we need to do is to stimulate and challenge policy, challenge the status quo, challenge and advocate for system change because when we go down the route of only looking at tertiary care, we negate what nursing has been, which has been, always, much more holistic.

**Mentoring and Coaching**

Mentoring and coaching can help rural nurses to navigate social distance and achieve academic progression. Tammie shared a story of training a new A.D.N. in the emergency department. Tammie expressed a great deal of pride in assisting this nurse to
academically progress and to assume a new social role in the nursing community as an advanced practice nurse.

I actually had a young guy start out as a C.N.A. And he worked with us while he was going to school. He first got an A.D.N., then continued onto school and had a B.S.N. and I trained him in our ER, during most of this time. So, we would talk often. And he really wanted to become an advanced practice nurse. So, he started looking at schools. And I told him I would help him, and he enrolled in a master’s program. I was his proctor, through all of that. I gave him all of his exams and coached him and encouraged him. And he became an advanced practice nurse. And he went away from here for several years, and practiced in a couple of different hospitals and I recruited him back two years ago and he is now a nurse practitioner for us. And, yes, that's one of my success stories, because I think, and, I don't take credit because, oh my gosh, he is, you know, a worker bee, but I'm so proud, and so proud of him.

Educational and organizational leader, Marie, discussed the importance of personal encouragement and counseling in helping those nurses who entered practice as A.D.N.s to gain confidence in moving between nursing professional roles. For Marie, these talks encompassed broad socializing concepts including but not limited to educational options and strategies. Marie expressed a great deal of personal satisfaction in recounting a story of a nurse she assisted to progress academically through the use of coaching and mentoring.

When you look at my hires over the years, one particularly comes to mind. She was qualified to teach in the Medical Assistant program, and she really knew that
her goal was to be an instructor of nursing. And we had some tough conversations, but it was, “If this is what you want, I'm very open to it.” And I think, having someone to encourage you and to nurture you and to say, “Yeh, you can do this,” is really important. And this particular nurse has really emerged as a leader. She has voice. She was a little timid to start with, but she's really committed to that. And I'm so proud of her. Every time I see her, I'm just like, bursting! And I think we've had so many people in that transition, going from B.S.N. to M.S.N., and just encouraging that. And it isn't an easy journey, but just to encourage it and to provide resources, where you are able to, I think that's huge.

**Promoting Academic Progression Within the Society of Nurse Education.**

Laura, educational and policy leader, hailed from a rural area and entered practice as a B.S.N.. She reflected on her past perspective regarding academic progression and nursing social distance as she entered practice in the 1980s:

The thought of a rural kid succeeding, going on to school, just wasn't in the purview. I mean, the fact I had a bachelor's degree was considered to be, um, unusual. To have or think about going on for a master's degree was nearly inconceivable and going on for a doctorate degree in nursing was not even on the radar.

Nursing academic leader, Shelli, alluded to nursing social distance while describing her work with rural associate degree nursing students:

Because we really try to help people be successful, we don't look just at GPA. Because a lot of these people have struggled. They need help. I love working with
this kind of student because, when you see the “Ah ha!” moments, when you see them, and then, at pinning, they are there with their families. And you wonder, “How the heck did they ever do this?” These are the working, the salt of the earth people that are working, and they are so proud.

Organizational and educational leader, Marie, lessened nursing social distance when she organized an affiliation between her A.D.N. program and a private B.S.N. program, including offering that program an office on the A.D.N. campus. By bringing the B.S.N. program onto the rural A.D.N. campus, she sent a message that higher education belongs in rural areas and that rural nurses do academically progress:

One of the reasons we brought a B.S.N. program on this campus was so that there would be exposure to “this is not it for you.” We have encouraged our student nurses to really look at the big picture about what it is they can do - what their career might look like - maybe not today, but you know, ten years from now or twenty years from now.

Educational leader Shelli injected inclusive progression talk throughout the associate degree program, “We want to encourage people to continue on. That's been our mantra from the day they walk in the door. This is a pathway. It's not a terminal degree.”

Marie, educational and organizational leader, spoke of her nursing program’s annual Nurses’ Week celebration and yearly pinning ceremonies, where faculty members invite alumni who have academically progressed to speak with A.D.N. students regarding their progression journeys. Bridging social distance between enrolled A.D.N. students and their progressing colleagues from earlier A.D.N. cohorts sends the message that
‘people like me earn baccalaureate and graduate degrees.’ Educational leader Shelli described her associate degree school of nursing’s graduation presentation:

We actually have an alumni speak every year at graduation. And we purposefully pick someone that's in grad school or in the B.S.N. program because we want to encourage people to go on and to see, you know, how excited they are about their jobs. One of them was a DNP student, and she said, that, actually, the DNP program was easier than her associate degree program here. The graduating students, of course, just loved that.

Marie bridged nursing social distance by providing models of academic progression in the form of faculty members who hailed from the rural community. She employed A.D.N. faculty members who were in the process of completing their M.S.N. coursework. Her decision to hire faculty members who had not yet earned their M.S.N. necessitated increased onboarding and training costs and required that Marie request and receive waivers from the State of Wisconsin allowing these faculty members to practice while enrolled in their M.S.N. programs. Marie stated this decision was helpful in promoting academic progression because the model set by these faculty members helped students to realize that ‘people like me’ academically progress. The majority of Marie’s A.D.N. faculty members at the time of the interview had academically progressed after entering practice as A.D.N.s from Marie’s program. She added, “students identify with someone they can commiserate with as a student, someone with practical experiences.”

Associate degree nurse leader Shelli discussed the positive results obtained from the social support provided by her academic team in mentoring and coaching students to academically progress following graduation:
A lot of our students do go on, because, I think for a variety of reasons we really push it. And they may not go right away because they need a breather and just to start making money. A lot them work in the hospitals where they require them to have a bachelor's degree within five years, which we support, and we're totally in favor of that. That's not a problem at all. Because we encourage it.

Leaders referred to a relatively recent change in the progression behavior of A.D.N. graduates. Tammie spoke of her belief regarding socializing associate degree nurses to academic progression “maybe at the A.D.N. academic levels, they're maybe doing a lot more educating and promoting that, because most of them the A.D.N.s are entering practice with that goal.” Organizational leader Joyce, noted a change in the progression message emanating from associate degree nursing programs:

My experience is that the community colleges have done a much, much better job of helping us set that expectation for academic progression, especially for the A.D.N.s. And they are coming to us now understanding that this, this isn't a stopping point - “I absolutely have to get my bachelor's degree.”

Policy leader, Gail, noted movement toward academic progression emanating from A.D.N. nursing programs:

I know that when I give lectures or guest lectures in the different schools - and even the students that I precept - I precept B.S.N. completion students - they all say that they heard about it through the A.D.N. program saying, “This is just your first step.” That was encouraging to hear and I'm hearing that that's the message that is actually happening within the associate degree programs.
Promoting Academic Progression Within the Society of Nursing Practice.

Sarah, policy leader described the power of rural nursing organizational leaders to bridge social distance by influencing progression behavior through respectful and supportive personal interaction:

I think the fact that affects progression is your employer. Is there a leader in your workplace that values this, that encourages you, that tells you how you can make it happen, how it's doable? Is there a leader that brings people in, that offers scholarships, I think that's the factor that makes a difference?

Acute care leaders exposed RNs to academic progression resources and information, normalizing and inviting the idea of progression. Tammie explained:

We brought in the university to come and talk to them and they had just a large number of people come through and learn more. And, if they don't do it this year, they will. You know, it's in the back of everyone's mind.

Marie, educational and organizational leader, proposed a wrap-around message of academic progression, beginning with initial employment:

I think that nurse leaders need to nurture academic progression and to really encourage people - the minute somebody is hired you encourage them with, “What are your plans? What are you thinking?” There are people who don't want to academically progress, absolutely, but maybe there are a lot of times that people do not even know what they want. What I wanted twenty years ago, from what I want now, are, they're entirely different things.
Tammie engaged her organization’s society of nurses in progression policy design. She reported that engagement of front-line organizational nurses in the design and implementation of progression policies paid dividends:

And our clinical ladder, I think, has really encouraged people. And that clinical ladder, those recommendations, come from our front line nurses. This group of nurses meet regularly and approve education, you know, everything that's working toward that higher degree.

**Celebrating Progressing Nurses**

Paid release time was offered in nurse leader Jackie’s organization to allow progressing nurses to complete academic projects. These projects were then integrated into nursing department systems. This support for progressing nurses’ academic work allowed for the development of new systems which strengthened patient care outcomes. This practice offered highly visible support for nurse academic progression to the entire unit team. Jackie described an example in which a progressing nurse used her scholarly project, designed to decrease patient incontinence, to provide leadership and to promote improved patient outcomes within the organization:

So, we allowed her time to work on that program while she was here, as the floor activity allowed. But, I think it was a win-win. It was a win-win for her to have the opportunity to impact something that she was passionate about and certainly, the organization and our patients will benefit from that program.

Nursing leaders work to limit social distance within the profession, welcoming nurses to academically progress within a warm and welcoming society of nurses. The society of rural nurses is embedded in a larger rural culture. Rural nurses are born into or
enter into this pre-existing rural culture. Entrance into this culture shapes social interaction (Stryker, 2008) and identity formation. It informs the degree of agency one wields over their own nursing practice and contributes to decisions about how one does or does not engage with nursing academic progression. In the next section, I will explore the category of bridging cultural distance with respect to rural nurse academic progression.

**Working Through Cultural Distance**

Access to higher education is just not seen as part of one's journey when you grow up rural.

—Laura, nurse educational and policy leader

The category of working through cultural distance captures the concerns of and the work being done by nurse leaders to promote rural nurse academic progression with nurses who live and work within a rural culture. Nurse leaders are challenged to help rural A.D.N.s to explore their current cognitive frames and identities, to maintain those that are consistent with academic progression, to explore formation of new identities consistent with the path to progression, and to work within the context of rural culture to promote academic progression and to promote the best possible patient outcomes.

**Rural Nurse as Technical Expert**

Cognitive frames are structures through which one categorizes and makes sense of the world (Lakoff, 2014). Through framing, persons define the ways in which life is conceived and experienced (Semino et al., 2018).

The identity of the rural associate degree nurse as a technical bedside expert is a common cognitive frame, foundational to the identity of many rural nurses. Academic
and organizational leader, Marie, engaged this frame to describe the practice of associate degree nurses, “I think you're looking at a specific skill set that is bedside.”

The cognitive frame which emphasizes the preeminence of nursing bedside technical skill can lead associate degree nurses to believe that academic coursework associated with RN to B.S.N. programs of study is not relevant to their nursing practice. Joyce, organizational leader, referring to rural A.D.N.s, stated, “I think one of the challenges is actually getting them to a point where they see value in it, without knowing, having gone through it.” Sue, organizational and policy leader, spoke of the potential effect of the technical expert self-identity on the decisions of A.D.N.s to engage in academic progression:

I think there is historical context to, I believe that, how would I say this - historical context that there isn't value to greater education because, from history, it's “I'm a technical expert at the bedside and there is no value to another degree.” So, I think there's cultural, historical morays that also impact those individuals who want to obtain greater education.

Long-term care organizational leader Louise explained a stance toward nurse educational preparation that equated nurse academic progression with further acquisition of hands-on nursing skills.

We don't talk about an applicant’s level of nursing degree that much when we do the interview. You know, obviously, I look at it when I look on their application to see where they graduated and got their RN. But, its not - it doesn't even come up. And, maybe it's wrong, but when we hire here, we're looking for compassion, empathy, the personality, because we can teach the skills.
Rural Culture and Academia

Educational and policy leader, Laura, a rural native, explained the cultural conflict often experienced when rural persons pursue higher education.

So, you go on to school and you negate the values that you have been raised with and people will negatively influence you because you are leaving that family nest. You are leaving that level of poverty. Oftentimes, conversation turns to a challenge of that you are thinking that you are better than those of us around here, and all of those poverty issues.

Laura illuminated the connections between interdependence, group identity, and rural culture. To a rural person who has experienced resource-scarcity and interdependence, the risk of losing or electively tossing away one’s critical rural social support system in order to academically progress, particularly if the likelihood of securing a well-paying job in the rural setting related to that progression is not likely forthcoming, can be frightening, and perhaps dangerous.

Laura discussed the cultural distance that can be created by academic progression:

My husband and I speak often about how fortunate we were that both of us decided to go on to school from this rural environment because our thinking has been shaped, in many different ways, way more so than our high school colleagues, who, it's very difficult to relate to anymore because of how we think about our world and the priorities we have put in place. And, you know, it would be very difficult to have maintained any kind of relationship with someone who hadn’t minimally, gone on for advanced education.
Elizabeth shared her thoughts regarding why some rural nurses choose not to academically progress, even when provided full tuition and stipends for enrolling, “You know, not everyone aspires to - I think sometimes, people equate more education with climbing the corporate ladder. So, I think, not everyone aspires to do that.”

Sue’s, Laura’s, and Elizabeth’s insights are supported by Cramer’s (2016a) work with the concept of rural consciousness. Rural consciousness describes a self-perception of some rural persons as disadvantaged with respect to urban dwellers, receiving fewer resources and being less privileged than urban dwellers and than rural public employees. Common to a rural consciousness perspective is a distrust of formally educated authority figures.

Thomas et al. (2011) described a similar rural concept, that of a “cultural backlash against urban cultural hegemony.” The concepts of rural consciousness (Cramer, 2016a), urbanormativity, and cultural backlash (Thomas et al., 2011) are closely intertwined and have potential to impact rural nurses’ academic progression decisions.

**Evidence for Academic Progression.** Leaders shared experiences of speaking with associate degree nurses who regarded baccalaureate coursework as a task to complete, rather than a life path to learning, self-development, and improved patient health outcomes. Sue attributed this view to a lack of knowledge when she described an interaction with a group of newly hired A.D.N.s.

So, I said, “For those of you who are coming in with an associate's degree, why do we have the requirement, in your offer letter, of the B.S.N.?” Blew my mind. So, we got answers from, "It looks good on paper” - These are actual answers. “It
looks good on paper.” “The Joint Commission requires it.” “You’re on a magnet journey.”

Not one of those associate's degree persons reported ever hearing of the IOM report. Nor, when we talked, could they articulate the difference between a meta data analysis or a meso data analysis. Not one of those people could speak to any of that.

Population-based practice and abstract statistical probabilities may not be fully consistent with the cognitive frames of rural persons (Cramer, 2016a), for whom cause and effect are more likely to be sensory, rather than statistically mediated. When rural nurses’ cognitive frames relate more strongly to tangible versus statistical evidence, even evidence-based knowledge to which the nurse has been exposed may be disregarded because it is not consistent with their existing cognitive frames (Lakoff, 2014). To rural persons, leaders who argue for behavioral change, such as academic progression, based on population-level patient outcome improvement may be viewed as unrealistic and even elitist (Cramer, 2016b).

Koessl et al. (2013) associated a lack of knowledge regarding research methods and scientific evidence with rural nursing practice and posited this relative lack of knowledge may constitute a barrier to its use. Cramer’s (2016a) research with rural persons indicated that members of rural populations value tangibility. They are more likely to perceive and interact in the world of the concrete than are urban dwellers. Long and Weinert (2013) determined rural nurses are more likely than urban nurses to be familiar with their patients and those patients’ family members and friends and to derive evidence and conclusions based on personal interaction.
Situating evidence for nurse academic progression can be challenging for rural nurse leaders. Rural persons have demonstrated a preference for evidence based on personal experiences over evidence based on statistical data (Cramer, 2016a; Cramer & Toff, 2017). The outcomes data which drive the nurse academic progression recommendations are population-level and not easily relatable to personal experience. In fact, rural nurses often personally know nurses whose academic progression resulted in increased debt, relationship strain, and other negative outcomes. Alternately, rural nurses are unlikely to be aware of a case in which a specific patient’s outcomes were improved because of the knowledge gained by a nurse in their RN to B.S.N. educational program.

Rural persons live in a practical culture where evidence takes many forms. Evidence may be statistical and population-level or it may be practical and highly visible. The number of nursing aspirational roles are limited in rural areas. A lack of nursing aspirational roles for nurses who academically progress can provide evidence against academic progression for rural nurses. Rural nurses are often aware of every aspirational nursing professional role within their rural community. They may know when the current occupant of that role is likely to vacate the role. And they likely know at least some of the nurses who would serve as competition for that aspirational role. Rural nurses weigh the costs of progression against the likelihood of attainment of the aspirational role in making progression decisions. Margaret shared her long-term care organization’s support for one nurse who aspired to one available aspiration role.

She was probably the only person that we really truly were able to help - one of our nurse managers - because we had more flexibility so she did do a completion program that was a one-day-a-week - physically-present sort of program and we
accommodated her schedule. We gave her every Wednesday off, or whatever it was and covered her workload and let her do that so that she could take on the role we needed to be filled.

When nurses progress academically from an A.D.N. to a B.S.N. degree and are not reimbursed for their educational costs or given additional pay based on this progression, the employing organization is providing evidence that academic progression is not a priority for the organization. Employer non-support for academic progression provides evidence against progression (Harris & Burman, 2016). Stephanie shared the statements of associate-degree nurses who associated progression behavior with their employing organizations’ funding priorities,

Comments are about “Our organization doesn't reimburse us,” you know, that type of thing. Um, some organizations don't reimburse until after you've successfully complete that semester and they don't have the cash on the front end - you know so, there's some of those challenges.

Rural nurse leaders were sometimes advocating nurse academic progression when they had not progressed past their own associate’s degree. Many rural associate degree nurses had assumed formal leadership positions prior to the release of the IOM report. While some of those nurse leaders had progressed academically since the IOM report, many had not. Inconsistencies between leader behavior and academic progression goals can impact the progression behaviors for rural nurses. Organizational and policy leader, Tammie, addressed her decision to not enroll in academic progression:
I haven't advanced my A.D.N. degree but I have taken lots and lots of coursework. I strongly believe in developing yourself and just being the best that you can be and have really grown with my organization.

Long-term care leader Elizabeth shared her approach to encouraging academic progression, despite her own decision to lead with her associate’s degree:

I've had to say to them, "You know, don't stop now.” So, I think my role is in that. I'm not a very good role model for that because I didn't take my own advice. But, I think times are different now. And I think there's much more required of a registered nurse, even an entry-level registered nurse.

Another challenge for rural acute care organizational leaders is situating patient outcomes-based evidence for academic progression in organizations when many senior bedside nurses have chosen not to progress. Tammie shared her thoughts:

There's, a few of the more seasoned people, you know - that's not a desire of theirs, you know. They've been in nursing for 30-plus years and they're content to just work toward their retirement. But they also are part of that, because they are constantly helping and encouraging the new nurses and mentoring them, and, yeah - it's a scary thought for me when all of those folks are gone.

Organizational leader Jackie also led a significant number of senior nurses who had chosen to remain at the A.D.N. level of practice, while simultaneously leading strong RN to B.S.N. completion efforts in her less seasoned nurses:

So, on our staff, it is only our senior nurses, um, that have pretty much stayed at the A.D.N. level. I would say, currently, our staff is probably 70% B.S.N., minimally, and 30% A.D.N. We're not quite to the 80/20, but we're getting there.
Louise, long-term care leader entered practice with a baccalaureate degree. She discussed the stance of her organization, aligned with an acute care system, toward nurse academic progression:

It is not required for leadership to have their B.S.N. in this organization and we have senior leaders who practice with associate’s degrees. It gives me mixed feelings. I look at my assistant, and she's a two-year nurse, but she is amazing. And she is so well respected by all of her staff. And she has done a lot of leadership and communications courses, on her own - and different things that we've sent her to to help groom her for this role. Our long-term care policy organization offers those courses. She's probably gotten more out of that than maybe she would have out of completing her B.S.N.

Leaders situate evidence for progression with associate degree nurses, but also with the greater rural population and with non-nurse policy leaders. Marie described the challenges that arise when those who influence rural health policy and workforce are not yet familiar with the important role of nursing in promoting patient outcomes, “at a local level, having people understand the importance of maintaining integrity and excellence in nursing is very difficult sometimes.”

Marie advocated for an organized system of RN to B.S.N. educational promotion across the region’s A.D.N. educational programs. Marie’s program is located in a rural district which contains no urban areas or urban healthcare facilities. She noted the social contract is strong in the area and the A.D.N. faculty are committed to nurse academic progression, providing evidence of the importance of progression to the A.D.N. students. She stated her concern that this may not be a priority in all associate degree programs:
I think, actually, if there were a better focus on academic progression for rural nursing, I think that would be a huge thing. I haven't seen a whole lot of that on the front burner. I think people are doing it 'in spite of' not 'because of' and that's kind of a difficult place to be. I think we do this locally, but we do this because we are the profession of nursing versus having it in a spotlight. I think there's an assumption that we're going to go ahead and do this and I don't think that all schools are necessarily good at that, to be honest. If you worry about those four semesters, and, if you get through this, then, “See ya.”

**Discomfort with Advocacy.** Laura, educational and policy leader, shared her concerns regarding rural cultural norms and advocacy. She stated that this discomfort with advocacy may impact rural nurses and rural nurse academic progression:

But, people are very uncomfortable with policy and empowerment and encouraging that self-efficacy and self-sufficiency, in many ways. To say we do know what we're talking about, as nurses and, regardless of the level of where you're prepared, you have an ethical, legal, and professional responsibility to advocate, not only on behalf of our nursing profession, but, because it's the right thing to do for our patients… So, I think that advocacy is an area that many nurses and frankly, many people just feel very uncomfortable about because it's conflictual, right? Um, but we have to have conflict and nurses have to get comfortable with conflict and we have to get comfortable with being advocates and stronger because, right now, we are not strong enough. Being the largest healthcare workforce, our voice is not being heard. And we're allowing medicine and other disciplines to say what is right for the health of our populations and
we're not using our numbers and our voice in sufficient volume to really honor that license to social contract that we have with our patients and public, in my opinion.

Louise, long-term care leader, shared that she had not heard of the IOM report recommendations and was not familiar with the findings of a positive statistical relationship between levels of nurse education and patient outcomes. As she was not familiar with this researched-based information previously, she had not yet had the time and space to consider preferences for nurse educational levels in light of this new practice input. She explained:

As far as the different levels of education for nurses - I don't prefer one over the other. I mean, I feel like, all of them are excellent nurses. And I really have mixed feelings about it, because everyone takes the same boards, you know, to get your RN. And it just depends on the individual. I feel like, if you pass boards, and it all depends on the person, and the orientation that you provide them.

Rural nurses construct and maintain their professional identity through the frames of rural identity, an identity informed by place and class (Cramer, 2016a). Sue described professional practice factors which inform the development of rural nurse identity formation.

I think when people get into the experience of what is rural health it's an entirely different animal and you really have to be able to be able to think critically, problem solve and really be able to think on your feet.
Effect of Place

The place where one is born and grows up impacts life trajectory (McGeary, 2019). Laura explained the effect of place from her own perspective as a nurse leader who grew up living in poverty.

I continuously feel the challenges because the rural environment has been so decimated for so long that access to higher education is just not seen as part of one's journey when you grow up rural.

Educational advancement may be perceived as a self-indulgent luxury in cultures with relatively high concentrations of poverty (Cramer, 2016a; Stephens et al., 2018). Rural nurses who live in under-resourced cultures may have difficulty justifying the costs of academic progression to family and friends. Rural nurses who secure educational loans for progression without the prospect of a related more highly paid position may face negative financial results. They may experience social consequences from friends or family who have difficulty justifying resource utilization based on a benefits to unknown patients and populations.

Nurse Leaders Working Through Cultural Distance

Using Rural Frames to Communicate Progression Information. Sarah used a face-to-face approach, which appeals to rural populations, to communicate population-level outcomes data to a group of rural nurses.

I was speaking to a group of acute care RNs in a small rural city. It was after the IOM report came out, and I was talking about the research that indicated hospitals with a larger percentage of baccalaureate nurses really had better outcomes and there was actually fairly strong research evidence that having a baccalaureate in
nursing made a difference. One of the nurses raised her hand and said, “Do you have any idea where you are speaking?” And I said, “Yes, I'm in a rural area and I’m speaking to you. If the evidence says patients do better, doesn't that make you think, ‘Oh golly, darn, I ought to be working on my degree?’” I think that was a hard lesson for those people to hear.

Many seasoned rural nurse organizational leaders have not chosen to progress academically. This behavior can have a cooling off effect on academic progress for the organization’s nurses. Tammie shared a story of acute care organizational leaders who set examples for nurses by academically progressed from A.D.N. to B.S.N. and M.S.N. degrees. She explained, “we had some nursing leaders that had A.D.N.s that had gone on to get their bachelor's and just really, that says a lot, especially when they were in their late 40s, early 50s.”

**Revisiting the Message.** Rural persons have fewer opportunities for scholarly discussion or to engage in discussions regarding evidence and outcomes. Laura shared her thoughts:

It is very much a structural, socioeconomic strata that is perpetuated more so in rural environments than in urban environments, where you have different influences and different aspects where you can access resources. But, in rural areas, we don't have as many physicians, we don't have as many lawyers, we don't have occupations that support higher education or higher socioeconomic levels.

Leaders of rural nurses may have different life experiences and perspectives than do rural associate degree nurses. Access to information and to organizational resources may vary between the two groups, with leaders more likely, on average, to have had
access to and multiple exposures to a broader range of information and resources. Marie, educational and organizational leader, shared her belief that leaders should share academic progression information continuously from the beginning of employment. She noted that some nurses may not wish to progress, while others may not be aware of their progression choices or the resources which may be available to them for progression.

Sue, organizational and policy leader, reinforced Marie’s remarks regarding the importance of providing progression information to rural nurses, “I absolutely believe that um, from a rural standpoint, there is not always understanding of what is available.”

**Providing Aspirational Roles.** Jackie, rural nurse organizational leader promotes evidence for the value of academic progression by offering aspirational roles for nurses who academically progress. The organization requires a minimum of a B.S.N. for a nurse leadership role, with an M.S.N. or specialty certification preferred. The relatively large number of aspirational roles available to rural nurses in her organization may impact progression behavior. Her organization provides tuition support, and has sustained high levels of academic progression without requiring attainment of a B.S.N. as a condition of continued employment policy. Despite a large percentage of A.D.N. hiring, she describes collective progression behavior, “Somewhere around 75% of our staff initially come onboard as A.D.N. nurses, but, every single one that we've hired within the last couple of years comes on board with a plan for progression.”

Jackie also provides evidence for the value of progression through highlighting nurses who progress academically and through sharing their academic projects in order to improve nursing care and patient outcomes. These projects served as examples and incentives for other nurses to enter the progression pathway.
Rural nurse leaders work to meet rural nurses where they are – in a rural culture. They simultaneously work to draw together the rural nurse and the greater nursing profession. In the next section, I will explore the participants’ data regarding lessening professional distance.

**Lessening Professional Distance**

The category of lessening professional distance comprises the concerns expressed by and the work being done by leaders of rural nurses to promote rural nurse academic progression by more closely aligning rural nurses with the greater nursing profession.

**Professional Distance, Academic Progression, and Academia**

Associate degree schools of nursing serve as an entry point into the nursing professional pathway for many rural persons. Participant leaders ascribed associate degree schools of nursing with the accountability to inculcate A.D.N. students with the values of academic progression and nursing professionalism. Joyce, organizational leader, explained her observations regarding the professionalism of recent A.D.N. graduates.

We recruit primarily from A.D.N. programs and many graduates of A.D.N. programs don't understand the concept of being a professional. I do a nursing orientation segment for all of our new nursing employees, and that is one of the questions that I ask them during that, “What is the difference between a job and a profession?” There’s usually at least one in the room who's willing to voice what it is. But the rest are pretty reluctant and I really try to emphasize that as nurses, you are professionals. This is not a job and, your license doesn't allow it to be a job.
Organizational and policy leader, Sue, spoke to the condensed associate degree curriculum and the potential effect on professionalization of rural associate degree nurses:

I think, in the associate's degree, the technical, clinical focus is so intense and dramatic to get people through that I'm not sure they're thinking big enough. And I'm not sure that our current structure allows or supports that. I also think people are educating, no, they are training, they are not educating, they are training to pass the NCLEX© versus training to increase people's knowledge.

Acute care policy leader, Stephanie, addressed concerns related to the intersection of academic and organizational values. Unspoken is the role of professional values in bridging the identified gap:

What I'm hearing from colleagues, is that, there's so much more on-the-job training that's needed, than ever before. And so, it's that challenge of “How do we get more clinical time? How do we get more hands-on time so that they're more ready to function?” And so there's a, there's a gap that's been created just because of the changing requirements. So we have to somehow think about that gap between academia and practice.

Nursing policy leader, Gail, mused regarding the contrast between the region’s very professionally active advanced practice nurses and the less professionally active nurse leaders and front-line nursing population:

How do we get that spark that our advanced practice nurses have and push that out to our other rural leaders so that we are building students who are ready to return to school?
Gail commented on the solid professional connections she notes between traditional B.S.N. and A.D.N. schools of nursing and the nursing professional organizations. She reports less affiliation between the few rural private, for-profit schools of nursing and the greater nursing profession, “I rarely hear that any of the private or those for-profit schools of nursing in the rural areas are engaged in activities and communication with the nursing professional organizations.” Gail’s observations are concerning. If schools of nursing are not connecting with the professional organizations, the nursing graduates may not be prepared to build strong professional ties upon graduation.

In order to promote academic progression from associate to baccalaureate degree nursing programs, it is important these nursing faculty have strong relationships across these programs. Lessening professional distance between associate degree and baccalaureate degree nurse educators is an opportunity for leaders of rural nurses. Shelli described her experiences of historical professional distance between educators regarding associate degree nurse academic progression:

When I started working across the A.D.N. and B.S.N. schools of nursing, it seemed the faculty and the deans from the four year schools were all feeling that the technical colleges were saying to students, “Well, this is all you need to do - to have an associate's degree.” But, we're not saying that. And then, when I would say to them, “That's not what we are saying,” They responded, “Well, you may not be saying that, but the others ones are.” And I responded, "No, that is not true. We're all like this.”
**Professional Distance, Academic Progression, and Practice**

Professional distancing can occur between the rural A.D.N. nurse and the profession or between the rural nurse leaders and the profession. Long-term care leader, Louise, shared that she was not aware of the IOM goal of 80% of nurses earning a baccalaureate or graduate degree or of the evidence that higher levels of nurse education were correlated with improved patient outcomes and reduced costs. On learning of this evidence, she quickly dedicated herself and her team to more actively working toward nurse academic progression, “So, we should be pushing it more. And we will, now that we know this. My assistant and I will encourage progression.” She also responded with an interesting question and statement: “Why is that? Why would those patients do better? That is interesting to me.”

Elizabeth, long-term care leader, referred to the utility of nurse academic progression with references to enhancing leadership skills and offerings. She did not discuss academic progression as being correlated with improved patient outcomes.

Some of the nurses are perfectly satisfied to work at the bedside the rest of their life. Thank goodness. Maybe the missing link is how you can do that better with more education? With more education, perhaps, can you bring more to the bedside?

Organizational leader, Joyce, sought to promote professionalization among her nursing team and to shorten the professional distance between her nursing team and their sources of professional guidance:

Well, I think if we can encourage them to be involved in their professional organizations - which is a struggle. I think that there's a lot of opportunity there to help them make those connections to the American Nurses Association or to a
specialty-specific professional organization. I'll be honest with you, we have not had a lot of success in that area. But, if, and again, if the organizations could somehow support that in terms of reimbursement - we do reimburse professional dues for our supervisors but we do not do that for our front line staff.

Academic leader, Laura, spoke of the difficulties she and her colleagues experienced with accessing professional nursing knowledge while practicing in a rural public health setting. She spoke of her delight in finding ‘second-hand’ research articles and in reading and circulating these throughout the office.

I had always wanted to go back to school. I was kind of one of those, I call it a weird nurse. I was always looking at the research, whatever I could get my hands on. But, also remember that, in public health, we had no resources either, right? Because we didn't have an affiliation with an academic environment. So, back then, you couldn't access, and to this day, you still can't access professional journal articles unless you are in school, so, what we did get were second hand. And I just loved learning and reading.

Long-term care leader, Louise, when asked about the sources she used to stay current with nursing profession standards stated:

Probably our employing organization. You know, our staff educator is great on keeping up on things. We have a lot of different councils that are constantly looking at best practices and things like that. And also through our regulators, too. Um, we have a lot of resources for long term care for best practices and standards.
Policy leader Sarah spoke of the joint work accomplished between acute care nurse executives and acute care policy organizations and the influence of acute care policy organizations with nurses:

The cooperative work between nurse execs and acute care policy organizations is a distinguisher in the area. Nursing professional organizations have to recruit their members one nurse at a time and so, it is very hard to recruit a big chunk of individual nurses. Whereas, acute care policy organizations recruit one hospital at a time, which probably employs 30 or 40 or up to 500 or 1000 nurses. So, you end up having a much larger impact with every single member.

Sarah’s and Louise’s comments regarding the influence of the nurses’ employing organizations on sources of professional information and likely, distance from nurse professional organizations, are supported by the literature which indicates levels of professional affiliation are impacted by variables in the nurse’s employing organization. Apker et al. (2003) found high levels of organizational autonomy, colleague support, and bedside care work were associated with higher levels of nursing profession affiliation. However, higher levels of perceived support from nurse managers predicted organizational, but not nursing profession affiliation. Predominance of institutional values over nursing professional values may restricts nurses’ moral expression (Caram et al., 2018), impinging on the professions’ theoretical frameworks and conceptual models which are based in the concept of an independent nursing professional lens.

Stephanie, healthcare policy leader, shared communications and concerns between academic and healthcare organizational policy leaders regarding progression:
Our policy leaders have invited the academic leaders in a few times and have talked about bringing them into the conversation regularly. And, reflecting on the barriers to academic progression, how can we overcome those barriers to get people back to the table and to school? And then I think, you know, obviously, the colleges need to make money, but some of the the tuition is awfully high, and that's a huge issue, as well.

**Connection with Professional Sources**

Rural acute care leader, Joyce, reported difficulty engaging nurses in external professional nursing conferences. This lack of interest in extra-organizational professional contact puzzled Joyce:

> We try to, we encourage nurses to go out to outside conferences and um that, you know, it shouldn’t be as hard as it is to get them to go out to those things, especially when the expenses are all paid. But it is a challenge to get nurses to, at least for us, to get nurses to step outside and to really rub elbows with other people in their profession. I don’t know why that is. I don’t know.

**Promoting Legislative Voice for Academic Progression**

A rural nurse organizational and educational leader, Marie, shared her concern for the maintenance of legislative support for rural nursing and for the development of nursing leaders who have a strong professional legislative voice.

> I think it's huge, especially when you have, when you have professional legislative voice and you have an understanding of what the needs are - particularly in rural areas, to provide that advocacy, access, and education. I think it goes without saying that those are the components.
Marie discussed the inconsistent levels of legislative support for rural healthcare, in general. This inconsistency complicates long-term planning for rural nurse progression funding in acute care settings. She described the frustrations involved with the work of maintaining consistent resource allocation from legislative sources:

Just being able to maintain, in this rural area because it kind of ebbs and flows.

There are times when we feel like we hit the lottery and then there are times like, “Yeh, what do you need? You need something else? Didn't we give you enough?”

Marie voiced her concern with the lack of a state continuing education unit (CEU) requirement. She spoke of the message that CEUs requirements communicate - that nursing is a profession which requires a life-long commitment to learning. She advocated for adoption of a state requirement for CEUs for maintenance of the registered nursing license. Twelve states, including Marie’s, did not require CEUs for continued licensure at the time this research was conducted (Nurse.org, n.d.).

**Nurse Leaders Lessening Professional Distance**

**Providing Information and Expectation.** Rural persons value face to face and personal communications (Cramer, 2016a) and this preference favors mentoring and coaching as progression strategies.

Educational and organizational leader Marie described her perspective:

I have always been a big proponent of continuing education. I think that the starting point of the associate degree is just that - I think it is a starting point… I think education and having pathways available, particularly for nurses is really, really important. I think bringing someone into advanced practice and being able to provide care, I think that is really the answer in rural health care…It should be
an encouragement for entry point skill set, and then education and case management, and then advanced practice. So, I'm a huge advocate. I actually brought the availability of B.S.N. onto our campus, and I think that was an important piece of it, because, this isn't the end point. This is your beginning journey.

Nursing policy leader, Gail, visits schools of nursing, physically, and virtually. She teaches nursing students about professional affiliation and promotes academic progression:

I had the opportunity to go to different schools of nursing, including the rural schools to talk about the trends in nursing and some of the policy issues. So, I've had the opportunity to meet a lot of students and faculty.

For some nurse leaders, the work of lessening professional distance with the rural nursing workforce began with the prerequisites for entry to the rural A.D.N. program. Tammie, who led organizationally and from a policy perspective, promoted professionalization of the rural associate degree population through serving as a nursing assistant instructor within her local A.D.N. program. She reported:

I feel that is such an important part, to bring those people from that level, because now, primarily everybody goes to C.N.A. classes just to become an RN eventually, or that's their goal. So I can see the value in that and the importance of making sure we have good strong C.N.A.s.

**Engaging A.D.N. Students in Professionalizing Activities.** Nurse leaders for both academic and nursing policy settings collaborated to bring more than 800 nursing students, including associate degree students, to the most recent state capital legislative
day, according to policy leader, Gail. Such activities lessened the professional distance between rural associate degree nursing students and the larger nursing profession.

Gail hailed the use of the ‘Push-pull’ model of academic progression, with associate degree schools of nursing communicating the message to students, ‘You guys need to go on’ and the hospitals and universities finding ways to ‘pull them along.’

Gail shared her excitement regarding a future nurse leader award bestowed recently by a regional nursing professional organization on an associate degree nursing student enrolled in an area rural nursing program. Gail reported the information supporting the award, supplied by the rural student’s academic leaders, reflected the leadership and growth displayed by this rural associate degree nursing student. She praised the work of the selection committee in creating a large and welcoming professional nursing community which encompassed all levels of pre-licensure nursing students.

**Curriculum Innovation.** Associate degree academic leader, Shelli, shared her excitement regarding creative curriculum partnerships, designed to help the A.D.N. students transition seamlessly to a B.S.N. education and to finish in an efficient and cost-effective manner:

And so, the one model that's looking real promising that I'm real excited about is the one plus two plus one. And they're now doing it with a regional A.D.N. and B.S.N. consortium. Students do the first year at the university, the next two years at the technical college, then you can get your RN license, then you go back for your bachelor’s degree. And we just signed an agreement with a local private 4-year college which has a similar thing, but it's only a semester and they'll get their
bachelors. So, that's really good. There's some national models that they we’re looking at, that they were trying to promote that you would do your associates degree with your bachelor’s degree. The problem is you don't get your RN until you finish both. So, what is the advantage, you know?

RN to B.S.N. educational leader, Nicole, also sought to lessen professional distance by keeping A.D.N. students seamlessly within the nursing professional education pipeline through their B.S.N. coursework:

I'm trying to work on a dual degree with our local associate degree nursing program. Right now I'm in the process of putting together a proposal by helping students to dual enroll because of the numbers in nursing programs. I can only speak for the curriculum I know, but the associate degree students are now required to complete their general education courses in order for prioritization into the nursing program. I'm not certain if that's similar with all associate degree programs. And so, those folks might be placed toward the top of the pool, but then, they're taking fewer credits, sometimes not even able to apply for financial aid, because they don't have enough credits, So I'm looking at where can we start slotting in the baccalaureate degree requirements so they can work toward the baccalaureate degree while completing the associate's degree so that they come back to us with, hopefully, maybe a year left and - there's that bachelor's degree.

**Bridging Professional Distance Between Educators.** Nursing policy leader, Gail, discussed the progress which has been made in lessening professional distance between faculty of A.D.N. and B.S.N. programs in the region. When asked if she believes progress with nurse academic progression is occurring in the region, she replied:
You know, I would have said “No”, but with our last state nurse educators meeting, with all of the conversation about academic progression and what the schools are doing to partner, I felt really encouraged and very appreciative of the schools partnering and really making that a good partnership. So, I don't know if our region is one of the model regions or not, but I'd certainly think that they would be up there in terms of those progression models for the nurses.

Engaging Rural Nurses with Nursing Research and Knowledge Generation.

Laura, educational and policy leader, lessened nursing professional distance when she collaborated with an associate-degree nurse educator on a research project which introduced pre-licensure baccalaureate students to rural populations and rural health needs. Laura reported that this collaboration presented an opportunity for inclusion and perspective sharing and resulted in the associate degree educator stating:

You know, what I can do better, as an associate degree nursing faculty, I should be telling our students that they need to academically progress because of community health, because of population health, because we don't have that in our curriculum and because it is the thing we need to do. Because we know that when we are compared to other professions, we can't hold our own when we're sitting at the table with a physician, a PT, an OT, all of them who have gone on now for their doctorate degree.

Leaders of rural nurses have concerns regarding lessening professional distance between rural associate degree nurses and the larger nursing profession. They also employ a variety of interventions to lessen professional distance and promote academic progression.
In chapter four, I presented the data with respect to the research questions, organizing the data according to the five categories which comprise the theory of leading through distance. In chapter five, I will discuss the interpretations, implications, importance, and significance of the findings for nursing and for the academic progression of rural nurses.
CHAPTER 5

Discussion

Interpretation of the Findings

The purpose of this research was the development of a substantive theory which explains the concerns experienced by and processes used by leaders of rural nurses to promote rural nurse academic progression.

The first research question was, ‘What are the central concerns of nursing profession leaders as they work to promote rural nursing educational advancement?’ The second research question was: ‘What do they do to resolve these concerns?’

The theory of leading through distance explains and predicts leadership of rural nurse academic progression. The work is conceptualized by participants through the lens of their chief concern – the delivery of rural nursing. Leaders navigate vocational, resourced-based, social, cultural, and professional distances in the promotion of rural nurse academic progression. This research integrated these categories into a substantive theory which can be used as a guide for future research and for development of interventions that promote rural nurse academic progression.

Leading through distance posits five categories of nurse leader concern and action regarding the leading of rural nurse academic progression. The substantive theory examines the interplay of nurse leader concerns and strategies and how these interact to explain the leadership of rural nurse academic progression.

The five categories of nurse leader focus regarding rural nurse academic progression are: delivering rural nursing, reconciling resource distance, bridging social distance, working through cultural distance, and lessening professional distance.
As shown in Figure 1, the theory of leading through distance posits that leaders of rural nurses promote rural nurse academic progression by reconciling resource distance, bridging social distance, working through cultural distance, and lessening profession distance; all through the perspective of their professional practice of delivering rural nursing.

**Figure 1**

*Theory of Leading Through Distance Model*
In the following section, the interpretations of the findings are presented. These begin with the category of delivering rural nursing.

**Category: Delivering Rural Nursing**

Leaders of rural nurses do the essential work of providing rural nursing care. Their imperative to provide nursing to rural people and populations informs and impacts their work of leading rural nurse academic progression.

**Delivering Rural Nursing – The Concerns**

The necessity of delivering rural nursing impacts rural nurse leaders and impacts the progression of rural nurses differently, related to each leader’s nursing practice setting. Nurse leader participants spoke to the uncertainty of consistently delivering rural nursing care due to potential rural workforce shortages. Access to nurses and other healthcare professionals, in general, was cited as a primary concern by leaders. It is this concern for delivering rural nursing which drives the necessity for rural associate degree nursing programs in order to educate rural persons to provide needed rural nursing care.

Recruiting non-rural nurses to rural areas is identified as a non-viable strategy by leaders. Two participants openly pondered what would possibly bring non-rural persons to rural areas to practice nursing. Two others discussed their perspectives that efforts to bring urban natives to rural areas for educational and practice experiences consistently ended with the urban native returning to practice nursing in the urban setting.

Rural academic leaders voiced concern that professional nursing entry-to-practice discussions which included talk of eliminating associate degree nursing programs may reflect an unaware perspective and lack of understanding of the realities of rural populations and the rural workforce development. Participants evoked themes of taken-
for-grantedness in their comments regarding delivering nursing care for rural populations. Marie stated her concern that there is an assumption by the general public and by policy makers that rural healthcare organizations “will always be here”. She described having difficult conversations with legislative policy leaders regarding rural healthcare funding, which many rural healthcare organizations rely upon in order to support nurse academic progression. Marie shared her belief that employing organizations should provide financial support for nursing academic progression. She shared her concern that delivering rural nursing will continue to be a hard-fought battle, not to be taken for granted. Her concerns are validated by data, with 2019 comprising the largest number of U.S. rural hospital closures on record. The most common reason offered for rural hospital closures was financial distress (NC Rural Health Research Program, 2020).

Organizational and policy leader, Sue, cited concerns that the associate’s degree may not fully prepare rural nurses for broad generalist rural workforce practice. She voiced concerns regarding reliance on NCLEX© passage as a marker of competence for nursing graduates, in general. She stated her belief that passage of this examination may not indicate sufficient preparation for rural nurses to provide the high levels of nursing care required of the rural nurse generalist who may be providing maternity and emergency care within the same practice shift.

The policies of employing organizations regarding academic progression funding impact nurses. Policy leader, Stephanie, reported that, when employing organizations do not financially support academic progression, nurses often attribute their non-progression decisions to the employing organizations (Harris & Burman, 2016). They rationalize that their employing organization does not recognize value in educational attainment to the
B.S.N. level. Such attributions are strengthened when employing organizations do not recognize educational attainment with differentiated salary reimbursement based on educational attainment (Owens, 2012).

Rural nursing occupational inequities regarding academic progression support were broadly reported by participants. These inequities matter to nurses and to the rural persons who need nursing care. Leaders of rural nurses employed in acute care organizations were much more likely to report providing financial and workplace support for academic progression than were leaders of rural nurses employed outside of acute care organizations, though tuition support was not universally available in all acute care organizations.

Leaders from rural long-term care organizations, particularly stand-alone facilities, not affiliated with acute care organizations, reported having significantly fewer resources to support nurse academic progression. This situation was strongly linked by participants to long-term care funding structures. Long-term care populations in rural facilities have higher rates of Medicaid funding than are experienced in many urban long-term care facilities (Foutz et al., 2017). State funding formulas which pay lower rates to rural long-term care facilities further aggravate this funding inequity (Division of Medicaid Services, 2018).

Rural acute care facilities frequently promote from within. Acute care leaders hire enrolled nursing students as C.N.A.s and promote them into nursing roles after graduation. Associate degree nurses who wish to practice in the acute care environment but who have not entered the acute care organization as C.N.A.s may begin their nursing practice in long-term care and then enroll in academic progression in order to be more
employable to acute care organizational leaders. This situation creates a strong motivation for academic progression. It also contributes to workforce instability and increased costs related to recruitment and training for long-term care nurse leaders; as well as decreased continuity of care for vulnerable rural long-term care residents.

Despite these challenges, rural long-term care leaders continued to actively support their progressing nurses, even with the understanding that many progressing nurses would leave the leader and the long-term care facility for different nursing aspirational roles on attaining their B.S.N. degrees.

**What Works – Delivering Rural Nursing**

Rural acute care leaders promoted progression by establishing an expectation for continual learning following nurse entry into practice as A.D.N.s. Acute care leaders engaged novice A.D.N.s in nurse residency programs, in unit engagement activities, and in organizational trainings. These residency programs maintained active professional learning and growth (Bratt et al., 2014), minimizing the effect of enrollment gaps occurring between A.D.N. and B.S.N. program enrollment.

Acute care leaders were creative and forward thinking. They anticipated future changes in nursing roles and educational needs, and were working proactively with their nurses to promote academic progression. Rural acute care leaders worked to bring groups of B.S.N. students to their organizations for clinical rotations, exposing the current nursing and pre-nursing workforce to B.S.N. students, B.S.N. educational competencies, and learning strategies.

Acute care leaders used preferential hiring and promotional practices and required B.S.N. attainment as a condition of continued employment. These practices clearly
identified the value leaders placed on academic progression and helped to tip the progression value proposition toward B.S.N. attainment. When acute care leaders did not engage in practices to promote and support academic progression, leaders noted that nurses attributed their non-progression to the employing organization’s values regarding academic progression.

Leaders stated that policy leadership which worked to promote academic progression included standardization of the A.D.N. educational curriculum across the state’s technical education system. This standardization helped A.D.N. and RN to B.S.N. educational programs to streamline academic progression processes. Policy leaders also worked with rural healthcare organizations and rural nursing programs to situate more associate degree clinical experiences in rural acute care and rural long-term care organizations.

The imperative to deliver the rural nursing was the chief concern of leaders of rural nurses. This concern informs the leadership of rural nurse academic progression. Through the lens of delivering rural nursing, nursing leaders worked to reconcile resource distance.

**Category: Reconciling Resource Distance**

Reconciling Resource Distance is a foundational concept. It is necessary for progression and educational attainment. However, reconciling resource distance is not sufficient to assure progression behavior. For leaders who sought to promote academic progression for rural nurses, assuring a favorable value proposition was a necessary first step.
Cost

Participants consistently cited the cost as a key challenge to leadership of academic progression. High cost was cited as a barrier by leaders who had no access to academic cost reimbursement for nurses and by those who had full or nearly full access to cost reimbursement for the nurses they led. Cost was discussed primarily in terms of tuition.

Callender and Mason (2017) found that high school students from lower socioeconomic groups deferred enrollment in higher education related to fear of debt. They also noted more debt-averse attitudes in persons from lower socioeconomic groups than from those in higher socioeconomic groups. This fear of debt was discussed on a personal basis by leader participant Stephanie as she recounted her own progression journey which was catalyzed only by a one-time organizational policy push with full funding to help licensed practical nurses earn associate degrees in nursing.

Acute care leaders rarely discussed the complete academic progression value proposition – the interplay of costs and benefits of academic progression for rural nurses. The power of the rural acute care organization as an, and perhaps the, employer of choice in rural settings is an unspoken and perhaps unrecognized variable for many acute care leaders. Two of the three rural acute care participant leaders employed academic progression as a requirement for continued employment with the leader’s organization. This ‘benefit’ of continued employment conferred by educational attainment has a strong effect on the value proposition for rural acute care nurses and is consistent with the relatively high levels of academic progression noted in rural acute care organizations when compared with the greater rural nurse population.
Some leader participants added the variable of improved patient outcomes to the benefits side of the academic progression value proposition. They cited the responsibility of the individual nurse for their own education, professional growth, and development, as did Zittel et al. (2016). The value of academic progression with regard to patient outcomes is important and will be explored more thoroughly in a following section which addresses working through cultural distance.

Long-term care leaders, however, did openly discuss the full cost-to-benefit rural academic progression value proposition. And they did so with respect to retaining their long-term care nurses following progression. The long-term care nurses they led faced a much less favorable academic progression value proposition than did most acute care nurses.

The current value proposition for rural long-term care nurse academic progression is not a strong one. The cost of tuition is high. Leaders who employ practicing rural A.D.N.s reported a need for long-term care nurses to improve their knowledge and skills but acknowledged there is little to no economic incentive for progression behavior for nurses who wish to remain practicing in long-term care. With high costs, low personal benefits, and an unclear vision regarding patient and resident benefits, progression behavior is rare within the long-term care nurse population.

Interestingly, progression behavior was rare in the rural long-term care nurse population, even when tuition reimbursement was available. Nurse leader Louise reported relatively low levels of academic progression, despite available funding for progression related to her organization’s affiliation with a rural acute care organization. Her reports of her nursing team as highly satisfied and content with their practice are consistent with the
findings of Harris and Burman (2016) who noted a negative correlation between job satisfaction and A.D.N. intent to academically progress. These findings support the theory that access to resources and a financially sound value proposition is not the sole determinate of progression behavior for many rural nurses.

Nicole, RN to B.S.N. educational leader, reported an increase in the number of associate degree long-term care nurses academically progressing in an attempt to leave long-term care practice for practice in an acute care setting. In this case, the value proposition is enhanced when rural nurses aspire to higher wages, improved benefits, and a greater number of aspirational roles available in rural acute care settings. While this model promotes academic progression, it also depletes the long-term care nursing workforce, imperiling the provision of nursing care to vulnerable rural long-term residents.

**Online Options and Cost**

Online options for academic progression can decrease costs and promote progression behavior for rural nurses. Historical progression models with RN to B.S.N. programs bringing physical instruction to rural locales provided extensive academic support for rural nurses’ progression, decreased barriers related to technology learning, and promoted the creation of personal time-space for learning. These models, however, are giving way to more asynchronous online delivery options which allow rural nurses to work a greater number of hours per week, preserving wages and benefits. Educational leader Nicole discussed this recent movement from face-to-face to online program delivery and shared reports of high stress levels in rural nurses attempting to
academically progress while simultaneously managing full-time workloads in their places of employment during online academic progression enrollment.

Relational and Caregiving Costs

The rural nursing workforce comprises a largely female population. The rural population is vulnerable in many aspects and females within this culture experience a collectively more gendered reality than do urban females (Brown & Schafft, 2019). The rural nurse academic progression value proposition is impacted by relational and caregiving costs and by the vulnerability of the rural population, including rural nurses. Role demands regarding child care, partner support, parental care, and community care are key considerations for rural nurses. Roles pressures on rural women are high and this can impact the academic progression value proposition through the imposition of increased non-financial personal costs.

Technological Distance

Several leaders spoke of the unexpected technology challenges experienced by rural nurses related to academic progression. The general societal narrative regarding technology barriers in rural areas pertains to access to broadband (Perrin, 2019). Issues with broadband accessibility were discussed by leaders, but these were eclipsed by concerns related to the level of technological knowledge, skill, and confidence of rural associate degree nurses, specifically those who had not been enrolled in higher education in recent years. Leaders identified digital literacy as an unexpected barrier to academic progression.

Information technology skill levels and limited access to technology for rural nurses (Pew Research Center, 2019) may impact the decisions of practicing nurses to
academically progress. While the great majority of nurses use technology extensively in their professional roles, gaps were noted between skilled use of occupational technological applications and the use of those applications which are needed for success in academic roles.

This distance between nurse occupational technological skill and confidence levels and the technological prowess and confidence needed for successful academic attainment was a source of concern for several leaders. Leaders identified the importance of assisting nurses to gain skills and confidence using academic student information systems, learning management systems, and commonly used word and data processing applications.

**Reconciling Resources – What Works**

Leaders reconcile resource distance when they provide resources to lower the cost of academic progression. Rural acute care leaders had the greatest ability to provide financial progression support to their nurses, but this financial support was not universally offered in all rural hospitals. One organizational policy leader estimated 50% of regional rural hospitals provided a system of tuition cost support for all nurses.

Long-term care leaders who practiced in settings affiliated with acute care organizations reported access to tuition reimbursement but also reported low rates of academic progression in their A.D.N. team members. As in the more experienced A.D.N. acute care nurse population, tuition reimbursement, alone, does not appear to drive progression behavior for long-term care nurses.

Leaders reported their work to decrease physical distance to education through bringing RN to B.S.N. education to the rural settings for face-to-face learning was
effective. Acute care leader Joyce identified the additional benefit of face-to-face learning in allowing for focused assistance with technology for participating nurses. Interestingly, RN to B.S.N. educational leader Nicole reported a recent move away from on-site rural A.D.N. to B.S.N. programming related to demand from the enrolled nurses. There was no indication from the acute care leaders who orchestrated these onsite courses of a wish to move from face-to-face to online delivery. In fact, several leaders expressed concern about programs that were entirely online. The move from face-to-face to online instruction for rural A.D.N.s seemed to be driven by nurse, rather than leader preference.

Leaders described their efforts to reconcile resource distance by providing flexible scheduling and by granting requested time off for nurses who were academically progressing. Individual assistance for progressing nurses from rural nurse leaders was strong and supportive.

Reconciling resource distance matters to academic progression and educational attainment. It is a gateway variable, necessary, but not sufficient to ensure progression behavior. For many rural nurses who were fortunate enough to have a positive value proposition with adequate financial, social, and technological support, progression behavior still did not occur. Other variables appeared to be impacting progression behavior. In the next section, I will explore the category of bridging social distance.

**Category: Bridging Social Distance**

Once the necessary, but not always sufficient category of reconciling resource distance has been considered, the nurse leader who wishes to promote rural nurse academic progression may proceed to consideration of the category of bridging social distance.
The profession of nursing exists within the larger society (Shaker-Field, 1991) and the social fabric of the nursing profession has evolved along with that society (Cooper et al, 2009). Nurse leaders seek to promote social inclusion for nursing students and nurses. When a nurse considers academic progression, they often consider new nursing social roles that progression may afford. This role change can mean a change to the nurse’s sense of social being within the profession. Factors supporting recognition and social inclusion include mutual recognition, valuing differences, and voice (Yanicki et al., 2014). In this research, leaders shared their work to bridge nursing profession social distance with associate degree students and nurses.

Leaders of rural nurses are a relatively affluent group when contrasted with the rural nurses they lead. This statement is supported by the shared formative educational experiences of these leaders of rural nurses. Differences in nurse professional generational experiences also challenge leaders of rural nurses to examine the experiences and perspectives of rural nurses in order to best design systems and approaches which will bridge social distance and promote rural nurse academic progression. There is more work to be done in helping leaders of rural nurses to reflect on the larger society of nursing, to situate themselves and those they lead within that society, and to help A.D.N.s to identify and navigate the social aspects of their academic progression goals.

Enrollment in a rural technical college is something that rural people do. It is something that their friends, their family members, and their neighbors do. Enrollment in a four-year college or university is a less familiar behavior for many rural persons. Some rural nurses may be exposed to negative messaging regarding association with higher
education (Cramer, 2016a). Overall, rural people have less exposure to the society of nurses within higher education. As participant Laura shared, there are simply fewer professionals available in rural areas with whom to socialize and form relationships. This results in fewer opportunities for rural persons to become comfortable with and familiar with the society of higher education and evolving nursing professionalism.

Leaders of rural nurses worked to bridge nursing social distance on both individual and cohort levels. Leaders expressed pleasure with their work mentoring and coaching individual rural nurses, helping the nurses to bridge nursing social distance and to take on new and evolving roles in the profession.

Nurse leaders hired and celebrated nursing faculty from rural backgrounds who attained M.S.N. degrees while actively teaching A.D.N. students. Academic leaders brought alumni who had academically progressed to speak with the A.D.N. students on Nurses’ Day and at graduation and pinning ceremonies. These efforts sent a message that ‘people like me’ - rural nurses and rural people do enroll in baccalaureate and graduate nursing education programs.

Nurse leaders promoted academic progression and nursing social growth through their professional roles and through constant personal encouragement. They brought RN to B.S.N. programs to their organizations for recruitment activities and to provide instruction – a masterful way to bridge social distance by helping the students and nurses to gain nursing social knowledge, skills, and attitudes in a comfortable and familiar rural setting.

Leaders engaged the organizational nursing team in designing career ladders and systems of reimbursement and reward for academic progression. They celebrated nurses
who were academically progressing, offering them release time for learning, and inviting them to use their academic projects to promote improved outcomes within the healthcare organization. They invited the progressing nurses to provide education to their own nursing teams regarding their academic work. Leaders supported initiatives tied to academic progression projects, helping the progressing nurse to explore new social roles within the society of nursing.

Leaders helped nurses to imagine themselves in new nursing social roles in order to promote progression. Rural A.D.N.s contemplate academic progression within a larger rural culture. Membership in the rural culture may inform beliefs regarding academic progression. Next, I will share the interpretation of the findings regarding the efforts of nurse leaders to work through rural cultural distance to promote nurse academic progression.

**Category: Working Through Cultural Distance**

Rural nurses contemplate academic progression within the context of rural culture. For many nurses, the culture of academia and the rural culture in which they live and practice are cognitively congruent. For these nurses, cultural distance does not interfere with progression behavior. For other rural nurses, a more highly gendered rural culture or rural consciousness cognitive frame may impact academic progression behavior.

Leaders of rural nurses helped A.D.N.s to navigate cultural distance. In a highly gendered rural culture, the female nurse is more likely to have multiple life role responsibilities that place excessive demand on their time and resources (Brown & Schafft, 2019). A decision to enroll in academic progression may have consequences for
rural nurses which are unseen and unanticipated by nurse leaders who are more affluent or less familiar with rural culture. Entering an academic progression program is a major life change and Wong (2017) found that women frequently shoulder the labor associated with the practical and emotional consequences of major life changes.

In the rural consciousness framework (Cramer, 2016a), rural dwellers are more likely to value knowledge created through personal experience and to distrust evidence derived through scientific and statistical means. The cognitive frames associated with rural consciousness can make belief in evidence-informed practice and outcomes thinking challenging when this evidence is inconsistent with the rural person’s practical experiences and their personal identity. Rural consciousness may lead rural nurses to value their own practical experiential knowledge and that of close colleagues over knowledge derived from statistical and scientific methods. This analysis was supported by Koessl et al. (2013) who found, when rural nurses do not have access to evidence, they are more likely to consult a colleague rather than seeking out research-based evidence. When statistical and population-based evidence does not fit the cognitive frame of the intended receiver, it is often summarily dismissed, regardless of its strength (Lakoff, 2014).

Perceptions of the professorate as an outgroup, with a different identity from rural persons may manifest in reluctance to engage with higher education (Cohen et al., 2006) and reluctance to educationally progress to the level of a person who has a baccalaureate or graduate degree. While an associate degree, perhaps from a local technical college is a common in-group behavior among rural inhabitants, enrollment in a university is less common and may be viewed as an out-group behavior. Academic advancement may
imperil identity and group affiliation (Bryan & Simmons, 2009). Many participants including Tammy, Jackie, Stephanie, Joyce, and Louise shared stories of nurses who would not academically progress, despite generous tuition and occupational and social support. For these nurse leaders the categories of delivering rural nursing, reconciling resource distance, and bridging social distance had been largely addressed. The reasons for failure to progress are likely multifactorial, but cultural distance is a potential factor for consideration.

Nurses need access to high-quality evidence to guide their practice. Rural nurses are less likely to have access to this evidence than are urban nurses and this restriction compounds challenges related to working through cultural distance. Many rural healthcare organizations do not offer nurses access to academic databases. In rural organizations with a large percentage of A.D.N.s, nurses may be less likely to be aware of the relevance of nursing research to their practice and to their patients’ health outcomes, simply due to decreased rates of exposure to this evidence. Koessl et al. (2013) found rural nurses who practiced at the bedside and those who had practiced for 20 years or more had the lowest levels of positive attitudes toward the use of evidence and evidence-based practice. The cultural distance between rural nurses and nursing academia can be vast.

Leaders of rural nurses bridged cultural distance when they provided clear and practical evidence for the value of nurse academic progression. Conditions of continued employment policies, differential salary schemes based on degree attainment, and the provision of aspirational roles provided practical evidence for the value of nurse academic progression. Such tangible evidence, coupled with the provision of information
regarding the relationship between nurse educational levels and positive patient outcomes helps to bridge cultural distance and allows rural nurses to better articulate their progression decisions and to support these decisions to friends and family members.

When leaders of rural nurses have delivered rural nursing, reconciled resource distance, bridged social distance, worked through cultural distance and are still seeking to promote academic progression, the category of lessening professional distance may be considered.

**Category: Lessening Professional Distance**

In this section, I offer the interpretation from the data regarding the category of lessening professional distance. Lessening professional distance refers to the concerns of and the work done by leaders of rural nurses to promote academic progression through iteratively connecting rural nurses with the greater nursing profession.

Professional organizations “create and symbolize ‘professional’ behavior and practices” (Noordegraf, 2011, p.467). Lessening profession distance may be the most critical of categories, because it promotes the career-long association of the rural nurse with the profession. Professional bonds between rural nurses and the greater profession buoy the professional both during and between periods of academic enrollment and during and between periods of vocational practice. Lessening professional distance for rural nurses is critical to the future of rural nursing and to the future of the nursing profession.

**Lessening Professional Distance and Academia**

Leaders shared concerns regarding associate degree nursing graduates and the degree of professional affiliation and identification which could reasonably be attained
during the brief and intense period of associate degree enrollment. Their stories reflected a sense of the NCLEX© examination as a link between academic and vocational affiliative phases of A.D.N. practice.

Inconsistencies with professional distance between pre-licensure nursing programs and nursing professional organizations were identified. An opportunity for rural for-profit schools to strengthen ties with nursing professional organizations was identified by nursing policy leader, Gail, who reported little contact between these schools and nursing professional organizations.

A region-wide alliance between leaders of associate and baccalaureate programs and schools of nursing has been in place formally for several years. Though participants reported recent improvements in the relationships between baccalaureate and associate degree academic leaders, they noted that opportunities remained to promote academic progression for rural nurses by strengthening trust and collegiality across programs and schools of nursing.

Organizational leaders expressed concern for the amount of on-the-job training required of graduate nurses, as well as for the cost of tuition. One organizational policy leader shared her concern that governmental intervention might be required in the future to address the shortage of nurses that will be needed to care for an aging population.

*Lessening Professional Distance in Practice*

Opportunities were noted to strengthen affiliative ties between nursing leaders and the profession. Practicing rural nurse leaders were not universally aware of the IOM report and of the evidence of correlation between higher levels of nurse education and improved patient outcomes. Awareness of the IOM report recommendations was most
common among rural academic leaders and rural acute care organizational leaders and less common among rural long-term care practice leaders. Long-term care leaders shared perspectives which associated academic progression with the attainment of leadership-related objectives rather than patient outcome-related objectives.

Educational leader, Laura, discussed the difficulty rural nurses encountered with accessing nursing scholarly journals and other evidence on which to base nursing practice. Her concerns were consistent with the data provided by other rural leaders and highlighted an important aspect of the professional distance experienced by rural nurses.

Nursing organizational leaders consistently cited healthcare, rather than nursing professional sources as providing important nursing professional practice guidance. Leaders were concerned with low levels of nurses’ attendance at nursing professional conferences and affiliative meetings. The leaders reported nurses forgoing professional conferences despite generous reimbursement and paid time off for engaging in these activities.

**Theoretical and Practical Implications of the Findings**

Successfully leading across distance to promote rural nurse academic progression is a complex endeavor. It entails leadership through workforce, resource, social, cultural, and professional distances. The theory of leading through distance can be used on an individual, organizational, or community level to understand leadership of rural nurse academic progression.

The theory of leading through distance states leaders of rural nurses promote rural nurse academic progression by reconciling resource distance, bridging social distance, working through cultural distance, and lessening profession distance all through the
perspective of their professional practice of delivering rural nursing. In the following section, I will discuss the theoretical and practical implications of the findings.

**Delivering Rural Nursing - Theoretical and Practical Implications**

Delivering rural nursing emerged as the main concern of the nurse leader participants and it was through the perspective of delivering rural nursing that other categories were perceived and navigated. The category of delivering rural nursing comprises the concerns expressed by and the strategies employed by rural nurse leaders as they work to promote rural nurse academic progression while delivering rural nursing care. Delivering rural nursing can be examined at various levels – from the perspective of the individual nurse leader to the delivery of nursing care to the greater community.

Leaders deliver rural nursing by educating rural nursing students and by bringing urban B.S.N. students to rural acute care organizations for clinical learning experiences. They deliver rural nursing by using shared A.D.N. curriculum that allow for ease of transferability to RN to B.S.N. or RN to graduate educational programs. They also deliver rural nursing by creating pre-licensure clinical experiences in the rural nursing students’ rural communities.

Leaders deliver rural nursing by enacting policies which allow for hiring of A.D.N.s but which require them to academically progress as a condition of continued employment. Requiring a minimum of a B.S.N. in order to assume supervisory roles helps leaders to deliver rural nursing. And, they deliver rural nursing through policy work which helps assure financial resources flow to rural healthcare organizations to support academic progression.
The work of delivering rural nursing can result in increased levels of B.S.N. attainment across communities as nurses via for positions at organizations that provide financial support for academic progression. It can also unintentionally exacerbate inequities which exist between rural nurse practice settings. Rural nurse leaders and rural nurses frequently equate nurse academic attainment with a signal to ‘move on’ to a different aspirational role. Rural acute care organizations provide a wider range of aspirational roles than do rural long-term care organizations. These available roles allow A.D.N.s who attain the B.S.N. more opportunities to assume an aspirational role while remaining with their current acute care employing organizations. Aspirational roles or differential salaries based on educational attainment are rare in long-term care practice settings and nurses who progress academically while employed in long-term care often leave their organizations for practice outside of long-term care.

We have explored the theoretical and practical implications of delivering rural nursing. Next, I will discuss the theoretical and practical implications of reconciling resource distance.

**Reconciling Resource Distance - Theoretical and Practical Implications**

Reconciling resource distance speaks to the value proposition of academic progression including resource availability. It first includes a consideration of costs and benefits in deriving a perceived progression value proposition. These costs and benefits include complex fiscal and relational variables, often unique to the the individual nurse, to their practice, and to their life circumstance. When the value proposition for progression is positive, leaders noted that rural nurse academic progression was more likely to occur.
Rural nurse academic progression occurs within the context of U.S. higher education funding realities. Simply, a leader will not be able to assist an RN to academically progress if that RN lacks the resources to fund education or cannot secure a loan to do so. Therefore, the ability of leaders of rural nurses to affect policy that reconciles resource difference is important to rural nurse academic progression.

Once the categories of delivery rural nursing and reconciling resource distance have been considered and found to not represent barriers to progression, the three remaining theoretical categories can be considered in promoting rural nurse academic progression. These categories include the effect of social distance within the society of nurses on the leaders’ ability to promote rural nurse academic progression; working through cultural distance – the impact of the distance between urban and rural cultures on the leading of progression behavior; and lessening professional distance – the potential for leaders to promote rural nurse progression through further strengthening the ties between rural nurses and the sources of nursing profession power. In the next section, we will explore the implications of the category of bridging social distance

**Bridging Social Distance – Theoretical and Practical Implications**

Nursing comprises the largest population of U.S. healthcare professionals. Within this profession a vast social landscape contains each nurse. Changes in education, in practice, and practice setting are only a few variables which can alter the nurse’s professional social landscape. Variables including social class and demographic factors also influence the nurse’s social reality. Anticipated changes to the nurse’s professional social position can be welcomed by nurses or these may be perceived as concerning or threatening. When leaders help nurses to navigate nursing profession social change, they
are helping them to bridge social distance. And bridging social distance is important because it helps nurses to envision transition to new roles and practices and to do so successfully and confidently. For some rural nurses, the ability to foresee and welcome successful social transitions can be a determining factor in academic progression.

The social fabric of nursing is in a constant state of evolution (Cooper et al., 2009). When canvassing the nursing social fabric of the leader participants, one notes a subculture of nurse leaders, many who entered the profession in the 1960s, 1970s, and 1980s, many with baccalaureate degrees. This subculture operates from a perspective of relative affluence and is highly congruent with a traditional female-dominated Eurocentric society (Choperena & Fairman, 2018).

In 1970, the State’s first cohort of 100 associate-degree nurses graduated from a vocational school in Milwaukee (Shaker-Field, 1991). Since that time, the number of associate degree nurses has grown substantially. The number of new associate-degree nurses entering the profession yearly is approximately equal to the number of new baccalaureate graduates (National Council State Boards of Nursing, 2020). This massive influx of associate degree nurses, many who brought a working-class perspective to the profession has enriched the social fabric of the profession. And these associate degree nurses hail largely from the across the state and region, injecting area social and cultural influences into the society of nursing. The new nursing social perspectives they bring are often different from those experienced by the older, dominant nursing professional social perspective and this difference can lead to unintended marginalization and exclusion (Salas, 2005).
When rural nurses academically progress, they may anticipate nursing social movement away from their current place of comfort toward a place perceived as different, unknown, scary, and maybe even unwelcoming. Leaders help A.D.N.s and A.D.N. students to bridge social distance through individual coaching and mentoring.

Academic leaders bring alumni who have academically progressed back to their pre-licensure schools to share their stories of successfully bridging social distance. They bring baccalaureate faculty and even entire RN to B.S.N. programs to the associate degree campus, helping A.D.N. students to recognize that baccalaureate education does belong in rural areas and that rural people belong in baccalaureate educational settings.

Organizational leaders help progressing A.D.N.s to share their new knowledge with their nurse colleagues and to celebrate the progressing nurse’s work by incorporating academic projects into continuous improvement activities on the nursing units. Through inclusive and positive leadership, all can be invited into the social tent and the achievements of the progressing nurse can be celebrated as a win for all nurses, helping to bridge social distance and to helping nurses to model such behavior with their rural patients.

**Working Through Cultural Distance - Theoretical and Practical Implications**

Culture impacts basic social processes and learning (National Academies of Sciences, Engineering, and Medicine, 2018) and learning occurs according to a predictable process with motivation preceding learning. Once rural associate degree are supported or at least not encumbered by their leader’s need to deliver rural nursing, have the resources required for progression, and are confident with their current and future roles within the society of nurses, they may be prepared to academically progress. If
progression behavior does not occur, nurse leaders may explore the effects of working through cultural distance on progression behavior. There are theoretical and practical implications of working through cultural distance.

It is incumbent on leaders of rural nurses to provide evidence for the importance of rural academic progression to the baccalaureate or graduate degree level. This evidence is well established with regard to the relationship between nurse educational levels and patient outcomes.

It is also important that the rural nurse leader is aware of rural cultural constructs that may interfere with traditional academic approaches to conveying evidence with rural populations. In the case when a rural nurse evokes a strong cognitive frame as a technical bedside expert, it may be helpful to evoke this frame when providing information regarding progression. It may also be helpful to assure tangible evidence for progression is aligned with desired behavior. For example, financial support for tuition costs and differential reimbursement based on academic attainment provide strong practical evidence for the value of progression (Owens, 2012), as do celebrating and recognizing the work of nurses who academically progress. The leader can also scan the environment for opportunities to mitigate the effects of policies and behaviors that provide evidence against academic progression (Harris & Burman, 2016) such as a lack of policies which require attainment of a baccalaureate or graduate degree within a prescribed period of time after initial employment; or the lack of policies with require a baccalaureate or graduate degree in order to be appointed to a leadership role.

Knowledge regarding the role of cultural interdependence may be useful for rural nursing leaders in promoting academic advancement. Wright (2014) found rural associate
degree graduates engaging in academic progression activities for the purpose of
remaining in and improving their rural communities. Persons from working-class
backgrounds were more likely to engage in higher education when such education was
aligned with efforts to help their community (Stephens et al., 2018). By appealing to
nurses’ sense of cultural interdependence, academic progression may be promoted.

Education is an experience. Persons who experience resource abundance are
likely to value the acquisition of experiences over the acquisition of material goods.
Resource abundance frees persons to pursue self-improvement strategies including
educational experiences. Rural persons are more likely to identity with a perspective of
resource deprivation than are non-rural persons (Cramer, 2016a). Those who experience
resource deprivation must carefully monitor access to material goods and are likely to
experience as great a degree of satisfaction with the purchase of material items as they
are with the purchase of experiences (Lee et al., 2018). Therefore, rural persons may be
less likely to favor experiential acquisitions over material ones than are members of
groups that experience a sense of resource abundance. For rural persons, cost matters and
policies that financially support progression may have a greater impact on progression
behavior than would appeals to personal growth or population-level outcomes.

Rural persons have limited access to higher education and to a culture of
academia. Simply due to the nature of the rural economy, they are less likely to come in
contact with this academic culture or to have family members and friends who feel
culturally competent in academic settings. A sense that one is not aware of the ‘rules of
the game’ can be a powerful dissuading force to engagement in higher education
(Stephens et al., 2018; Tinto, 2012). Leaders can mitigate the effects of rurality by
helping A.D.N. students and nurses to navigate and to feel comfortable with higher education.

Finally nurse leaders can work to construct their own rural culture of nurse academic progression, one that acknowledges evidence-based practice and population-level patient outcomes, but which also celebrates the tangible progress that is made when nurses who academically progress share their learning to improve practices and patient care in the rural healthcare organization and community. Rural organizational leader, Jackie has employed this approach and enjoys high rates of academic progression in a rural setting, without the use of policies which require academic progression for continued employment. By bringing the academic into the rural organization, cultural distance may be more easily navigated by rural nurses.

**Lessening Professional Distance - Theoretical and Practical Implications**

The work done by leaders of rural nurses to lessen professional distance has theoretical and practical implications for rural nurses and patients. A profession comprises individuals who possess unique knowledge and specialized skills. A professional competently applies this knowledge and these skills, guided by the profession’s code of ethics and a creed of service to others (Abbott, 1988; Goode, 1960).

Nurses convene into professional organizations for many purposes including the promotion of nursing practice and the furthering of nursing education (Cooper et al., 2009). The promotion of nurse education is a stated goal of the American Nurses Association, with the securing of federal funding for nurse education and training identified as a priority organizational issue (American Nurses Association, 2020).
Professional organizations represent the interests of nurses and the patients they serve. The American Nurses’ Association’s 2017-2020 strategic plan includes an objective to “Deliver the most relevant content, programs, services, practices, policies, and advocacy to the registered nurse population via targeted segmentation” (American Nurses’ Association, 2019).

Rural nurses are one significant segment of the nurse population and their interests can be difficult to represent. This difficulty in connecting with rural nurses and rural nurse practice can further challenge professional affiliation between rural nurses and nursing professional organizations. Rural nurse leaders reported concerns regarding professional distance between rural nurses and the larger nursing profession.

Leaders discussed professional affiliation activities which occurred during enrollment in both associate degree and baccalaureate degree nursing educational experiences. Leaders described more tenuous professional affiliation during breaks in enrollment and even described nursing practice being directed from vocational sources rather than professional sources. When professional distance is lengthened, the influence of the employing organization on nurse progression behavior may be strengthened (James, 2017). In such organizations and without strong nursing leadership for academic progression, progression behavior may be impacted.

**Theoretical Importance of the Findings**

Nurse academic progression matters to patients, communities, and populations because it is associated with improved outcomes. The theoretical implications of the findings include both a broadening and a focusing of nurse leaders’ conceptualization of
the work of promoting rural nurse academic progression. The theory allows leaders to examine the issue of rural nurse academic progression from a systematic perspective.

Each leader brings their own perspectives, experiences, and biases to the challenge of leading rural nurse academic progression. The theory invites a broad perspective-taking toward the problem by inviting leaders to explore five categories of concern and strategy and by minimizing the natural tendency to approach the problem solely from the perspective of the individual nurse leader.

**Clinical Significance of the Findings**

Improved patient outcomes (Harrison et al., 2019; Aiken et al., 2011) and decreased costs of nursing care provision (Yakusheva et al., 2014) have been correlated with higher levels of nurse education. The research supporting these findings was largely conducted in urban acute care settings. We do not yet have a base of rurally-situated research on which to confidently claim this same correlation between rural nurse education level and rural patient outcomes.

Leaders report inequities between the level of progression resources for rural nurses who practice in acute care settings and those who practice in long-term care settings. Rural nurse practice migration from long-term care to acute care was also reported. Both of these findings have the potential to worsen outcomes for vulnerable long-term care rural patients and residents.

Nurse migration from urban to rural areas is rare and rural nurse leaders reported they must grow their own nurses from the rural population in order to deliver rural nursing. This critical rural workforce need, along with relatively low rural wages and high rates of rural poverty, drive the need for associate degree nursing programs in rural
settings. Because rural associate degree nursing programs supply a significant percentage of the rural nursing workforce, the need for progression resources and novel curriculum offerings that keep nurses enrolled through the B.S.N. are needed to meet patient needs for a well-educated rural nurse work force.

Leaders reported vocational forces having strong influence over rural nursing practice. Vocationalizing forces may promote organizational efficiency and even some positive patient outcomes, but vocationalizing forces can also diminish the influence of nursing professional organizations on rural nurses (James, 2017), allowing for a predominance of medical versus nursing-centered care.

**Relationship Between the Findings and the Conceptual Model**

Few previous findings regarding the leadership of rural nurse academic progression were available for analysis. Watson’s Theory of Human Caring was used as a model to guide to my perspective taking and to assist in ongoing reflexivity.

Watson (2008) directs readers to “Cultivate caring consciousness and intentionality as a starting point”. Caring is foundational to nursing practice and largely universal to the nurse-patient relationship. Through analysis of this research, I ask the reader to intentionally extend caring consciousness to the rural nurse and to the rural nurse leaders, understanding that workforce, resource, social, cultural, and professional distances may impact these nurses and their leadership of academic progression behaviors. Watson further directs us to “Invite and authentically listen to the inner meaning, the subjective story of other” and to “Hold other with an attitude of unconditional loving-kindness, equanimity, dignity, and regard” (2008, Chapter 1, *Caritas* Literary Dimensions section).
Implications for Nursing Practice, Education, and Research

Implications for Nursing Practice

Practice Implications Regarding Delivering Rural Nursing

Leaders of rural nurses worked to provide rural nursing care. The findings indicated that delivering rural nursing is the main concern of rural nurse leaders, and it is through the lens of delivering rural nursing that their work to promote nurse academic progression occurs.

The leadership of academic progression and the provision of rural nursing are aligned behaviors for most leaders of rural nurses. But for some leaders, especially those who practice in long-term care, academic progression behavior can result in nurses leaving long-term care for other aspirational roles, complicating the work of long-term care leaders to provide rural nursing. To their credit, long-term care leader participants continued to encourage nurses in academic progression – selfless leadership behavior that promoted high-quality patient care and which benefitted rural nurses and the greater nursing profession.

Practice Implications Regarding Reconciling Resource Distance

The findings indicated that reconciling resource distance is pivotal to academic progression, though provision of progression resources, alone, did not guarantee progression behavior. Conceptualization of resource distance in terms of a complete value proposition including considerations of both costs and benefits was helpful in exploring this concept.

Leaders noted costs related to academic progression included fiscal and relational costs which extended beyond the costs of tuition and textbooks. Reconciling resource
distance by connecting nurses with resources was associated with progression behavior by rural nurse leaders. Policy-level advocacy, on the part of rural nursing leaders, for rural nurse progression resources is needed and important.

**Practice Implications Regarding Bridging Social Distance**

Leaders helped rural nurses to navigate the society of nurses and to become comfortable with taking on new roles. It is important that leaders of rural nurses reflexively examine their own social role within the profession and that they are sensitive to the possible needs of rural A.D.N.s for navigational assistance as they progress and assume new and unfamiliar nursing social roles.

**Practice Implications Regarding Working Through Cultural Distance**

Leaders of rural nurses practice nursing leadership within a rural culture. Similar to the navigation of nursing societal roles, it is important that these leaders are sensitive to the impact of rural culture on rural nurse academic progression behavior. Patterns of rural evidence preference can help the nurse leader to design systems which clearly reward progression behavior in tangible ways, strengthening the effects of the strong patient outcome-related evidence which already exists for nursing academic progression.

**Practice Implications Regarding Rural Nurse Professional Affiliation**

The importance of the rural population in influencing public policy has received increased scrutiny since approximately 2010 (Cramer, 2016a; Scala & Johnson, 2017). The profession of nursing is highly influenced by public policy as a result of the funding structures which support both nursing education and practice. The foundations of nursing practice are embedded in the scientific process and and the search for nursing knowledge.
Approximately 16% of nurses are rural nurses (Bureau of Health Professions, 2013) and those rural nurses share many social and cultural perspectives. This population is, in many ways, as with the general rural population in the larger political landscape, a diaspora – widely dispersed but sharing a similar perspective. In recent years, social media and digital communication has allowed that diaspora to connect socially, culturally, and even politically.

It is important that rural nurses are affiliated with the greater nursing profession. If this affiliation is not created and strengthened, rural nurses may be at risk for dwindling professional affiliation as a result of vocationalizing forces (James, 2017) and of a shared rural culture which is not strongly aligned with academia. It is imperative, therefore, to the continued integrity of rural professional nursing practice that the bonds between rural nurses and the greater profession are strengthened iteratively.

**Implication for Nursing Education**

**Implications regarding Bridging Technology Distance**

The data suggest a technology distance that impacts progression behavior, particularly when nurses are removed from academic enrollment for a length of time. Currently, that gap is noted most clearly in A.D.N.s who are practicing in acute care, and who have been away from academia for several years. This population is interesting because they are likely to have access to progression resources yet are not choosing to progress. This gap has been illuminated because the profession is now actively seeking to attain a nurse population educated to the B.S.N. or graduate level at a rate of 80% or greater.
It is possible that, in any circumstance in which a population of nurses is removed from academia for an extended period of time, that their knowledge, skills, and confidence with academic technology will erode. Further research into this phenomenon is certainly indicated as a result of the findings of this research.

It is important that nurse leaders consider this phenomenon in nursing profession planning. At this point in time, we seek to promote A.D.N. to B.S.N. attainment and we see a potential relationship between time away from academia and nurse progression behavior. In a future time, will we seek B.S.N. to graduate attainment in order to be prepared, as a profession, to meet future population health needs? What lessons regarding academic and technological engagement will we have learned, based on this research? How can leaders maintain ongoing engagement between nurses and academia to assure nurse readiness with the knowledge, skills, and confidence to academically progress in order to meet future patient, community, and population nursing needs? There is much knowledge yet needed to be developed in order to be ready for the future of nursing education and practice.

**Implications of the Research for Nursing Research**

Many rural nurses enter academia through a rural associate degree nursing program. They engage with their pre-licensure nursing education program and form their beginning perspective of nursing professionalism. They begin to explore the larger nursing profession and their own role within that profession.

If a break in enrollment occurs after earning the A.D.N. and prior to academic progression to B.S.N., the A.D.N. may lose contact with academic aspects of the nursing profession. In rural areas, in particular, access to academic literature, research findings,
and academic colleagues is extremely limited or nonexistent during times of non-enrollment.

After the A.D.N. graduates and time passes since enrollment in formal nursing education, rural nurses’ professional practice may become less guided by sources of professional knowledge such as their pre-licensure program or school of nursing. Their practice may become increasingly guided by their employing organization. As the affiliative ties to the employing organization strengthen, the nurse’s tie to their profession and professional institution can be weakened by the forces of vocationalism (James, 2017).

Research is indicated to create knowledge regarding where rural nurses find their professional knowledge and sources of professional direction. Some participants reported rural nurses find their source of professional knowledge and guidance in their professional organizations. But very few rural nurses from this Midwestern state are members of the state’s nursing association. According to policy leader, Sarah:

Participation in the state’s professional nurses’ association has always been low. um, I don't know, the last time I knew the membership figure, it was right around 2,000. There are 90,000 registered nurses in the State, to it is very hard for there to be a great deal of impact.

Rural nurses have considerably fewer opportunities to reconcile resource distance than do urban nurses. Rural nursing employers are less likely to reconcile resource distance with systematic tuition support than are urban employers. Rural nurses are less likely to hear the message of progression from their employer than are urban nurses. Limiting professional distance matters for the academic progression of rural nurses.
because nursing professional organizations have the potential to serve as vital progression information lifelines for rural nurses.

The nursing profession comprises a significant number of rural nurses. Approximately 16% of nurses live and practice in rural areas (Bureau of Health Professions, 2013). Though dispersed geographically, this cohort shares many nursing social and rural cultural characteristics. National and state professional organizations have the obligation to interact iteratively with this significant nursing professional cohort. Why is professional affiliation with rural nurses important? Because it matters to achieving health equity for rural patients and communities. The health outcomes of rural persons are poorer than the health outcomes of urban persons on many measures (Probst et al., 2019).

Research is needed to generate nursing knowledge regarding how iterative connections between rural nurses and nursing professional organizations manifest. This could begin with a commitment to rural nursing research, including research conducted collaboratively with rural nurses and regarding rural patients. When 16% of a profession shares an important demographic attribute, it is reasonable to consider the establishment of goals for the percentage of nursing research dollars which should be allocated to nursing research regarding that large cohort and the population they serve.

A significantly large subgroup of any population that lacks relative access to communication, information, and professional resources may be at risk for extra-professional influences. And those influences can impact the nursing profession. Rural nurses and rural nurse leaders, when they do not experience nursing professional influence, may become susceptible to forces of vocationalism which could run counter to
the interests of the nursing profession and the vulnerable rural populations they serve (James, 2017). For example, plans to apprenticeship pre-licensure nursing education, intended to ease rural nursing workforce needs, could be introduced in rural areas and then become contagious, spreading outward from the rural areas. More research is needed to study the affiliation of rural nurses to the greater profession and to assure that solutions introduced to address workforce issues include a strong nursing profession voice.

**Implications for Vulnerable Populations**

The findings constitute a frame through which leaders of rural nursing conceptualize and promote the academic progression of rural nurses. Vulnerability as a layered concept (Luna, 2009) allows for a layered conceptualization of population- and individual-level vulnerabilities. Rurality is associated with a number of relatively poor health outcomes and rurality is a quality shared by rural nurses and the patients for whom they provide nursing care. Female gender is another variable associated with vulnerability and one shared by the majority of rural nurses and half of the rural population they serve. Low rural wages when contrasted with urban wages (Bishaw & Posey, 2016) and limited access to broadband constitute vulnerabilities for rural nurses and their patients. For rural nurses, access to nursing knowledge and academia, and to the larger society of professionals, in general, constitute layered vulnerabilities through which the nurse navigates in order to academically progress and to thrive professionally.

It is important that the IOM goal be maintained and actively pursued past 2020 because the gap between current progress toward the goal and actual goal attainment comprises many vulnerable rural nurses. If we, as members of the nursing profession, decide that the goal is unattainable, if we decide the resources needed to attain the goal
are too vast, we are turning away from vulnerable rural nurses and excluding both them and their patients from the benefits derived from academic progression (Coyte & Holmes, 2006; Georges, 2011).

**Strengths, Weaknesses, and Limitations of the Study**

The broad range of perspectives and expertise of the study participants brought strength to the findings. Fourteen participant interviews were conducted in the course of the research, not an extensive number, though their perspectives were broad and drawn from deep experience as leaders of rural nurses. The participants were all leaders of rural nurses. Rural nurses serving in front-line rolls were not included as participants and their perspectives were not represented in this research.

The study was conducted with participants from one Midwestern state. Therefore, the findings fit and work in this Midwestern state, but may have less fit in other rural regions. The research was conducted by a novice researcher who herself was a rural nurse and rural nurse leader, making reflexivity and bias-checking of critical importance.

**Suggestions for Future Research**

There are many approaches to future research which could promote rural nurse academic progression. These include theory testing regarding the substantive theory of leading across distance. Such research could add to nursing knowledge regarding the leadership of rural nurse academic progression. Further work could be done to formally extend the theory, as well.

Quantitative research is indicated to investigate a possible relationship between the time since rural nurse academic enrollment in an associate degree nursing program and the likelihood of enrollment in a baccalaureate or graduate program of nursing study.
Information derived from such research could help rural nurse leaders to focus the delivery of resources and interventions during the most effective periods to promote nurse academic progression.

Further research regarding nurse education levels and patient outcomes in rural acute care, long-term care, and primary care practice settings is needed both to create knowledge regarding rural nursing care and to create nursing knowledge regarding how rural nursing may impact rural health and rural health disparities (Braveman et al., 2011).

Nursing knowledge regarding the relationship between rural nurses and the larger nursing profession is important, particularly at a time in history when social media allows rural nurses to coalesce as a meaningful and distinctive nursing cohort. Creating nursing knowledge regarding the relationship between rural nurses and the larger nursing profession could prove useful in supporting academic progression behaviors during breaks in academic enrollment. Development and testing of interventions to strengthen the iterative relationship between rural nurses and professional nursing organizations could provide important nursing knowledge for the profession.

Yanicki et al. (2014) identified conscious raising as an intervention to promote social inclusion. The findings invite nurse leaders who strive to promote rural nurse academic progression and to improve patient outcomes to design interventions which promote conscious raising regarding the needs of rural nurse leaders in the support of rural nurse academic progression.

It is my hope that, undergirded by Watson’s Caritas Literacy Dimensions, the profession of nursing can make intentional inroads into developing further knowledge regarding the nursing care of rural patients and populations, and into rural nursing
practice. It is my hope this knowledge can be used to lead nurse academic progression through the various distances between rural nurses and their educational progression goals. It is also my hope that the profession of nursing can provide an example to our larger society of the power of inter-professional caring to strengthen a profession and to promote equity for vulnerable rural persons and populations.


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Appendix A

Agreement of Consent for Research Participants
MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS
Leading the Educational Progression of Rural Nurses
Cynthia J Larsen
Graduate Nursing Department

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

PURPOSE:
The purpose of this research study is to identify, describe, and explain the concerns of nursing professional leaders and healthcare leaders as they work to promote the educational advancement of rural nurses. You will be one of approximately 20 participants in this research study.

PROCEDURES:
Each participant will review this consent document, have opportunities to ask questions, and will then either agree to or decline to give consent for participation.

If consent is given, an initial interview will be held. This interview will likely be from 40 to 60 minutes in length. Prior to doing the interview, each participant will complete a brief demographic questionnaire. Following completion of the demographic document, the researcher will inform the participant prior to beginning audio recording of the interview. If an online interview is held, the participant may complete the demographic document and submit by email or the participant may choose to answer the demographic questions for the researcher, with the researcher completing the document. The demographic questionnaire will be coded with a number and will not include the participant’s name, though the researcher will retain a hard-copy file which crosswalks participants’ code numbers to their interview data and to their demographic file. This document linking the participant to the demographic data and to the interview transcript will be stored in a locked file cabinet in the researcher’s locked office until the research is completed. The crosswalk document will be shredded at the conclusion of the research. The de-identified demographic data and the associated de-identified interview data will be retained indefinitely in secure location, by the researcher for ten years following the conclusion of the research.

The researcher will inform the participants, prior to the first interview prompt, that audio recording will begin. The researcher will then interview the participants, using an interview guide. Topics to be covered will include:

• Educational progression for rural nurses
• The role of nursing leaders in promoting rural nurse educational progression

Interviews will occur in an area which is convenient for the participant and may be conducted by video conference, if the participant prefers.

You will be audio recorded during the interview portion of the study to ensure accuracy. The tapes will be transcribed within a month of the interview occurring. The audio tape will then be destroyed. The de-identified transcript will be destroyed within 10 years of the conclusion of the study. For confidentiality purposes, your name will not be recorded on the audio recording or the transcript of the recording.
DURATION:
- Your participation will consist of one to two interviews, each likely between 40 and 60 minutes in length. The duration of the entire study will be one year.

RISKS:
- The probability that participation in this research would place participants at occupational, professional, or personal risk is judged by the researcher to be low, but present. The magnitude of potential harm related to such risk is judged to be low, as well.
- Collection of data using the internet involves the same risks that a person would encounter in everyday use of the internet, such as hacking or information being unintentionally seen by others.
- Although your privacy is very important, and the following topics are not intended to be part of this study, if you talk about actual or suspected abuse, neglect, or exploitation of a child or elder, or if you talk about hurting yourself or others, the researcher or other study team member must and will report this to the Wisconsin Department of Children and Families Services, or law enforcement agency.

BENEFITS:
- There are no direct benefits to you for participating in this study. This research may benefit society by contributing to the creation of nursing knowledge in ways that could promote rural nurse educational progression.

CONFIDENTIALITY:
- Data collected in this study will be kept confidential.
- All your data will be assigned an arbitrary code number rather than using your name or other information that could identify you as an individual.
- The key linking names to ID numbers will be stored in hard-copy form in the researcher’s locked file cabinet in her locked office. This linking document will be destroyed at the conclusion of the research. No study data will be stored in this locked cabinet.
- De-identified transcripts from interviews will be stored on the researcher’s password protected computer. Following completion of the research, the de-identified transcripts and associated de-identified demographic forms will be stored on an encrypted computer drive in the locked file cabinet in the researcher’s locked home office for 10 years following conclusion of the research.
- It is possible that de-identified research data could be used in future research regarding educational progression for rural nurse within ten years of initiation of this study.
- When the results of the study are published, you will not be identified by name.
- Direct quotes may be used in reports or manuscripts. These will be carefully de-identified to assure privacy.
- The remaining de-identified data will be destroyed by deleting electronic files 10 years after the completion of the study.
- Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

VOLUNTARY NATURE OF PARTICIPATION:
- Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.
- Due to the nature of the methodology used, de-identified coding of your data will begin immediately following your interview.
- You may skip any questions you do not wish to answer.
Your decision to participate or not will not impact your relationship with the investigators or Marquette University.

ALTERNATIVES TO PARTICIPATION:
- There are no known alternatives other than to not participate in this study.
- If you do not wish to participate in this study you can choose to inform the researcher at any time before, during, or after the interview.

CONTACT INFORMATION:
- If you have any questions about this research project, you can contact Cynthia Larsen, 330 South Tyler Street, Lancaster, WI 53813. Cell - 608-778-4842. Cynthia.larsen@marquette.edu. The Faculty Supervisor for this research is Dr. Marilyn Frenn, Marquette University. Marilyn.frenn@marquette.edu.
- If you have questions or concerns about your rights as a research participant, you can contact Marquette University’s Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.
Appendix B

IRB Protocol Approval
Date: 01/02/2018  
HR-1712021255  
Principal Investigator: Cynthia Larsen  
Faculty Advisor: Dr. Marilyn Frenn  
Department: Nursing  
Study Title: Leading the Educational Progression of Rural Nurses

New Study Approval
☑ This protocol has been determined to be Exempt under category # 2 as governed by 45 CFR 46.101(b).
☐ This protocol has been approved as minimal risk under Expedited category # as governed by 45 CFR 46.110.
☐ This protocol has been reviewed by the Institutional Review Board on [date] and approved as:
☐ Minimal risk  
☐ Greater than minimal risk

Approval Date
☑ This exempt determination was made on 01/02/2018.
☐ This study was approved on [date] for a period of twelve months. This IRB approval will expire on [date]. Please submit a continuing review application if approval is requested beyond this date.

Consent
☑ Please use the final version of the exempt information sheet or consent form submitted to the IRB. Contact the IRB office if you have questions about which document you should be using.
☐ The IRB approved informed consent form is attached. Use the stamped copies of this form when enrolling research participants. Each research participant should receive a copy of the consent form.
☐ This study has been approved for waiver of documentation of consent under 45 CFR 46.117(c)(1) or (2). Please use the approved consent information sheet with your participants.
☐ This study has been approved for alteration or waiving of consent under 45 CFR 46.116(d).

Study specific notifications
☐ The IRB approved recruitment materials are enclosed with this letter. Use stamped copies of these documents for recruitment purposes.
☐ This study involves students collecting data through surveys- please review the MU Questionnaire/Survey Procedures: http://www.marquette.edu/osd/policies/survey_procedure.shtml
☐ This study involves recruitment emails for online surveys to be sent to 100 or more Marquette students, faculty or staff. Please review the website of the Online Survey Review Group: http://www.marquette.edu/onlinesurveys/
☐ This protocol involves the use of electrical or mechanical systems that require direct human contact. Electrical and mechanical safety inspections should be conducted per Marquette University Human Research Protection Equipment and Electrical Safety Testing Policy 98.106.
Date: 01/02/2018
HR-1712021255
Principal Investigator: Cynthia Larsen
Faculty Advisor: Dr. Marilyn Frenn
Department: Nursing
Study Title: Leading the Educational Progression of Rural Nurses

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Appendix C

Interview Guide

Please tell me about your nursing educational journey.

Please tell me about your experiences with the education of rural nurses.

What works to promote the educational progression of rural nurses?

What obstacles exit to the educational progression of rural nurses?

Do you have a story or two you would like to share of promoting rural nurse academic progression?