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Job sharing in a rural satellite health clinic: A human health resource model for retention

Research study submitted in partial fulfillment for the requirements of the

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Ursula Danner, Lakehead University

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Abstract

Disparities in health care access and health human resources exist in rural communities. Rural nursing practice is very challenging which leads to retention issues. Job sharing is an innovative scheduling solution. The Healthy Work Environment Framework (RNAO, 2007) is used to demonstrate how job sharing within a rural delivery model, facilitates healthy and stable work conditions that lead to job retention. It also describes the benefits that are experienced across individual, organizational and external systems.

Problem Statement

Disparities exist in the health status and the health care access of rural, remote and northern communities in Canada. Health status of this population group is poorer than those in urban centers. Access to health services are more difficult because of the distances required to travel to obtain needed diagnostic and specialized services and the difficulty with health care provider retention (CIHI, 2006; Hay,Varga-Toth & Hines, 2006; Kirby, 2002 January; Nursing Sector Study Corporation, 2006; Romanow, 2002). There is a geographical discrepancy in the distribution of human health resources in Canada, with some rural areas having severe shortages of health care providers (Fletcher, 2001; Pong & Russell, 2003). Recommendations from numerous reports addressing this gap suggest exploring innovative and successful health human resource retention models in rural and remote communities. Reports also suggest the sharing of best practice retention strategies (Barer & Stoddart, 1999; Hay,Varga-Toth & Hines, 2006; Hutten-Czapski, 2001; Kirby, 2002 October; Nursing Sector Study Corporation, 2006; Romanow, 2002). Innovative retention solutions are needed (Hutton-Czapski, 2001; Nursing Sector Study Corporation, 2006; Robinson III & Guidry, 2001).

The Rural Context

Definition Of Rural

A unified definition of "rural" does not exist as discovered through a rural health workforce policy review by Pong and Russell (2003) and an environmental scan completed through the Rural and Remote Health Innovations Initiative (2003). Pong and Russell (2003) found that in the various documents they studied, the terms rural, remote, isolated, northern and underserviced were used interchangeably to describe communities that were at a distance from an urban center. In their synthesis and review, these authors chose to use the word "rural" broadly in their report to include all the above terms. For the purpose of simplicity, this author has chosen to use the term "rural" in the same way for the remainder of this paper.

Population Health

Over 95% of Canada's land mass is rural, populated by 30 % of the total Canadian population (Kirby, 2002, January, p. 137). More than half of the 1.4 million Canadian aboriginal people live in rural communities (Ministerial Advisory Council on Rural Health, 2002, p.10). Similar demographic and socioeconomic trends characterize rural communities: population densities are small, there are higher percentages of children, adolescents and seniors, and socio-economic status is less when compared to urban communities (CIHI, 2006; Hay, Varga-Toth & Hines, 2006; Kirby 2002, January; Robinson III & Guidry, 2001). Morbidity from chronic disease is higher as is mortality from accidents, suicides and chronic disease (CIHI, 2006). Poorer health behaviors especially behaviors around diet, inactivity and smoking have been reported as well (CIHI, 2006). Chronic gaps exist in access to mental health services, care for seniors and

children with special needs as well as activities in health promotion (CIHI, 2006; Hay,Varga-Toth & Hines, 2006). A gap in services for women's health care is emerging as well (Hay,Varga-Toth & Hines, 2006).

Rural Health Human Resources

Shortages of rural health care workers are ongoing (Hay,Varga-Toth & Hines, 2006). Information collected by the Northern Development Ministers forum in 2002 (as cited in Pong & Russell, 2003) indicated the shortages included physicians, nurses, technicians in diagnostic services and allied health care workers. In their report to the Canadian Institute for Health Information, Pong and Pitblado (2005) determined that in Canada, 16 % of family physicians and approximately 2% of specialists worked in rural areas in 2004 (p. viii). The Canadian Institute for Health Information (2000) also reported that 17.9% of all nurses in Canada worked in rural areas (p. 4). Recruitment and retention of rural health human resources is an ongoing issue (Kirby, 2002 January; Pong & Russell, 2003). There have been vacancy rates on aboriginal reservations of forty percent resulting in closures of some northern nursing stations (Fletcher, 2001, p.12). If there are no closures, there is frequent nursing turnover. This turnover has serious effects on patient care (Minore, Boone, Katt, Kinch, Birch & Mushquash, 2005). Reasons for the recruiting difficulties are reported as resulting from geographic isolation, high stress and burnout due to the rural practice setting, competing urban opportunities, lack of employment support for spouses, lack of community resources for family and lack of professional support (Barer and Stoddart, 1999; Kirby, 2002 January; Pong & Russell, 2003, Robinson III & Guirdy).

The future does not hold promise with regards to human health resource supply. A report by the Canadian Institute for Health Research in June 2002 (as cited in, Kirby 2002 October, p. 185) noted a peak of physician supply in 1993 and a 5% decline since then. Barer and Stoddart (1999) suggested relying more on non-physician personnel with extra training to provide front-line primary care in rural communities so access is increased. Nurse practitioners (NP) have been introduced into the health system and have been well received. However there have been issues of physician acceptance of the role (Blythe & Bauman, 2006; Pong & Russell, 2003).

Shortages are predicted for the nursing profession. A Canadian Nurses Association report (as cited in Kirby, 2002 October, p. 187) projects a shortage of 78,000 nurses in 2011 and up to 113,000 nurses by 2016. These shortages are attributed to women having more career choices, higher educational requirements for the profession, an aging workforce and difficult working conditions (Halliwell, Shamian & Shearer, 2004). These statistics will definitely influence access to rural health care in the future.

The Nature Of Rural Nursing Practice

"In the absence of physicians, nurses are the gatekeepers of the health care system……Nurses are hired to work in remote and isolated areas that cannot support physicians….(Blythe & Bauman, 2006, p. 9). Considering the important role that nurses have in rural health care delivery, Pong and Russell (2003) found few policy documents focused on rural nursing. Rural nursing issues have been integrated into general nursing issues with regards to work environment and human resource supply. As a result, the specific needs of this specialized group are neglected (Blythe & Bauman, 2006; Nursing Sector Study Corporation, 2006; Pong & Russell,

2003; Romanow, 2002). Nursing policies that are urban focused may not be the most suitable for the delivery of rural health services (Blythe & Bauman, 2006; MacLeod, Kuglig, Stewart & Pitblado, 2004; Romanow, 2002).

The *Report of the National Survey of Nursing Practice in Rural and Remote Canada* (Stewart, D'Arcy, Pitblado, Forbes, Morgan, Remus, Smith & Kosteniuk, 2005) collected data to determine the characteristics of those nurses working in rural and remote Canada in 2001 and 2002. Some of the findings of 3, 933 nurses who responded to the questionnaire indicated that rural and remote nurses were an average of 44 years old, had an average of 20 years working experience, were married or with a partner and on average had college training. The study found that five percent of respondents identified themselves as aboriginal.

Rural nurses often work in community settings with clinical, administrative and professional support at a distance (Andrews, Stewart, Pitblado, Morgan, Forbes & D'Arcy, 2005; Hegney, McCarthy, Rogers-Clark & Gorman, 2001; MacLeod, Kuglig, Stewart & Pitblado, 2004; Minore, Boone & Hill, 2004). Stewart et al's (2005) study found 70% of their respondents worked in communities that were further than 100 km away from a major center. The Canadian Institute for Health Information (as cited in Andrews, Stewart, Pitblado, Morgan, Forbes & D'Arcy, 2005, p. 16) reported that in 2000 there were 399 communities in Canada that were run by a "Sole RN". "Personal isolation is compounded by professional isolation, harsh environmental conditions, limited or expensive means of traveling away from the community and isolation from friends and family who frequently live in the south" (MacLeod, Browne & Leipert, 1998, p. 75).

Other challenges include working outside clinic hours because nurses, as part of the community, are seen as available (Andrews, Stewart, Pitblado, Morgan, Forbes & D'Arcy, 2005; MacLeod, 1999; Minore, Boone & Hill, 2004). Stewart et al's (2005) study found that 48% of respondents were required to be on-call (p. 5). Rural nurses carry enormous responsibility and accountability and require a generalist knowledge base. They work in an expanded scope of practice. There are minimal opportunities for upgrading of their skills or for continuing education (Andrews, Stewart, Pitblado, Morgan, Forbes & D'Arcy, 2005; Canadian Nurse Practitioner Initiative, 2005; MacLeod, 1999; MacLeod, Browne & Leipert, 1998; Ministerial Advisory Council on Rural Health, 2002). The work is challenging which attracts nurses to this type of practice (Minore, Boone & Hill, 2004).

In general, poor nursing work-life and job dissatisfaction were both major contributors to nurses leaving their profession (Canadian Policy Research Network, 2002; Shamian, Villeneuve & Simoens, 2004). Stress, heavy workloads and long hours are some of the problems in the work environments of nurses. These problems are affecting their physical and psychological health (Bauman et al, 2001 as cited in Canadian Nursing Advisory Committee, 2002). Practicing in rural communities is not easy. "The key for governments, employers and policy makers is to recognize that if we want nurses and other health professionals to come into the system and stay in it, we have to create and maintain stable, healthy work environments" (Canadian Nursing Advisory Committee, 2002, p. 12). Improving working conditions in rural and remote communities have been recommended by several reports. (Canadian Nursing Advisory, 2002; Canadian Nurse Practitioner Initiative, 2005; Ministerial Advisory Council on Rural Health,

2002). Creating innovative work schedules including job sharing arrangements was recommended as one solution to improve working conditions by the Canadian Nursing Advisory Committee (2002).

Job Sharing

Work scheduling, especially that of job sharing, influences retention (Colwill, Penney, & Taft, 2003; Hall, 1993; Marshall, Pottage & Musgrove, 1993; Morella & O'Hanlon, 2003; Tiney, 2004). Job sharing is a flexible work schedule option and "*involves two or more people sharing the duties of one full-time job. Job-sharers are normally accountable for a whole job and can, therefore, retain the status and prospects of equivalent full-time employees*" (Branine, 1998, p. 20) The benefits of this human resource strategy includes retention of personnel with their skills, increased productivity, increased efficiency and increased personal growth (Branine, 1998, Taylor, 1997, Worzniak & Chadwell, 2002). "Strategies that lead to successful development of a positive, challenging work environment will enhance the retention of NPs in existing positions and may facilitate recruitment of other nurses into this advance nursing role" (Canadian Nurse Practitioner Initiative, 2005, p.2). Job sharing is an innovative scheduling option that needs to be explored within the context of rural nursing practice (Robinson III & Guidry, 2001).

Purpose Of Paper

This paper will explore job sharing of nurse practitioners within a rural satellite clinic as a health human resource model for rural health service delivery. It will describe the role of job sharing using the *Healthy Work Environment Conceptual Framework* (RNAO, 2007) to demonstrate how job sharing facilitates a healthy work environment thus contributing to job retention. Suggestions will be made for future research to formerly explore this concept.

Literature review

Research conducted on job sharing or flexible scheduling in the nursing work environment is limited. In 2001, the Provincial Scheduling Working Group, the Health Employers Association of British Columbia and the British Columbia Nurses' Union (Ministry of Health Planning Nursing Directorate, 2003) explored innovative scheduling for the purpose of implementation. They reviewed 16 articles, 10 web sites and contacted 22 organizations. They found that articles repeatedly emphasized that scheduling was important to retention but found that little was recently written that provided specific information or new ideas on scheduling.

The same organization conducted 14 focus groups with 51 nurses to determine what they liked and disliked about scheduling, ways that scheduling could increase work-life balance and control over their work and to seek feedback on innovative job scheduling ideas. An overwhelming response of their focus group was to "stop trying to encourage nurses to work full time" as

participants felt strongly that most nurses did not want to work full time due to the demands of the job. There was a unified agreement that part time work would result in a happier and healthier workforce (Ministry of Health Planning and Nursing Directorate, 2003, p. 11). Innovative job sharing as a scheduling option received the highest rates of interest from this focus group. One recommendation from this project was that innovative job sharing should be explored.

Carpenter's (2003) thesis dissertation involved a satisfaction study of the rural RN workforce of northern Idaho. Her study collected data from 169 nurses working in a rural setting. Analysis found that regardless of age or number of years worked, flexibility in work scheduling was seen as most important to job satisfaction.

Blythe, Baumann, Zeytinoglu, Denton & Higgins (2005) conducted a qualitative study to investigate nurses' preferences for full-time, part-time or casual work. They held focus groups with 55 RNs , RPNs and nurse managers. They also conducted a review of policy documents pertaining to these work arrangements. Within their study, job sharing only occurred in the two of the three teaching hospitals and depended on the staffing needs and attitudes of the nurse manager. Nurses were concerned that their job share position, which included benefits and holidays, might eventually be converted to part time positions where benefits were not available.

Taylor (1997) analyzed the introduction of a nurse job share partnership into a primary health care team. The team was never involved in the implementation process. The analysis found that job sharing only benefited the nurse partners as they were able to support and validate one

another clinically. However, as a result of a sense of power imbalance, the partnership was seen to be a threat to the remainder of the primary care team. The job share team felt that, combined, they had greater experience and skills than the remainder of the team, an attitude not shared by the others. The pair worked independently of the primary health team to the exclusion of other members causing confusion over the pair's boundaries within the team. Communication was poor. There was mistrust and feelings of uncertainty by the other team members. The analysis concluded that all team members needed to be involved in the change strategy of implementation of a job share partnership for a positive outcome to result.

Kearns, Webbing & Ryne (1999) found that the job sharing post between two case managers in a community mental health team in London, England was successful. This positive outcome resulted because the job share team was included in implementing the position and the remainder of the staff was supportive, flexible and understanding. The job share pair reported improved work-life balance with increased energy, increased motivation and enthusiasm for their work. Clients were pleased with the continuity of care. Attendance at meetings by both workers was one of the difficulties that occurred. However, in general, the community mental health team was pleased with the job share arrangement.

As two family physicians, Worzniak and Chadwell (2002) described their job share model. Professional growth, increased patient satisfaction and the ability to balance work with personal priorities were the benefits they described they received. Cross-coverage and communication were challenges that they encountered but was resolved with the use of pagers, email or the faxing of notes to one another.

Kane (1999) completed a research study of 269 nurses to determine differences in job satisfaction, burnout and desire to leave their position based on full-time, part-time or job sharing positions. The nurses were selected from large Canadian teaching hospitals and questionnaires were sent. Using a variety of measurement scales, satisfaction, burn-out, intent to leave and family stressors were measured. Demographics were also collected. The study found that employment status was influenced by age of the nurse and age of the respondent's children. The majority of nurses who job shared were between the ages of 35-49. Those with preschool children were more likely to work part time or job share. Through multivariate analysis, job sharing nurses reported higher job satisfaction but there was no significant difference in scores when burnout or propensity-to-leave was measured. The author concluded that job sharing had a significant influence on job satisfaction and retention and was a scheduling option that needed to be considered by administrators.

Dubourg, Ahmling and Bujas (2006) completed a nurse staff survey in a day surgery setting to determine if there were differences perceived in roles of their job share managers when compared to full-time managers in the same position. The study was small. It evaluated two full time managers and one job share manager team. The managers' staff was surveyed with 33 respondents only. Management areas that were assessed were in communication, leadership, mentoring and teamwork. The study found slightly higher scores for the job share nurse managers in communication, leadership and mentoring but lower scores in teamwork in comparison to the full time managers. The full time managers involved staff early and achieved more team cohesion than their job share counterparts. The authors concluded that disjointed

leadership, poor communication and lack of accountability did not occur with the job share nurse management team as might be expected. The study found that there was higher enthusiasm and greater skill in completing difficult tasks with this team and described the need for effective communication, consultation with one another, role clarification and planning as key to the success of this model.

Outcome measures of job sharing were examined by Valentine and Martin (1996). A questionnaire was sent to 126 medical staff in a children's hospital in Australia. The questionnaire addressed whether staff had experience working with a job share team, whether they felt job sharing should continue, the effects of job sharing on patient care, and at what level of training and which staff should do job sharing. The study had a 60% response rate. The findings indicated support for the continuation of job sharing however, 46% felt their workload increased and 16% thought that patient care was adversely affected. The authors concluded that although there were difficulties that arose from job sharing, staff perceived that the benefits outweighed them. Good communication was suggested as the solution to enhancing patient care within this job model.

Flexible scheduling was ranked as a very effective retention strategy is LaSala's (1995) thesis dissertation studying the nurse recruitment and retention strategies and barriers in rural health settings in the commonwealth of Virginia.

Minore, Boone and Hill (2004) had similar results in their survey study of nurses' opinion of working in remote First Nations communities. The nurses who were surveyed were

representative of the region where a nursing relief pool could be established and drawn from. 76.4% of the 622 respondents of the survey felt that rotating work schedules would be a successful recruitment strategy. The study found that nurses would be willing to work part time for their employer in their home community and part time in a First Nations community on a rotating basis. Job sharing was suggested as an approach to guaranteeing job security. However the authors explained that establishing such a job sharing model would be difficult as the provision of health services to First Nations peoples and the rest of the province follow different governmental boundaries. Health care services for First Nations communities are provided by the federal government while services to non-aboriginal communities are provided by the provincial government.

Conceptual Framework

The nature of the rural work environment is a factor in recruitment and retention of rural nurses. Work environments that are healthy increases job satisfaction and staff productivity (RNAO, 2007, Bauman et al, 2001). "A healthy work environment for nurses requires transformational change, with interventions that target underlying workplace and organization factors" (Lorne, G., 2004. as cited in RNAO, 2007, p. 14).

Rural nursing practice needs to be evaluated from a systems perspective. General systems theory studies relationships between the components of a system and how it operates as a whole. A disturbance in one component can cause the system to be dysfunctional (Abbey, 1978). Rural nursing as a system, interacts with many systems including; economic systems, political systems, health care systems and cultural/geographic systems (LaSala, 1995). Within the rural health

work environment, interacting systems include: the nurse practitioner, the organization, the community and regulatory and government bodies.

The *Conceptual Model for Healthy Work Environments for Nurses* (RNAO, 2007) takes a systems approach to the work environment of nurses. Three system levels and their interdependence are addressed which interact to influence a healthy work environment. They are the individual (micro level), the organization (meso level) and external system determinants (macro level). Components within each level are examined from a physical/structural policy perspective, a cognitive/psycho/social/cultural perspective and a professional/occupational perspective. The outcomes of each level can influence the nurse/patient/client, the organization and society (Figure 1).

Within the physical/structural policy component of this model, physical work demand factors and scheduling are assessed at an individual level. At an organizational level, organizational structures that respond to physical demands or work are evaluated. The effect of external policy factors such as funding, health systems reform and health care delivery models are examined at an external level.

The professional/occupational component looks at the nurse's personal attributes and the skills and knowledge required in responding to his or her environment. The organizational/professional and occupation factors include scope of practice, level of autonomy, control over practice and the interdisciplinary relationships. Provincial and national policies and regulations are examined at an external level.

Cognitive/psycho/socio/cultural components evaluate the psycho-social work demand factors at an individual level. Within the organization, organizational social factors including communication practices, organizational stability and relationships with management are evaluated. At the external level, the influence of the community on the organization and the individual is studied.

Using this framework and focusing on job sharing, the interdependence between the nurse practitioners who job share (micro level), the organization (meso level) and the external context consisting of professional associations, regulatory bodies and the government (macro level) can be evaluated within a rural nursing practice system.

Figure 1

Conceptual Model for Healthy Work Environments

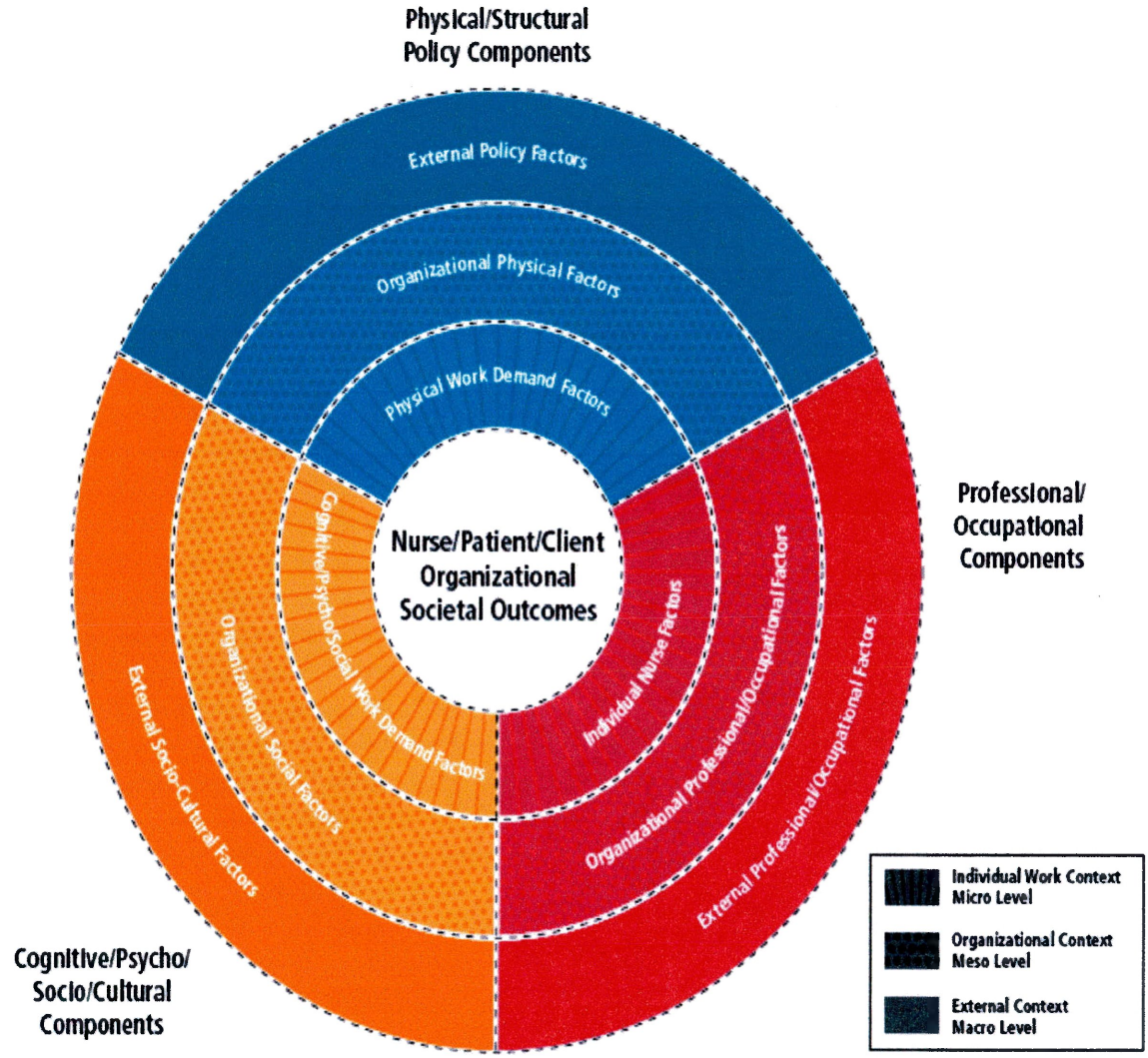


Figure 1. Conceptual Model for Healthy Work Environments for Nurses – Components, Factors & Outcomes[I-III]

Registered Nurses' Association of Ontario (2007). *Professionalism in Nursing* Toronto: Registered Nurses Association of Ontario, p.16.

A Model of a Rural Health Service

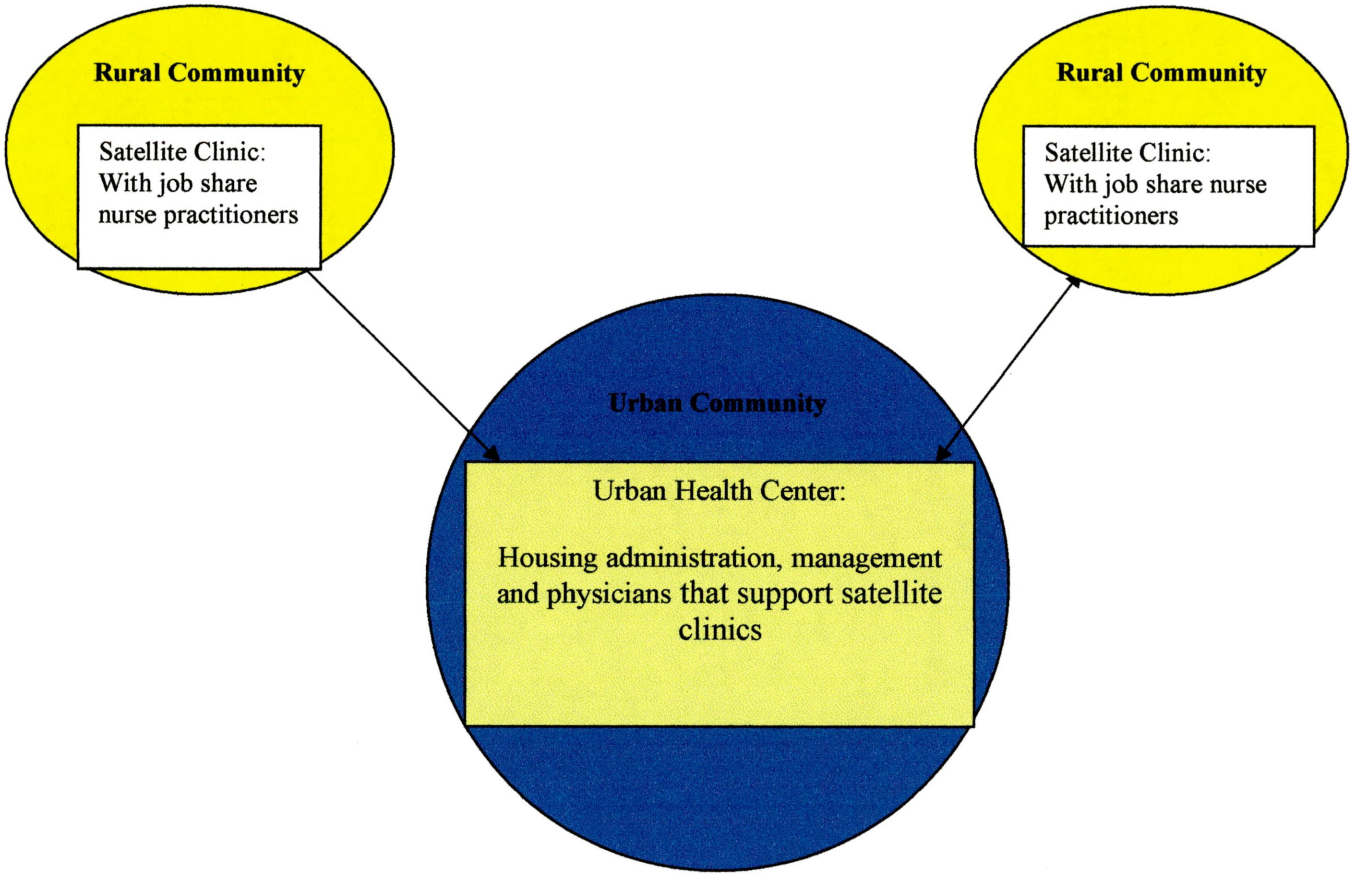
Rural or remote health delivery would be provided by a satellite health clinic that would be managed by a larger health center located in a proximal urban community (Figure 2). The satellite clinic would be staffed by a team of nurse practitioners in a job share position. Each nurse practitioner is provided with receptionist support. Health care would be available 24 hours to the community throughout the week by the nurse practitioner with acute support from the ambulance services. Services on weekends would be covered by ambulance only.

Scheduling of each nurse practitioner would be 5 days on and 5 days off with no weekend coverage. The nurse practitioner would commute from the urban center and live in the community for the required time period. Housing would be provided and shared between the two job sharers.

Management and administrative support would be provided from the urban site. Management would be in regular contact with the satellite staff via phone or videoconference. Monthly visits to the sites would also occur. Physician consultation would be by phone or video-conferencing. The physician would also make monthly visits to the community to run clinics.

The urban health center could have the potential to supervise several rural communities with nurse practitioners who job share and a physician assigned to each community.

Figure 2: Rural health services model



A Systems Perspective of a Rural Job Sharing Model (Table 1)

Micro Level: Job Sharing and the Individual Nurse Practitioner

Job sharing allows for flexibility in scheduling. Schedules can be determined by the nurse practitioner team. In rural communities accessible by car, a schedule of 5 days on and 5 days off is practical to establish. In remote communities, accessible by plane only, the schedule may require more time covered per rotation (four weeks on and four weeks off). The nurse practitioners would see clients scheduled during their stay. Follow up of clients could be continued on the nurse practitioner's next session of work.

Sharing of client care can also occur, especially for the more complex patient. A client that is challenging can have a second "look at" by the partner. This would enable the skills of two nurse practitioners to be used and allow for more complete assessments and treatments to be planned. The assessment and treatment workload burden is then shared.

However, there can also be the potential for misunderstandings to occur about workload expectations. This can affect the team's relationship. It is therefore important to have clear understanding of the job description and of individual/job share roles and responsibilities. Both nurse practitioners of the job share team need to agree on how activities will be coordinated (Chapin, 1992; Marshall, Pottage & Musgrove, 1993; Mickan & Roger, 2000).

Table 1: Job sharing illustrated using the *Healthy Work Environment* systems framework

	Physical/Structural/Policy Components	Professional/Occupational Components	Cognitive/Psycho/Social/Cultural Components
Micro **Individual Work Context**	**Benefits** • Flexible schedule • Shared workload • Stable employee benefits • Guaranteed work days	**Benefits** • Autonomy of practice • Continuity of patient care • Professional growth • Opportunities to pursue personal interests • Creates partnerships that share expertise • Work/life balance **Required** • Similar work and professional philosophies are a key to success	**Benefits** • Decreased stress/burnout • More productivity and energy to work • Commitment to the organization **Required** • Clear understanding of roles and responsibilities • Communication is key to success
Meso **Organizational Context**	**Benefits** • Continuous coverage • Decreased absenteeism • Increased work productivity • Retention of skilled workers • Leverage point for recruitment **Required** • Organization policy statement and guidelines on the expectation of the job share position	**Benefits** • Fosters problem solving by job share team because of autonomy and control over practice • Maintains corporate knowledge • Management's time better facilitated as retraining occurs less frequently **Required** • Policies to deal with care outside of scope of practice • Facilitate physician availability and good collaborative relationships for consultation	**Benefits** • Organizational stability through retention **Required** • Organizational climate inclusive of job share personnel • Clear Communication pathways • Participative management style

	Physical/Structural/Policy Components	Professional/Occupational Components	Cognitive/Psycho/Social/Cultural Components
Macro **External Policy Factors**	**Benefits** • Meets four of the five 2006 Health Systems Strategic Directions developed by the Ministry of Health and Long Term Care **Required** • Provincial human health resource strategy that supports a job share initiative targeting end of career or recently retired nurse practitioners or those pursuing post graduate education	**Benefits** • Job sharing is considered a family-friendly work option by the federal government • Job sharing has been included in many collective agreements • Collaborative working NP/physician relationships are supported by the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario **Required** • Collaborative professional policies that are rural/remote specific	**Benefits** • Meets the health care needs of a vulnerable and under serviced population • Facilitates human resource pool that is changing demographically • Supports a healthy work environment resulting retention

Job sharing can demonstrate stable financial benefits to the nurse practitioner who is working half time. The number of working days is guaranteed. Sick leave, vacation time and benefits are provided and are prorated to time worked (Chapin, 1992; Kane, 1999). Opportunities can also be seized to participate in other job contracts that fit within the designated job share schedule and therefore can contribute to personal pursuits (Gliss, 2000).

Job sharers have more autonomy of their practice because of scheduling choices and because of the nature of working in the rural satellite clinic (Andrews, Stewart, Pitblado, Morgan, Forbes & D'Arcy, 2005; Hegney, McCarthy, Rogers-Clark & Gormain, 2001; MacLeod, Kuglig, Stewart & Pitblado, 2004; Minore, Boone & Hill, 2004). While in the rural setting, they have to manage their time and schedules independently and problem solve immediate issues. They have to rely on their own skills and knowledge as consultations are only immediately available via technology and from a distance. The nurse practitioners require confidence in their work abilities as they require a generalist knowledge base and may be confronted with cases that are beyond their scope of practice. Each partner will have to determine their own learning needs to keep their skills and knowledge current.

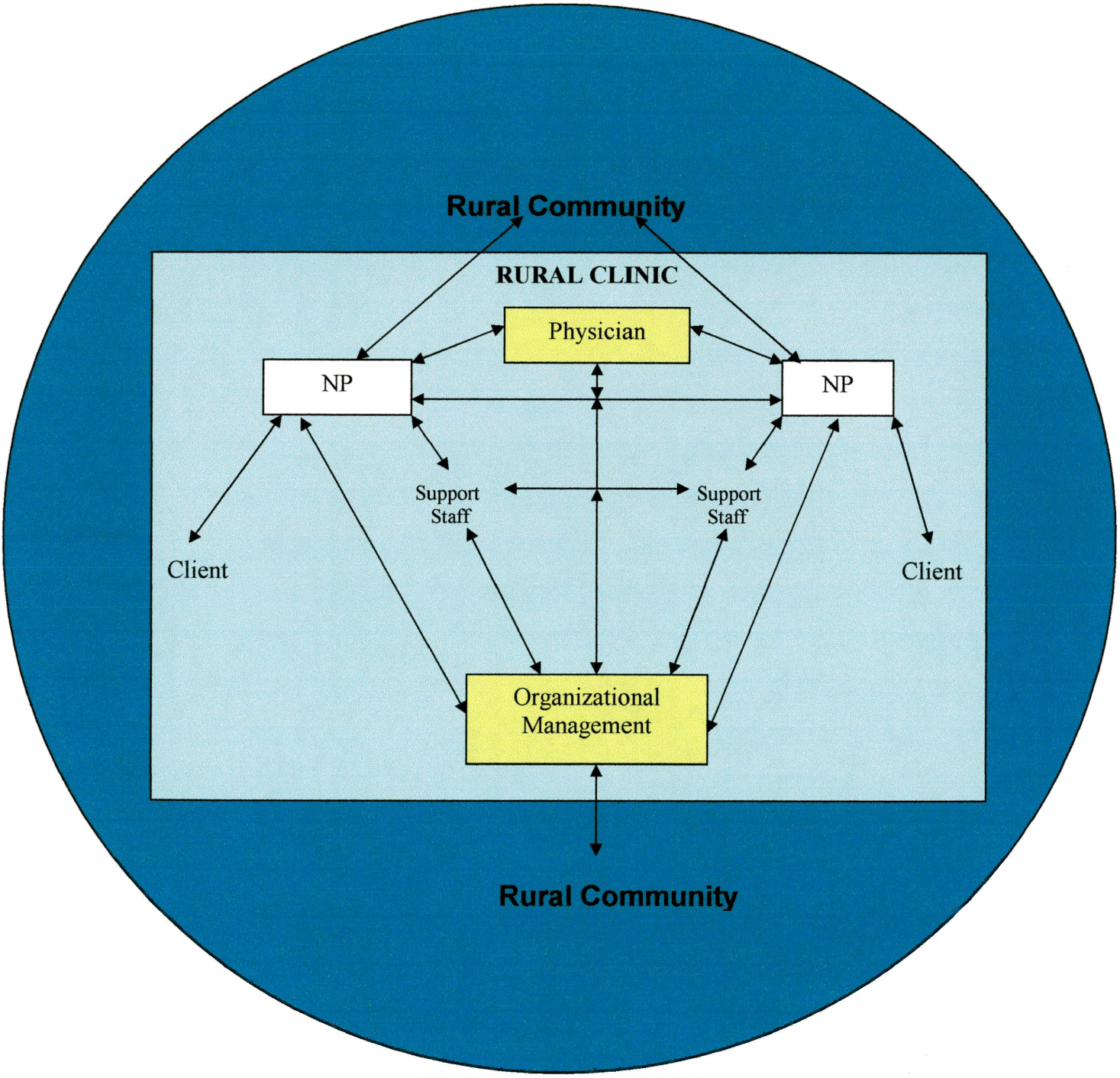
This model is very conducive to professional growth (Gliss, 2000; Kane 1999; Taylor 1997; Marshall, 1997; Worzniak & Chadwell, 2002). Educational opportunities can occur while working or on the nurse practitioners time off. Sessions could be conducted on work time over videoconferencing or the internet. Monthly community visits by the physician would provide excellent learning opportunities as the physician can share knowledge with the nurse practitioner when seeing clients. Finally, the flexibility in scheduling allows for opportunities for the nurse

practitioner to have more freedom to pursue continuing education opportunities on their own time. With organizational support, the job share team can remain skilled and current in knowledge.

Job sharing also allows for partnerships to exist where each nurse practitioner can learn from each other through information sharing and through collaboration of client cases. The key to success is that both partners are compatible in their professional and work philosophies (Branine, 1998; Gliss, 2000; Mickan & Roger, 2000; Taylor, 1997). Experienced and skilled practitioners can share their expertise (Gliss, 2000; Ministry of Health Planning Nursing Directorate, 2003; Taylor,1997).

Communication is crucial to the continuity of care and key to the success of the functioning of the partnership (Marshall, Pottage & Musgrove, 1993; Micken & Rodger, 2000; Sciacca & Green, 2001; Valentine & Martin, 1996). Within the rural job share model, communication is complex as the nurse practitioner is responsible for linkages with the partner, the client, the physician, the manager of the organization and the community (Figure 3). Ongoing communications about specific client care and administration issues are necessary. Communication pathways need to be understood and practices followed especially with regards to conflict management. Documentation of client care needs to be thorough so there is mutual understanding of how future care is to proceed. Communications sources need to be determined and whether they are verbal or written. Electronic medical records would enhance this practice.

Figure 3: Communication pathways of job sharing nurse practitioners within the organization



Finally, at an individual level, the flexible scheduling of job sharing supports a work-life balance. It decreases stress and burnout because there is time away from the work. It enables the individual to pursue interests or family obligations outside of the work schedule. This fosters more energy and enthusiasm for work and results in a greater commitment to the job and organization (Chapin, 1992; Colwill, Penny & Taft, 2003; Marshall, 1997; Marshall, Pottage & Musgrove, 1993; Morella & O'Hanlon, 2003; Saltzman, 1988).

Meso level: Job Sharing and the Organization

The benefits of job sharing to the organization are numerous. The job share team can provide staff flexibility for continuous health care coverage of the rural communities especially for vacation and extended sick leave (Colwill, Penney & Taft, 2003; Hall, 1993; Taylor, 1997; Thornicroft & Strathee, 1992; Tiney, 2004). Decreased sick time and absenteeism are outcomes which also contribute to continuous health coverage as well as increased work productivity (Colwill, Penney & Taft, 2003; Gliss,2000; Kane,1999). Job sharing helps in the retention of skilled and experienced staff (Branine, 1998; Gliss,2000; Marshall, Pottage & Musgrove, 1993; Marshall, 1997; Taylor, 1997; Tiney, 2004). Job sharing can also be used as a leverage point for recruitment (Gliss, 2000). The direct costs to the employer of two job share positions are comparable to that of one full-time employee (Olmstead & Smith (1989) as cited in Kane,1999).

Autonomy and control of the nurse practitioners' job share practice along with the crossover of experience and skills can result in the team problem-solving on their own. This leaves time for management to focus on other issues at hand (Colwill, Penney & Taft, 2003; Sciacca & Green, 2001; Tiney, 2004). As there are two experienced workers in the same position, when a leave

occurs corporate knowledge prevails because skills and corporate memory are maintained. This again frees the manager from continually retraining (Hall, 1993; Sciacca & Green, 2001).

The organization must understand the nurse practitioner scope of practice. Policies and structures must be in place to ensure that either collaboration or evacuation to an urban facility take place when care presents outside of the scope. Good collaborative relationships with the consulting physician must be facilitated which includes the enabling of the physician to be available when needed (College of Nurses of Ontario, 2005).

Havloc, Lau & Pinfield (2002), discuss how work schedule congruence results in a person-organization fit and contributes to employee satisfaction. A person-organization fit is created when the organization supports and provides the resources for their employees to meet their needs and the demands of the organization. Job sharing facilitates this fit. The demands of rural nursing have already been discussed. Job sharing balances the work-life needs (discussed previously) of the nurse practitioner while providing health care services to the rural community for the organization. Work congruence is present and the nurse practitioner is satisfied resulting in retention of staff as an outcome. When retention is present, the organization and the rural community benefit from the organizational stability.

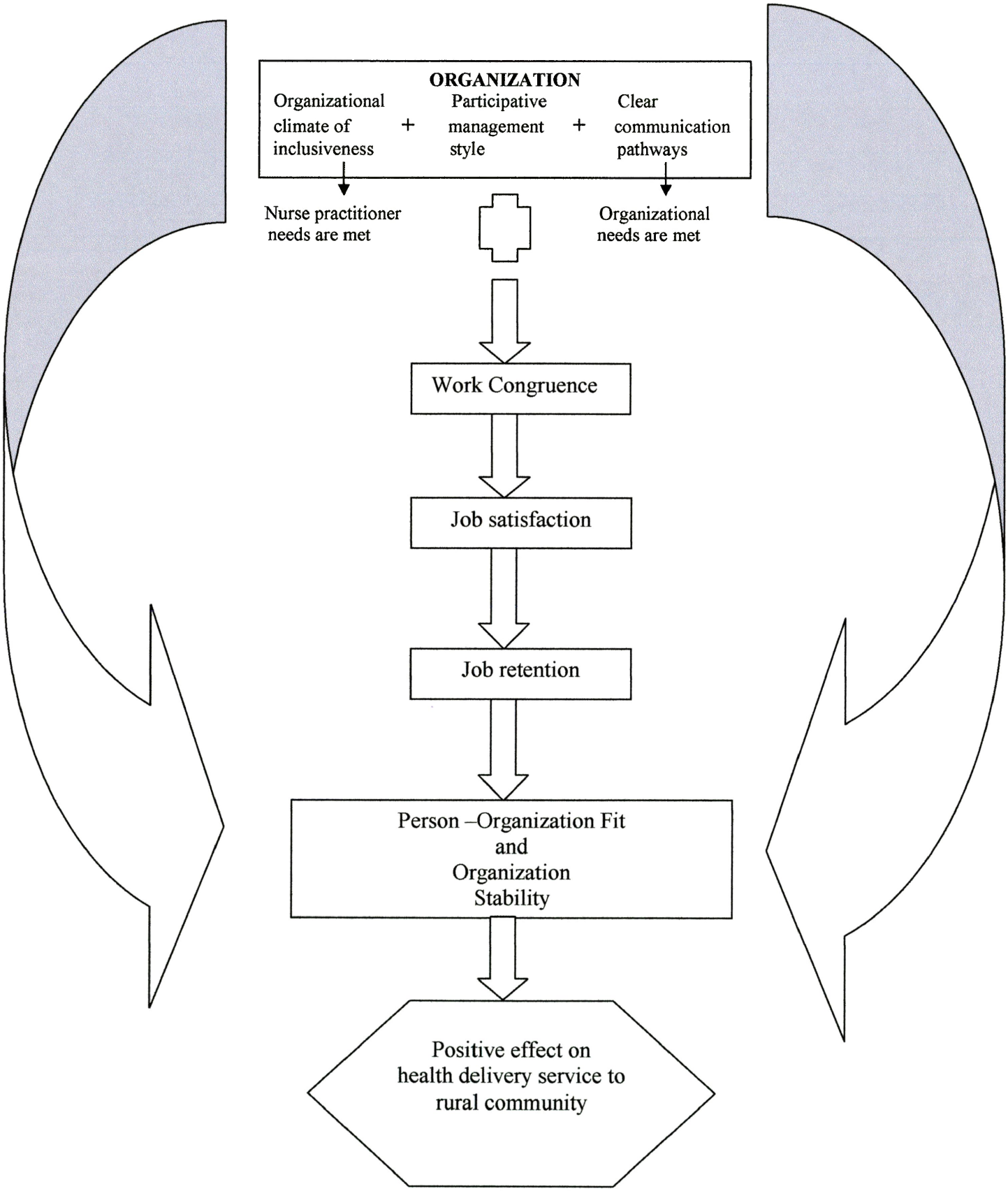
Several other components are required for a person-organization fit to occur within a rural job share model. An organizational climate that is inclusive of job share partners must be present,

clear communication pathways must be practiced and participative management style that allows for autonomy must be endorsed (Figure 4)

The organization must facilitate the inclusion of the nurse practitioner partners and the job share model in their organizational environment. An organizational policy statement about the expectation of the job share role must be created with guidelines included on how the model is to be delivered (Branine, 1998; Chapin 1993; Manitoba Civil Service Commission, n.d.; Thornicroft & Strathdee, 1992). This process demonstrates the organization's commitment to the job share model and prevents misunderstandings about how it will be managed.

Both nurse practitioners must be included in clinical and administrative meetings. Scheduling monthly meetings that alternate with each staff's work schedule will provide opportunity for both partners to be involved. The partner not working could be offered time off in lieu of the time spent at the meeting as an incentive to participate. The meetings could be attended by the nurse practitioner that is not in the community using either telephone or videoconferencing. Regular contact with the two nurse practitioners both formally through meetings or informally through telephone calls will foster support , flow of information , problem solving, team functioning and avoidance of misunderstandings (Mickan & Rodger, 2000; Taylor, 1997). Ongoing organizational notices could be emailed regularly to both nurse practitioner partners. Such inclusion activities promote cohesion with the nurse practitioner team and the organization.

Figure 4: How job sharing supports person-organization fit



Characteristics of a successful job sharing model include this regular communication with staff. However, as previously mentioned communications with two people in a rural setting can be challenging. Management needs to communicate with each job sharer, the physicians, clients and the community (Figure 3). Communication pathways and practices must be established at an organizational level. An understanding of the conflict management process is also required when communication breakdown occurs (Branine, 1998; Marshall, Pottage & Musgrove, 1993).

Because of the nature of the job share position and of rural/remote practice, a level of autonomy and control over the practice is required by the nurse practitioners. They are practicing at a physical distance and often autonomously within the community they are placed. This means that management and the organization must release some control.

A participative management style is an organizational approach that has contributed to nurse job satisfaction. It is considered the highest quality of management style in the delivery of health care services. It incorporates an inclusive atmosphere where employees' ideas and feedback are sought, freedom for discussion is encouraged, complete confidence in the worker exists and communication is ongoing and flowing in all directions within the organization. Information is shared and accurate. An open minded mentality prevails. Goals are set that include the employee. Problem solving and decision-making are interactive. Both management and the employee are empowered so that organizational transformation can occur (Moss & Rowles, 1997; Muller, 1995). The organization must foster this type of management style in order that this rural model of health delivery service is a success.

Macro level: Job sharing and External Policy Factors

Job sharing meets four of the five strategic health directions for the Ontario healthcare system as presented by Health Minister George Smitherman in 2006 (Table 2). The draft directions were delivered to each Local Integrated Health Network to support the development of their regional integrated health systems plans. The strategic directions as outlined by Minister Smitherman (Ministry of Health and Long-Term Care, 2006) focus on the following areas:

1. Renewing community engagement and partnerships concerning health care
2. Improving the health status of Ontarians
3. Ensuring equitable access to health care
4. Improving the quality of health outcomes
5. Establishing a framework for a sustainable system

Improved health status

Through work congruence, job sharing provides organizational stability. This means that staffing would be more consistent and as a result there would be continued health care services to the population. Expertise in skills and knowledge is shared with the two partners and the client can benefit from a "two heads are better than one" approach to their care. The ongoing consistency of health care provision can then allow the focus of services to be on health promotion and preventative programs with ongoing follow-up available. Positive outcomes in health status would result.

Equitable Access

Retention of staff and continuous coverage provided in the actual rural communities results in health care services that are accessible and provision of care that is timely. This decreases the barriers experienced by a population that would otherwise have difficulty entering the health system.

Quality of health outcomes

Organizational stability within the community enables first point of entry into the health system for this population group. Using the same entry point also enables the health care system to be navigated as the nurse practitioners direct coordination of services. This can ensure that the appropriate service is received especially when the client has to leave the community to receive care in the urban center. More efficiency in delivery of care is the result.

Sustainability of the health care system

The rural job share model allows for sustainability in provision of services because the nurse practitioners experience less stress and burnout, more professional growth and a work/life balance. This results in retention of staff. It is a model of care that can access end-of -career or newly retired nurse practitioners. With many of the nurse practitioners predicted to be in this position in the future, it is a model that can utilize this valuable resource of skills and expertise and both the employee and employer benefit. Nurse practitioners who are pursuing graduate education can also be utilized. There is opportunity for seasoned nurse practitioners to train younger nurse practitioners while in the field. Health human resources are optimized and sustainability in health delivery service for rural communities is achieved.

Table 2: How job sharing meets the provincial strategic directions for rural healthcare delivery

Provincial strategic directions	Job share rural/remote health model
1. Improved health status	• Continued and consistent health services provided because of organizational stability • Clients receive expertise and skills of two nurse practitioners • Consistency of staff contributes to health promotion and preventative programs • Positive community health outcomes result
2. Equitable Access	• Retention of staff and continuous coverage in the rural community decreases barriers to access
3. Quality of Health Outcomes	• Improves navigation through coordination of services especially when in the urban centers • Ensures more appropriate services are received from the urban centers • More efficiency in delivery of services
4. Sustainable framework	• Retains staff • Provides opportunities for end-of - career or retired nurse practitioners and graduate students, tapping into a valuable human resource pool • Provides opportunities for training of younger staff

A review by the federal government has found that many collective agreements contain provisions for job sharing. This model of employment is considered to be "family-friendly" (Human resources and social development Canada, 2005).

Collaboration between physicians and nurse practitioner has been supported by the College of Physicians of and Surgeons of Ontario (2003). The Ontario Medical Association (2002) has been involved in providing input into how this collaborative practice should evolve. The College of Nurses of Ontario (2005) outlined the criteria that needs to be met for consultation and collaboration responsibilities of the NP role. Not in place are collaborative guidelines that are rural and remote specific where consultations take place via technology or over the phone. There are no specific details of how these exchanges should be documented and whether physicians can give direction if the clients are not in their care. This makes it necessary to roster the client to a specific physician who through monthly on-site visits will be familiar with the client.

At a systems level, the rural job sharing model provides consistent services to a population group whose overall health status is poorer than their urban counterparts. The model is conducive to the changing demographics of the nursing profession and can facilitate those changes. It has the potential to target a human resource pool (end-of- career, retired, graduate student) that might otherwise not be available. Job sharing supports a healthy work environment and ultimately leads to retention. This has the potential to become a substantial achievement of health care delivery for rural and remote Ontario.

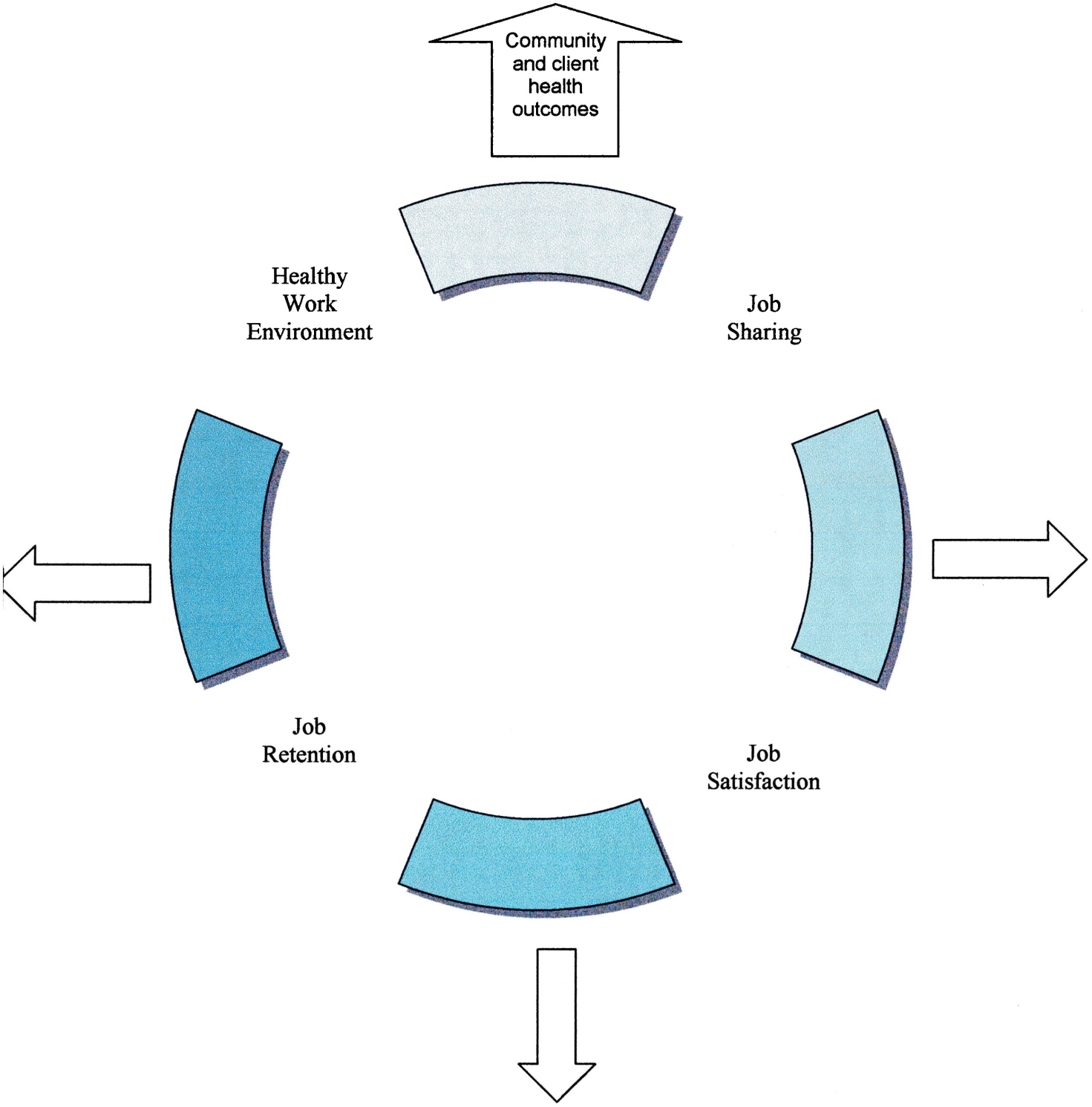
Summary

Job sharing enhances the work environment of nurse practitioners working in a rural model of health care. This paper has shown how the nature of this work schedule within such a model can enhance the well-being of the individual nurse practitioner, enhance client health outcomes, provide organizational stability and contribute to an efficient and effective delivery of health services that target a vulnerable and underserviced population group.

Literature suggests that job satisfaction is directly related to the environment of its workers. Where work environments are cohesive and service capability is maximized and where there is commitment to the organization, job satisfaction occurs (Blegen, 1993; Newman & Maylor, 2002; Shader, Broome, Broome, West & Nash, 2001). When job satisfaction is present, retention is present. Retention of nurses positively affects patient care and satisfaction (Cowin, 2002; Kangas, Kee & McKee-Waddle, 1999; Newman & Maylor, 2002).

Job sharing fits into health human resource paradigm that includes a healthy work environment, job satisfaction and job retention (Figure 5). It is revolving in nature as one aspect directly influences the next. It achieves organizational stability and consistency as well as continuity in client care. This ultimately positively impacts the health care outcomes of the rural community it serves.

Figure 5: Job sharing paradigm for rural health care delivery



Future qualitative research is required to determine how job sharing by nurse practitioners functions to affect their retention. A qualitative evaluation of an existing job share rural model in the form of a case study using document analysis, direct observation and participant interviews can discover key indicators for success that in the future can be measured.

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