Rooted in Community, Rising to the Call: Empowering Nurses to Transform Rural Health in Maryland

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When I think about the health of Maryland's communities, I find myself drawn not to the well-resourced corridors of urban medical centers but to the Eastern Shore farmlands, the Appalachian hollows of Western Maryland, and the quieter stretches along the Chesapeake. These are places where the healthcare system often feels distant, where a missed appointment can go months before it's rescheduled. Rural Maryland is medically underserved, and the consequences are not abstract. Yet within this crisis, I see extraordinary opportunity. And I believe nurses and nurse leaders in particular are the profession best positioned to seize it.

The Reality We Cannot Ignore

Maryland is among the wealthiest states in the nation. But wealth does not distribute evenly and neither does health. Nearly the entire Eastern Shore is designated a medically underserved area, with some counties having their entire populations living in federally recognized shortage areas for primary care, dental services, and mental health. The consequences are measurable and stark: residents of some Eastern Shore counties live as many as seven years less than their neighbors in suburban Maryland (University of Maryland School of Medicine, 2024). Seven years of birthdays, grandchildren, and ordinary life, lost to a ZIP code. The Maryland Department of Health's Community Health Resources Commission has responded with meaningful investment, over $110 million in grants to rural programs, reaching more than 218,000 individuals across the state's 18 rural jurisdictions (Maryland Department of Health, 2024). This reflects genuine commitment. But grants alone cannot solve a workforce crisis. What rural Maryland needs is a sustainable, empowered nursing workforce: present, prepared, and positioned to lead.

Why Nurses

Nursing is the largest health profession in the United States, yet only 16% of registered nurses practice in rural areas (Arredondo et al., 2026). This is not simply a pipeline problem. It reflects deeper systemic forces: scope of practice limitations, professional isolation, limited opportunities for advancement, and a persistent underinvestment in the rural nursing workforce.

What strikes me most, though, is this: rural nurses are already there. They are trusted members of their communities. They often serve as the first connection between a family and the healthcare system. Research confirms that rural nurses are uniquely positioned to advocate for their communities and to contribute meaningfully to the policies that shape rural health (Smith & Laver, 2026). Yet their voices remain underrepresented in professional associations, leadership structures, and policy spaces. Empowering rural nurses means more than preparing them clinically. It means positioning them as advocates, innovators, and leaders within the communities they already call home.

What Gives Me Hope

I am encouraged by what I see happening in Maryland and beyond. At Johns Hopkins School of Nursing, an innovative clinical education initiative is reimagining nurse preparation by embedding students in homes, schools, outpatient centers, hospice facilities, and community health centers rather than confining training to hospital settings (Johns Hopkins School of Nursing, 2024). This deliberate choice builds a pipeline of nurses who are comfortable and capable in the very settings where rural communities need them most. You can read more about this initiative in the accompanying article in this issue.

At the state level, the Maryland Loan Repayment Programs offer real financial support for nurses who commit to practicing in shortage areas, directly addressing one of the most cited barriers to rural practice (Maryland Department of Health, n.d.). And the Area Health Education Centers, including AHEC West and the Eastern Shore AHEC, continue their important work recruiting, training, and retaining a diverse health workforce for underserved communities.

Strategies That Can Move the Needle

Transforming rural health in Maryland will not happen through a single initiative or policy lever. It requires a coordinated, multi-level strategy that works across education, leadership, practice, and policy at once. Based on the evidence and on what I have witnessed in my own work, the following strategies hold the greatest promise.

Build the pipeline early and intentionally. The journey toward rural nursing practice often begins, or fails to begin, in nursing school. When students train exclusively in large academic medical centers, they develop a mental model

of nursing that centers the hospital. We must deliberately disrupt that model. Community-based clinical rotations, rural immersion experiences, and partnerships with federally qualified health centers and rural health clinics expose students to the richness of community practice before they ever make a career decision. At Johns Hopkins School of Nursing, we are already doing this, and early results are promising (Johns Hopkins School of Nursing, 2024). Nurse educators across Maryland must follow suit, building curricula that normalize rural practice as a legitimate, rewarding, and intellectually demanding career path.

Invest in professional development and reduce isolation. Research consistently shows that professional isolation is a primary driver of rural nurse burnout and attrition (Smith et al., 2023). Rural nurses often lack access to continuing education, mentorship, peer communities, and leadership development, which are the very resources that sustain urban nurses' growth. Addressing this requires intentional investment: telehealth-enabled peer networks, regional nursing leadership forums, and mentorship programs that pair rural nurses with experienced leaders. Organizations like the Maryland Nurses Association and the Maryland Organization of Nurse Leaders are uniquely positioned to build and sustain these structures, and I believe they have a responsibility to do so.

Center nurse leaders as architects of the rural practice environment. Nurses stay not primarily because of salary, but because of the quality of their work environment, the strength of their leadership, and the sense of belonging they find in their practice (Smith et al., 2023; Oliver et al., 2025). Nurse leaders at every level, from charge nurses to CNOs, shape those conditions. In rural settings, where resources are constrained and teams are small, a single strong leader can be transformative. A nurse leader who invests in the team, advocates for their development, creates space for their voices, and models courageous leadership does more for retention than any financial incentive. We must identify, develop, and support these leaders, and ensure they are not leaving rural settings because they themselves lack support.

Leverage technology without losing humanity. Telehealth, remote patient monitoring, and digital health tools have opened new possibilities for rural care, and nurses are well positioned to lead their implementation. Mobile health units staffed by nurses are expanding preventive care in communities that would otherwise go without. Telehealth clinical rotations allow students to participate in rural care without requiring physical presence. These tools are not a substitute for in-person nursing, but where geography itself is the barrier, they are a powerful complement. Nurse leaders must champion thoughtful integration of technology into rural practice, ensuring that efficiency gains never come at the cost of the relational, person-centered care that defines nursing at its best.

Amplify rural nurses' voices in policy. Most importantly, the nurses who live and work in rural Maryland must have a seat at the table where decisions are made. Too often, health policy is designed for rural communities without meaningful input from the professionals who understand those communities most intimately. Zalon et al. (2024) have called on nurses to move intentionally along a continuum from health policy literacy to active advocacy and influence, offering a framework for assessing and expanding policy engagement across dimensions of engagement, partnership, and reach. I take that call seriously. Rural nurses must be recruited into professional associations, invited onto policy advisory bodies, and supported in developing the advocacy skills that translate frontline knowledge into systemic change.

Own this as a nurse leader's imperative. The preceding strategies require action from many actors, but one audience carries particular responsibility, and I want to address them directly. Nurse leaders, this issue belongs to us in a particular way. We set the tone for what nursing can be. We decide which voices get amplified, which experiences get validated, and which practice settings are treated as aspirational. When leadership development programs orient exclusively toward urban health systems, or when conference agendas include no session on rural practice, we send the message, even unintentionally, that rural nursing is somehow less. Changing that means actively recruiting rural nurses into state and national organizations, extending leadership pipelines into rural communities, and using our influence to advocate for the infrastructure and funding rural nurses need. Healthy work environments are built deliberately, and my own program of inquiry has reinforced what many nurse leaders already know: the behaviors of nurse leaders are among the strongest predictors of staff retention, team cohesion, and patient outcomes (Frangieh et al., 2024). In rural settings, where teams are small and turnover is costly, that truth is amplified. Investing in rural nurse leadership is not a luxury. It is a workforce strategy.

On the Eastern Shore, in the Appalachian hollows, along the quieter stretches of the Chesapeake, families are waiting. They are waiting for a provider who knows their community, for care that does not require a two-hour drive, for a healthcare system that sees them. Maryland's rural communities cannot wait much longer. The need is clear, the moment is now, and the profession has both the capacity and the responsibility to respond. The strategies are within reach if we have the collective will to pursue them. Nurses have always risen to the call. Rural Maryland is calling now, and I believe we are ready. ■

References online:
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