

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

Beyond the Headlines: The Hidden Registered Nurse (RN) Workforce in North Carolina

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Keywords: Jill Forcina, Meghan K Davenport, Katie Fitzpatrick, Kaniqua Outlaw, registered nurses, nursing, North Carolina, nursing workforce, workforce issues

<https://doi.org/10.18043/001c.162602>

North Carolina Medical Journal

Vol. 87, Issue 2, 2026

North Carolina's nursing shortage includes a large, underused reserve of licensed but inactive or unemployed nurses. Drawing on licensure data, surveys, and program evidence, this commentary identifies why nurses disengage and outlines a five-part, near-term strategy to re-engage this workforce using existing state infrastructure.

Introduction

North Carolina's nursing shortage is often framed as a pipeline issue, solvable by producing more graduates. Licensure data and recent retention analyses suggest another actionable opportunity hiding in plain sight: a substantial pool of nurses who are licensed in North Carolina but are inactive or unemployed. This commentary outlines the scale of the opportunity using current state data, examines why registered nurses step away and what keeps them from returning, and proposes a five-part workforce reengagement framework that North Carolina can operationalize quickly by leveraging licensure and employer data and nurse refresher infrastructure that is already in place.

Defining the Data: Inactive or Unemployed

North Carolina Board of Nursing's (NCBON) licensure data allows us to distinguish among license categories of registered nurses (RNs) who are not working in nursing:

- Inactive: license not currently active for nursing practice in North Carolina.
- Not employed in nursing: active license but unemployed or employed in a non-nursing role.

Although North Carolina has over 161,000 actively licensed RNs, nearly 17,000 are not retired but are not employed in nursing; separately, an additional approximately 81,000 RNs hold inactive North Carolina licenses.^{1,2} Collectively, this represents a substantial reserve of nearly 100,000 licensed nurses who are not currently engaged in the nursing workforce.

This reserve is not static. As nurses continue to exit the workforce, the pool of disengaged license holders grows annually, creating a continuously renewing reservoir of skilled professionals. Recent longitudinal analyses from the Cecil G. Sheps Center for Health Services Research documented a 15.1% two-year RN exit rate in 2023,¹ suggesting that even as the state expands educational pathways, it is simultaneously accumulating a growing reserve of licensed nurses who could be reengaged. Even a modest conversion of this reserve into active practice would meaningfully strengthen nursing capacity, particularly in high-vacancy and high-need settings.

Importantly, non-participating nurses are not evenly distributed across the state. Analyses using county information recorded in licensure files for nurses with a North Carolina residence or practice location show consistent metro–nonmetro differences in both licensure and employment status. Actively licensed RNs associated with nonmetro counties are less likely to be employed in nursing than their metro counterparts (84.6% versus 87.7%); $\chi^2(1, N = 142,985) = 154.96, P < .001$, and RNs associated with nonmetro counties are also less likely to hold an active license overall (61.4% versus 65.3%); $\chi^2(1, N = 172,950) = 192.18, P < .001$. Together, these findings suggest disproportionate disengagement from the nursing workforce in nonmetro communities.³ Recognizing the geographic dynamics is essential for designing effective re-engagement strategies, including targeted return-to-practice programming, rural-focused licensure support, enhanced continuing professional development, and workforce participation initiatives aligned with areas of greatest potential impact.

1 Analyses were conducted using 2024 North Carolina Board of Nursing licensure data obtained through the Cecil G. Sheps Center for Health Services Research, with permission from the North Carolina Board of Nursing. The analysis used “inactive per board status” to determine inactive RN license.

2 Analyses were conducted using “inactive per board status,” excluding records with missing state codes and those classified as “retired,” to produce a conservative estimate.

3 Geographic location in licensure data is assigned using a hierarchical approach that prioritizes reported employment county and defaults to home county when no employer is listed. Consequently, nurses actively employed in nursing may be geolocated based on workplace, whereas nurses who are inactive or not employed in nursing may be classified using residential information. To assess whether county-level patterns might reflect this assignment structure, analyses were replicated at the AHEC regional level. Significant variation across regions was observed for both employment among actively licensed RNs: $\chi^2(8, N = 142,985) = 244.26, P < .001$ and licensure status: active versus inactive; $\chi^2(8, N = 172,950) = 1205.38, P < .001$. Because aggregation to the regional level reduces sensitivity to county-level misclassification, and because many nurses commute across county boundaries, the persistence of these patterns at the regional level supports interpretation as substantive geographical differences in workforce engagement rather than measurement artifact.

Why Nurses Disengage and How to Get Them Back

Nursing workforce researchers at the University of North Carolina at Charlotte (UNCC) recently conducted a survey to better understand factors contributing to nursing workforce exit and potential reentry in North Carolina. The survey targeted RNs aged 18–70 whose NCBON records from 2024 indicated they were not currently employed in a nursing role, including those with an active license without a listed employer, as well as those holding inactive or expired licenses.

A total of 725 respondents completed the emailed online questionnaire focused on their exit and potential re-entry. From these respondents, a subgroup of 313 (43%) experienced RNs (at least 5 years of nursing experience) who signaled at least some openness to re-entry and interest in a refresher program were identified as “highly qualified potential returners.” This subgroup was predominantly women and white, with an average age of 57 and an average of 24 years of nursing experience prior to stepping away from practice. Most still resided in North Carolina or a neighboring state, and a substantial portion previously practiced in hospital settings.

When asked why they exited nursing, respondents most often described personal and family responsibilities. These findings align with the state licensure data. Among the nearly 17,000 actively licensed North Carolina RNs who are not employed in nursing and not retired, nearly a quarter (22%) reported that they were unemployed specifically due to home or family caregiving responsibilities.⁴

At the same time, respondents to the UNCC survey described a broader set of workplace-related factors that contributed to their decision to leave nursing. More than half cited workplace factors, including workload intensity, documentation burden, physical strain, staffing concerns, and relational stressors, such as treatment by patients or dissatisfaction with management, which contributed to their decision. A notable number of respondents also described work schedules and inflexibility as key challenges. Findings from national surveys are similar: respondents in the 2024 National Nursing Workforce Study cited stress, workload, and understaffing as the top three reasons nurses intended to leave the workforce aside from retirement; federal workforce survey data indicate that nurses who exited the profession most frequently cited adverse working conditions, burnout, and inadequate staffing as key reasons for leaving the nursing workforce.^{2,3} These patterns suggest that while the RN’s personal responsibilities matter, structural conditions within the control of employers and policymakers also play a significant role in workforce exit.

⁴ Licensure data was provided by the Cecil G. Sheps Center for Health Services Research, with permission from the North Carolina Board of Nursing.

Among respondents to the UNCC survey who expressed openness to reentry, the most compelling motivators for returning to nursing were a desire to do meaningful and/or challenging work and the opportunity for additional income. These motivations provide important context for understanding re-engagement potential and underscore that many nurses who have stepped away from practice retain both professional interest and economic incentive to return.

Consistent with this finding, the factors shaping willingness to return closely mirrored those that contributed to workforce exit. Job design and workplace culture, including manageable workloads, predictable or redesigned schedules, and supportive teams, emerged as primary considerations for return to practice. A small minority cited clinical skills or technological changes as their main barrier to returning, despite expressing willingness to complete a refresher course.

These findings are reinforced by national evidence, including a recent study conducted by nursing workforce researchers at the University of Pennsylvania, in which respondents identified adequate staffing, flexible scheduling, and improved compensation as the most influential factors for returning to nursing.⁴ Together, the evidence indicates that refresher programs alone are unlikely to be effective unless paired with workplaces designed to make returning worthwhile.

Insights from the NC AHEC RN Refresher Program

Additional insight comes from nurses who have already taken concrete steps toward returning to practice. Data from the North Carolina Area Health Education Centers (NC AHEC) RN Refresher Program illustrate the characteristics of RNs who enroll in a structured re-entry pathway. The NC AHEC RN Refresher Program is an NCBON-approved program designed to help RNs re-engage in the workforce through combined didactic and clinical training. Among individuals who registered and were approved for the program between summer 2024 and the time of this writing, the average enrollee is approximately 50 years old and has been out of practice for more than a decade. Over half hold an inactive or expired license, while a notable proportion maintain an active license, suggesting they are unemployed in nursing and view the refresher as a mechanism to become reengaged.

As reported by prospective enrollees, barriers to enrolling in the course include program cost, physical ability concerns, time commitments, lack of confidence after time away, the volume of required clinical hours, and competing personal responsibilities. These reports reinforce the need for refresher pathways that are flexible, affordable, and aligned with the realities of potential returners. NC AHEC has begun addressing these issues through price reduction, scholarships, interest-free loans, and other supports designed to reduce financial burden and expand access.

NC AHEC's experience adapting RN refresher programs demonstrates that effective reentry requires building on the skills returning nurses already possess. Prior program evaluation findings showed that nurses were more confident and better prepared for reentry when their clinical hours occurred in settings that matched their prior experience and where they intended to work again.⁵ The clinical environment is a crucial component of rebuilding competence, comfort, and professional identity. In recognition of this, the NCBON, in partnership with AHEC, broadened refresher clinical hour requirements in 2017 to allow students to complete hours in these familiar settings rather than limiting all placements to medical-surgical units. Successful reentry programs must intentionally build on nurses' existing expertise and place them in environments designed to strengthen their readiness to return.

NC AHEC's recently updated program graduate follow-up survey provides additional, early insight into the realities of RN reentry. While findings are preliminary and based on a relatively small number of respondents, several consistent themes are emerging. Among program graduates who are currently working, a substantial share of the graduates are employed part-time or per diem. Only a very small number of full-time graduates have returned to acute-care hospital roles; most are working in settings known for more predictable shifts, shorter hours, and lower physical demands, such as ambulatory, community-based, or outpatient environments. Notably, a meaningful proportion reported they are still seeking RN work. These respondents described difficulty finding roles that matched their interests or qualifications. They also expressed a preference for part-time, temporary, flexible, or remote positions, underscoring that interest in reentry is strong but contingent on job structures that reflect the realities of nurses' lives, physical capacities, and professional priorities.

Policy Implications

North Carolina's nursing workforce planning is supported by a mature and well-established infrastructure for data, forecasting, and regional coordination. The North Carolina Health Professions Data System (HPDS), housed at the Cecil G. Sheps Center for Health Services Research, provides longitudinal, licensure-based data on the supply, distribution, and characteristics of licensed nurses across the state.⁶ Building on these data, NC NurseCast, North Carolina's nursing workforce supply and demand forecasting tool, projects future trends by practice setting and region, identifying where shortages are most likely to emerge.⁷ Complementing these analytic tools, the North Carolina Health Talent Alliance (HTA) brings together health systems, AHEC regions, educators, and workforce organizations in a statewide, employer-led partnership focused on regionally aligned, demand-driven talent pipeline strategies.⁸

Table 1. Practical Strategies to Re-Engage Inactive and Unemployed Nurses in North Carolina

Strategy	Description	Primary Levers / Infrastructure
Precision outreach	Use licensure data to identify inactive and unemployed RNs by county, specialty, and prior practice history; match outreach to local employer needs.	NCBON licensure data; HPDS; HTA; AHEC regional networks
Scale refresher pathways	Expand access to RN refresher programs through financial supports and employer partnerships ^a that link program completion directly to high-demand roles.	NC AHEC RN Refresher Program; employer partnerships; scholarships and loans
Paid RN returnships	Offer structured, paid, mentored return-to-practice periods in settings with predictable workloads to rebuild confidence and competence.	Health systems; community providers; workforce funding
Design flexible roles	Create roles with schedules that fit real lives, including shorter shifts, job sharing, variable-hour pools, school-time shifts, and part-time positions with benefits.	Employers; workforce policies; scheduling redesign
Reinstate with support	Provide concierge re-entry services—including licensure navigation, résumé assistance, and interview preparation—to streamline the transition from interest to employment.	AHEC; workforce intermediaries; employer HR teams

^a Interest-free loans and other financial supports for NC AHEC RN Refresher Program participants are currently made possible through multiple partnerships.

Within this context, North Carolina's inactive and unemployed nurses represent one of the state's most immediate and least leveraged opportunities to strengthen near-term workforce capacity, particularly in rural and community-based settings. The evidence presented here makes clear that these nurses are not unreachable. Rather, they are motivated but discerning, with decisions about reengagement shaped by job design, flexibility, and workplace conditions that align with their personal and professional realities. Importantly, much of the infrastructure needed to support effective reengagement is already in place. From robust licensure data and forecasting tools to regional, employer-based collaboratives, North Carolina's existing infrastructure creates a clear opportunity for strategic coordination and alignment rather than reinvention. What is needed now is a coordinated mechanism that connects these assets, simplifies re-entry, and supports nurses from initial interest through successful and sustained return to practice. As summarized in Table 1, practical strategies include precision outreach using licensure data, expanded refresher pathways linked directly to employment, paid and supported return-to-practice models, flexible role design, and concierge-style re-entry supports. These approaches shift reengagement from an individual burden to a system responsibility shared by employers, educators, and workforce partners.

Critically, the same redesign elements that can bring nurses back also hold the potential to prevent future exits among nurses who have not yet left. By reshaping work in ways that prioritize flexibility, predictable workloads, appropriate role fit, and respect for professional expertise, North Carolina can simultaneously strengthen re-entry pathways and create environments that support longer, more sustainable nursing careers.

Conclusion

Ultimately, success in RN reengagement should not be measured solely by how many nurses return, but by how many are able to remain in practice over time. Reengagement efforts that focus narrowly on skills refreshment or licensure reactivation risk falling short if they are not accompanied by meaningful changes in how nursing work is structured. With intentional coordination across data systems, employers, educators, and workforce partners, North Carolina is well positioned to transform its underused reserve of licensed nurses into a durable and responsive workforce that supports both re-entry and long-term retention in the communities and settings where nurses are most needed.

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Acknowledgments

The authors thank Kathy Peticolas of NC AHEC for her leadership in strengthening RN Refresher Program data systems and the Sheps Center team for technical assistance with the licensure data. The authors also gratefully acknowledge the philanthropic and funding partners whose support enables the provision of interest-free loans and other financial assistance for RN Refresher Program participants, substantially reducing financial barriers to workforce reentry.

Conflicts of Interest

The authors have no conflicts of interest or financial support to disclose.

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Published: June 30, 2026 EDT.

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