Future of Nursing: State Implementation Program

Full Proposal Narrative

Identifying Information

Project Title: Utah Nurse Residency Implementation Program

Application I.D.: 15411

Applicant Name: Juliana Preston, MPA

Legal Name of Applicant Organization: *HealthInsight*

Utah Background and Introduction

Utah is the 11th largest state in the U. S. (84,900 square miles) comprised of urban population clusters and large rural regions. Utah's 2011 total population count was 2,817,222. This represents a population increase of 53,337 people or 1.9% from 2010, ranking Utah third among states in population growth. Utah grew more than twice as fast as the nation from 2010 to 2011. Utah will continue to experience population growth at a rate higher than most states in 2012 due to strong natural increase in addition to in-migration. Natural increase (births less deaths) is anticipated to add 39,100 people to Utah's population. While net in-migration has slowed since the peak of the economic expansion, Utah's net migration is projected to remain positive at 5,000 people. Twenty percent of the population is ethnically diverse with Hispanic/Latino origin as the fastest growing group at >13%.

The nursing workforce in Utah consists of 25,867 RN and 2,141 APRNs. The RN/population ratio in Utah is 598/100,000 (lowest in the United States) compared to the national average of 854/100,000. Thirty seven percent of the RN workforce is between the ages of 45-59 and 66% are employed in the hospital setting. Five large health care delivery systems employ the majority of Utah RNs: Intermountain Healthcare, MountainStar, Iasis, VA Medical Center, University of Utah Hospitals and Clinics. While gender diversity of the RN workforce in Utah is almost double the national average, ethnic diversity of the RN workforce is estimated to be 10-12%, less than the national average of 16.8%.

Nursing education in Utah is comprised of seven long-standing state-supported schools, two long-standing private schools and nine new proprietary programs. A recent survey of nursing programs indicated that of the 1,292 new RN graduates produced each year 72% (932) are prepared at the Associate Degree level and 28% (360) are baccalaureate prepared. Last year 308 AD prepared nurses returned to school to complete their BS degree in Nursing.

The Utah Action Coalition for Health (UACH) developed out of a partnership between *HealthInsight,* a long standing convener of the healthcare community in Utah and the

Utah Organization of Nurse Leaders (UONL). Both organizations and the broad stakeholder Coordinating Council share the desire to ensure Utahns the best health and healthcare possible.

IOM Recommendation and Selection Process

UACH selected IOM Recommendation 3, Implement Nurse Residency Programs to address in this State Implementation Program. Key stakeholders throughout Utah will work together in a statewide, coordinated effort to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed their pre-licensure RN degree program or when they are transitioning into new clinical practice areas as RNs. Three major factors led to the selection of this IOM Recommendation: 1) interest level of key stakeholders, 2) perceived need to improve and strengthen current orientation/residency programs in the state and 3) readiness to work together on this recommendation.

The RN Residency Implementation Program will examine current residency programs in the delivery system in relation to the capstone of the education process in an effort to merge the experiences into one for a better prepared RN. The goals of the work would be to create a more prepared graduate, a more standardized approach to the capstone and to residencies, and also to shorten the orientation time for the new graduate upon entry in the acute-care hospital. This pilot could expand from the acute care setting to other care facilities in the future, but ultimately this could save resources currently wasted in orientation (specifically replacement) costs for new graduates across the state.

As nursing students transition from their student role into a professional practice role they can be overwhelmed by the broad range of abilities and complex skills they must quickly master in order to meet the increasing needs of patients in a variety of settings (Anderson, Hair, & Todero, 2012; IOM, 2011; Strauss, 2009). High turnover rates for these new graduate nurses has increased attention and concern over this critical transition to practice interface (Anderson et al., 2012; Eigsti, 2009; IOM, 2011). New graduate nurse retention rates have been identified as the lowest, with turnover rates ranging from 30% to 70% within the first year of employment (Hillman & Foster, 2011; Maxwell, 2011; Strauss, 2009). The financial costs of high turnover have been documented between $8,000 and $88,006 per nurse (Hillman & Foster, 2011; Maxwell, 2011). The financial burden is augmented by the impact turnover may have on staff as they continually train and rehire new graduates (Hillman & Foster, 2011).

Turnover has been attributed to problematic orientation processes, preceptor skills and participation, job dissatisfaction and stress (Anderson et al., 2012; Hillman & Foster, 2011). New graduate nurses experience stress within the workplace due to limited nursing experience, low confidence, inability to communicate with doctors, limited organizational and leadership skills (Anderson et al., 2012; Thomson, 2011). Nurse Residency programs have been established to alter the transition through mentoring, education, orientation, and preceptorships (Maxwell, 2011; IOM, 2011). Augmenting the competency of new graduate nurses eases the transition to the role of professional nurse, which has an added value of improving the nursing environment itself.

Orientation is standardized, reducing costs and allowing managers to estimate their needs. Training programs increase leadership opportunities for nurse residents, which also increases the pool of those ready and willing to mentor new graduate nurses (Hillman & Foster, 2011). Competencies beyond the educational setting are imperative to prepare nursing graduates for clinical practice. (Hillman & Foster, 2011; IOM, 2011; Maxwell, 2011).

While Recommendation 3, Implement Nurse Residency Programs is the primary priority recommendation addressed in this state implementation program grant proposal, two related IOM recommendations will influence and infuse this statewide initiative. The RN Residencies will "ensure that nurses engage in lifelong learning" (Recommendation 6) by launching and encouraging this behavior throughout the year long program. Nurse Residents will develop career plans for continued professional development and engagement in lifelong learning to maintain the competencies needed to provide care for diverse populations across the lifespan. In addition the Utah Nurse Residency Implementation Program will focus on preparing and enabling nurses to lead change to advance health (IOM Recommendation 7).Leadership skills and leadership development will be a core concept threaded throughout the year long nurse residency program. Appropriate opportunities to gain leadership experience at different levels within the organization will be identified and encouraged for the Nurse Residents. Preceptors and mentors will also benefit from this program through increased engagement in the future of nursing and opportunities for leadership.

UACH used a three-step iterative process for the identification and selection of this IOM recommendation as the priority. Stakeholder surveys, focus groups and partner organization board meetings led to the approval and final decision related to the direction for this State Implementation Program project. The process:

1) During the first year of action coalition formation surveys were distributed to nursing and non-nursing stakeholders. Individuals were asked to rank order the 8 IOM recommendations in terms of top priorities for Utah. Participants were also asked to indicate specific recommendations they were most interested in implementing. The following five goals were identified in this first round of priority setting and consensus building:
    1. Increase the education level of nurses (% baccalaureate & doctoral prepared)
    2. Provide residency training for new nurses
    3. Remove legislative and financial practice barriers
    4. Develop leaders & leadership opportunities
    5. Collaborate to design new models of community-based care

2) Focus groups were conducted with nurse educators and nurse administrators to define level of interest, issues and approaches for the top two goals above. Provide residency training focus groups (2 groups with 13 CNO and key health care industry stakeholders) reported the following profile and themes:
    - General interest and support for working on this recommendation
    - Most healthcare systems have some orientation, internships in place

- Current programs are not standardized (vary in length and content) and are not CCNE accredited
- Health systems have an interest in partnering with educational programs
- A broad range of facility experience and use of simulation will increase the value of residency orientation
- Mentor and preceptor preparation should be a key component
- Need recruitment tool to attract top talent
- Plan should include reviewing existing & innovative delivery models and curriculum

3) Following the focus groups, a letter of agreement /institutional commitment was developed using the *HealthInsight* compact model. Five actions were outlined and commitment compacts including those requirements were signed by major employers of nurses in Utah (See sample RN Residency Compact):

    1. Collect facility baseline information for existing residency programs and perform annual evaluation of existing and new RN and APRN residency programs
    2. Define an appropriate 3 year target and identify human and financial resources needed to meet this goal
    3. Develop specific strategies such as: develop new residency program opportunities for RNs, expand existing residencies to meet accreditation standards, partner with an appropriate educational institution to provide curriculum and program development support
    4. Identify an appropriate organizational representative and alternate to participate in UACH quarterly meetings, annual summit and other activities
    5. Share recruitment and retention data, strategies and outcomes with UACH Coordinating Council and other participating organizations.

Action Plan (with specific goals and strategies)

Implementation Plan for IOM recommendation #3, Nurse Residency Program. With the multi-stakeholder UACH Coordinating Council providing guidance and oversight, Deans and Educators throughout Utah will work with the Chief Nurse Executives to form RN Program Partnerships to develop and coordinate innovative “transition to practice” models. These education practice partnerships will provide an opportunity for academically-based nurse faculty to work closely with clinically-based nurse educators and administrators to facilitate optimal learning and better coordinate and build upon pre-licensure learning experiences (capstone practicum) with entry to practice (orientation residency experiences).

Target residency applicants will be RNs entering practice for the first time and those transitioning to a new practice area. Consistent guidelines related to content, mentoring and length of program will be developed. Curriculum will be modeled on the CCNE core curriculum requirements for accreditation (Commission on Collegiate Nursing Education (CCNE), 2008). The core competencies of the curriculum are leadership, patient outcomes, professional role and interprofessional/team communication. Innovations in

capstone experiences, student/new graduate articulation models, and delivery methods will be encouraged and analyzed. Baccalaureate and associate degree prepared nurses may participate in the demonstration pilots; however the transition to practice pathways and experiences will be differentiated for these two groups.

Six education/practice partner teams have been identified for statewide RN Residency implementation. These teams are dispersed throughout the state and represent diverse education program types and health care delivery models. As indicated in initial baseline assessments, there is a range of variability in orientation components, curricular content and experiential and program length. None comply with the UHC/AACN recommendations and none are 12 months in length. Although the VA Medical Center plans to apply for CCNE accreditation of its RN Residency, none have achieved this status.

Table 1. RN Residency Program Partners

Education Partner	Hospital Partner
1. Weber State University NLN-AC & Northwest Commission (NWCCU) Degrees: Graduates: AD = 318 RN-BSN = 143 MSN = 24	**Davis Hospital and Medical Center** (Iasis); a 225-bed facility opened in 1976 and has grown to become a first class medical facility located in Northern Utah, Davis County. Current transition to practice includes: 6-8 weeks, 135 hours preceptorship
2. Salt Lake Community College NLN-AC & Northwest Commission (NWCCU) Degrees: Graduates: AD = 229	**St. Mark's Hospital** Mountain Star (HCA); a 317-bed facility delivering exceptional patient care since 1872 to the Salt Lake County community. They have 600-physician medical staff and more than 1,500 employees & volunteers Current transition to practice includes: didactic orientation and clinical using CCRN curriculum.
3. University of Utah CCNE & Northwest Commission (NWCCU) Degrees: Graduates: BS = 140 RN-BS = 53 MS = 39 DNP = 45 PhD = 3	**University of Utah Hospitals and Clinics** (UUHC) is 4 hospitals (550 beds) and over 30 clinics, including 10 Community Clinics with 1000 Board-Certified Physicians trained in 200 medical specialties. They have about one million outpatient visits per year, 30,000 inpatient admissions and 25,000 surgeries. They employ about 1,665 RNs throughout the University Healthcare System in varying capacities. Current transition to practice includes: Clinical and new employee orientation and critical care and oncology internships.

Education Partner	Hospital Partner
4. Brigham Young University CCNE & Northwest Commission (NWCCU) Degrees: Graduates: BS = 76 MS = 14	**Utah Valley Regional Medical Center** (UVRMC) is part of the Intermountain Healthcare system in Provo. This 367 bed facility is designated as a level II trauma center with programs and services including Heart & Vascular Services, the Newborn ICU, Cancer Services and Stroke Services, Emergency, Critical Care, Neurosurgery, Women's and Children's Services, Behavioral Health, and Rehabilitation Center. Current transition to practice includes: 36 hours didactic & 144 hours clinical
5. Southern Utah University CCNE & Northwest Commission (NWCCU) Degrees: Graduates: BS = 40 RN-BS = 26 **Dixie State College** NLN-AC Northwest Commission (NWCCU) Degrees: Graduates: AD = 89 RN-BS = 15	**Dixie Regional Medical Center** is a 245-bed hospital located on two campuses - River Road and 400 East in St. George, Utah. Dixie Regional Medical Center is the major medical referral center for northwestern Arizona, southeastern Nevada and southern Utah. Current transition to practice includes: 12 weeks orientation with 12 month mentorship
6. University of Utah CCNE & Northwest Commission (NWCCU) Degrees: Graduates: BS = 140 RN-BS = 53 MS = 39 DNP = 45 PhD = 3	**George E. Wahlen Department of Veterans Affairs Medical Center** is the major referral center for the Intermountain West veteran population. The hospital with 121 beds and related health care services and clinics provides care that ranges from basic primary care to complex surgical procedures. Current transition to practice includes: Received grant to initiate RN Residency Sept 2012 with 6 BS prepared nurses.

Utah Nurse Residency State Implementation Program Action Plan

GOAL 1: To increase the number of formalized, evidence-based, year long, residency programs (from 1 to 6) in Utah supporting registered nurses in the transition into practice.

Table 2. Strategy

STRATEGY: Build a statewide consortium of RN Residency Program Partners (from schools of nursing and hospitals)		
ACTVITIES	**TARGET DATE**	**DELIVERABLES**
1. Convene the consortium member to create a shared vision with clear expectations (commitment with timelines) based on evidence and stakeholder input.	January 2013	Summary of vision, expectations, with timelines and commitments
2. Coordinate an ongoing collaborative for shared learning among consortium partners.	Start Feb 2013 and ongoing	Communication network established as determined by consortium such as a Listserve, Newsletter, Group Skype calls
3. Initiate residency program in five new sites	Start between June 2013 and June 2014	Six RN Residency Programs across the state
STRATEGY: Provide coaching and resources to facilitate design, implementation, and evaluation of each residency program		
ACTVITIES	**TARGET DATE**	**DELIVERABLES**
1. Provide a competency toolkit and facilitate program implementation at each site.	January 2013	Toolkit distributed to members
2. Provide coaching to each Residency Partner team in-person, by phone or other electronic process at least quarterly	Start Feb 2013 and ongoing	Coordinator completes coaching and creates visit summaries
3. Confirm measures and milestones and define the evaluation plan and timeline with the partner teams	January 2013	Evaluation plan complete

GOAL 2: To ensure consistency and quality in Utah residency program curriculum, implementation and evaluation.

STRATEGY: Develop and provide core components and resources (e.g. educational materials, innovative tools, teaching strategies, best practices) for shared use by programs in implementation and evaluation		
ACTVITIES	**TARGET DATE**	**DELIVERABLES**
1. Each partner team complete a comprehensive assessment of current approaches to capstone, orientation, internship or residency and evaluate redundancies and efficiencies within educational program offerings from the perspective of the school and the hospital.	March 2013	Complete assessments with gap and overlap analysis.
2. Develop innovative and collaborative model for curriculum, mentoring, and a seamless transition to clinical practice.	April 2013	Education & practice team faculty and mentors identified
3. Create an online repository using Instructure CANVAS to share educational resources.	Start May 2013	Educational platform in place with materials available.
4. Develop a mechanism to share simulation training resources, IPE training modules and specialty clinical training experiences across sites.	June 2013	Simulation and IPE experiences integrated into all RN Residency Programs.
STRATEGY: Design and implement a coordinated system to capture data for program evaluation and improvement at the individual and aggregate level (program and state) including national program reporting requirements.		
ACTVITIES	**TARGET DATE**	**DELIVERABLES**
1 Develop and implement a centralized web survey to capture complete data from individual residents.	June 2013	Recap data capture site created and measures digitized and uploaded.
2. Collect hospital based data on key nurse resident and program metrics.	December 2013	Program and Resident surveys completed and returned to UACH coordinator
3. Collect hospital based data on key outcomes metrics. (e.g., vacancy, turnover, retention, educational preparation).	June 2014	Hospital surveys completed and returned to UACH coordinator

GOAL 3: Increase gender and ethnic diversity of new RN graduates that have access to RN Residency Program to create a RN workforce that is as least as diverse as the population served.

STRATEGY: Design and implement a targeted recruitment strategy to support the successful recruitment and retention of ethnically diverse new RN graduates.		
ACTVITIES	**TARGET DATE**	**DELIVERABLES**
1. Develop and implement a web site to attract and recruit ethnically diverse nursing students into RN Residency Programs throughout the state.	March 2013	Web site activated with capability of tracking hits and inquires.
2. Develop a coordinated system to capture formative data for improvement at the individual and aggregate level that captures the culture and climate of the organization as it relates to inclusiveness and equity.	June 2013	Individual interim feedback and focus used to identify retention issues and organizational cultural & climate assessed
3. Imbed diversity data collection strategies within hospital based outcomes, nurse resident measures and program metrics.	December 2013	Date tracking reflects trends and success in increasing diversity of applicant pool & Residents.

Proposed Measures and Benchmarks

Benchmarks and outcome measures will be tracked on three levels.

1. Progress of each of the six pilot programs; including start date, numbers of participants and completion rates for each program will be monitored.

Table 3. Benchmarks and Outcome Measures

Utah RN Residency Program	Months	
Timeline	18	24
Number of RN residency programs that have completed planning phase	6	
Number of programs that have initiated training of residents	4	6
Number of programs that have completed pilot year of residency implementation		4
Degree of adherence with recommended core components for an evidence-based RN Residency program		100%
Use of core resources for program planning and implementation by RN Residency Partners (analytics to capture patterns of use)	100%	100%
Completeness of data for program evaluation and national benchmarking	50%	80%

2. Hospital level metrics including cost, retention, turnover and vacancy rates will be collected from all the participating hospitals. Data will be analyzed and shared with participating partners for quality improvement. Benchmarking data will be developed through extensive literature review around RN residencies, including:
   - Recruitment and Retention; Anderson et al., 2012; Eigsti, 2009; Nadler-Moodie & Loucks, 2011, Hillman & Foster, 2011; IOM, 2011; Maxwell, 2011; Strauss, 2009
   - Turnover and Replacement Costs; Maxwell, 2011, Anderson et al., 2012, Hillman & Foster 2011
   - Non-financial benefits such as reduced stress, increased job satisfaction, shortened time to competency, improved aptitude and performance of new graduates as well as their nursing unit , increased confidence and autonomy, enhanced quality of care and patient satisfaction, Anderson et al., 2012; IOM, 2011; Thomson, 2011

Table 4. Hospital Measures

Hospital Level Measures	Months	
	18	24
1. Number of programs that have initiated resident training	X	X
2. Number of Residents in training	X	X
3. Comprehensive Team Assessments/evaluation of redundancy		
4. Hospital Data on key nurse resident and program metrics	X	X
5. Hospital data on key outcome metrics (vacancy, turnover, retention, educational preparation)	X	X

3. A standardized, comprehensive evaluation plan will be developed, encompassing both trainee and program evaluation. Formative evaluation, conducted at the baseline and mid-point of the program, will guide program improvements and refinements. Summative evaluation, conducted at the end of the year-long residency program, will measure the efficacy of the program. The evaluation and entails both qualitative and quantitative methods. Data will be collected using focus groups, web-based surveys, resident tracking and performance evaluation.

   A. Resident tracking will be performed by each site. A spreadsheet of trainees will be maintained, documenting dates of entry and exit from the residency program.
   B. Resident performance evaluation will include on-going evaluation. Input for these reviews will be obtained from preceptors, program mentors, and faculty members. A performance plan will be developed when the trainee's initial competency assessment occurs. An individual Career Development Plan will be developed and progress on that plan will be evaluated by the designated mentor for the RN Resident.
   C. Clinical skills competency will be measured using the Resident Competency Assessment (RCA). A standard competency model and template will be utilized during the course of the program as a developmental roadmap as well as an assessment tool to measure progress in the trainee. Baseline and 6 month data will be used to plan targeted, individualized, simulated learning experiences.
   D. Residents will be engaged in facilitated small group discussion, using the format of a focus group, in order to gather interim program feedback and information gained will be used for process improvement. Residents will be given the opportunity to participate after 6 months and at completion of the program.
   E. Preceptor and Mentor evaluation will be completed by the RN Residents using the Preceptor Evaluation Form developed in conjunction with the Salt Lake City VA Medical Center. Residents will also complete an evaluation of their designated mentor, using the Mentor Evaluation Form.
   F. Demographic information will be collected via survey, and will follow the format of the UHC/AACN Nurse Trainee Demographic Information survey, allowing for comparison to published national data (Williams, 2007). The survey will collect information about ethnicity, gender, education, grade point average, and previous health care experience. Diversity of nurse residents (including but not limited to gender, race, and/or ethnicity) will be a target recruitment goal and will be tracked and reported for all pilot sites.
   G. The residents' experience will be an important metric and will be measured with the McCloskey/ Mueller Satisfaction Scale (MMSS) (Mueller, 1990).

Table 5. Evaluation Plan

Nurse Residency Program Evaluation Plan	Timeline/Interval
A. Resident Tracking	Ongoing
B. Resident Performance Evaluation	Ongoing
C. Resident Competency Assessment	Baseline, 6 month
D. Interim Feedback Focus Groups within Programs	6 & 12 month
Summative Evaluation; end of 12 month residency	

Nurse Residency Program Evaluation Plan	Timeline/Interval
E. Preceptor & Mentor Evaluation	18 & 24 month
F. Demographic Information	18 & 24 month
G. McCloskey/Mueller Satisfaction Scale	Baseline, 6 month, program completion

Description of Existing Infrastructure and Use of Funds

The infrastructure for the Utah Action Coalition for Health, launched in April 2011, consists of two community-based organizations committed to work together and engage other critical health care stakeholders across the state of Utah. The organization charts depicted in additional documents illustrate the infrastructure created in Utah to help implement the IOM recommendation. The applicant organization is *HealthInsight.* This non-nursing organization is a private, non-profit, community-based organization (CBO) dedicated to improving health and health care, locally governed in three western states: Nevada, New Mexico and Utah. *HealthInsight* is able to draw upon nearly 40 years of quality improvement expertise as well as being recognized as a community. The *HealthInsight* enterprise holds contracts, grants, and is certified, in key areas of healthcare improvement. A list of major affiliations, contracts and grants includes:

- Network for Regional Healthcare Improvement (NRHI) Collaborative
- Agency for Healthcare Quality and Research, Chartered Value Exchange
- Medicare Quality Improvement Organization
- Robert Wood Johnson Foundation *Aligning Forces for Quality*
- Office of the National Coordinator (ONC) for Health Information Technology; Beacon Community Cooperative Agreement
- ONC Regional Extension Center
- Community Health Information Exchange (Nevada)
- Prescription Improvement Coalition (New Mexico)
- URAC Accreditation

The Utah Organization of Nurse Leaders (UONL) is the other lead partner for the Utah Action Coalition for Health. This large nursing organization is the state affiliate of the American Organization of Nurse Executives (AONE). The mission of UONL is to advance the health of all Utahns through innovation and cultivation of excellence in nursing leadership through three major foci: leadership cultivation, advocacy, health policy, and workforce development. The UONL board has endorsed and adopted the IOM Recommendations and incorporated them into their new strategic plan.

UONL encourages membership of nurses from all types of nursing leadership roles throughout academia and the health care industry. The Executive Board consists of 14 people who are nurse leaders in practice or academia. A new board position has been created for UACH co-lead. The academic leadership committee (ALC) of UONL is led by a Dean and consists of the deans and directors of all the nursing programs throughout the state. ALC-UONL members include nurse leaders from associate degree, baccalaureate and graduate degree nursing programs in Utah. In addition one representative from the technical colleges with LPN programs is on the committee.

Matching Funds – UACH has identified a strong funding and programmatic partner in the Utah Cluster Acceleration Partnership for Healthcare (UCAP) that shares the vision and goals of the Utah Action Coalition for Health. UCAP consists of the Utah System of Higher Education (USHE), Utah's Department of Workforce Services (DWS), and the Governor's Office of Economic Development (GOED). These organizations have joined together to improve the coordination and leveraging of Utah's economic development endeavors and resources and have agreed to fund $75,000 to this project.

The objective of UCAP is to accelerate key industry clusters as engines of job creation and economic growth. Clusters provide a framework for formulating and implementing effective public policies and making public investments to foster economic development. This year's focus is on the healthcare industry. The overarching goal of the healthcare UCAP is to ensure the right number of well-prepared nurses is in place to meet the future healthcare needs of Utah citizens in a cost effective manner. The following three priorities for the nursing workforce have been identified and are being developed as state-wide pilot projects: 1) transition to practice, 2) care management curriculum and 3) innovative student placement models to increase access.

The objective of the UCAP projects in general is to capitalize on the position and contribution that institutions of higher education can make to the overall economic development of their respective regions and the Utah state economy as a whole. This untapped potential, if capitalized successfully, will directly contribute to the acceleration of targeted industries like healthcare as well as the wide spectrum of economic growth opportunities across the state.

The funding requested in this SIP application along with the matching funds committed by UCAP will greatly strengthen infrastructure of the Utah Action Coalition for Health as a whole and specifically support the implementation of the RN Residency program. As detailed in the budget the largest portion of the funds will be allocated to an UACH Coordinator. This initial funding will also allow us to seek additional matching funds from state-based foundations and private donors. Our strategic plan includes further building and strengthening the URAC infrastructure through communications, grant writing and meeting support.

In addition to implementing a statewide program for RN Residencies this funding will help the Utah Action Coalition for Health build the infrastructure needed for the collection and analysis of nursing and other health care workforce data that is critical to all the work of the Utah Action Coalition for Health**.** We are leading a collaborative effort to improve research and the collection and analysis of data on the health care workforce here in Utah. The Utah Action Coalition for Health will be working with The Utah State Board of Nursing, the Utah State Board of Nursing, the Utah Department of Workforce Services and the Utah Medical Education Council in this effort to ensure that the data are timely and publicly accessible.

Specific Barriers and Challenges:

Focus groups were conducted with nurse educators and nurse administrators to define specific issues and considerations in providing nurse residencies. The following profile

and themes emerged from two focus groups with 13 CNO participants and key health care industry stakeholders related to challenges involved in developing and implementing RN Residencies in their health care institutions:

- Residency training is needed for AD prepared nurses
- High cost of residency positions
- Retention of residents needs to be addressed
- Nice to have a cohort, but may need to be flexible with residency start dates
- Include rural setting and design for all settings
- Hospital and community based residencies are needed for APRNs
- Consider unit-based and rotational models – build on capstone/student internship
- Include generalist and specialty residencies
- Include simulation-based experiences & team training
- Financial model and cost remains an issue
    - Use of existing or new FTE for Resident positions
    - Track cost savings on orientation
    - Track vacancy and retention data
- Evaluation and sustainability
    - Outcomes measures re: personnel
    - Recruitment benefits
    - Orientation costs

Existing state level data and capacity:

While the capacity and ability to collect and collate coordinate state level data related to the RN workforce this goal has not been achieved due to lack of coordination and infrastructure. Currently RN workforce data is collected and resides in three separate agencies: Department of Workforce services, Utah State Board of Nursing and Utah Medical Education Council (UMEC). These data bases do not interact or share data. In addition health care systems and nursing education systems track data related to RN graduates and employees. The current situation does not allow for the accessing or aggregating data and advanced analytics are needed to create a useful workforce supply and demand model. Department of Professional Licensing (DOPL) performs regular surveys of licensed individuals and it is hoped DOPL will add specific questions around educational preparation to future surveys. Further, allowing access to the DOPL database for aggregation with UMEC data would provide for robust analysis of nursing professionals across the state. Dept of Workforce services also has aggregate, census track level data that could be contributed to a state-wide data pool and centralized approach to analysis. Negotiation has begun to access these disparate data sources.

List of key stakeholders and partners:

The following list shows the variety and level within organizations committed to the success of UACH and this SIP in particular.

Table 6. Utah Action Coalition Organization Chart

Utah Organization of Nurse Leaders (UONL) in partnership with *HealthInsight*	
Utah Action Coalition for Health (UONL)	
Utah Action Coalition Coordinating Council Members	
NAME	**ORGANIZATION**
Juliana Preston UACH Co-Lead	*HealthInsight* Executive Director Utah
Maureen Keefe, RN, PhD, FAAN UACH Co-Lead	University of Utah College of Nursing Dean
Susan L. Beck, PhD, APRN, FAAN	University of Utah College of Nursing, Professor
Michelle Carlson, BS, SSW	*HealthInsight* Project Coordinator
Beth Cole, PhD, APRN, FAAN	Utah Organization of Nurse Leaders President
Teresa Garrett, RN, MSN	Utah Department of Health Department Director
Kim Henrichsen, RN, MS	Intermountain Healthcare CNO
Debra F. Hobbins, DNP, APRN, LSAC	Boards of Nursing and Pharmacy Bureau 7 Manager,
Penny Kaye Jensen, DNP, APRN, FNP-C, FAANP	American Academy of Nurse Practitioners President
Gail McGuill, RN, MSN, NEA-BC	Shriners Hospital for Children, CNO
Christie North	*HealthInsight* Vice President, Utah Programs
Alan Ormsby	AARP Utah State Director
Margaret Pearce, RN, PhD	University of Utah Hospitals and Clinics CNO
Lynn Purdin	Utah Department of Workforce Services Program Specialist
Carolyn Reese	Utah Health Care Association Nurse Consultant
David Squire	Utah Medical Education Council Executive Director
Kim Wirthlin	University of Utah HS Public Affairs and Marketing Associate Vice President