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Nursing Workforce Development In Rural Home Health: Design Of A Nurse Fellowship Curriculum

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Nursing Workforce Development in Rural Home Health:

Design of a Nurse Fellowship Curriculum

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This DNP Project is accepted in partial fulfillment of the requirements for the degree Doctor of Nursing Practice.

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anything worth doing, is worth doing *very* well.

Abstract

As the population of the United States ages, so does the population of registered nurses. The result of this phenomenon is an increased demand for nursing services at the same time there is a growing shortage of nurses; this is particularly true in rural home health. It is imperative that organizations develop strategies to combat the widening divide between supply and demand. One opportunity is implementation of structured transition in practice programs, such as residencies and fellowships, to attract nurses into rural home health settings. While these programs are on the rise in hospitals, there are few in rural areas or home health nursing. Using the available evidence on rural and home health nurse retention and leveraging existing frameworks such as the American Nurse Credentialing Center Transition in Practice Program and Quality and Safety Education for Nurses, this author designed a rural home health nursing fellowship to attract and retain registered nurses into home health practice. This paper describes the process for designing the "Rural Home Health Nurse Fellowship" and includes the resulting core learning domains, program requirements and evaluative measures.

Key words: nurse, rural, home health, retention, professional development, fellowship

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List of Common Abbreviations

ANA – American Nurses Association

D-HH – Dartmouth-Hitchcock Health

NAHC – National Association of Home Care and Hospice

PCA – Practicing Clinician Advisor

RN – Registered Nurse

VNAHSNNE – VNA Health System of Northern New England

VNH – Visiting Nurse and Hospice for Vermont and New Hampshire

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CHAPTER 1

SIGNIFICANCE OF THE ISSUE AND PROBLEM STATEMENT

Introduction and Significance

The American Nurses Association (ANA, 2017) estimates that 500,000 Registered Nurses will retire by 2022 and that the United States will need 1.1 million nurses to replace them and expand healthcare services to meet the needs of our aging population. Labor statistics indicate while some areas of the country will be able to meet this demand, others such as rural areas like New England (Auerbach, Beurhaus, & Staiger, 2017) will likely experience significant shortfalls. The United States Census Bureau estimates that the population of people age 65 years and older will almost double between 2012 and 2050, from 43.1 million to 83.7 million (Ortman, Velkoff, & Hogan, 2014), which will have significant implications for healthcare systems in regard to workforce demand. New England trends are similar to the national projections, with recent increases in the numbers of people 65 years and older reaching 18% of the total population (Auerbach, Beurhaus, & Staiger, 2017; United States Census Bureau, *Quickfacts NH, VT*, n.d.). To meet this growing need, the United States must increase nursing full-time equivalents (FTE) by roughly 20%. The data from Vermont and New Hampshire indicate a 19% and 16% increase in FTE needed, respectively (ANA, 2013, 2017).

While these numbers seem staggering unto themselves, there are additional factors to consider that are specifically relevant to New England and may increase the demand for nurses beyond the ANA projections for rural areas. In a study of RN workforce by United States geographic regions, Auerbach, Beurhaus, and Staiger (2017) identified two factors concerning for New England: 1) a lack of RN entry-into-practice per capita growth, and 2) the oldest RN

workforce in the country as evidenced by the highest percentage of those over 50 years of age. These variables could result in additional demand for this area of the country, as the "baby boomers" retire while there is no projected growth for the RN population, and specifically for new RNs entering practice.

A concern for all rural practice areas is the phenomenon of "RN leakage." RN Leakage is a concept similar to patient leakage, meaning that options exist in their own communities for nursing work, yet they choose to leave the immediate area to work elsewhere; in the patient scenario, they choose to receive specialty services outside of their community or local health system (for example, a diabetic sees an endocrinologist that is not associated with their primary care/hospital network). The Rural Health Research Center describes this phenomenon in a policy brief titled "Characteristics of Rural RNs Who Live and Work in Different Communities," (Skillman, Palazzo, Doescher, & Butterfield, 2012). The brief details an overall growth in RN's who live in rural communities and commute to other geographic area types (large rural, suburban, urban); this trend has increased from 14% in 1980 to an impressive 37% in 2004. Additionally, the more rurally the RN lives, the more likely they are to commute to another region. During this same time period the RN population in rural areas only increased by 3%, suggesting there are other drivers for the 23% increase in rural nurse commuters that are not explained by changing demographics alone.

Problem Statement

Given the aging population, increased demand for nurses, and RN leakage from rural practice to other area types, it is imperative for rural health systems and nursing leaders to implement retention strategies to maximize the nursing workforce in northern New England. However, there is "a lack of readily available information [on]… strategies that have been empirically tested for their effectiveness" (Twigg & McCullough, 2013, p. 91). There is a need

to design, implement and evaluate the impact of a structured professional development and career planning program on rural nurse retention.

CHAPTER 2

BACKGROUND

Review of the Literature

Organizational factors that lead to nurse retention are well-known and include professional development which is the "process of improving and increasing capabilities of staff through access to education and training opportunities" (Professional development, 2017), as well as career planning to achieve competency or advance to a particular position. The aim of the literature review is to identify factors positively associated with professional development and career planning programs and the impact of these programs on retention of rural nurses and nurses practicing in home health.

An integrative review was completed using the matrix method as described by Garrard (2017) as it is considered the appropriate method for synthesis of the literature. A keyword search was completed in October 2017 and November 2018 of the following databases: PubMed, CINAHL, and ERIC. The search terms included: *nurse retention, rural, home care, satisfaction, professional development and career planning*. Database searches identified 366 studies which were screened via title and abstract for relevance. Of these, 45 were identified for further review against the selection criteria and 19 were included in the synthesis. The search strategy and selection details are shown using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flowchart (Appendix A). Studies selected met the following criteria: published in the English language, conducted in a developed country, focused on factors associated with nurse retention or nurse satisfaction, focused on the rural or home health nurse,

described or evaluated interventions for professional development or career development. The synthesis includes fifteen empiric and four theoretical studies.

The majority of studies reported results of nurse satisfaction as a proxy measure for nurse retention and was therefore used as the dependent variable in this synthesis. The analysis revealed common factors positively and negatively associated with nurse satisfaction, as well as factors specific to rural and home health settings. The factors are categorized as either *intrinsic* (internal, coming from self) or *extrinsic* (structural, outside of self) as a means to relate findings to nurse retention strategies and are summarized in Table 1. Review of professional development and career planning programs are also summarized.

Intrinsic Factors

Positive associations.

A nurse's sense of *competency*, described as the "…abilities, knowledge, and skills that enable a person to act effectively in a job or situation" (Competency, 2017), is foundational to satisfaction in the workplace and the profession (Hall, Waddell, Donner, & Wheeler, 2004; Healey-Ogden, Wejr, & Farrow, 2012; Molinari, Jaiswal, & Hollinger-Forrest, 2011). When evaluating competency needs, it is important to note that nurses practicing in rural settings have different needs than their counterparts in suburban and urban settings. Long and Weinart (1989) pioneered the development of rural nursing theory, setting apart this specialty, and studies have shown that rural nurses identified competency as a generalist nurse and the ability to manage crisis situations as particularly important to their confidence and job satisfaction (Molinari & Monserud, 2008; Rohatinsky & Jahner, 2016). This construct is also present in the home health environment where a variety of skills and knowledge are required to manage a disparate panel of home health patients (Tourangeau, et al., 2014). For example, a rural home health case manager may see patients with a variety of conditions such as congestive heart failure, total joint

replacement, and complex wounds. This differs from counterparts in urban and suburban hospital settings, where there would be specialized units for cardiac, orthopedic and medicine. For rural and home health practice, maintaining competency in a variety of conditions is foundational to the RN role and is necessary for an RN's sense of self-efficacy.

Self-efficacy, or the belief in one's abilities, builds from a nurse's sense of competency. When an individual is competent, they build confidence in their ability to manage difficult situations and take control of their practice. Self-efficacy is critical to the RN practicing in rural areas and home health settings, as it provides the confidence and motivation to handle the unforeseen and crisis situation as an autonomous practitioner. As competence and confidence grow, the nurse's sense of self-efficacy develops which has been shown to positively associate with job satisfaction (Adeniran, Bhattacharya, & Adeniran, 2012; Hall, et al., 2004; Van Waeyenber, Decramer, & Anseel, 2015).

The decision to take a position or to stay in a job is largely influenced by the *perceived benefit* of holding that particular job. What constitutes a "benefit" depends on an individual's values, life experience, and personal circumstance and will vary from person to person. Chang, et al. (2015) found that nurses identify compensation, professional development, and promotional opportunities as benefits that influence their satisfaction or intent-to-stay. While compensation is important to rural nursing, studies have differentiated that the perception of being well-compensated is of higher significance than the actual salary indicating investment in compensation packages may not be the highest priority for rural health organizations (Hanson, Jenkins, & Ryan, 1990; Molinari, et al., 2011). A perceived benefit specific to rural nurses is a "rural lifestyle" which is described as small community living, providing care to people they know, and being outdoors (Molinari, et al., 2011; Molinari & Monserud, 2008).

Negative associations.

There was limited data in this review on intrinsic factors negatively associated with nurse satisfaction. Hanson, Jenkins, and Ryan (1990) found that age (the younger the nurse, the more likely to leave) and time on the job (less than 12 months) were predictors of intention-to-quit, which is another proxy measure for nurse retention. Similarly, Ellenbecker and Hall (2012) report longer tenure positively related to retention in home health settings. However, this was contradicted by Penz, Stewart, D'Arcy, and Morgan (2008) who found that age had no bearing on job satisfaction. This is an area worth further exploration given the transient nature of the millennial generation and the current and future implications for the nursing workforce; however, this is outside the scope of this synthesis and DNP project.

Extrinsic Factors

Positive associations.

A positive *work environment* has long been championed as the cornerstone of nurse satisfaction and this is commonly understood among nurse leaders and administrators. Although many components fall under this umbrella term, a few key elements stand out: *workload* (availability of nursing personnel), *resources* (adequate equipment and supplies), and *schedule* (flexibility and life balance) in rural and home health nursing (Ellenbecker, 2004; Molinari & Monserud, 2008; Penz, Stewart, D'Arcy & Morgan, 2008; Tourangeau, Patterson, Saari, Thomson, & Cranley, 2017). When nurses feel adequately supported in their work, the level of stress is decreased and the ability to feel satisfaction is greater. Peer support and *mentorship* is another important mechanism of support for rural home health nurses. These nurses practice in relative isolation and are routinely presented with new clinical scenarios given the generalist nature of both rural and home health nursing practice. Having an available mentor to teach and guide nurses through these complex situations has been shown to have a significant impact on job satisfaction (Ellenbecker, 2004; Rohatinsky & Jahner, 2016).

In order to manage these complex situations, the rural home health nurse requires the *autonomy* to make decisions and intervene in the best interests of the patient. Autonomy is the "freedom to act on what you know" (Hall, et al., 2004), and leverages the competency of the nurse to provide nursing care. In a study of ten rural organizations in Georgia, Hanson, et al. (1990) found the strongest factor related to job satisfaction was autonomy in nursing practice. Organizations must allow for independent decision-making by nurses and support the consequences of these decisions to fully achieve autonomy in practice (Fusilero, et al., 2008; Hall, et al., 2004; Hanson, et al., 1990; Tourangeau, et al., 2014; Twigg & McCullough, 2013).

Negative associations.

Many of the factors that are positively associated with nurse satisfaction are also identified as the most significant detractors. For example, if a nurse is highly satisfied when there are adequate resources available to provide quality nursing care, when those resources are not available, the nurse's satisfaction goes down. Researchers have aptly described these challenges and among the most prominent are:

- lack of *academic preparation* for the rural generalist role (competency);
- *resource availability* (supplies, equipment, and personnel – particularly mentors);
- *access* to programs and tools to maintain and enhance competency;
- lack of *autonomy;* and
- *limited career opportunities* (Ellenbecker, 2004; Fusilero, et al., 2008; McCoy, 2009; Molinari, et al., 2011; Molinari & Monserud, 2008; Penz, et al., 2008; Rohatinsky & Jahner, 2016; Tourangeau, et al., 2014).

Table 1. Synthesis of results: Factors associated with rural nurse satisfaction

Category	Positive Associations	Negative Associations
Intrinsic	▪ Competency o Generalist o Crisis management ▪ Self-efficacy ▪ Perceived benefits o Professional development o Career opportunities o Rural lifestyle	▪ Age* ▪ Time in job*
Extrinsic	▪ Work environment o Workload, Resources o Schedule ▪ Mentorship ▪ Autonomy	▪ Educational preparation o Limited exposure to rural practice ▪ Access to programs and tools ▪ Resource availability ▪ Limited career opportunities
*Conflicting evidence, needs further examination		

Professional Development and Career Planning

Healthcare organizations approach professional development and career planning in a variety of ways. Advancement through a defined clinical ladder program (Adeniran, et al., 2012, Cooper, 2009; Fusilero, et al., 2008), mentoring and a formal career planning process (Hall, 2008; Hall, et al., 2004), and staffing models (Healey-Ogden, et al., 2012) were evaluated for their impact and each had positive associations with nurse satisfaction. The findings are reflected in the synthesis of intrinsic and extrinsic factors and identified competency (skill development), self-efficacy, perceived benefits, mentorship and autonomy as critical elements for the success of these programs. There were no relevant articles found that studied programs in the home health setting.

Summary of Main Findings

Given global population trends and the risk for nursing shortages in certain areas, factors associated with nurse retention are widely studied. Despite evidence that factors in rural areas differ from those in urban areas (Hall, 2008; Long & Weinart, 1989; Molinari & Monserud, 2008; Penz, et al., 2008), there were no studies identified that evaluated the impact of the work environment, and specifically professional development and career planning programs, on nurse

retention in rural areas. However, there were studies that evaluated nurse satisfaction in relation to organizational characteristics (Fusilero, et al., 2008; Hall, et al., 2004; Molinari & Monserud, 2008; Penz, et al., 2008) and this author identified intrinsic and extrinsic factors that are positively associated with nurse satisfaction in rural areas. These findings provide insight to the rural nursing workforce and can be utilized by nurse leaders and health system administrators in planning effective recruitment and retention strategies.

Implications for Practice

This integrative review provides a new perspective on the factors associated with nurse satisfaction in rural areas and the home health practice setting that is worth exploring further. The intrinsic and extrinsic factors identified provide a potentially useful framework for professional development and career planning that could positively impact both nurse satisfaction and retention. Appreciating that autonomy in practice is a primary driver of rural nurse satisfaction (Hanson, et al., 1990; Tourangeau, et al., 2014); this is a critical concept to explore in these settings. If autonomy is dependent on competency, and competency is achieved through professional development (Hall, et al., 2004), then it would be prudent to design programs incorporating these constructs and then to evaluate the impact on nurse satisfaction and retention. A conceptual model based on positively associated factors (Appendix B) provides such a framework for program design across the lifespan of the nurse, from point-of-entry to retirement. The strength of the framework is that it is broad enough to apply across settings yet allows for individualization to address the unique needs of a given population. The DNP project will utilize these concepts and constructs of the proposed model, as well as identify additional factors associated with retention of rural home health nurses as the evidence evolves.

Theoretical Framework

The project will be designed using Bandura's (1977, 1994) theory to maximize learning experiences to promote self-efficacy. "Perceived self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance…"(Bandura, 1994, p.1). This theory is well suited to the goal of the DNP project as it provides principles for education to influence a person's thinking which then leads to a desired behavior (Appendix C), in this case, choosing to continue to practice nursing in a rural home health environment. Self-efficacy, as described by Bandura, is important to the DNP project as it influences an individual's *motivation* and *resiliency*. The theory holds that people derive self-efficacy from four sources of information, a) performance accomplishments, b) vicarious experience, c) verbal persuasion, and d) physiological states. These principles will be incorporated into the program to achieve optimal results and are described in turn.

- To achieve a sense of *performance accomplishment*, opportunities for participants to master a particular aspect of care will be provided. Through demonstration and return demonstration (either simulated or in a real care setting), participants will be recognized for their achievements during the program.
- To strengthen belief through *vicarious experience*, participants will be paired with mentors practicing in rural home health settings. "Seeing people similar to oneself succeed…raises observers' beliefs that they too possess the capabilities…"(Bandura, 1994, p. 2).
- To *verbally persuade* participants of the continued value of nursing in rural practice, mentors will receive coaching and instruction on ways to engage, describe and persuade participants that nursing is a meaningful career with development and advancement opportunities within the rural setting. Mentors will also provide positive feedback as home health and rural competency develops within the nurse.

- To optimize *physiological response*, the program leaders and mentors will provide a supportive environment that engages participants in nursing as a profession, reducing anxiety and self-doubt.

These experiences would be the "sources" of information for each participant, promoting self-efficacy for nursing as a career. Bandura's theoretical model provides a useful framework for both developing interventions and evaluating the effectiveness of the program.

Organizational Scan

The project setting is a rural home health and hospice agency (Visiting Nurse and Hospice of VT and NH or VNH) that serves communities across 4,000 square-miles and is a member of the Dartmouth-Hitchcock Health (D-HH) system. The system is a comprised of one tertiary academic medical center, one community hospital, three critical access hospitals, and two inpatient acute rehab units. Given the challenges that all members of the D-HH system are experiencing with recruitment and retention, workforce development emerged as a top priority during a system-wide strategic planning process that occurred between April and September of 2018.

As nurses are the largest segment of staff across the health system, there is support for initiatives focused on nursing, specifically from the Chief Nurse Executive and the Chief Human Resources Officer. Workforce development strategies have been implemented, primarily in the academic health center, such as a year-long nurse residency program, nurse mentorship programs, and a clinical advancement program. However, none of these programs are available to the nursing team at the VNH; they are designed for nurses working at the medical center and have not yet been updated to reflect the needs of the growing Dartmouth-Hitchcock Health system or designed to reach staff in geographically disparate locations.

The turnover rate at VNH is considerably higher than desired, at 31%. By way of comparison, organizations that have achieved Magnet Recognition, the gold standard in nursing practice environments, have an average of 9.9% turnover (American Nurses Credentialing Center, n.d.). Magnet organizations include academic medical centers, community hospitals, rehabilitation hospitals and clinics. While there are currently no home health agencies that have Magnet designation, the need for a positive work environment that fosters engagement and commitment are the same. At the time of this paper, the nursing vacancy rate at VNH is 44% (H. Amoth, Human Resource Director, personal communication, March 1, 2019).

This situation has serious financial implications. Temporary labor (nurse travelers) is used to cover these vacancies and have associated premium costs of $1.5 million per year (Apicella, 2019); this additional expense causes a significant financial drain on the organization and limits the ability to invest in staff retention programs. Given that 71% of VNH care episodes include skilled nursing, implementing programs that improve retention of core nursing staff and reduce or eliminate the unnecessary expense of temporary labor is critical to the sustainability of VNH.

To adequately address the intrinsic and extrinsic factors associated with rural and home health nurse satisfaction, the lived experience of the VNH nurse must be understood. The 4,000 square miles covered by VNH includes the most rural areas of VT and NH. RN's provide care in remote areas that are difficult to access, often via dirt roads that are not maintained and difficult to traverse, and where cellular phone and broad-band coverage is limited or non-existent. This limits the ability to access resources in real-time, including important information stored in the electronic medical record. The primary referral source to VNH is Dartmouth-Hitchcock Medical Center, which has the highest acuity rate (Case-Mix Index or CMI) in New England at 2.16, which is higher than Tufts, Massachusetts General Hospital, Brigham and Women's and the

Leahy Clinic who hold the next highest CMI's in the region (Malcolm, 2019). VNH nurses need to be skilled to meet the complex needs of patients' being discharged from the medical center. They are independent practitioners and must have the competence, confidence, and resiliency to address unexpected and emergent situations in the field.

Fortunately, the work environment at VNH currently addresses several of the extrinsic needs identified by nurses. This includes *access to resources,* such as the interdisciplinary team for a comprehensive approach to patient care, *basic mentorship* through a team leader model; safety and ergonomic *training* resulting in a low on-the-job injury rate, and annual market adjustments for a competitive wage. Although compensation was not identified as a key driver of satisfaction in the literature review, it is best practice and necessary to mitigate this risk of voluntary turnover in the organization. Additionally, a home health residency program for new graduates is in place to meet the needs of inexperienced nurses transitioning into their first professional role.

However, there are considerable gaps in structure and process at VNH to support the intrinsic needs of experienced nurses new to rural home health practice. There is limited *professional development*, beyond a basic orientation to home health regulations and documentation standards, based on the assumption that experienced nurses are fully competent to manage patients in a rural home setting. There is no formalized *clinical competency* program to ensure RNs have the knowledge and skill to manage the variety of conditions and acuity of today's home health patient, as well as the ability to manage unexpected, emergent situations. While basic mentorship is available through the team leader model, there is not a formal process for reflection on practice and development of expertise and *self-efficacy* in home health nursing. VNH would benefit from a formal on-boarding process for experienced RN's new to home health and/or rural practice, that supports their transition to a specialized practice environment,

and that provides the supports and resources needed to excel in their new role. Offering this benefit to nurses would also be a strategic differentiator from other home health agencies in the region.

Project Goal and Aims

The goal of the DNP project is to develop and implement a professional development program, specifically a model for **a rural home health nurse fellowship**, that incorporates the intrinsic and extrinsic factors described above; to support experienced nurses with the transition to rural home health nursing and ultimately improve retention of these nurses. There has been much debate in the nursing community regarding the appropriate term to use for educational programs that a nurse or nurse practitioner participate in beyond their baccalaureate, masters, or doctoral level programs. The term fellowship is intentionally chosen to differentiate the program from nurse *internships* that are designed to provide student nurses with clinical experiences that enhance their learning in a supervised setting and from nurse *residencies* that are designed for new graduate registered nurses transitioning to independent practice as novice clinicians. For this project, fellowship is a program of professional development for experienced and competent registered nurses, to develop competency in the specialty practice of rural home health and is in concert with the definition approved by the American Academy of Orthopeadic Manual Physical Therapists (2000), a similar professional role that advances health and recovery for individuals and populations. To accomplish this goal, the following aims are identified:

1) Synthesize the current evidence related to professional development, retention, and career planning of the rural nursing and home health workforce to identify domains for a rural home health nursing fellowship;

2) Collect empirical data regarding nurse retention from practicing home health nurses and analysis of VNH exit interview data to further inform the domains of the fellowship model;
3) Utilize the experienced nurses (Aim 2) as Practicing Clinician Advisors (PCAs) to obtain feedback and pilot proposed structures and processes of the fellowship model;
4) Develop a model for a home health nurse fellowship, that includes evaluation methods;
5) Disseminate the fellowship framework and evaluation model through presentation to the VNA Health System of Northern New England (VNAHSNNE) and the VNA's of Vermont.

CHAPTER 3

METHODS

Introduction

The purpose of the DNP project is to support experienced nurses with the transition to rural home health nursing and improve retention of these nurses. This is accomplished through the design of a fellowship model that addresses the intrinsic and extrinsic factors associated with home health and rural nurse satisfaction. The fellowship model utilizes the self-efficacy framework as described by Bandura (1977, 1994) and outlined in Chapter 2, as this concept is identified as important to rural nurses. The project site is the Visiting Nurse and Hospice of VT and NH and the primary project population is experienced nurses transitioning to home health practice from other specialty areas or practice settings, from any location (within the D-HH system, within the service region, or outside of the service region). Experienced home health nurses will also participate in the fellowship, to ensure all practicing RNs are prepared according to VNH standards of practice. The project was developed in collaboration with the D-HH Workforce Development team and VNH nursing leadership. To illustrate the evolving nature of

an evidence-based project and the continuous learning that occurs over the span of a DNP project, the proposed methods for each aim will be followed by the actual implementation of each aim.

Aim 1: Synthesize the current evidence related to professional development, retention, and career planning of the rural nursing and home health workforce to identify domains for a rural home health nursing fellowship

Aim 1: As originally proposed.

Review of the evidence and synthesis are described in detail in Chapter 2 and the corresponding Appendices A and B. As nursing fellowship domains are not currently defined by the American Association of Colleges of Nursing, the review of evidence will be the basis for determining the fellowship domains. The conceptual framework developed during the evidence review identifies competency and self-efficacy as potentially important domains to include. Likewise, the intrinsic and extrinsic factors will further inform potential domains as well as specific elements; these will include competency as a generalist and in crisis management, and resource availability as in mentorship. Additional review is needed to understand the domains of healthcare related professional fellowships, such as the program requirements for the Accreditation Council for Graduate Medical Education and the American College of Clinical Pharmacy, as these may further inform the domains for a rural home health fellowship.

Aim 1: As implemented.

Review of the evidence and literature synthesis are described in detail in Chapter 2 and the corresponding Appendices A and B. To mitigate for potential gaps in the literature, review of four related frameworks was conducted and included 1) Quality and Safety Education for Nurses (QSEN, 2020) 2) Home Health Nurse Scope and Standards of Practice (HH SSP) (ANA, 2014), 3) American Nurses Credentialing Center (ANCC) Practice Transition Accreditation Program

(PTAP)(2020) and 4) Accreditation Council on Graduate Medical Education (ACGME) Common Program Requirements (Fellowship)(2018). These frameworks were chosen at the recommendation of content experts within the DNP student's professional network as they are widely accepted in the healthcare industry as standard-setters for education and professional development for nurses. The ACGME was chosen as a benchmark program specifically for its long-standing history and known rigor for both program structure and clinical competency framework.

The structure and content of each framework was reviewed and compared against the domains identified through the literature synthesis and the empirical data collected as part of Aim 2. Crosswalks between the frameworks were developed to identify gaps in the draft home health fellowship domains. The gap analysis is organized in two sections, program requirements and competencies, and are discussed with the project results in the next section.

In addition to the gap analysis, the DNP student and clinical education manager (MSN with experience as undergraduate faculty and inpatient nurse educator) collaborated with the program coordinator for the existing VNAHSNNE home health nurse residency program to align curriculums and to share resources and expertise. The residency program follows the QSEN framework and was informative to the process of refining fellowship domains. The collaboration will continue throughout the course of fellowship development, leveraging the expertise of the residency program coordinator and leveraging the outcomes of the residency professional development program to inform the design of the fellowship.

Aim 2: Collect empirical data regarding nurse retention from practicing home health nurses and analysis of VNH exit interview data to further inform the domains of the fellowship model

Aim 2: As originally proposed.

Utilizing the concepts of Community-Based Research Methods (Iennaco, 2018) to elucidate important domains for the fellowship program, individual and small group interviews will be held with nurses practicing at the project site. The goal is to recruit up to five nurses who have practiced for a minimum of two years. A member of the D-HH workforce team (or designee) will conduct the interviews to mitigate bias in participant response. The D-HH Workforce Specialists are experts in northern New England workforce issues and in the development of training programs to build pipelines for hard-to-fill positions within the health system; examples include pharmacy technician, medical assistant, and licensed nursing assistant programs and will recognize relevant issues in the content analysis. The questions will be open-ended to allow for idea generation rather than specific opinions regarding potential fellowship domains. The interviews will be audiotaped for post-session review; written consent will be obtained from the participant.

Content analysis will be performed by the project team (DNP student, D-HH Workforce Development specialist) of the audiotaped interviews and written responses from VNH exit interviews. The project team will identify and reconcile themes from the data with those identified in the synthesis of the literature. Consensus among the project team will validate themes for inclusion in the fellowship domains.

Aim 2: As implemented.

Individual and Group Interviews.

Utilizing the concepts of Community-Based Research Methods (Iennaco, 2018) to elucidate additional domains for the fellowship program, individual and small group interviews were held with nurses practicing at the project site. The DNP student collaborated with the organization's human resource team to identify nurses who met the eligibility criteria (home health RN with a minimum of two years' experience). Prior to sending the invitation to

participate, the DNP student held a meeting with the Director of Home Health Services and Clinical Managers to review the DNP project and objectives of the interviews to gain support for clinical nurse participation. Once support was confirmed, an electronic invitation was sent to eight eligible nurses detailing the DNP project and purpose of the sessions. Seven nurses responded affirmatively to the invitation and five were able to participate at the scheduled times. Each participant signed a consent (Appendix D) to participate in the quality improvement activity on the day of the session.

To mitigate bias in participant response, the individual and group interviews were conducted by two members of the health system workforce development team (facilitators). The facilitators were chosen due to expertise in northern New England workforce issues and the development of training programs to build pipelines for hard-to-fill positions within the health system; examples include pharmacy technician, medical assistant, and licensed nursing assistant programs. As regional experts, they were well-suited to recognize relevant issues during the sessions and in the post-session review of content.

The DNP student and facilitators met in advance of the sessions to review the DNP project proposal, clarify the objectives of the interview sessions, craft the questions and plan session logistics. The questions were open-ended to allow for idea generation rather than specific opinions regarding potential fellowship domains (Appendix E). The interviews were audiotaped for post-session review and consent specific to audiotaping was included in the quality improvement participant consent form. In addition to the audiotape, written notes were taken by an administrative assistant for cross-reference.

Content analysis of the audiotaped interviews and written notes was performed by the DNP student and facilitators to identify additional domains to include in the fellowship design. Analysis was conducted via a three-step process, beginning with a session debrief with the DNP

student, facilitators and administrative assistant to confirm integrity of the process. This was followed by independent review of audiotapes and written notes by the student and facilitators, where each identified themes found in the data. After individual review, the group met to share their findings, qualify their interpretation of data and to find consensus on new topics not present in the literature synthesis.

Exit Interviews.

Organizational exit interviews are voluntary and comprised of two parts, an interview conducted by a member of the human resource team and completion of an on-line survey. The data for calendar year 2019 was obtained and analyzed by the DNP student for content relevant to the fellowship domains. Ten online surveys were completed and the summary report generated by the online survey software was reviewed. The narrative notes from individual interviews were not available to the DNP student for analysis. The available data was not stratified by role; therefore no conclusions regarding nursing retention factors could be drawn.

Aim 3: Utilize the experienced nurses (Aim 2) as Practicing Clinician Advisors (PCAs) to obtain feedback and pilot proposed structures and processes of the fellowship model

Aim 3: As originally proposed.

The experienced nurses who participate in the interview process will be invited to act as "Practicing Clinician Advisors" to the project team. Input on drafts of the model will be solicited via electronic communication or interview; the information gathered will be assessed for feasibility and relevance for the fellowship model. Proposed structures and processes may be tested on a small scale by the PCAs to further inform the fellowship design.

Aim 3: As implemented.

The five experienced nurses who participated in the interview process were invited to act as "Practicing Clinician Advisors" (PCAs) to the project team; two of the original five PCAs left

the organization during the project planning phase and therefore were not invited to participate in the feedback session. Input on the draft fellowship model, including program structure (length, preceptors, multi-modal approach) and content (curriculum design and sequence) was solicited from the remaining PCAs via small group discussion led by the DNP student and manager of clinical education. Feedback from the session was incorporated into the fellowship design.

Aim 4: Develop a model for a home health nurse fellowship that includes evaluation methods

Aim 4: As originally proposed.

The fellowship model will be developed in accordance with the domains and elements identified through literature review and empirical data gathered through the interviews of practicing home health nurses and VNH exit interview data. The model will include didactic and experiential components to promote competency and self-efficacy in alignment with Bandura's theoretical framework. The structure and length of the fellowship will be determined based on further review of the literature and current healthcare fellowships. A resource plan will be included and will outline the infrastructure needs and associated costs to implement the fellowship. Tools to evaluate the model and return on investment will be designed as content is developed and in accordance with best practice.

Evaluation of the effectiveness and impact of the model will occur post-fellowship implementation and outside of the DNP project timeline; evaluation will include the outcome measures of participant turnover and self-efficacy. Nurse turnover will be measured using standard operational definitions and utilizing historical and concurrent VNH data; self-efficacy will be measured utilizing the "General Self-Efficacy Scale" developed by psychologists Schwarzer and Jerusalem (1995); pre and post data will be collected via electronic survey and analyzed using appropriate quantitative methods. The business case, or return on investment,

analysis will also be conducted. Program expenses such as FTE support, program infrastructure, and mentor/preceptor time, will be quantified; reduction in turnover and premium labor cost is expected to off-set infrastructure expenses and will be analyzed to determine program sustainability.

Aim 4: As implemented.

There was not significant change between the proposed methods and implementation. Tools to evaluate the fellowship program were determined as content was developed and in accordance with existing professional frameworks, including QSEN, PTAP, ACGME, and Bandura's self-efficacy model, and generally accepted business indicators. Three categories of measures were identified through the process and include 1) measures specific to the individual fellow, 2) measures specific to the fellowship program, and 3) the broader impact to the organization.

Aim 5: Disseminate the fellowship and evaluation model through presentation to D-HH nursing leadership, the VNA Health System of Northern New England (VNAHSNNE) and the VNA's of Vermont

Aim 5: As originally proposed.

The framework and evaluation model will be disseminated locally through presentation at D-HH nursing leadership meetings and regionally through the VNA's of Vermont Board of Directors and the VNA Health System of Northern New England. This project will build on the Home Health Nurse Residency program sponsored and developed by the VNAHSNNE leadership group; as a member of this group, the DNP student is aware that this project is of great interest and likely to be spread to other organizations. Regional dissemination will allow for robust outcome analysis and relevance at the national level.

Aim 5: As implemented.

While the DNP project is specific to the design of a rural home health fellowship, dissemination requires attention to the context that is driving the need for this professional development and retention strategy. As described in earlier chapters, there are significant shortfalls, both existing and projected, in the available rural nursing workforce. It is imperative that local, regional and national leaders and related organizations recognize the impact of this shortfall on the quality and safety of patient care delivery. Given this imperative, the DNP student engaged in multiple forums and sought opportunities to share the evidence-at-hand to raise awareness, influence thinking and drive subsequent action.

Local Dissemination.

Local dissemination began with the engagement of the health system's Chief Human Resources Officer and Chief Nurse Executive as immersion mentors, and the workforce development team as small group facilitators. Sharing the DNP project proposal and seeking support was part of the early dissemination work that established the need for rural home health workforce development in the minds of key stakeholders in the health system. Awareness of this project led to an invitation by health system leaders to participate in a visit with Bipartisan Health Policy Rural Health Task Force (see national dissemination for more details).

Early dissemination has also included discussion and presentation within the organization to garner support and participation in program development. Initial meetings included the VP for Patient Care Services, Clinical Directors and Managers, the Chief Financial Officer and Director of Human Resources. The agenda included an overview of the DNP project, objectives, and goals related to recruitment and retention. This was done in advance of the small group sessions, to ensure support for PCA participation. To raise awareness throughout the organization, the development of the fellowship was highlighted as a recruitment and retention tool in quarterly

employee forums throughout the project cycle. To maintain leadership engagement, periodic update meetings have been held with the team.

Regional Dissemination.

The DNP student is an active board member of related state associations and has provided each board with an overview of the project objectives and goals. This early dissemination garnered support for coordination and alignment with the existing home health residency program in New Hampshire. It also provided connections to the Vermont Talent Pipeline project and planning for student experiences as a pathway to home health practice. Next steps include sharing the final fellowship design and toolkit as a best-practice for the region.

National Dissemination.

Setting the stage for national dissemination was an important component of the DNP project. To raise awareness at this level, the DNP student co-presented at the National Association for Home Health and Hospice Care annual meeting (NAHC, Nov. 2019) on issues and strategies related to rural home health, workforce development and organization design to recruit and retain registered nurses. The presentation was well-received, generated much discussion with the conference participants and included post-meeting networking related to workforce challenges. A future goal includes submission of the final fellowship model for presentation to NAHC upon full implementation of the program.

Participation in the January 2020 D-HH site visit with the Bipartisan Health Policy Rural Health Task Force provided another platform to share the evidence related to rural nursing workforce and the experience of leading a rural home health organization. The DNP student was invited to participate in two panel discussions, 1) rural health system integration, and 2) rural workforce challenges. Both provided opportunity to highlight concerns related to workforce, competition within an integrated health system in a rural shortage area, and challenges for

recruiting to the region; these panel discussions will help shape the Task Force's final set of recommendations to Congress and the Administration.

Statement about Human Subjects

Approval for this project was obtained from health system Chief Human Resource Officer, Chief Nurse Executive and Institutional Review Board (IRB). While this project is quality improvement in nature, IRB review ensures appropriate protections are in place. Collection of empirical data through focus groups included processes to maintain nurse confidentiality. The focus group was conducted by independent facilitators with no knowledge of the participants beforehand; the facilitator and participants were required to sign a confidentiality agreement. Similarly, agreement for the audiotaping was signed and included provisions for the destruction of the audio recording at the conclusion of the project to further protect participant privacy. All data is reported as domains or elements, without any participant identifiers.

Project Evaluation

Completion of the project aims were used as milestones to define the timeline associated with the model development. The review of the literature was continuous until the development of the model began in October 2019. Associated subtasks were added to the timeline as they were identified. The Gantt chart was monitored by the DNP student and Faculty Advisor to ensure adequate progress was being made; adjustments were be made to the timeline as needed to accommodate iterative learning and include formative evaluation findings.

CHAPTER 4

RESULTS

Literature Synthesis and Framework Comparison

The literature synthesis revealed intrinsic and extrinsic factors relevant to rural and home health nurse satisfaction (Table 1). These factors contributed to the development of a conceptual

model (Appendix B) that informed the fellowship design. The domains identified through this process included mentorship, generalist practice, and crisis and emergency management. The comparative analysis between the domains identified in the literature and the selected frameworks is organized by program requirements and patient care competencies (Appendix F). Through this process, four program requirements and eight patient care competencies were added to the program design and curriculum content. It is important to note that the ANA Home Health Nursing standards were not listed in its entirety, given these standards set the minimum expectation for nursing practice within this specialty and will be imbedded throughout the fellowship program.

Empirical Data

Individual and Group Interviews

Content analysis revealed two additional concepts to include in the program design and curriculum. The first element was structural in nature; the PCAs described the importance of progressive learning and "ramping up" as part of the onboarding process. This represents both an increase in complexity of patient care assignments and a purposeful titration of the amount of work expected (patient visits) of a nurse new to home health practice. This is referred to as "scaffolded learning" in the program overview. The second was related to clinical assessment; the PCAs highlighted the importance of using the home environment as a critical component of the comprehensive nursing assessment. For example, it would be important to understand the food choices and availability of food for a diabetic patient by looking inside the refrigerator during the home visit.

Exit Interview Data

Exit interview data was not available to inform the design of the fellowship program. However, this lack of data presented an opportunity to work with the VNH Human Resources

department to develop new tools and processes for collecting this data moving forward. As the fellowship is implemented, these new tools will be utilized to understand the experience and reasons for leaving, should that occur.

Practicing Clinician Advisor Feedback

A one page program overview (Appendix G) and summary of the program domains (Appendix H) were reviewed with the PCAs. They agreed with the overall program structure of a six-month precepted learning experience, followed by a six-month mentorship for a total of one year fellowship. They discussed the importance of preceptor/preceptee match and the benefit of having more than one preceptor. It was agreed the fellowship model would include a primary and secondary preceptor to better support the new home health nurse and also provide exposure different styles and approaches to accomplishing the expected outcome.

Fellowship Model and Evaluation Methods

Curriculum Domains

The fellowship domains were developed in accordance with the literature review, comparison to existing professional frameworks, analysis of empirical data gathered through the interviews of practicing home health nurses and feedback obtained from the Practicing Clinician Advisors. The model includes didactic and experiential components to promote competency and self-efficacy in alignment with Bandura's theoretical framework. The high level overview of the program components and curriculum domains are described in Appendices F, G and H.

Evaluation Methods

Evaluation of the fellowship model is comprised of three parts; effectiveness of the fellow, effectiveness of the program and program and patient outcomes. Review of the professional development frameworks, QSEN, PTAP, ADGME, along with Bandura's self-

efficacy model, informed the evaluation methods and metrics for the fellowship program. The three categories of measurement are detailed in Table 2.

To adequately evaluate the success of the fellow and the effectiveness of the preceptor, tools for self-efficacy and clinical reasoning were identified. Review of available and validated instruments for self-efficacy led to the "new general self-efficacy scale" developed by Stanford University (Chen, 2001). This tool was modified to include patient care language and will be used to measure self-efficacy pre and post fellowship (Appendix I). The ability to clinically reason in the home health environment is a requirement for successful completion of the fellowship; this will be measured via self-assessment (Appendix J) and case study rubric (Appendix K)(Beliveau, 2019). Other tools, such as preceptor evaluation, course evaluation, and fellow satisfaction have yet to be developed but are recognized as necessary for a comprehensive evaluation. The evaluation process is expected to be iterative, where measures and tools will be modified through cycles of continuous learning.

Table 2. Fellowship evaluative measures by category

Category	Measure
Fellow (pre and post, and periodic assessments)	▪ Self-efficacy ▪ Clinical Reasoning Self-assessment ▪ Clinical Reasoning Case Study – Competency Assessment ▪ Home Health Nursing Competency Evaluations (evidence-based standard evaluations)
Program	▪ Preceptor self-efficacy (as selection criteria) ▪ Preceptor Clinical Reasoning Self-assessment (as selection criteria) ▪ Clinical Reasoning Case Study – Competency Assessment (as selection criteria) ▪ Preceptor evaluation ▪ Course evaluation; faculty evaluation ▪ Program evaluation
Organization	▪ Fellow satisfaction ▪ Fellow retention (voluntary turnover) ▪ Patient outcomes (ED visits and rehospitalization) ▪ Break-even analysis of program infrastructure to fellow turnover

Implications

The development of a rural home health nursing fellowship will provide a much-needed structure and process for onboarding experienced nurses into an entirely new specialty and setting. It has long been established that rural nursing practice is different than nursing practice in suburban and urban settings (Long & Weinart, 1989) and recognizing these differences is an important step towards satisfaction and retention of rural nurses, and in this case, those practicing in the home health setting. While much attention has been paid to the transition of new graduate nurses into practice (resulting in the now well-defined nurse residency program), there are limited standards for nursing fellowships that support the transition of experienced RN's from one practice setting to another. This project will serve as a model for organizations across the country, regarding the development process and final design.

Future implications include improved retention of experienced nurses through the implementation of the rural home health fellowship. As the DNP student is the current Chief Executive for the project site, implementation and evaluation will be conducted under a second phase of work.

How the DNP Project Relates to the Leadership Immersion

Developing and implementing a rural home health fellowship for registered nurses required immersion and learning within several domains of the DNP education essentials. Interprofessional collaboration with health system leaders in the areas of professional development, nursing education, and nursing practice were necessary to develop and implement the fellowship model. Quality improvement methods, analytical tools and change management science were used to effectively test and evaluate a new approach to experienced-nurse onboarding. Systems leadership, thinking and influence were applied to disseminate findings within the health system and relevant professional organizations. An external immersion mentor

(Appendix L) with home health expertise was identified to verify relevance of model domains for home health and rural practice.

Conclusion

There are not a sufficient number of registered nurses to care for the aging population in the United States; this is particularly true in rural areas and home health practice settings. This shortage poses significant challenges to healthcare organizations and risks to patients. Lack of adequate training and support for nurses to transition from urban and suburban areas, as well as from other practice settings such as inpatient hospitals, is a major barrier to developing an adequate home health nursing workforce to meet the growing demand for services. Healthcare leaders must address this critical gap to ensure the health and safety of our rural communities. Developing and implementing comprehensive orientation and professional development programs, such as this rural home health nurse fellowship, is a necessary step to close the growing gap between what we have and what we need.

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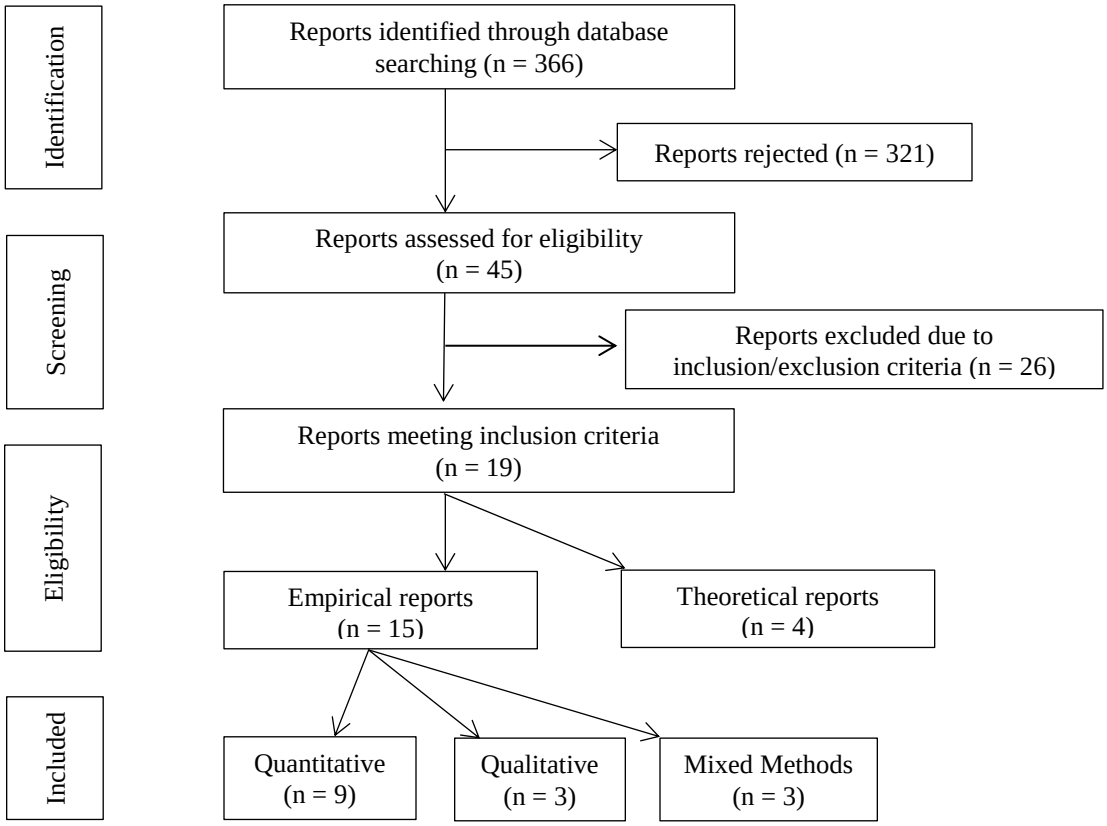
Appendix A

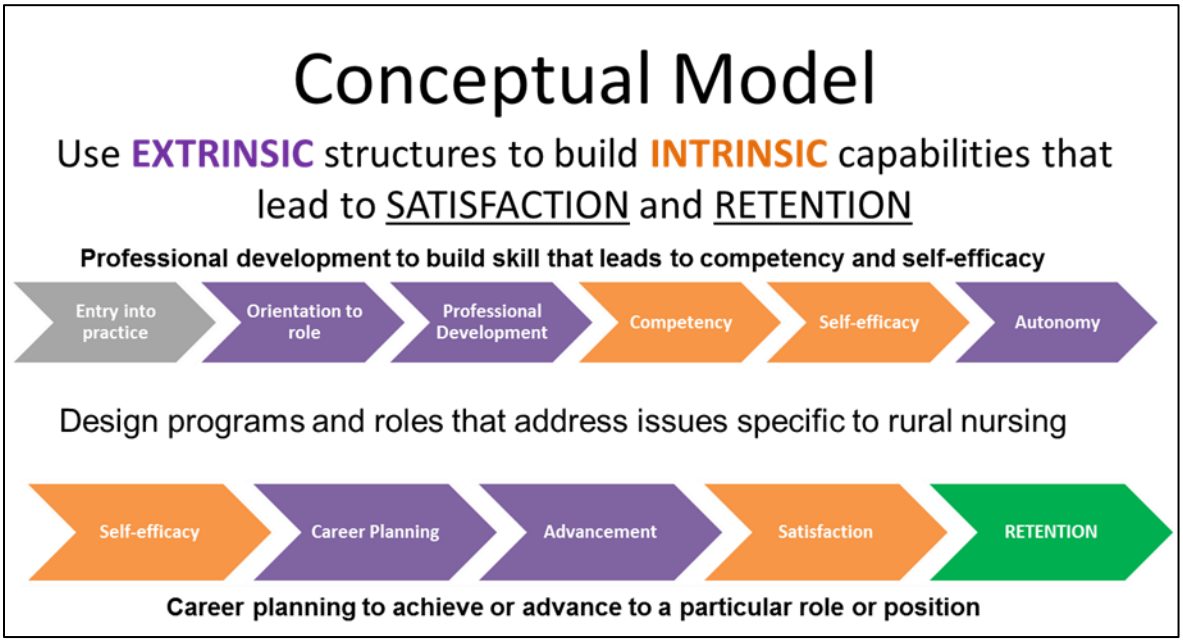
PRISMA flowchart



PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Appendix B

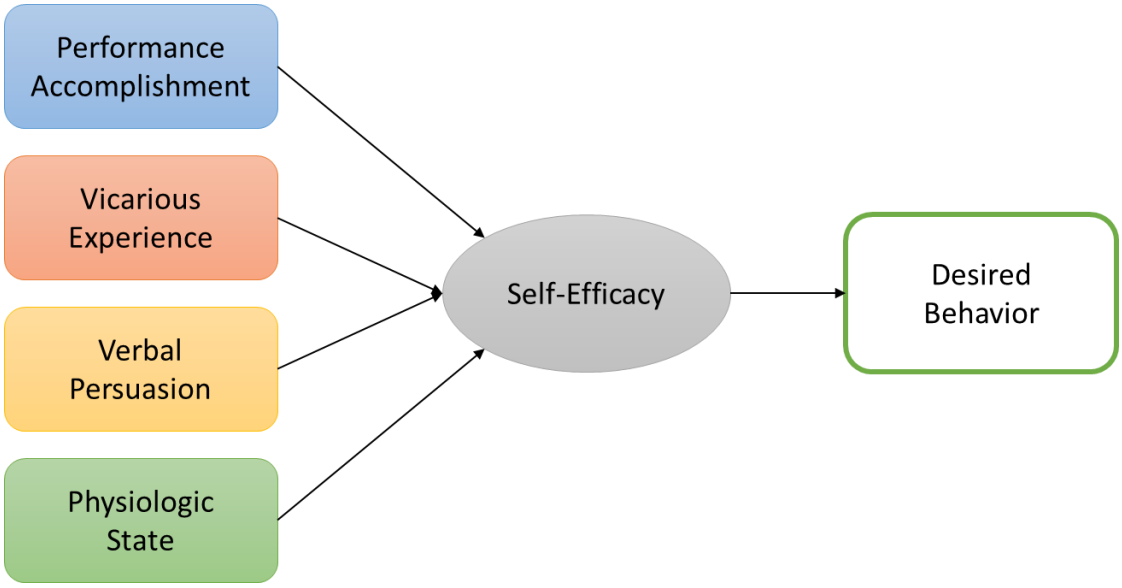
Conceptual Model



Concept model for professional development and career planning based on intrinsic and extrinsic factors associated with rural nurse retention.

Appendix C

Theoretical Framework



Visual diagram of Bandura's sources of information leading to self-efficacy and desired behavior.

Appendix D

CONSENT TO TAKE PART IN QUALITY IMPROVEMENT

Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)

DNP Project Title: Nursing Workforce Development in Rural Home Health
DNP Project Lead: Johanna L. Beliveau, BSN, MBA, RN

You are being asked to take part in a quality improvement project and taking part is voluntary.

You are being asked to take part in this quality improvement project because you are a VNH nurse clinician with perspective on VNH and home health nursing professional development.

The purpose of this project, including focus group participation, is to gather information to help inform understanding and future practice at an organizational level. Your decision whether or not to take part will not influence your current or future job status.

Please ask questions if there is anything about this project you do not understand.

What is the purpose of this focus group?

The purpose of the focus group is to learn about current perspectives, needs, and interests regarding nursing orientation and professional development at VNH.

Will you benefit from taking part in this focus group?

We hope to gather information that will guide organizational practice and policy in the future.

What does this focus group involve?

As part of this quality improvement project, you will be placed in a group of 3 - 4 individuals. A moderator will ask you several questions while facilitating the discussion. This focus group will be audio-recorded, and a note-taker will be present. However, your responses will remain confidential, and no names will be included in the final report.

You can choose whether or not to participate in the focus group, and you may stop at any time during the course of the session.

Please note that there are no right or wrong answers to focus group questions. VNH wants to hear the many varying viewpoints and would like for everyone to contribute their thoughts. Out of respect, please refrain from interrupting others. However, feel free to be honest even when your responses counter those of other group members.

Participation in this project may last up to 6 months. We may ask you to participate in more than one interview as the project evolves.

What are the options if you do not want to take part in this project?

You do not have to take part in this project. Participation is voluntary.

What are the risks involved with taking part in this project?

You may think or feel that you are sharing sensitive personal information about your employment situation with the interviewer that may affect your current or future employment status.

You may think or feel that you are sharing sensitive information about D-H or your work setting that you would not be comfortable discussing publicly.

Leaving the project

You may choose to stop taking part in this project at any time for any reason. If you decide to stop taking part, it will have no effect on your current or future employment status or conditions.

How will your privacy be protected?

The information collected as data for this project includes:

1. Signed Informed Consent
2. Audio recording of your focus group with a moderator
3. Information routinely collected or maintained by VNH

We will keep the information collected for this project secure and confidential. Participation and interview information will be de-identified for transcription, analysis, and publication. Focus group information will not be shared beyond the project team.

Should you choose to participate, you will be asked to respect the privacy of other focus group members by not disclosing any content discussed during the session. Project team members within D-H Workforce Development and the DNP Project lead will analyze the data, but—as stated above—your responses will remain confidential, and no names will be included in any reports.

Audio recording files, a database including the transcribed interviews, and other documents used for data analysis will be stored on a secure VNH data drive, in a secure folder to which only the project team has access.

The information collected for this project will be used only for the purposes of quality improvement as stated earlier in this form.

Whom should you contact with questions about this study?

If you have questions about this study you can call or email Johanna Beliveau, BSN, MBA, RN at jbeliveau@vnhcare.org, phone 888-300-8853.

Will you be paid to take part in this project?

Focus groups are arranged during your regular working day and your time is compensated accordingly.

What happens if you feel upset or concerned after taking part in this project?

All participants will be provided with contact information for VNH Human Resources and the VNH Employee Assistance Program at the beginning of focus group.

CONSENT

I have read the above information about the DNP quality improvement project on nursing workforce development in rural home health and have been given an opportunity to ask questions. I understand this information and agree to participate fully under the conditions stated above.

Participant's Signature and Date PRINTED NAME

Project Lead (or Designee) Signature and Date PRINTED NAME

Appendix E

Aim 2 - Focus Group Questions

Purpose: to improve the orientation and professional development of registered nurses practicing at Visiting Nurse and Hospice for VT and NH.

Questions

1. What was the best component/part of your orientation to VNH?
2. What was the least helpful component/part of your orientation to VNH?
3. What does it take to be an effective preceptor to new staff?
4. What can VNH do differently to help you to provide the best care?
5. What has been the most useful learning opportunity for you?
6. Remember a time working with a patient that you didn't have the knowledge needed to provide care. What did you do to resolve the situation? What could we have done differently in advance?
7. What do you need to learn to feel better about your job?
8. Do you ever think of leaving? Why? Why not?

Appendix F

Program Crosswalk – Gap Analysis

Key
RHHF – Rural Home Health Fellowship
ANCC TAP – American Nurses Credentialing Center Practice Transition Accreditation Program
ACGME – Accreditation Council on Graduate Medical Education Common Program Requirements (Fellowship)
QSEN – Quality and Safety Education for Nurses
HH SSP – Home Health Nurse Scope and Standards of Practice
A – Element added to RHHF after benchmarking and empirical data collection

Table 1. Gap analysis against structural program requirements.

PROGRAM REQUIREMENTS	**RHHF** *DRAFT*	**RHHF** *FINAL*	**ANCC TAP**	**ACGME**
OVERSIGHT				
SPONSORING INSTITUTION	X	X	X	X
PARTICIPATING SITES			X	X
RECRUITMENT				X
PERSONNEL				
PROGRAM DIRECTOR	X	X	X	X
FACULTY/PRECEPTOR	X	X	X	X
FELLOW SELECTION/APPOINTMENT				
ELIGIBILITY	X	X	X	X
NUMBER				X
EDUCATIONAL PROGRAM				
AIMS CONSISTENT W/ MISSION		**A**	X	X
CULTURE AND VALUES	X	X	X	
COMPETENCY-BASED	X	X	X	X
MULTIMODAL APPROACH	X	X	X	X
PROGRESSIVE RESPONSIBILITIES		**A**	X	X
SUPERVISION	X	X	X	X
EVALUATION				
FELLOW	X	X	X	X
FACULTY		**A**	X	X
PATIENT OUTCOMES		**A**	X	
PROGRAM	X	X	X	X

Table 2. Gap analysis against patient care competencies.

COMPETENCIES	**RHHF** *DRAFT*	**RHHF** *FINAL*	**QSEN**	**HH SSP**	**ANCC TAP**	**ACGME**
PATIENT-CENTERED CARE						
SOCIAL DETERMINANTS	X	X				X
ETHICAL DECISION-MAKING			X	X	X	
UNCONSCIOUS BIAS*		**A**	X			
TEAMWORK AND COLLABORATION						
COMMUNICATION SKILLS	X	X	X	X	X	X
INTERPROFESSIONAL TEAMWORK	X	X	X	X	X	X
SYSTEM/COMMUNITY – BASED		**A**		X		X
PRECEPTOR/MENTOR	X	X		X	X	
EVIDENCE-BASED PRACTICE						
CLINICAL REASONING	X	X	X	X	X	X
PATIENT CARE (POPULATION-BASED)	X	X			X	X
ENVIRONMENTAL ASSESSMENT		**A**		X		
MEDICATION ASSESSMENT		**A**		X		
FUNCTIONAL ASSESSMENT		**A**		X		
CRISIS & EMERGENCY MGT	X	X				
TECHNICAL SKILL/PROCEDURES	X	X				X
CARE MANAGEMENT/TRANSITIONS		**A**	X	X		X
QUALITY & SAFETY	X	X	X	X	X	X
IMPROVEMENT METHODS/METRICS			X			X
CULTURE OF SAFETY*		**A**	X			X
SAFETY EVENTS AND REPORTING*		**A**	X			X
REGULATORY REQUIREMENTS	X	X				
VALUE-BASED PAYMENT MODEL	X	X				
INFORMATICS (TOOLS AND STANDARDS)	X	X	X	X		
PROFESSIONALISM	X	X				X
WELL-BEING/RESILIENCY	X	X			X	X
SCHOLARSHIP			X	X	X	X

*Added to the organization's general orientation for all clinical staff

Appendix G

NURSE FELLOWSHIP

6:6:12 Model
6 Months Preceptorship:6 Months Mentorship:12 Months Professional Development

PROGRAM OVERVIEW:

The VNH of NH and VT offer a Home Health Nursing Fellowship that provides the professional with dynamic learning experiences for the nurse interested in entering the unique specialty of home health.

This fellowship follows the 6:6:12 model. The fellow will have 6 months of clinical preceptorship, followed by 6 months of mentorship, in conjunction with 12 months of professional development specifically targeted toward the following educational domains:

- Mentored and practice-based learning
- Care management and clinical reasoning in the home environment
- Crisis and emergency management
- Regulatory requirements and patient-driven payment models
- Documentation standards and tools to define and meet patient goals

The fellow is paired with a trained preceptor during the first 6 months and supported by a clinical educator. At 6 months, the fellow completes clinical preceptorship and transitions to mentorship for ongoing role development and support.

During the learning experiencing the home health fellow will be engaged using:

- Simulation-based educational experiences
- Small group discussions
- One to one skill training
- Preceptor and clinical educator driven case studies

Caseload and visit expectations are increased gradually as the fellow gains competence and confidence in their home health skills; individual goals are established in collaboration with their preceptor, clinical educator and supervisor.

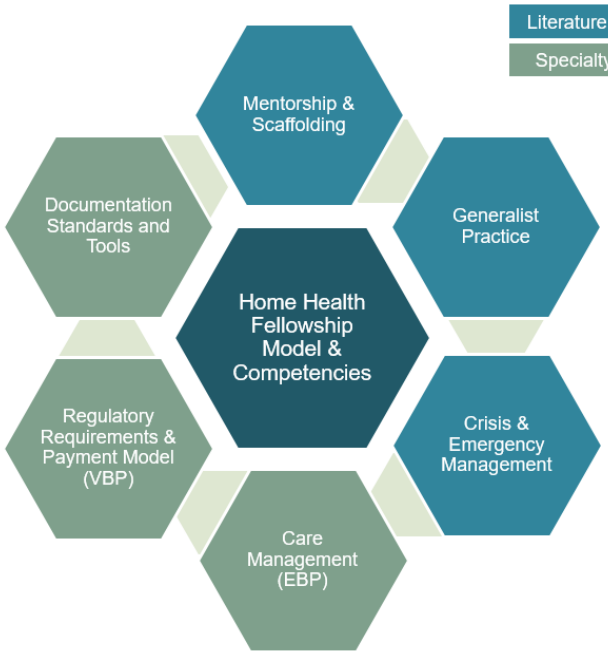
Enrollment is rolling and each cohort of fellows is integrated into the growing community of Master Fellows. For more information, please contact Human Resources. (emailHR@vnhcare.org) or call 888-300-8853

Appendix H

Fellowship Domains – At a Glance

Home Health Fellowship

- Evidence-based model through review of the literature and empirical data gathered through VNH nurses
- Structured to address *intrinsic* and *extrinsic* factors
- Designed to achieve self-efficacy and nurse satisfaction
- Multiple domains for comprehensive transition to home health practice
- Aligned with ANCC Practice Transition Accreditation program™



Mentorship & Scaffolding
- Guided entry into practice through Preceptor (6 mo) and Mentorship (12 mo) support
- Increasing complexity of assignments and productivity expectations throughout 6 month period

Generalist Practice
- Comprehensive Assessment and Goal-Directed Care (Case Study/Motivational Interviewing), Competency validation
- Interdisciplinary Team – Case Conference
- Preceptor & Mentor training

Crisis & Emergency Mgt
- Clinician and patient safety in the home setting
- De-escalation of aggressive, disruptive behavior
- Access to and utilization of resources to address clinical emergencies

Care Mgt (EBP)
- Care Management – Evidence-based Care Pathways
- Case Management – Individualized Plan of Care (Goal-directed), Patient Education
- Episode Management – deployment of resources to meet goals

Regulatory Rqmts & Payment Model
- CMS Conditions of Participation/Billing Rules
- VT Designation Rules/NH Licensure requirements
- Payment models – VBP (OneCare), Medicare (PDGM)

Doc Standards & Tools
- Documentation standards – SOC/ROC, DC, Change in Condition, Goal-directed care
- OASIS Walk / Certification
- EMR workflows

Appendix I

New General Self-Efficacy Scale

Overview

General self-efficacy relates to "one's estimate of one's overall ability to perform successfully in a wide variety of achievement situations, or to how confident one is that she or he can perform effectively across different tasks and situations;" self-efficacy is an important factor in nurse competency, and an important measure of success for the Home Health Nurse Fellowship.

Using the "New Generalized Self-Efficacy Scale," a fellow's sense of self-efficacy will be measured upon entry into the program and at periodic intervals throughout the 12 month program (3, 6, 12 months).

Instructions

Review the questions below and consider them in the setting of clinical practice in rural home health. Choose the response that best matches your level of agreement with the statement and enter the corresponding number into the response column.

Response Scale

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree.

Item	Question	Response
1	I will be able to achieve most of the goals that I set for myself *(i.e professional goals, developing expertise).*	
2	When facing difficult tasks *in the care of patients*, I am certain that I will accomplish them.	
3	In general, I think that I can obtain outcomes that are important to me *professionally and positive outcomes for my patients*.	
4	I believe I can succeed at most any endeavor to which I set my mind.	
5	I will be able to successfully overcome many challenges *to achieve positive patient outcomes.*	
6	I am confident that I can perform effectively on many different *patient care* tasks.	
7	Compared to other *clinicians in the same role*, I can do most tasks very well.	
8	Even when things are tough, I can perform *clinical care* quite well.	
	Total Points	
	Average Score (Self Efficacy Rating)	

Appendix J

Clinical Reasoning Self-Assessment

Overview

Nurse Fellows apply existing experience, knowledge and skills to home health case studies and practice the cognitive skills of analyzing, applying standards, discriminating, information seeking, logical reasoning, predicting, and transforming knowledge (Benner, Hughes & Sutphen, 2008). Self-assessment and reflective journaling aid in skill development.

Nurse Fellows must demonstrate competency through case study synthesis to successfully complete the Home Health Nurse Fellowship; competency is defined according to Patricia Benner's novice to expert continuum of nursing practice model.

Instructions

Review the questions below and consider them in the setting of clinical practice in rural home health. Choose the response that best matches your level of agreement with the statement and enter the corresponding number into the response column.

Response Scale

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree.

Item	I am capable to:	Response
1	Identify the primary problem and describe the underlying cause(s) for specific health conditions.	
2	Extract relevant clinical information from a patient situation for clinical decision-making.	
3	Recognize when there is insufficient knowledge and identify additional sources of evidence to increase understanding in a given situation in home health.	
4	Identify nursing priorities and formulate a comprehensive plan of care for the home health patient based on available clinical data.	
5	Manage patient complications/poor outcomes through application of evidence-based practice and appropriate use of resources in home health.	
6	Recognize my emotional response to uncertainty and implement strategies to cope with uncertainty and meet the patient's home health needs.	
	Total Points	
	Average Score (Self Efficacy Rating)	

Appendix K

Clinical Reasoning Case Study Rubric

Overview

Nurse Fellows apply existing experience, knowledge and skills to home health case studies and practice the cognitive skills of analyzing, applying standards, discriminating, information seeking, logical reasoning, predicting, and transforming knowledge (Benner, Hughes & Sutphen, 2008).

Nurse Fellows must demonstrate competency through case study synthesis to successfully complete the Home Health Nurse Fellowship; competency is defined according to Patricia Benner's novice to expert continuum of nursing practice model.

Evaluation

Facilitated case discussion will occur during designated class time and will be used to determine the fellow's ability to fully construct an appropriate home health plan of care, anticipate patient needs and mitigate potential risks. The clinical educator will complete the evaluation with input from the fellow's preceptor and clinical manager.

Objective	Proficient	Competent	Advanced Beginner
Content Knowledge – is the knowledge the Fellow brings to the case, not knowledge shared by the patient or through case study materials.	Comprehensively describes foundational knowledge and *integrates* impact of health condition on all systems into the thought process.	Describes a complete understanding of the health condition and how all systems are impacted.	Describes some general knowledge / foundational facts but with an incomplete understanding of the health condition.
Procedural Knowledge – the ability to apply the nursing process and determine appropriate interventions (care plan) and describe the expected outcome(s).	Discerns relevant information from all sources of evidence through an advanced understanding of the health condition and formulates a comprehensive nursing plan that anticipates most patient responses.	Applies and interprets information to justify or modify interventions based on experience. Identifies appropriate sources of evidence to formulate a complete nursing plan that anticipates some patient responses.	Uses rules to apply information to patient case and begins to recognize patterns to support decisions. Overlooks some sources of evidence resulting in an incomplete nursing plan.
Conceptual Reasoning – the ability to synthesize information upon which decisions are made utilizing reflection and self- awareness.	Able to critically self-reflect on reasoning ability and assigns meaning to current situation based on intuitive response from clinical and life experience. Articulates feelings associated with perceived ability to problem-solve and demonstrates high confidence in nursing practice.	Able to critically self-reflect on reasoning ability and describe relationship between past experience and decision-making. Articulates feelings associated with perceived ability to problem-solve and demonstrates confidence in nursing practice.	Limited ability to self-reflect on reasoning ability and to recognize knowledge gaps, requires supportive cues throughout process. Articulates feelings associated with perceived ability to problem-solve and has low confidence in nursing practice.

Appendix L

Immersion Mentor – Nancy Roberts, MSN, RN*

Nancy Roberts, MSN, RN, served as the President and Chief Executive Officer of VNA of Care New England and the Executive Vice President of Care Management for the Care New England Health System, from 1996 - 2016. She worked with the systems' hospital partners to develop results oriented, patient-centric and cost-effective programs and services to meet the unique needs of various patient populations along the continuum of care. Most recently, she served in the inaugural group of the Centers for Medicare and Medicaid Innovation Advisors. The project she piloted was a collaborative practice model between home health and primary care that measured the impact on patients of a well-defined and executed care delivery model. A member of multiple boards and committees including past president of the Board of Directors of the Visiting Nurse Associations of America, she is a sought-after public speaker and has provided expert testimony on healthcare reform issues at various conferences and meetings throughout the United States.

**Adapted from Practice Change Leaders for Aging and Health, Nancy Roberts, MSN, RN; retrieved from http://changeleaders.org/roberts.asp*