

**2023 – 2024 Faculty Senate – Pending Approval Approved at Mtg #20**  
**Meeting # 19 Feb. 6, 2024**  
Tuesday, January 30, 2024, 3:30 pm – 5:00 pm  
Zoom only

**Present:** Barannyk, Chapman, Gauthier (Chair), Haltinner (Vice Chair), Justwan, Kenyon, Kirchmeier, Torrey Lawrence (w/o vote), Maas, McKenna, Murphy, Ramirez, Roberson, Rinker, Sammarruca (w/o vote), Schiele, Shook, Schwarzlaender, Tibbals.

**Absent:** Blevins (excused), Raney (excused), Mittelstaedt (excused), Long.

**Call to Order:** Chair Gauthier called the meeting to order at 3:30 pm.

**Approval of Minutes (vote):**

The minutes of the 2023-24 Meeting #18, January 23, 2024, were approved as distributed.

Chair Gauthier proposed to change the order of the agenda, because Aleksandra Hollingshead cannot speak later due to a conflict. The proposal was approved by general consent.

**Announcements and Communications:**

- Report from the Ubuntu Committee – Aleksandra Hollingshead, Department Chair, Curriculum and Instruction.

Aleksandra is the chair of Ubuntu. Her visit's main purpose is to share information about the 2024 MLK Jr. Art and Writing contest. The deadline for (digital) submission is February 16, 2024, by 5pm. Please share with students in your departments or units. To commemorate the life, work and legacy of Dr. Martin Luther King Jr., University of Idaho undergraduates, graduates and professional students enrolled for the 2024 spring semester at any U of I location are invited to create a written work or piece of art in any medium of their choice about equality and social, racial and ethnic justice. The contact person is Caitlin Cieslik-Miskimen, [caitlinc@uidaho.edu](mailto:caitlinc@uidaho.edu). They are working on securing some funds for the student awards.

<https://www.uidaho.edu/student-affairs/ubuntu/mlk-art-and-essay-contest>

She also wanted to share with Senate some concerns about the Ubuntu committee, perhaps to be delegated to the Committee on Committees. The concerns are about structure, fast turnover (length of service), and confusion about attendance expectations. Over 50% of the members are non-voting ex-officio delegates from the different diversity units, which is good. However, because of misunderstanding of attendance expectations, people work in silos. The committee needs better coordination. If the purpose of Ubuntu is to support diversity work focused on students, perhaps we should reconsider the committee structure and establish clear communication channels with the diversity and inclusion staff.

Vice Chair Haltinner noted that the Committee on Committees is in the process of auditing all committees. She reached out to Yolanda Bisbee with some suggestions about the committee make-up.

Responding to a charge from Senate on specific tasks, Ubuntu reached out to the Registrar's Office multiple times to ask that students be allowed to use their preferred names on their diplomas but didn't receive a response. They contacted the Admission Committee about more inclusive statements on the admission page but didn't hear back. They have been looking into more equitable language in position postings and search committee work. These plans are now on hold until the end of the legislative session. One successful area is the committee work with

IPO to provide more clarity in the communication system with international students about scholarships available to them.

#### **Chair's Report:**

- Brandi sent responses to some of the questions about the State Board switching from TIAA to Fidelity, namely, Optional Retirement Plan Transition to Fidelity:
  - Rankings: Fidelity is a mutual fund company and does not hold reserves in a general account, so ratings are not applicable.
  - Bitcoin: Fidelity made some announcements about making bitcoin investments available through retirement plans. This will not be an option for the ISBOE plans. Currently the self-directed brokerage is limited to mutual funds and therefore bitcoin is not (and will not be) an option for this plan.
- There was a critique from a senator about the Talking Points (TP). We think that the TP are very important to engage constituents and get immediate feedback about what was heard and discussed during the Faculty Senate meetings. The TP do not replace the minutes. We will put a disclaimer at the bottom of the TP to clarify that they are not intended to replace approved minutes.

The Faculty Secretary followed up. She confirmed that traditionally TP have been a quick and informal way to let constituents know about the current issues senate addresses weekly and to stimulate interest to know more from the supporting documents. Requiring that TP be approved by all senators before going out would defeat their purpose. She encouraged feedback.

#### **Provost's Report:**

- U of I was founded January 30, 1889, so it's 135 years old today!
- Tomorrow at 12: 30 in the ISUB Lobby: McNair Research Expo. Check it out if you can, it should be very interesting work.
- 10<sup>th</sup> day enrollment was measured last week. It indicated an increase of 6.8% over the same point in time last spring. The final number will probably be smaller, because dual credit registration data may have come in earlier than last spring (dual credit timing is different depending on the school district). The final number is expected to be an increase in the range of 3-5%.

#### **Committee Reports (voting):**

- **Proposed changes to the University Catalog**
  - UCC 508 Microelectronics Fabrication – Feng Li, Electrical & Computer Engineering, Attach. #2.  
The scheduled speaker was not present. Senator Roberson offered to say a few words and answer questions. The courses required for the certificate will provide students with specialized knowledge and skills in microelectronics fabrication and prepare them for careers in the industry.  
Vote: 22/22 yes. Motion passes.

Jeff Seegmiller introduced the new medical program to which the following UCC items belong. In the state of Idaho, there is a shortage of medical professionals, poor health care, and a high suicide rate. We rank 50<sup>th</sup> in the country in the number of mental health professionals and health professionals. They are proposing a novel medical program to meet

critical needs in the state and save lives. Jeff Seegmiller is enthusiastic and grateful to all who have contributed to this important effort.

- UCC 549 Master of Science in Gerontology – Thomas Farrer, Associate Program Director, Medical Education Program (WWAMI), Attach. #3.  
Generally, the number of people above 50 years of age is growing; between 2012 and 2030, it is predicted that this population will grow by 33%. We need a workforce to meet the needs of this growing population.  
Discussion:  
Chair Gauthier asked whether the program is multidisciplinary. Response: Yes, it covers many areas of aging, such as elder care, elder law, etc.  
A senator inquired about the teaching power to deliver those classes. Response: Some will be new hires; others will come from WWAMI. Current staff and faculty will be re-directed to the new School of Health and Medical Professions.  
A senator asked whether courses that appear to be at the 600 level, such as GERO 6XX, indicate plans to develop a doctoral program. Response: That is not the case.  
Vote: 23/24 yes; 1/24 no. Motion passes.
- UCC 551 Direct-Entry Doctor of Nursing Practice-Nurse Anesthesia – Russell Baker, Associate Program Director, Medical Education Program (WWAMI), Attach. #4.  
In Idaho, the current nurse population clusters around the largest city in Idaho Public Health Districts, with significant migration of nurses away from Idaho rural communities. Thus, there is a great need to train and prepare CRNAs in Idaho to work in Idaho’s rural communities. The development of an advanced practice entry-to-practice CRNA program in the state will aid in the development of a CRNA workforce to meet the needs of Idahoans.  
Vote: 21/21 yes. Motion passes.
- UCC 540 Direct-Entry Master of Science in Nursing – Jeff Seegmiller, Director, Medical Education Program (WWAMI), Attach. #5.  
This program is an entry to the medical profession. Applicants don’t need to have a bachelor’s in a nursing field. Currently, no institution in Idaho offers a Direct Entry Master of Science in Nursing. A direct-entry nursing education program addresses unmet needs for a struggling rural workforce.  
Vote: 22/22 yes. Motion passes.
- UCC 548 Doctor of Psychology in Clinical Psychology – Thomas Farrer, Associate Program Director, Medical Education Program (WWAMI), Attach. #6.  
There is a critical shortage of mental health providers in all Idaho counties. There are only two clinical psychology doctorate programs in Idaho, one at Idaho State University and a second at Northwest Nazarene University. The program at ISU is accredited by the American Psychological Association. However, the program turns away 90-95% of their applicants. Thus, many suitable applicants will have to leave the state to continue seeking a doctoral degree. This program will help meet the needs of Idaho citizens with mental health conditions.  
Vote: 22/22 yes. Motion passes.

- UCC 550 Master of Physician Assistant Studies – Russell Baker, Associate Program Director, Medical Education Program (WWAMI), Attach. #7.  
Currently, Idaho State University runs the only PA program in the state, which accepts about 10% of the applicants. The pool of applicants who are not accepted has a large portion of Idaho residents. A comparable PA at the University of Utah has similar PA production as ISU and reports a 4% admission rate for the PA program. Thus, more than 90% of applicants are not accepted into either of these programs, while there is strong interest in pursuing a career as a PA.  
Vote: 21/21 yes. Motion passes.
- UCC 99 School of Health and Medical Professionals – Jeff Seegmiller, Director, Medical Education Program (WWAMI), Attach. #8.  
The School of Health and Medical Professions will be the foundation on which our programs will grow. The school will be housed within the College of Graduate Studies. The bulk of these specific programs are currently not being offered in our state institutions, except for the Physician’s Assistant Program. Proposals for each of these academic programs are included in this School/Program proposal submission.  
Vote: 20/20 yes. Motion passes.
- **Proposed changes to the Faculty Staff Handbook**
  - FSH 3440 Compensation of Classified Employees – recalled from the agenda.
- **Changes to the Administrative Procedures Manual (non-voting):**
  - APM 50.51 Request for Job Reclassification – Brandi Terwilliger, Director of Human Resources, Ashley Rodriguez, Senior HR Business Partner, Attach. #10.  
Information contained in this item is now maintained on the HR website.
  - APM 45.16 Sponsored Project Payment Management – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs, Attach. #11.  
Rewritten to clarify processes to match Chart V (Banner) updates and to update format.
  - APM 45.17 Fixed-Price Sponsored Projects – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs, Attach. #12.  
Updating for current processes in Chart V and new CFR regulations governing fixed-price sponsored funding.

**New Business:**

None.

**Adjournment:**

The agenda being completed, the Chair adjourned the meeting at 4:19pm.

Respectfully Submitted,

Francesca Sammaruca

Secretary of the University Faculty & Secretary to Faculty Senate

University of Idaho  
2023 – 2024 Faculty Senate Agenda

Meeting #19

Tuesday, January 30, 2024 at 3:30 pm  
Zoom Only

- I. Call to Order
- II. Approval of Minutes
  - Minutes of the 2023-24 Faculty Senate Meeting #18 January 23, 2024 **Attach. #1**
- III. Chair's Report
- IV. Provost's Report
- V. Committee Reports (voting)
  - Proposed changes to the University Catalog
    - UCC 508 Microelectronics Fabrication – Feng Li, Regular Faculty, Electrical & Computer Engineering **Attach. #2**
    - UCC 549 Master of Science in Gerontology – Thomas Farrer, Associate Program Director, Medical Education Program (WWAMI) **Attach. #3**
    - UCC 551 Direct-Entry Doctor of Nursing Practice-Nurse Anesthesia – Russell Baker, Associate Program Director, Medical Education Program (WWAMI) **Attach. #4**
    - UCC 540 Direct-Entry Master of Science in Nursing – Jeff Seegmiller, Director, Medical Education Program (WWAMI) **Attach. #5**
    - UCC 548 Doctor of Psychology in Clinical Psychology – Thomas Farrer, Associate Program Director, Medical Education Program (WWAMI) **Attach. #6**
    - UCC 550 Master of Physician Assistant Studies – Russell Baker, Associate Program Director, Medical Education Program (WWAMI) **Attach. #7**
    - UCC 99 School of Health and Medical Professionals – Jeff Seegmiller, Director, Medical Education Program (WWAMI) **Attach. #8**
  - Proposed changes to the Faculty Staff Handbook
    - FSH 3440 Compensation of Classified Employees – Brandi Terwilliger, Director of Human Resources, Ashley Rodriguez, Senior HR Business Partner **Attach. #9**
- VI. Committee Reports (non-voting)
  - APM 50.51 Request for Job Reclassification – Brandi Terwilliger, Director of Human Resources, Ashley Rodriguez, Senior HR Business Partner **Attach. #10**
  - APM 45.16 Sponsored Project Payment Management – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs **Attach. #11**
  - APM 45.17 Fixed-Price Sponsored Projects – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs **Attach. #12**

VII. Announcements and Communications

- Report from the Ubuntu Committee – Aleksandra Hollingshead, Department Chair, Curriculum and Instruction
- Information on First Aid Training and Stations on Campus – Beau Babcock, Occupational Safety Technician

VIII. New Business

IX. Adjournment

Attachments

- **Attach. #1** Minutes of the 2023-24 Faculty Senate Meeting #18 January 23, 2024
- **Attach. #2** UCC 508
- **Attach. #3** UCC 549
- **Attach. #4** UCC 551
- **Attach. #5** UCC 540
- **Attach. #6** UCC 548
- **Attach. #7** UCC 550
- **Attach. #8** UCC 99
- **Attach. #9** FSH 3440
- **Attach. #10** APM 50.51
- **Attach. #11** APM 45.16
- **Attach. #12** APM 45.17

**2023 – 2024 Faculty Senate – Pending Approval**

Meeting # 18

Tuesday, January 23, 2024, 3:30 pm – 5:00 pm

Zoom only

**Present:** Barannyk, Blevins, Chapman, Gauthier (Chair), Haltinner (Vice Chair), Justwan, Kenyon, Kirchmeier, Torrey Lawrence (w/o vote), Long, Maas, McKenna, Mittelstaedt, Murphy, Ramirez, Raney, Roberson, Rinker, Sammaruca (w/o vote), Schiele, Shook, Schwarzlaender, Tibbals.

**Absent:** Kenyon (excused), Hobbs, Reynolds

**Call to Order:** Chair Gauthier called the meeting to order at 3:30 pm.

**Approval of Minutes (vote):**

The minutes of the 2023-24 Meeting #17, January 16, 2024, were approved as distributed.

**Announcements and Communications, Part 1:**

- **Admissions Standards** - Use of Standardized Tests for Admission Decisions – Dean Kahler, Vice Provost, Strategic Enrollment Management.

After reviewing AY 2022-23 admission standards, Vice Provost Kahler presented retention rates by high school (HS) GPA. **The data are attached to these minutes.** From Fall 2015 through Fall 2022, the retention rate with HS GPA of 3 and above has been around 80%, with a slight downward trend (81% in Fall 2015 vs. 77% in Fall 2022). The lack of SAT/ACT scores doesn't appear to change in a significant way the trends that we saw before waiving those scores.

Discussion:

In response to a question, Vice Provost Kahler noted that the HS GPA has been found to be a good predictor of success by other peer universities as well.

A senator cited the New York Times article “The Misguided War on the SAT” (nytimes.com) as an interesting take on the subject.

As for the slight decline in the retention rate of our best students (GPA 3 and up), the reasons can be diverse – sometimes they are non-academic, financial or family related. Additional analysis needs to be done on those trends to get better insight.

A senator is concerned that our current trend of lowering the standards and reducing barriers to entry to move students through may be seen unfavorably from the outside. Vice Provost Kahler responded that many campuses are having similar conversations. Next Monday, there is a meeting (Jean-Marc will be there) with the State Board (SB) staff to discuss our direct admit Idaho program. WSU has already dropped SAT scores from their admission standards. Provost Lawrence added that the SB is strongly committed to access and to educate more Idaho students, as demonstrated by the \$75M invested in the “Launch” initiative.

Provost Lawrence summarized the question before Faculty Senate: If we take no action, the current emergency action will expire and admission standards for Fall 2025 will revert to their pre-COVID status. If the Faculty Senate wants to act, the main question is whether dropping SAT scores caused large differences in retention and completion rates. The data suggests that it didn't. Vice Provost Kahler agrees.

Addressing a question about the current minimum GPA (which is 2.6, same as originally), the Provost noted that, with the current standards, a student with a GPA of 2.6 is directly admitted, whereas, in the former system, a student with a GPA of 2.7 would have not been directly



admitted if they had a low SAT score. So, the main question is: Are those students succeeding or do we need to be more careful with the group at the bottom?

**P3 Update** – Toni Broyles, Special Assistant to AVP Auxiliary, Cami McClure, Assistant Vice President, Auxiliary Services.

From campus-wide surveys, the issues that come up most frequently are pay, housing and childcare. With regard to housing, they are at the stage of research and analysis to provide recommendations. They are looking at housing for undergraduate (UG) students, graduate students (GS), married students with children (parenting housing), employees, and sometime in the future, retirees. They did an initial survey last year and one is on-going this year, for UG, GS, faculty and staff. The largest response rate is from employees. They are now pushing for a higher response. Toni asked to let students know about this feedback opportunity open to the entire campus.

Toni displayed a map showing the location of university housing. The “UG corridor” is where UG, and some GS, predominantly live. Apartment living is on the so-called “South Hill,” the older part built in the 1960s and the newer in the 1990s. Those buildings are old, parking is limited, and so is access to emergency services. Nothing has been decided, as they are at the stage of preliminary design of some reconfiguration. The average age of our buildings is 53 years. As a future R1 university, and to be among the 25 top public residential universities (a priority for President Green), we need suitable on-campus housing. The plan is to keep UG housing where it is, and keep the amenities, such as food services, in the UG corridor. Also, some separation between graduate housing and parenting housing is appropriate. Plans include a dedicated building for graduate and professional students. The university has recently procured the area where the Wells Fargo ATM used to be and some old railroad land nearby.

Units and departments work hard to bring the best faculty to campus, but when these new faculty come, they may not find suitable housing. It’s important to let them know that new faculty have at least one place to land when they first arrive. As part of their recruiting package, units/departments may consider showing to prospective faculty some of the apartments the university can make available as a landing place.

In summary, they are doing inventory and research analysis across the whole spectrum, from UG to Emeriti who wish to remain in contact with the university but seek a smaller, easy-maintenance residence.

Discussion:

To the question of our capacity, Toni replied that the final survey will provide more information. On the South Hill, there are probably 250 beds for graduate and professional students and 150 for parenting housing. The UG sector will require mostly renovation. There, we can add about 800 beds if needed. Furthermore, major employers in the area (SEL, Gritman, Pullman Regional) are experiencing similar problems when seeking to hire highly trained personnel who come to town but can’t find proper housing. Should we end up with more university housing than needed, renting living space to these local employers could be a source of revenue.

It was pointed out that extension students who come to the Moscow campus for a limited time also need a place to stay, in addition to housing in Southern Idaho. Toni responded that they are also considering setting aside space for visiting lecturers and extension people and for Study Abroad students.

A senator wondered whether establishing a relation with local “Airbnb” could help for short-term visitors. Toni replied that it could be an option (there 1,000 Airbnb in Moscow), but only for short-term living.

For any questions or feedback, reach out to Toni at [tonibroyles@uidaho.edu](mailto:tonibroyles@uidaho.edu)

**Chair's Report:**

- We just heard presentations about admissions and housing, which are important factors for the long-term evolution of the university. If the university grows, are we ready for more students? What kind of growth can we accommodate?
- These types of conversations reinforce the role of senate leadership as a place of dialog and shared governance. Please help us make our role more efficient and productive, by providing your feedback.

**Provost's Report:**

- 10<sup>th</sup> day data on Spring semester enrollment will be available next week.
- UI's legislative presentations begin this week and will take place over the next 1-2 months. This is a different schedule than previous year. Vice Provost for Faculty Diane Kelly-Riley sent a communication to standard pay faculty on 1/19/2024 about tentative deferred pay implementation. Please visit:

<https://www.uidaho.edu/provost/faculty/salary/deferred-pay>

**Discussion:**

A senator inquired whether deferred pay is a “done deal” as far as Faculty Senate involvement is concerned. The Provost responded that the implementation will likely require changes in FSH/APM and, thus, Senate will be involved. Implementation plans are ongoing and the President supports what's being done. As a follow-up, the senator suggested making this point clearer on the webpage.

**Changes to the Administrative Procedures Manual (non-voting):**

- APM 45.09 Effort Reporting and Personnel Activity Reports – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs.  
Change of our effort reporting system and process needed to be reflected in the APM – from PAR to Effort Reporting, with the use of Banner.  
**Discussion:**  
There was a suggestion to clarify the meaning of “Hatch, Smith-Lever” in section B.
- APM 45.10 Facilities and Administrative (Indirect) Rate – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs.  
Update for consistent format, to clarify statements and applicability for location and type, and change ‘Public Service/Outreach’ to ‘Other Sponsored Activity’ per our last F&A rate agreement.  
**Discussion:** None.
- APM 45.12 Sponsored Project Closeout and Recordkeeping Responsibilities – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs.  
Reformat to conform to standard APM style, clarify closeout and recordkeeping processes due to shift to electronic record keeping and other system changes. Mostly, changing nomenclature and formatting.  
**Discussion:** None.
- APM 45.15 Subawards and Subcontracts – Sarah Martonick, Director, Office of Sponsored Programs, Office of Research Assurances, Heather Clark, Accounting Manager II, Office of Sponsored Programs.

Clarification of the subaward request and issuance process to include new requirements and processes. No substantial changes in responsibilities, monitoring, or timelines. Adding 2 CFR 200 in place of the A-121 and A-133 references, and formatting to standard APM format.

Discussion: None.

- APM 95.21 University Closures – Shane Keen, Clery Compliance Officer, Public Safety and Security.

Comprehensive review. Language clarified throughout.

Discussion: None.

### **Announcements and Communications, Part 2:**

- FY24 CEC Summary – Kim Salisbury, Associate Vice President, Budget and Planning, DFA Budget and Planning.

Kim displayed a slide showing a summary of FY24 CEC. She went over the breakdown of the Gen Ed budget into various categories – across the board to address inflation, bring salaries up to 80% of target, merit funds, promotion and tenure increments, etc. The table also shows overall increase in salary over FY23; total merit increases; average starting percentage, average increase percentage, and average final percentage of target; number of CEC eligible and CEC non-eligible employees; number of employees receiving merit increases; number of employees brought up to 80% of target; number of eligible employees still below 80% of target.

**The slide with the detailed data is attached to these minutes.**

Discussion:

Kim explained how the \$600 for across-the-board increases came to be. Working backwards from the total Gen Ed budget, they addressed priorities such as raising salaries to 80% of target, then met other Gen Ed obligations. What was left, in steps of \$100, amounted to \$600 per FTE. Provost Torrey added that this year a percentage increase was recommended, rather than a flat number for all eligible employees.

Clarification was asked about the group of eligible employees still below 80% of the target. This is due to grant funding in a small number of areas.

- Parking – Steve Mills, Director, Parking and Transportation Services.

Availability: One of the aspects that senators wanted to discuss is the reason why in the Greek housing area, (Blake, Taylor, Sweet and 7<sup>th</sup>), all parking permits are purple or magenta. This is to provide parking to students who bring a car to campus. Some students also use the gravel area west of the Kibbie Dome.

The second question was about the cost and how it is determined: Since 2009, our parking permits have gone up about 40%, which is consistent with the nationwide increase, and less than 72% of the universities that they looked up.

Discussion:

Why not adopt a sliding scale, where the cost of the permit is commensurate to one's salary? Steve does not see this as an equitable solution. The university salary may be only one source of an individual's income. Also, with income-based permit costs, more employees will be able to purchase gold permits, which will create additional problems. Eventually, with this model, parking would become underfunded. Lots are very expensive to maintain.

Why should we pay for parking at all? Most employers provide parking. Vice President Foisy addressed this question. Parking must be a fully self-sustained, auxiliary operation by SB mandate. No Gen Ed funds can go into it.

Moscow is walkable and there is public transportation to campus, but what about people who live outside of Moscow? Are students promised a parking spot if they have a car on campus?

Yes, they are, although -- Dean of Students Blaine Eckles added -- it's a challenge. They discourage students from bringing a car to campus.

The presentations on Computing Resources Available for Research, and the Report from the Ubuntu Committee were postponed due to the late hour.

**New Business:**

None.

**Adjournment:**

The agenda not being completed, the Chair called for a motion to adjourn. So moved (Tibbals, Mittelstaedt). The meeting was adjourned at 5:02pm.

Respectfully Submitted,

Francesca Sammaruca  
Secretary of the University Faculty & Secretary to Faculty Senate



University  
of Idaho

# UNDERGRADUATE ADMISSION STANDARDS

INSTITUTIONAL RESEARCH

# 22-23 CATALOG ADMISSION STANDARDS



1. Submit ACT or SAT scores if available. New first-year students entering in 2022 or 2023 who are unable to sit for an ACT or SAT exam due to COVID-19 will automatically be considered for admission if their cumulative unweighted GPA is 2.60-4.00. Those who have cumulative GPAs of 2.30 - 2.59 who are unable to sit for an exam will be admitted through the [Vandal Gateway Program](#). Students in this GPA range are also welcome to appeal through our [Admissions Committee](#). **Every student who has a test score is encouraged to provide it for admission as well as class placement.**
2. Graduate from a regionally accredited high school with a combination of cumulative GPA<sup>1</sup> and test scores<sup>2</sup> as defined in the following table:

High School GPA	ACT Composite	SAT Evidence-Based Reading & Writing + Math (SAT taken March 2016 and after)	SAT Critical Reading + Math (SAT taken prior to March 2016)
3.00 - 4.00	Any test score	Any test score	Any test score
2.60 - 2.99	Any test score	Any test score	Any test score
2.50 - 2.59	17 - 36	910-1600	830-1600
2.40 - 2.49	19 - 36	990-1600	910-1600
2.30 - 2.39	21 - 36	1070-1600	990-1600
2.20 - 2.29	23 - 36	1140-1600	1070-1600

# 22-23 CATALOG ADMISSION STANDARDS



**I** Either achieve a 2.6+ High School GPA or obtain a lower GPA with a increasing, sliding scale test score

**I** The vast majority of incoming new frosh have a 2.6 High School GPA or better

High School GPA	ACT Composite	SAT Evidence
3.00 - 4.00	Any test score	Any test score
2.60 - 2.99	Any test score	Any test score
2.50 - 2.59	17 - 36	910-1600
2.40 - 2.49	19 - 36	990-1600
2.30 - 2.39	21 - 36	1070-1600
2.20 - 2.29	23 - 36	1140-1600

Fall Term	Frosh Cohort Total	No ACT / SAT	Pct No Test	Had HS GPA 2.6+	Had 2.6+ (%)
201510 - Fall 2015	1587	43	3%	1495	94%
201610 - Fall 2016	1660	28	2%	1540	93%
201710 - Fall 2017	1537	37	2%	1431	93%
201810 - Fall 2018	1434	19	1%	1330	93%
201910 - Fall 2019	1475	19	1%	1378	93%
202010 - Fall 2020	1425	20	1%	1334	94%
202110 - Fall 2021	1656	474	29%	1571	95%
202210 - Fall 2022	1951	606	31%	1808	93%
202310 - Fall 2023	1869	715	38%	1732	93%



# RETENTION BY HIGH SCHOOL GPA

High School GPA	STATUS	Fall 2020		Fall 2021		Fall 2022	
		N	Retention Pct	N	Retention Pct	N	Retention Pct
	GONE	8		14		15	
	HERE	22	73%	18	56%	47	76%
[3.00 - 4.00)	GONE	249		314		372	
[3.00 - 4.00)	HERE	905	78%	1056	77%	1239	77%
[2.60 - 3.00)	GONE	85		97		83	
[2.60 - 3.00)	HERE	95	53%	104	52%	114	58%
[2.50 - 2.60)	GONE	9		12		9	
[2.50 - 2.60)	HERE	12	57%	9	43%	13	59%
[2.40 - 2.50)	GONE			5		16	
[2.40 - 2.50)	HERE			10	67%	16	50%



# RETENTION BY HIGH SCHOOL GPA



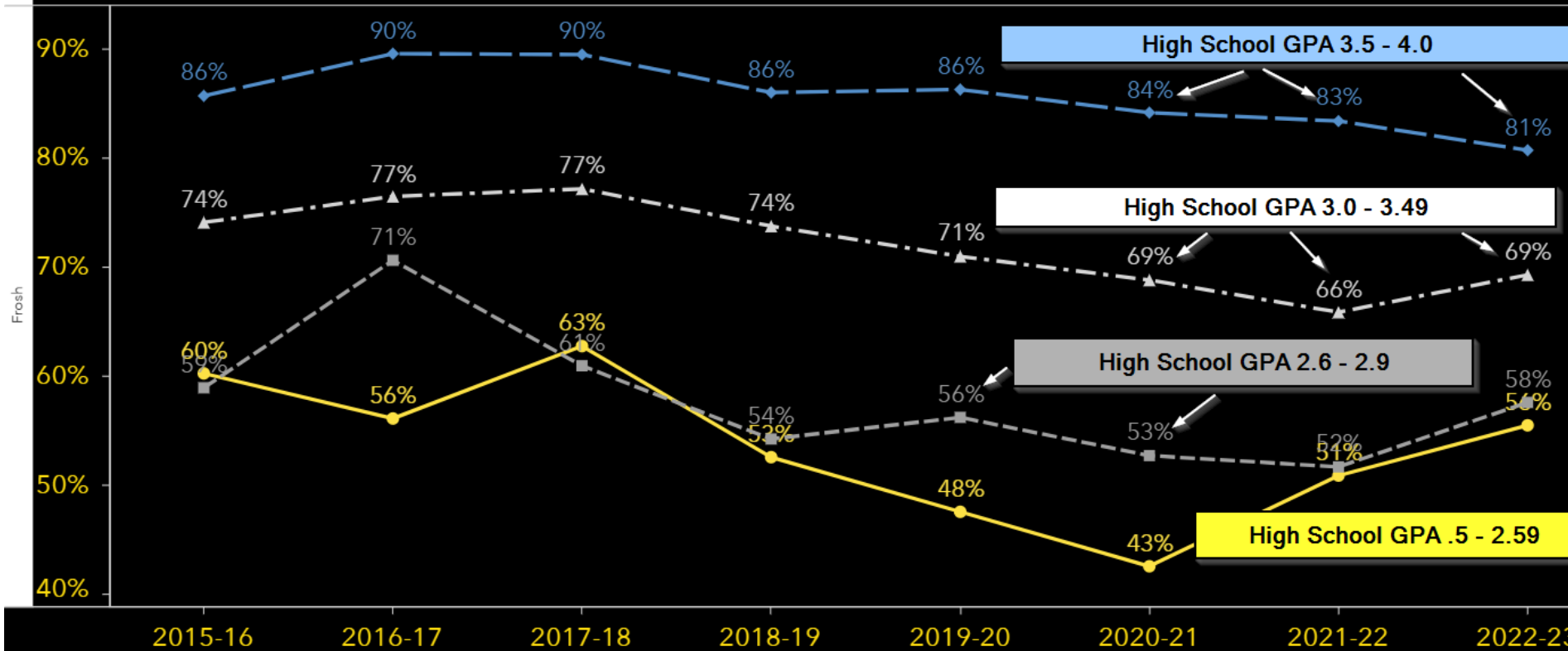
(HIGHER HIGH SCHOOL GPA ASSOCIATED WITH HIGHER RETENTION)

## New Freshman Retention by High School GPA

All UI - STUD\_TYPE > University of Idaho

STUD\_TYPE

Freshman Percent





# RETENTION BY HIGH SCHOOL GPA

(HIGHER HIGH SCHOOL GPA ASSOCIATED WITH HIGHER RETENTION)

Fall Term	Frosh Cohort Total	Overall Retained	Overall Retained (%)	Retention HS GPA 3.0+	Retention HS GPA [2.6-3.0]
201510 - Fall 2015	1587	1218	77%	81%	59%
201610 - Fall 2016	1660	1343	81%	84%	71%
201710 - Fall 2017	1537	1227	80%	85%	61%
201810 - Fall 2018	1434	1089	76%	81%	54%
201910 - Fall 2019	1475	1123	76%	81%	56%
202010 - Fall 2020	1425	1048	74%	78%	53%
202110 - Fall 2021	1656	1205	73%	77%	52%
202210 - Fall 2022	1951	1445	74%	77%	58%
202310 - Fall 2023	1869	<i>Not Available Yet</i>			



# RETENTION BY HIGH SCHOOL GPA

	Retention - Returning One Year Out / Fall-to-Fall								
High School GPA	Fall 2015	Fall 2016	Fall 2017	Fall 2018	Fall 2019	Fall 2020	Fall 2021	Fall 2022	
[3.00 - 4.00)	81%	84%	85%	81%	81%	78%	77%	77%	
[2.60 - 3.00)	59%	71%	61%	54%	56%	53%	52%	58%	

**FY24 CEC SUMMARY**

**Snapshot as of 05.18.2023**

	Staff GenEd	Staff GenEd	Non-Staff Total	Faculty GenEd	Faculty GenEd	Non-Faculty Total	GenEd Total	Non-GenEd Total	Grand Total	Staff % of Total	Faculty % of Total
FY24 Target Salary	\$ 47,763,716	\$ 44,172,405	\$ 91,936,121	\$ 48,478,160	\$ 23,963,002	\$ 72,441,162	\$ 96,241,876	\$ 68,135,407	\$ 164,377,282	55.93%	44.07%
Pre-CEC Salary	\$ 42,030,925	\$ 44,401,786	\$ 86,432,711	\$ 43,599,797	\$ 22,577,863	\$ 66,177,660	\$ 85,630,722	\$ 66,979,649	\$ 152,610,371	56.64%	43.36%
Across the Board Increase \$600 per 1 FTE	\$ 397,537	\$ 475,568	\$ 873,104	\$ 286,895	\$ 153,665	\$ 440,559	\$ 684,431	\$ 629,232	\$ 1,313,664	66.46%	33.54%
Up to Minimum Classified/Exempt Minimums	\$ 120,725	\$ 79,669	\$ 200,394	\$ -	\$ 1,336	\$ 1,336	\$ 120,725	\$ 81,005	\$ 201,730	99.34%	0.66%
Up to 80% of Target	\$ 477,432	\$ 189,625	\$ 667,057	\$ 102,019	\$ 35,285	\$ 137,304	\$ 579,451	\$ 224,910	\$ 804,361	82.93%	17.07%
Merit Pool Funds	\$ 506,427	\$ -	\$ 506,427	\$ 459,765	\$ -	\$ 459,765	\$ 966,192	\$ -	\$ 966,192	52.41%	47.59%
Promotion and Tenure Increments	\$ -	\$ -	\$ -	\$ 178,940	\$ 272,283	\$ 451,224	\$ 178,940	\$ 272,283	\$ 451,224	0.00%	100.00%
University-Wide CEC	\$ 1,502,120	\$ 744,862	\$ 2,246,982	\$ 1,027,620	\$ 462,568	\$ 1,490,188	\$ 2,529,740	\$ 1,207,430	\$ 3,737,171	60.13%	39.87%
Additional Unit Funded Non-Merit	\$ 267,234	\$ 667,503	\$ 934,736	\$ 185,654	\$ 364,876	\$ 550,530	\$ 452,888	\$ 1,032,379	\$ 1,485,266	62.93%	37.07%
Additional Unit-Funded Merit	\$ 74,262	\$ 386,022	\$ 460,284	\$ 53,382	\$ 260,589	\$ 313,971	\$ 127,644	\$ 646,611	\$ 774,255	59.45%	40.55%
Additional Unit-Funded Increases	\$ 341,495	\$ 1,053,525	\$ 1,395,020	\$ 239,036	\$ 625,465	\$ 864,501	\$ 580,531	\$ 1,678,989	\$ 2,259,521	61.74%	38.26%
<b>Total CEC Investment in Salaries</b>	<b>\$ 1,843,616</b>	<b>\$ 1,798,387</b>	<b>\$ 3,642,002</b>	<b>\$ 1,266,656</b>	<b>\$ 1,088,033</b>	<b>\$ 2,354,689</b>	<b>\$ 3,110,272</b>	<b>\$ 2,886,420</b>	<b>\$ 5,996,691</b>	<b>60.73%</b>	<b>39.27%</b>
Final FY24 Base Salary	\$ 43,835,374	\$ 46,240,342	\$ 90,075,716	\$ 44,955,370	\$ 23,582,009	\$ 68,537,379	\$ 88,790,744	\$ 69,822,350	\$ 158,613,094	56.79%	43.21%
Overall Increase in Salary over FY23	4.29%	4.14%	4.21%	3.11%	4.45%	3.57%	3.69%	4.24%	3.93%		
Total Merit Increases (Pool + Unit Funds)	\$ 580,689	\$ 386,022	\$ 966,711	\$ 513,148	\$ 260,589	\$ 773,736	\$ 1,093,836	\$ 646,611	\$ 1,740,447	55.54%	44.46%
Starting Average % of Target			89.72%			92.41%			90.66%		
Average Increase as % of Target			3.87%			3.34%			3.69%		
Final Average % of Target			93.59%			95.75%			94.34%		
# Eligible Employees			1475			737			2,212	66.68%	33.32%
# Employees Not Eligible for CEC			112			27			139		
# Employees Brought up to 80% of Target			184			41			225	81.78%	18.22%
# Employees Receiving Merit			507 34.4%			340 46.1%			847 38.3%	59.86%	40.14%
# Eligible Still Below 80% of Target Due to Funding			14			2			16	87.50%	12.50%

Calculations do not include employees ineligible for CEC or the President (SBOE determines)

# 508: MICROELECTRONICS FABRICATION

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## In Workflow

1. 129 Chair (joel@uidaho.edu)
2. 08 Curriculum Committee Chair (gabriel@uidaho.edu)
3. 08 Dean (gabriel@uidaho.edu; long@uidaho.edu)
4. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
5. Degree Audit Review (rfrost@uidaho.edu)
6. Registrar's Office (none)
7. Ready for UCC (disable)
8. UCC (none)
9. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
10. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
11. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
12. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
13. Catalog Update (sbeal@uidaho.edu)

## Approval Path

1. Thu, 07 Sep 2023 16:02:24 GMT  
Joseph Law (joel): Approved for 129 Chair
2. Fri, 22 Sep 2023 16:10:59 GMT  
Gabriel Potirniche (gabriel): Approved for 08 Curriculum Committee Chair
3. Fri, 22 Sep 2023 16:19:14 GMT  
Suzanna Long (long): Approved for 08 Dean
4. Tue, 03 Oct 2023 00:36:27 GMT  
Linda Lundgren (lindalundgren): Rollback to Initiator
5. Tue, 24 Oct 2023 19:38:37 GMT  
Joseph Law (joel): Approved for 129 Chair
6. Tue, 24 Oct 2023 20:18:43 GMT  
Gabriel Potirniche (gabriel): Approved for 08 Curriculum Committee Chair
7. Tue, 24 Oct 2023 20:19:30 GMT  
Gabriel Potirniche (gabriel): Approved for 08 Dean
8. Sat, 04 Nov 2023 23:28:09 GMT  
Gwen Gorzelsky (gwen): Approved for Provost's Office
9. Thu, 21 Dec 2023 19:54:33 GMT  
Rebecca Frost (rfrost): Approved for Degree Audit Review
10. Wed, 10 Jan 2024 19:44:56 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
11. Tue, 16 Jan 2024 20:11:08 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
12. Tue, 23 Jan 2024 18:49:38 GMT  
Sydney Beal (sbeal): Approved for UCC

## New Program Proposal

Date Submitted: Wed, 04 Oct 2023 02:12:33 GMT

**Viewing: 508 : Microelectronics Fabrication**

**Last edit: Tue, 23 Jan 2024 18:49:28 GMT**

Changes proposed by: Feng Li

### Faculty Contact

Faculty Name	Faculty Email
Feng Li	fengli@uidaho.edu

Will this request have a fiscal impact of \$250K or greater?

No

**Academic Level**

Undergraduate

**College**

Engineering

**Department/Unit:**

Electrical &amp; Computer Engr

**Effective Catalog Year**

2024-2025

**Program Title**

Microelectronics Fabrication

**Degree Type**

Certificate

Please note: Majors and Certificates over 30 credits need to have a state form approved before the program can be created in Curriculum.

**Program Credits**

12

**CIP Code**

14.1099 - Electrical, Electronics and Communications Engineering, Other.

**Will the program be Self-Support?**

No

**Will the program have a Professional Fee?**

No

**Will the program have an Online Program Fee?**

No

**Will this program lead to licensure in any state?**

No

**Will the program be a statewide responsibility?**

No

**Financial Information****What is the financial impact of the request?**

Less than \$250,000 per FY

**Note: If financial impact is greater than \$250,000, you must complete a Program Proposal Form**

**Curriculum:**

All required coursework must be completed with a grade of C or better (O-10-a (<https://catalog.uidaho.edu/general-requirements-academic-procedures/o-miscellaneous/>)).

Code	Title	Hours
ECE 465	Introduction to Microelectronics Fabrication	3
Select one of the following:		3
ECE 460	Semiconductor Devices	
PHYS 464	Solid State Physics	
Select two from the following (must be different from the core course chosen):		6-7
CHE 455	Surfaces and Colloids	
ECE 418	Introduction to Electronic Packaging	
ECE 460	Semiconductor Devices	
ME 458	Finite Element Applications in Engineering	

MSE 423	Corrosion
MSE 432	Fundamentals of Thin Film Fabrication
PHYS 411	Advanced Physics Lab
PHYS 443	Optics
PHYS 464	Solid State Physics
STAT 301	Probability and Statistics

**Total Hours**

**12-13**

**Courses to total 12 credits for this certificate**

### **Distance Education Availability**

To comply with the requirements of the Idaho State Board of Education (SBOE) and the Northwest Commission on Colleges and Universities (NWCCU) the University of Idaho must declare whether 50% or more of the curricular requirements of a program which may be completed via distance education.

**Can 50% or more of the curricular requirements of this program be completed via distance education?**

Yes

**If Yes, can 100% of the curricular requirements of this program be completed via distance education?**

No

Note: Existing programs transitioning from less than 50% of its curricular requirements to 50% or more of its requirements being available via distance education is considered a Group B change and must complete the program proposal formwork before these changes will be processed.

### **Geographical Area Availability**

**In which of the following geographical areas can this program be completed in person?**

Moscow

### **Student Learning Outcomes**

**List the intended learning outcomes for program component. Use learner centered statements that indicate what will students know, be able to do, and value or appreciate as a result of completing the program.**

1. an ability to identify, formulate, and solve microelectronics fabrication problems by applying principles of engineering, science, and mathematics.
2. an ability to communicate effectively on topics related to microelectronics fabrication concepts and technologies with a range of audiences.
3. an ability to develop and conduct appropriate microelectronic fabrication experimentation, analyze and interpret data, and use engineering judgment to draw conclusions about microelectronics fabrication.

Overall, these learning outcomes demonstrate that students who have completed a certificate in microelectronics fabrication have acquired the knowledge, skills, and abilities necessary to succeed in various fields of the microelectronics fabrication industry. The students are well-prepared to pursue further education or employment in the microelectronics fabrication field.

**Describe the assessment process that will be used to evaluate how well students are achieving the intended learning outcomes of the program component.**

The assessment process for the certification in microelectronics fabrication will involve regular course evaluations of the course syllabus and student work. This will provide the departments with insight into the students' knowledge in microelectronics fabrication and/or related fields. The summary of the course evaluation and student work will be shared with an outside entity, specifically a representative from the industry and electrical and computer engineering advisory board. The feedback from the industry partner and industry advisory board help in evaluating the students learning outcome and program component.

**How will you ensure that the assessment findings will be used to improve the program?**

Course syllabus and student evaluation will be reviewed each semester, and course content will be adjusted as necessary. The annual assessment feedback from the industry partner and department advisory boards will be reviewed by the departments, and the required refinement to the syllabus will be done on an annual basis. An important aspect of these classes is the ability of the students to learn about microelectronics fabrication related topics therefore, the content taught in the class will be evolving on an ongoing basis.

**What direct and indirect measures will be used to assess student learning?**

Exams, assignments, and/or class projects will be required for all the relevant classes and graded on a regular basis. In the selected required courses, an oral exam of the students will be required at the end of the class to evaluate student learning.

### **When will assessment activities occur and at what frequency?**

The size and scope of this program dictate that we will collect the assessment data during the courses and the survey data each semester. Every fall semester, the departments and curriculum committees will evaluate the students' assessment, industry partners, and advisory boards feedback and take corrective actions if necessary.

## **Student Learning Outcomes**

### **Learning Objectives**

1. an ability to identify, formulate, and solve microelectronics fabrication problems by applying principles of engineering, science, and mathematics.
2. an ability to communicate effectively on topics related to microelectronics fabrication concepts and technologies with a range of audiences.
3. an ability to develop and conduct appropriate microelectronic fabrication experimentation, analyze and interpret data, and use engineering judgment to draw conclusions about microelectronics fabrication.

Overall, these learning outcomes demonstrate that students who have completed a certificate in microelectronics fabrication have acquired the knowledge, skills, and abilities necessary to succeed in various fields of the microelectronics fabrication industry. The students are well-prepared to pursue further education or employment in the microelectronics fabrication field.

**A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any.**

The certificate in microelectronics fabrication is designed to provide students with specialized knowledge and skills in the field of microelectronics fabrication. This certificate program is intended to prepare students for careers in the microelectronics fabrication industry or related fields, as well as future graduate studies in the field of microelectronics fabrication.

The departments currently offer these proposed courses required for the microelectronics fabrication certificate, and these courses already have the required materials needed for the certification. Furthermore, we plan to add extra emphasis to microelectronics fabrication-related topics in the homework assignments, class example problems, and discussion sessions to elucidate design and engineering principles in the microelectronics fabrication and related fields. Therefore, we anticipate that the proposed certificate program will not add additional workload to the departments.

### **Supporting Documents**

508 Program Description.pdf

### **Reviewer Comments**

**Linda Lundgren (lindalundgren) (Mon, 02 Oct 2023 17:31:39 GMT):** 10/2/23: Per Dr. Li, the answer to self-support is no, so I changed the answer from yes to no.

**Linda Lundgren (lindalundgren) (Mon, 02 Oct 2023 18:11:31 GMT):** 5/2/23: LL uploaded program description emailed to her by Dr. Li.

**Linda Lundgren (lindalundgren) (Tue, 03 Oct 2023 00:36:05 GMT):** 10/2/23: Rolled back to Dr. Li to correct student learning outcomes so they match.

**Linda Lundgren (lindalundgren) (Tue, 03 Oct 2023 00:36:28 GMT):** Rollback: Dr. Li: Please correct student learning outcomes so that they match. Linda Lundgren

**Rebecca Frost (rfrost) (Thu, 21 Dec 2023 19:54:27 GMT):** Curriculum edited to catalog format. Original entry will need to be removed upon format confirmation.

Key: 508



## **Program Description**

### **Microelectronics Fabrication**

This certificate ensures undergraduate senior students know the basic microelectronic device structures and fabrication processes. This certificate is open to undergraduate students in Electrical Engineering, Computer Engineering, Mechanical Engineering, Chemical Engineering, Physics, and other related disciplines.

# 549: MASTER OF SCIENCE IN GERONTOLOGY

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## In Workflow

1. 276 Chair (mcmurtry@uidaho.edu)
2. 20 Curriculum Committee Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
3. 20 Dean (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
4. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
5. Degree Audit Review (rfrost@uidaho.edu)
6. Graduate Council Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
7. Registrar's Office (none)
8. Ready for UCC (disable)
9. UCC (none)
10. Post-UCC Registrar (none)
11. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
12. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
13. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
14. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
15. Theodore Unzicker (tunzicker@uidaho.edu)

## Approval Path

1. Thu, 12 Oct 2023 20:47:25 GMT  
Tyler Bland (tbland): Approved for 471 Chair
2. Thu, 12 Oct 2023 21:53:27 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Curriculum Committee Chair
3. Thu, 12 Oct 2023 21:53:50 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Dean
4. Fri, 13 Oct 2023 00:19:48 GMT  
Linda Lundgren (lindalundgren): Rollback to 22 Dean for Provost's Office
5. Fri, 13 Oct 2023 15:08:33 GMT  
Sydney Beal (sbeal): Rollback to 471 Chair for 22 Dean
6. Fri, 13 Oct 2023 15:33:05 GMT  
Tyler Bland (tbland): Rollback to Initiator
7. Fri, 13 Oct 2023 16:40:09 GMT  
Sydney Beal (sbeal): Approved for 471 Chair
8. Fri, 13 Oct 2023 16:40:20 GMT  
Sydney Beal (sbeal): Approved for 22 Curriculum Committee Chair
9. Fri, 13 Oct 2023 16:40:26 GMT  
Sydney Beal (sbeal): Approved for 22 Dean
10. Fri, 27 Oct 2023 22:15:09 GMT  
Linda Lundgren (lindalundgren): Rollback to 471 Chair for Provost's Office
11. Mon, 30 Oct 2023 15:28:03 GMT  
Tyler Bland (tbland): Approved for 471 Chair
12. Mon, 30 Oct 2023 19:19:31 GMT  
Jeffrey Seegmiller (jeffreys): Rollback to 471 Chair for 22 Curriculum Committee Chair
13. Mon, 30 Oct 2023 19:22:28 GMT  
Tyler Bland (tbland): Approved for 471 Chair
14. Mon, 30 Oct 2023 19:24:27 GMT  
Jeffrey Seegmiller (jeffreys): Rollback to 471 Chair for 22 Curriculum Committee Chair
15. Mon, 30 Oct 2023 19:25:28 GMT  
Tyler Bland (tbland): Rollback to Initiator
16. Thu, 07 Dec 2023 18:07:29 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
17. Thu, 07 Dec 2023 18:09:14 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
18. Thu, 07 Dec 2023 18:24:55 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
19. Sat, 09 Dec 2023 01:28:09 GMT

- Gwen Gorzelsky (gwen): Approved for Provost's Office
20. Thu, 21 Dec 2023 20:04:32 GMT  
Rebecca Frost (rfrost): Approved for Degree Audit Review
  21. Thu, 21 Dec 2023 20:31:32 GMT  
Jerry McMurtry (mcmurtry): Approved for Graduate Council Chair
  22. Tue, 16 Jan 2024 21:09:54 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
  23. Wed, 17 Jan 2024 16:16:41 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
  24. Tue, 23 Jan 2024 22:44:56 GMT  
Sydney Beal (sbeal): Approved for UCC
  25. Thu, 25 Jan 2024 16:54:14 GMT  
Sydney Beal (sbeal): Approved for Post-UCC Registrar

### New Program Proposal

Date Submitted: Thu, 07 Dec 2023 18:06:56 GMT

**Viewing: 549 : Master of Science in Gerontology**

**Last edit: Thu, 25 Jan 2024 16:34:31 GMT**

Changes proposed by: Whitney Vincent

#### Faculty Contact

Faculty Name	Faculty Email
Thomas J. Farrer, PhD	tfarrer@uidaho.edu

**Will this request have a fiscal impact of \$250K or greater?**

No

#### Academic Level

Graduate

#### College

Graduate Studies

#### Department/Unit:

Graduate Studies

#### Effective Catalog Year

2025-2026

#### Program Title

Master of Science in Gerontology

#### Degree Type

Major

Please note: Majors and Certificates over 30 credits need to have a state form approved before the program can be created in Curriculum.

#### Program Credits

30

#### Attach Program Change

Gerontology\_Budget-Proposal-Form\_final\_9-16-2021-1 (1).xlsx  
SBOE Gerontology-Proposal\_Form\_FINAL.pdf

#### CIP Code

30.1101 - Gerontology.

**Will the program be Self-Support?**

Yes

**Will the program have a Professional Fee?**

No

**Will the program have an Online Program Fee?**

No

**Will this program lead to licensure in any state?**

No

**Will the program be a statewide responsibility?**

No

## Financial Information

**What is the financial impact of the request?**

Less than \$250,000 per FY

**Note: If financial impact is greater than \$250,000, you must complete a Program Proposal Form**

### Describe the financial impact

Based on feedback from policymakers and Idaho business leaders, our request is dedicated to addressing healthcare workforce needs associated with the aging population, one of the most pressing issues the state is facing today. We acknowledge the importance of flexibility to adapt to evolving challenges and workforce needs of the future.

The primary beneficiaries, if this program request is granted, are the individuals and communities who will be served by these future gerontologists. Thus, the impact could encompass all of Idaho.

### Curriculum:

#### 1. Required:

- a. GERO 5xx: Theoretic foundations and introduction to gerontology: Examines historical developments of the field of gerontology from a multidisciplinary perspective and how gerontology fits into the health and social service landscape. Introduction to theories and critical issues of aging.
- b. GERO 5xx: Research methods in Gerontology: research, data analysis, research report. Subject matter will include ethics, sampling, reliability and validity, hypothesis testing, study designs, dissemination of research findings, and critical appraisal of research, with a central requirement of designing and writing a study proposal.
- c. GERO 6xx: Biological aspects of Aging: Theory and science of senescence and longevity, focusing on normal aging versus pathological changes to health status in the aging processes.
- d. GERO 6xx: Mental and Cognitive health in aging: Covers the complex topic of psychological health in aging, evidence-based interventions (first half of term) as well as cognitive aging and dementia (second half of term).
- e. GERO 6xx: Health promotion and preventative care in aging: Founded on principles of health education and promotion, the course covers evidence-based factors that reduce age-related injuries and illnesses and how to promote behavioral change, focusing on maximizing quality of life.
- f. GERO 6xx: Diversity and ethics in aging: This course covers a wide range of topics related to culture and diversity, focusing on social determinants of health, health culture in aging, historical factors that have shaped culture and diversity in the aging US population, and covers rights and safety of vulnerable populations (ADA law and other elder law principles).
- g. GERO 6xx: Integrative Capstone: Requires a faculty sponsor to direct a capstone project. This may include a service-based project, program development or review, research experience, and another field experience as appropriate and approved by the faculty sponsor. Students will demonstrate the integration of gerontology content from didactics.

#### 2. Electives:

- a. GERO 6xx: Community-Engagement and Leisure Arts in Aging: Interdisciplinary approaches to recreational therapy and leisure accessibility in aging and how engagement promotes physical and mental health in aging.
- b. GERO 6xx: The Business of Geriatric Care Management: Reviews business and ethical fundamentals of geriatric care management across multiple levels of care, from independent living communities to intensive long-term care models.
- c. GERO 6xx: Program Development and Evaluation for Aging: Examine components of successful program development, implementation science, identification of and involvement of stakeholders, fundraising, grant writing, and the processes of evaluation program outcomes.
- d. Rural Health and Aging: Survey course of the application of healthy aging and health intervention limitations in rural settings.
- e. Seminar on Aging in the Arts: How aging is accurately and inaccurately depicted in media and arts.

## Distance Education Availability

To comply with the requirements of the Idaho State Board of Education (SBOE) and the Northwest Commission on Colleges and Universities (NWCCU) the University of Idaho must declare whether 50% or more of the curricular requirements of a program which may be completed via distance education.

**Can 50% or more of the curricular requirements of this program be completed via distance education?**

Yes

**If Yes, can 100% of the curricular requirements of this program be completed via distance education?**

Yes

Note: Existing programs transitioning from less than 50% of its curricular requirements to 50% or more of its requirements being available via distance education is considered a Group B change and must complete the program proposal formwork before these changes will be processed.

## **Geographical Area Availability**

**In which of the following geographical areas can this program be completed in person?**

Online Only

## **Student Learning Outcomes**

**List the intended learning outcomes for program component. Use learner centered statements that indicate what will students know, be able to do, and value or appreciate as a result of completing the program.**

Learning outcomes are structured based on the Academy for Gerontology in Higher Education (AGHE) expected competencies in gerontology. These profession-wide competencies are expected of all graduates and are partially demonstrated via:

- Coursework: Students will obtain a grade of B or higher.
- Other didactics: Capstone Project in gerontology

The AGHE offers competencies for graduate-level education in gerontology in three categories. These include the following:

1. Category 1 - Core competencies (expected of all programs)
  - a. Frameworks for understanding human aging (e.g., developmental perspectives).
  - b. Biological aspects of aging.
  - c. Psychological aspects of aging.
  - d. Social aspects of aging.
  - e. The humanities and aging
  - f. Research and Critical Thinking.
2. Category 2 - Interactional Competencies (should be broadly represented):
  - a. Attitudes and perspectives: Developing a gerontological perspective
  - b. Ethics and Professional Standards
  - c. Communication with and on behalf of older persons.
  - d. Interdisciplinary and community collaboration
3. Category 3 – Contextual Competencies Across Fields of Gerontology
  - a. Well-being, health and mental health.
  - b. Social Health
  - c. Program/service development
  - d. Arts and Humanities
  - e. Business and finances
  - f. Policy
  - g. Research, application, and evaluation

Based on these competencies, student learning outcomes will include the following:

- Students will be able to identify and explain developmental perspectives associated with aging.
- Students will be able to compare and contrast biological and psychosocial aspects of aging and apply this knowledge in health and human service settings to have a positive impact on the health of older adults.
- Develop comprehensive and meaningful concepts, definitions, and measures for well-being of older adults.
- Students will be able to critically analyze ethical and professional standards in gerontology.
- Students will demonstrate effective communication skills through their interactions with older adults and they will demonstrate knowledge of community resources related to the health and well-being of older adults.
- Develop a gerontological perspective through knowledge and self-reflection as achieved through class discussions and group assignments.
- Students will demonstrate the ability to collaborate with others to promote integrated approaches to aging. Achieved via class work, group projects, and capstone projects.
- Students will promote quality of life among older adults. They will also promote older individual's strengths to maximize well-being, health, and mental health, including promoting engagement in the arts and the community.
- Students will demonstrate knowledge of the science of gerontology via class work on research methods and via writing projects that require integration of empirical literature. The capstone project may include a research project.

### **Describe the assessment process that will be used to evaluate how well students are achieving the intended learning outcomes of the program component.**

To evaluate how well students are achieving the intended learning outcomes, the following assessment processes will be employed:

1. Examinations and Quizzes: Regular assessments will include written examinations and quizzes to evaluate knowledge acquisition and critical thinking skills.
2. Clinical Skills Assessment: Clinical skills will be assessed through direct observation, practical examinations, and skills checklists during clinical rotations.
3. Case Studies and Care Plans: Students will complete case studies and care plans to demonstrate their ability to apply theoretical knowledge to real-world patient care scenarios.
4. Reflective Journals and Portfolios: Students will maintain reflective journals and e-portfolios, providing insights into their personal and professional growth.
5. Peer and Self-Assessment: Peer evaluations and self-assessment will be incorporated for group projects and personal reflection on skills development.

### **How will you ensure that the assessment findings will be used to improve the program?**

1. Faculty Meetings: Regular faculty meetings will involve discussions of assessment results, with a focus on identifying areas of improvement and refining teaching methods and curriculum.
2. Curriculum Review: Assessment data will inform curriculum revisions, ensuring alignment with current healthcare trends and best practices.
3. Faculty Development: Faculty will receive training and support to enhance assessment techniques and teaching strategies, addressing areas where student performance needs improvement.
4. Feedback Loops: Continuous feedback loops will be established with students, incorporating their input to make program enhancements.

### **What direct and indirect measures will be used to assess student learning?**

Direct measures include examinations, skills assessments, case studies, and practical evaluations. Indirect measures include student surveys, feedback from instructors, and analysis of retention and graduation rates.

### **When will assessment activities occur and at what frequency?**

Assessment activities will occur throughout the program at various frequencies:

- Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.
- Summative assessments (midterm, final examinations) will occur at the end of relevant courses and following year one and year two. Alumni and industry surveys will be completed two years following graduation.
- Clinical skills assessments and evaluations will be conducted during clinical rotations.
- Case studies, care plans, and projects will be assigned periodically.

## **Student Learning Outcomes**

### **Learning Objectives**

Learning outcomes are structured based on the Academy for Gerontology in Higher Education (AGHE) expected competencies in gerontology.

These profession-wide competencies are expected of all graduates and are partially demonstrated via:

- Coursework: Students will obtain a grade of B or higher.
- Other didactics: Capstone Project in gerontology

The AGHE offers competencies for graduate-level education in gerontology in three categories. These include the following:

1. Category 1 - Core competencies (expected of all programs)
  - a. Frameworks for understanding human aging (e.g., developmental perspectives).
  - b. Biological aspects of aging.
  - c. Psychological aspects of aging.
  - d. Social aspects of aging.
  - e. The humanities and aging
  - f. Research and Critical Thinking.
2. Category 2 - Interactional Competencies (should be broadly represented):
  - a. Attitudes and perspectives: Developing a gerontological perspective
  - b. Ethics and Professional Standards
  - c. Communication with and on behalf of older persons.
  - d. Interdisciplinary and community collaboration
3. Category 3 – Contextual Competencies Across Fields of Gerontology
  - a. Well-being, health and mental health.
  - b. Social Health
  - c. Program/service development

- d. Arts and Humanities
- e. Business and finances
- f. Policy
- g. Research, application, and evaluation

Based on these competencies, student learning outcomes will include the following:

- Students will be able to identify and explain developmental perspectives associated with aging.
- Students will be able to compare and contrast biological and psychosocial aspects of aging and apply this knowledge in health and human service settings to have a positive impact on the health of older adults.
- Develop comprehensive and meaningful concepts, definitions, and measures for the well-being of older adults.
- Students will be able to critically analyze ethical and professional standards in gerontology.
- Students will demonstrate effective communication skills through their interactions with older adults and they will demonstrate knowledge of community resources related to the health and well-being of older adults.
- Develop a gerontological perspective through knowledge and self-reflection as achieved through class discussions and group assignments.
- Students will demonstrate the ability to collaborate with others to promote integrated approaches to aging. Achieved via class work, group projects, and capstone projects.
- Students will promote quality of life among older adults. They will also promote older individual's strengths to maximize well-being, health, and mental health, including promoting engagement in the arts and the community.
- Students will demonstrate knowledge of the science of gerontology via class work on research methods and via writing projects that require integration of empirical literature. The capstone project may include a research project.

**A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any.**

Please refer to Section 2 on the attached State Board of Education Form

#### Supporting Documents

549 Program Description.pdf  
Org Chart\_Health Professions\_COGS\_SHAMP.pdf

#### Reviewer Comments

**Linda Lundgren (lindalundgren) (Fri, 13 Oct 2023 00:19:48 GMT):** Rollback: Please correct student learning outcomes so both boxes match. Email sent to Dr. Farrer on 10/12/23 re: the Student Learning Outcomes.

**Sydney Beal (sbeal) (Fri, 13 Oct 2023 15:08:33 GMT):** Rollback: Rollback per request of Linda Lundgren for learning outcome corrections

**Tyler Bland (tbland) (Fri, 13 Oct 2023 15:33:05 GMT):** Rollback: Corrections

**Linda Lundgren (lindalundgren) (Fri, 13 Oct 2023 16:57:18 GMT):** 10/13/23: LL uploaded program description.

**Linda Lundgren (lindalundgren) (Fri, 27 Oct 2023 16:35:05 GMT):** LL rolled back to department for corrections. Emailed Dr. Farrer on 10/27/23 at 9:23 am noting corrections that need to be made to the Full Proposal and CIM.

**Linda Lundgren (lindalundgren) (Fri, 27 Oct 2023 22:15:09 GMT):** Rollback: Rolling back for corrections emailed to Dr. Farrer on 10/27/23.

**Jeffrey Seegmiller (jeffreys) (Mon, 30 Oct 2023 19:19:31 GMT):** Rollback: Make requested changes

**Jeffrey Seegmiller (jeffreys) (Mon, 30 Oct 2023 19:24:27 GMT):** Rollback: Change

**Tyler Bland (tbland) (Mon, 30 Oct 2023 19:25:29 GMT):** Rollback: Correction

**Sydney Beal (sbeal) (Tue, 23 Jan 2024 22:44:54 GMT):** Approved at UCC pending the successful approval of the associated coursework

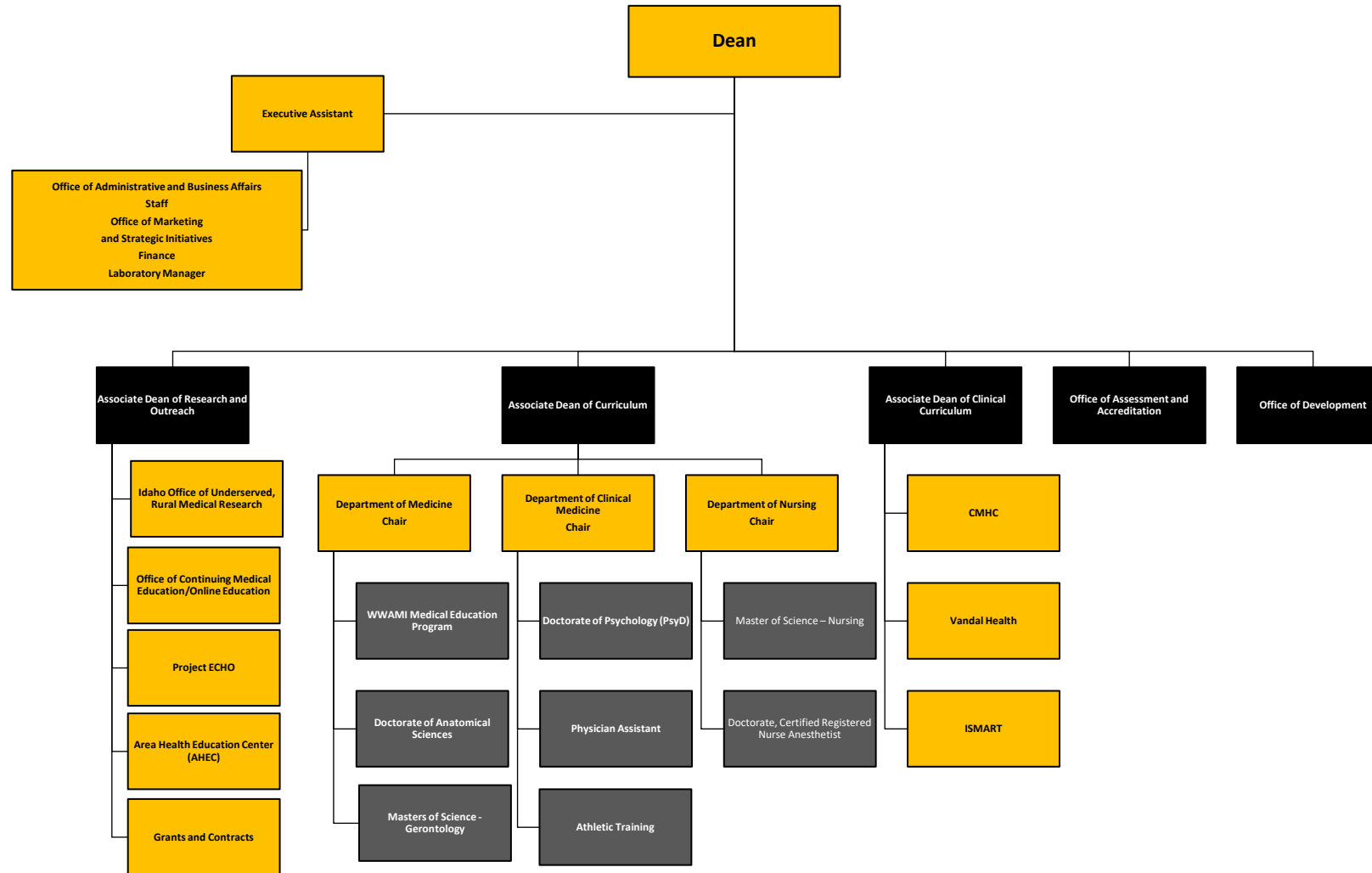
Key: 549

549 Program Description:

The MS in Gerontology prepares students for the scientific study of aging from a biopsychosocial perspective, including adult development, healthy aging, biological aspects of aging, social and emotional function in aging, and economic and policy factors related to aging.



# School of Health and Medical Professions



# 551: DIRECT-ENTRY DOCTOR OF NURSING PRACTICE - NURSE ANESTHESIA

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## In Workflow

1. 276 Chair (mcmurtry@uidaho.edu)
2. 20 Curriculum Committee Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
3. 20 Dean (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
4. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
5. Degree Audit Review (rfrost@uidaho.edu)
6. Graduate Council Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
7. Registrar's Office (none)
8. Ready for UCC (disable)
9. UCC (none)
10. Post-UCC Registrar (none)
11. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
12. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
13. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
14. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
15. Theodore Unzicker (tunzicker@uidaho.edu)

## Approval Path

1. Tue, 17 Oct 2023 15:25:36 GMT  
Tyler Bland (tbland): Approved for 471 Chair
2. Mon, 30 Oct 2023 19:20:33 GMT  
Jeffrey Seegmiller (jeffreys): Rollback to 471 Chair for 22 Curriculum Committee Chair
3. Mon, 30 Oct 2023 19:22:24 GMT  
Tyler Bland (tbland): Approved for 471 Chair
4. Mon, 30 Oct 2023 19:24:36 GMT  
Jeffrey Seegmiller (jeffreys): Rollback to 471 Chair for 22 Curriculum Committee Chair
5. Mon, 30 Oct 2023 19:25:20 GMT  
Tyler Bland (tbland): Rollback to Initiator
6. Wed, 06 Dec 2023 23:20:35 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
7. Wed, 06 Dec 2023 23:31:46 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
8. Thu, 07 Dec 2023 17:20:58 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
9. Tue, 12 Dec 2023 16:48:04 GMT  
Sydney Beal (sbeal): Rollback to Initiator
10. Tue, 12 Dec 2023 20:08:35 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
11. Tue, 12 Dec 2023 20:29:33 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
12. Tue, 12 Dec 2023 20:33:55 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
13. Wed, 13 Dec 2023 21:49:32 GMT  
Gwen Gorzelsky (gwen): Approved for Provost's Office
14. Thu, 21 Dec 2023 20:05:06 GMT  
Rebecca Frost (rfrost): Approved for Degree Audit Review
15. Thu, 21 Dec 2023 20:31:26 GMT  
Jerry McMurtry (mcmurtry): Approved for Graduate Council Chair
16. Tue, 16 Jan 2024 21:12:15 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
17. Wed, 17 Jan 2024 16:16:45 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
18. Tue, 23 Jan 2024 22:46:04 GMT

Sydney Beal (sbeal): Approved for UCC

19. Thu, 25 Jan 2024 21:48:17 GMT

Sydney Beal (sbeal): Approved for Post-UCC Registrar

## New Program Proposal

Date Submitted: Tue, 12 Dec 2023 20:08:06 GMT

**Viewing: 551 : Direct-Entry Doctor of Nursing Practice - Nurse Anesthesia**

**Last edit: Thu, 25 Jan 2024 21:49:25 GMT**

Changes proposed by: Whitney Vincent

### Faculty Contact

Faculty Name	Faculty Email
Russell Baker	russellb@uidaho.edu

**Will this request have a fiscal impact of \$250K or greater?**

Yes

### Academic Level

Graduate

### College

Graduate Studies

### Department/Unit:

Graduate Studies

### Effective Catalog Year

2025-2026

### Program Title

Direct-Entry Doctor of Nursing Practice - Nurse Anesthesia

### Degree Type

Major

Please note: Majors and Certificates over 30 credits need to have a state form approved before the program can be created in Curriculum.

### Program Credits

99

### Attach Program Change

Academic\_Degree\_and\_Certificate\_Full-Proposal\_Form\_FINAL\_Entry CRNA.pdf

### CIP Code

51.3804 - Nurse Anesthetist.

### Will the program be Self-Support?

Yes

### Will the program have a Professional Fee?

No

### Will the program have an Online Program Fee?

No

### Will this program lead to licensure in any state?

Yes

### Will the program be a statewide responsibility?

No

## Financial Information

### What is the financial impact of the request?

Greater than \$250,000 per FY

**Note: If financial impact is greater than \$250,000, you must complete a Program Proposal Form**

### Describe the financial impact

The direct-entry Doctor of Nursing Practice -Nurse Anesthesia (DNP-NA) is a newly proposed graduate program designed to prepare students to become Certified Registered Nurse Anesthetists (CRNAs). The DNP-NA program is an independent program and will be housed in the College of Graduate Studies at the University of Idaho. A School of Health and Medical Professions is currently being created and processed to eventually house these health care programs, under the College of Graduate Studies. Based on feedback from policymakers and Idaho business leaders, our request is dedicated to addressing healthcare workforce needs, one of the most pressing issues the state is facing today. We acknowledge the importance of flexibility to adapt to evolving challenges and workforce needs of the future. The primary beneficiaries, if this program request is granted, are the individuals and communities who will be served by these future healthcare providers. Thus, the impact could encompass all of Idaho.

### Curriculum:

See Attached SBOE Document

## Distance Education Availability

To comply with the requirements of the Idaho State Board of Education (SBOE) and the Northwest Commission on Colleges and Universities (NWCCU) the University of Idaho must declare whether 50% or more of the curricular requirements of a program which may be completed via distance education.

### Can 50% or more of the curricular requirements of this program be completed via distance education?

No

Note: Existing programs transitioning from less than 50% of its curricular requirements to 50% or more of its requirements being available via distance education is considered a Group B change and must complete the program proposal formwork before these changes will be processed.

## Geographical Area Availability

### In which of the following geographical areas can this program be completed in person?

Moscow

## Student Learning Outcomes

**List the intended learning outcomes for program component. Use learner centered statements that indicate what will students know, be able to do, and value or appreciate as a result of completing the program.**

Learning Objectives:

- o Integrate the chemistry and pharmacology of anesthesia and adjunct drugs and discuss pharmacokinetics and pharmacodynamics of the drugs.
- o Recognize chemical structures of anesthesia and adjunct drugs and make lateral applications based upon drug profiles and kinetics.
- o Discuss the normal physiology and anatomy of the central nervous system, respiratory system, cardiac/circulatory system, renal system, endocrine system, and digestive system.
- o Identify and explain the pathophysiologic conditions that occur in systems and make application in the administration of anesthesia.
- o Discuss the special considerations, anatomical and physiologic difference in neonates, infants, and children and apply the information in the administration of anesthesia to infants and children.
- o Discuss the normal physiologic changes of pregnancy, the physiologic changes in disease/high risk states in pregnancy and apply the information in the administration of anesthesia to the parturient for delivery and surgical conditions not resulting in delivery.
- o Explain the pathophysiology of common congenital heart diseases, coronary artery disease, and adult valvular heart disease.
- o Develop anesthesia care plans and administer anesthesia for open heart procedures, closed heart procedures, and anesthesia for the cardiac patient having noncardiac surgery, applying physiological and pharmacological principles.
- o Identify the special considerations, physiologic and pharmacologic profile changes of the geriatric (chronologic or physiologic) patient.
- o Identify the anatomy necessary to safely administer regional anesthesia (lumbar epidural, subarachnoid, IV regional and limited peripheral nerve blocks).
- o Develop care plans for regional anesthesia and combined general and regional anesthesia applying physiological and pharmacological principles.
- o Design and conduct a research project and implement Capstone projects.

- o Analyze and discuss the various components of organizational leadership including leadership styles, communication, planning, staffing, budgeting and evaluation.
- o Analyze and critique a variety of ethical issues related to anesthesia and the medical setting.

**Describe the assessment process that will be used to evaluate how well students are achieving the intended learning outcomes of the program component.**

Student success in achieving the intended learning outcomes of the program will be monitored throughout the program's didactic and clinical phases. The program's faculty and clinical preceptors will evaluate students through a variety of assessment tools, including but not limited to multiple choice examinations, collaborative group projects, objective structured clinical examinations (OSCEs), and clinical performance evaluations.

**How will you ensure that the assessment findings will be used to improve the program?**

Assessment findings will be used in compliance with external program accreditation requirements to ensure program-self-study and improvement is occurring regularly. Student board exam performance and external accreditation requirements will be assessed annually to examine program performance.

**What direct and indirect measures will be used to assess student learning?**

- o Examinations and Quizzes
- o Clinical Skills Assessment
- o Case Studies and Care Plans
- o Reflective Journals and Portfolios.
- o Preceptor, Peer, and Self-Assessment
- o Board Examination

**When will assessment activities occur and at what frequency?**

- o Assessment findings will be used for continuous program improvement through the following mechanisms:
- o Faculty Meetings: Regular faculty meetings will involve discussions of assessment results, with a focus on identifying areas of improvement and refining teaching methods and curriculum.
- o Curriculum Review: Assessment data will inform curriculum revisions, ensuring alignment with current healthcare trends and best practices.
- o Faculty Development: Faculty will receive training and support to enhance assessment techniques and teaching strategies, addressing areas where student performance needs improvement.
- o Feedback Loops: Continuous feedback loops will be established with students, incorporating their input to make program enhancements.
- o Assessment Activity Timing (assessment activities will occur throughout the program at various frequencies):
- o Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.
- o Summative assessments (midterm, final examinations) will occur at the end of relevant courses and following year one and year two. Alumni and industry surveys will be completed two years following graduation.
- o Clinical skills assessments and evaluations will be conducted during clinical rotations.
- o Case studies, care plans, and projects will be assigned periodically.

## Student Learning Outcomes

### Learning Objectives

- Learning Objectives:
  - Integrate the chemistry and pharmacology of anesthesia and adjunct drugs and discuss pharmacokinetics and pharmacodynamics of the drugs.
  - Recognize chemical structures of anesthesia and adjunct drugs and make lateral applications based upon drug profiles and kinetics.
  - Discuss the normal physiology and anatomy of the central nervous system, respiratory system, cardiac/circulatory system, renal system, endocrine system, and digestive system.
  - Identify and explain the pathophysiologic conditions that occur in systems and make application in the administration of anesthesia.
  - Discuss the special considerations, anatomical and physiologic difference in neonates, infants, and children and apply the information in the administration of anesthesia to infants and children.
  - Discuss the normal physiologic changes of pregnancy, the physiologic changes in disease/high risk states in pregnancy and apply the information in the administration of anesthesia to the parturient for delivery and surgical conditions not resulting in delivery.
  - Explain the pathophysiology of common congenital heart diseases, coronary artery disease, and adult valvular heart disease.
  - Develop anesthesia care plans and administer anesthesia for open heart procedures, closed heart procedures, and anesthesia for the cardiac patient having noncardiac surgery, applying physiological and pharmacological principles.
  - Identify the special considerations, physiologic and pharmacologic profile changes of the geriatric (chronologic or physiologic) patient.
  - Identify the anatomy necessary to safely administer regional anesthesia (lumbar epidural, subarachnoid, IV regional and limited peripheral nerve blocks).

- Develop care plans for regional anesthesia and combined general and regional anesthesia applying physiological and pharmacological principles.
- Design and conduct a research project and implement Capstone projects.
- Analyze and discuss the various components of organizational leadership including leadership styles, communication, planning, staffing, budgeting and evaluation.
- Analyze and critique a variety of ethical issues related to anesthesia and the medical setting.

**A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any.**

Certified Registered Nurse Anesthetists is a growing field, ranked as the #8 in best-paying jobs, #10 in healthcare jobs, #12 in STEM jobs, and #25 in overall jobs by US News and World Report. The Bureau of Labor Statistics estimates the 2022-2032 job outlook to increase by 38% for advanced nursing degrees, much faster than average, which includes faster than national average increases for advanced practice CRNAs. Specifically, North Idaho projections are for a 27.5% increase for CRNAs by 2030, with similar job growth expectations for the rest of Idaho. The Idaho Department of Labor projects 60 new CRNA openings per year in Idaho over this timeframe.

In Idaho's current situation, the nurse population clusters around the largest city in Idaho Public Health Districts, with significant migration of nurses away from Idaho rural communities to either the one large town in their district or to the Treasure Valley (Boise/Meridian/Nampa), with the largest migration to Ada and Canyon counties over the past several years. Further, self-reported data from Idaho CRNAs indicates that nearly 25% of CRNAs work part-time, which necessitates a greater number of CRNAs to meet the needs of our state, and it is expected that nearly 20% of Idaho CRNA workforce will retire (i.e., 55 or older) in the next 10 years. The migration of nurses away from rural communities, lack of CRNAs, and overall healthcare provider shortages in Idaho exacerbates the need for an increase in CRNAs in Idaho. This can be seen in self-report data that indicates that nearly 25% of Idaho CRNAs report that CRNAs are the only anesthesia providers in their community, and that some communities only have one CRNA as the sole anesthesia provider available in a rural community.

Thus, there is a great need to train and prepare CRNAs in Idaho to work in Idaho's rural communities. Currently, there are no other CRNA programs in Idaho (the closest CRNA program is at Gonzaga University); thus, 100% of Idaho CRNAs received their education outside of Idaho (84% at master's degree level). With only one reported doctoral trained CRNA in Idaho, and the upcoming shift to required doctoral preparation for entry-level CRNAs in 2025, it is important for Idaho to develop an advanced practice entry-to-practice CRNA program in Idaho. The development of an advanced practice entry-to-practice CRNA program in Idaho will aid in the development of a CRNA workforce to meet the needs of Idahoans.

#### Supporting Documents

Org Chart\_Health Professions\_COGS\_SHAMP.pdf  
Budget-Proposal-Form\_final\_9-16-2021\_CRNA.xlsx

#### Reviewer Comments

**Jeffrey Seegmiller (jeffreys) (Mon, 30 Oct 2023 19:20:33 GMT):** Rollback: MAKE CHANGES

**Jeffrey Seegmiller (jeffreys) (Mon, 30 Oct 2023 19:24:36 GMT):** Rollback: Change

**Tyler Bland (tbland) (Mon, 30 Oct 2023 19:25:20 GMT):** Rollback: Correction

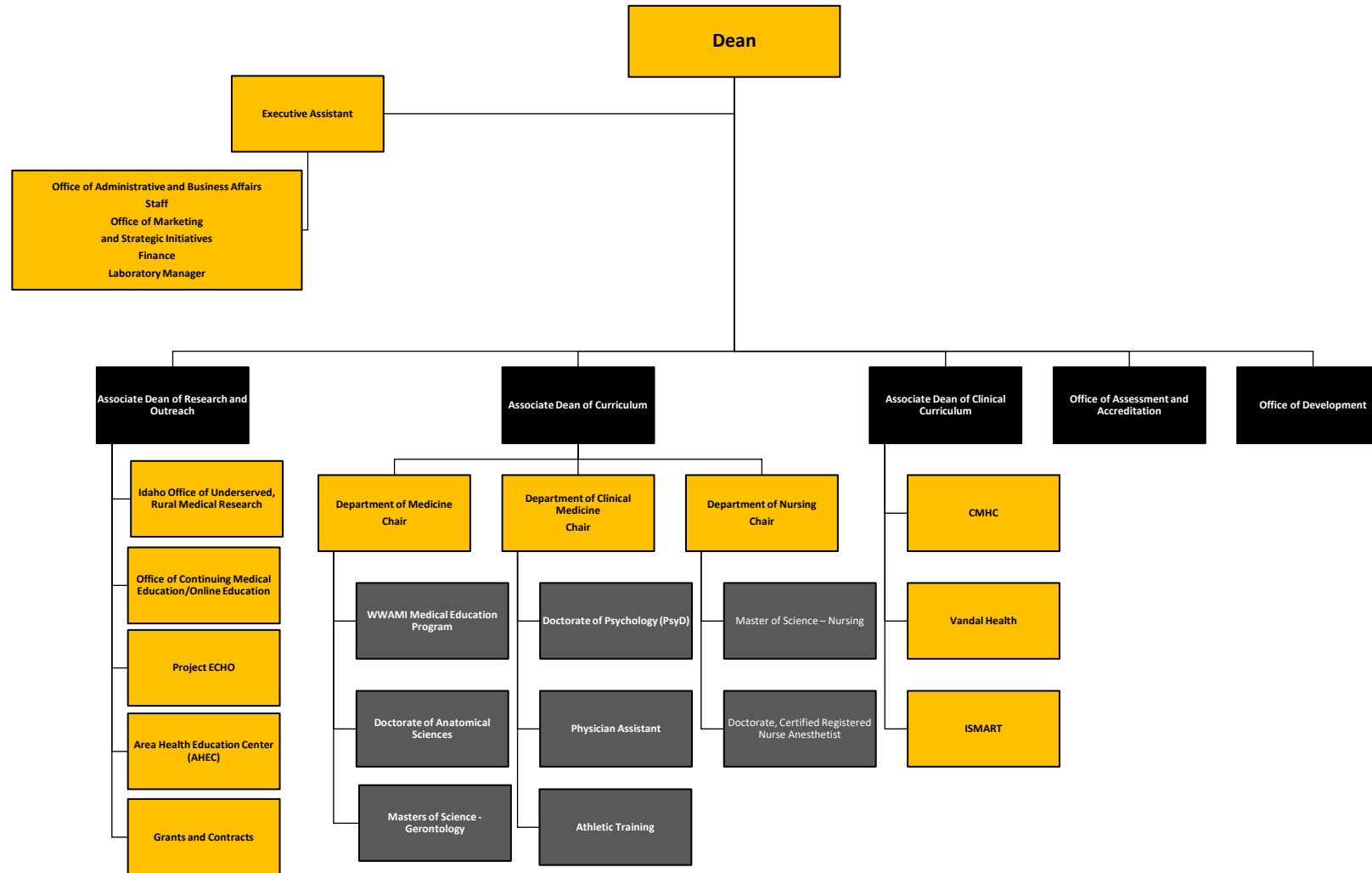
**Ken Udas (kudas) (Tue, 12 Dec 2023 16:17:41 GMT):** - I would like to confirm that this proposal does not entail a request for funding outside of the academic unit. - It is indicated that an Online Fee will be assessed and that the program will be less than 50% delivered at distance. Is this correct? - It is indicated that the the program can be completed at Coeur d'Alene, Moscow, and Online Only. Is this accurate?

**Sydney Beal (sbeal) (Tue, 12 Dec 2023 16:48:04 GMT):** Rollback: Rolled back per request

**Sydney Beal (sbeal) (Tue, 23 Jan 2024 22:46:01 GMT):** Approved at UCC pending the successful approval of the associated coursework

Key: 551

# School of Health and Medical Professions



**Program Resource Requirements.**

- Indicate all resources needed including the planned FTE enrollment, projected revenues, and estimated expenditures for the first **four** fiscal years of
- Include reallocation of existing personnel and resources and anticipated or requested new resources.
- Second and third year estimates should be in constant dollars.
- Amounts should reconcile subsequent pages where budget explanations are provided.
- If the program is contract related, explain the fiscal sources and the year-to-year commitment from the contracting agency(ies) or party(ies).
- Provide an explanation of the fiscal impact of any proposed discontinuance to include impacts to faculty (i.e., salary savings, re-assignments).

**I. PLANNED STUDENT ENROLLMENT**

	<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>		<u>FY 29</u>	
	FTE	Headcount	FTE	Headcount	FTE	Headcou	FTE	Headcount
A. New enrollments		10		15		20		20
B. Shifting enrollments								
<b>Total Enrollment</b>	0	10	0	25	0	45	0	55

**II. REVENUE**

	<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>		<u>FY 29</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
1. New Appropriated Funding Request								
2. Institution Funds	\$422,600.00	\$250,000.00		\$250,000.00				
3. Federal								
4. New Tuition Revenues from Increased Enrollments	\$400,000.00		\$1,000,000.00		\$4,500,000.00		\$5,500,000.00	
5. Student Fees								
6. Other (i.e., Gifts)								
<b>Total Revenue</b>	\$822,600	\$250,000	\$1,000,000	\$250,000	\$4,500,000	\$0	\$5,500,000.00	\$0

**Ongoing is defined as ongoing operating budget for the program which will become part of the base.**

**One-time is defined as one-time funding in a fiscal year and not part of the base.**



**III. EXPENDITURES**

	<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>		<u>FY 29</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>A. Personnel Costs</b>								
1. FTE	5.5		5.5		6.5		7.5	
2. Faculty	\$240,000.00		\$240,000.00		\$360,000.00		\$480,000.00	
3. Adjunct Faculty			24000		48000		72000	
4. Graduate/Undergrad Assista								
5. Research Personnel								
6. Directors/Administrators	275000		275000		275000		275000	
7. Administrative Support Persc	115000		115000		115100		115100	
8. Fringe Benefits	102600		104592		125684		146776	
9. Other:								
<b>Total Personnel and Costs</b>	<b>\$732,600</b>	<b>\$0</b>	<b>\$758,592</b>	<b>\$0</b>	<b>\$923,784</b>	<b>\$0</b>	<b>\$1,088,876</b>	<b>\$0</b>

	<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>		<u>FY 29</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>B. Operating Expenditures</b>								
1. Travel	\$20,000.00		\$20,000.00		\$20,000.00		\$20,000.00	
2. Professional Services	\$10,000.00		\$10,000.00		\$15,000.00		\$20,000.00	
3. Other Services								
4. Communications	\$20,000.00		\$20,000.00		\$20,000.00		\$20,000.00	
5. Materials and Supplies	\$25,000.00		\$25,000.00		\$25,000.00		\$25,000.00	
6. Rentals								
7. Materials & Goods for Manufacture & Resale								
8. Miscellaneous	\$15,000.00		\$15,000.00		\$15,000.00		\$15,000.00	
<b>Total Operating Expenditures</b>	<b>\$90,000</b>	<b>\$0</b>	<b>\$90,000</b>	<b>\$0</b>	<b>\$95,000</b>	<b>\$0</b>	<b>\$100,000</b>	<b>\$0</b>

	<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>		<u>FY 29</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>C. Capital Outlay</b>								
1. Library Resources								
2. Equipment		\$250,000.00	\$25,000.00	\$250,000.00	\$25,000.00		\$25,000.00	
<b>Total Capital Outlay</b>	<b>\$0</b>	<b>\$250,000</b>	<b>\$25,000</b>	<b>\$250,000</b>	<b>\$25,000</b>	<b>\$0</b>	<b>\$25,000</b>	<b>\$0</b>

	<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>		<u>FY 29</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>D. Capital Facilities Construction or Major Renovation</b>								
<b>E. Other Costs</b>								
Utilites								
Maintenance & Repairs								
Other								
<b>Total Other Costs</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL EXPENDITURES:</b>	\$822,600	\$250,000	\$873,592	\$250,000	\$1,043,784	\$0	\$1,213,876	\$0
<b>Net Income (Defici</b>	\$0	\$0	\$126,408	\$0	\$3,456,216	\$0	\$4,286,124	\$0

Budget Notes (specify row and add explanation where needed; e.g., "I.A.,B. FTE is calculated using..."):

I.A.B.	10 students in the first year and a 5 student increase in cohort size each subsequent year.
III.B	Conference travel for professional development; professional services; program communciations; accreditation costs; program supplies.
III.C	Training equipment and simulation equipment purchases; subsequent upgrades and maintenance.

# 540: DIRECT-ENTRY MASTER OF SCIENCE IN NURSING

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## In Workflow

1. 276 Chair (mcmurtry@uidaho.edu)
2. 20 Curriculum Committee Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
3. 20 Dean (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
4. Whitney Vincent (wvincent@uidaho.edu)
5. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
6. Degree Audit Review (rfrost@uidaho.edu)
7. Graduate Council Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
8. Registrar's Office (none)
9. Ready for UCC (disable)
10. UCC (none)
11. Post-UCC Registrar (none)
12. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
13. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
14. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
15. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
16. Theodore Unzicker (tunzicker@uidaho.edu)

## Approval Path

1. Mon, 09 Oct 2023 21:55:22 GMT  
Tyler Bland (tbland): Approved for 471 Chair
2. Mon, 09 Oct 2023 23:26:31 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Curriculum Committee Chair
3. Mon, 09 Oct 2023 23:29:24 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Dean
4. Wed, 08 Nov 2023 22:22:10 GMT  
Linda Lundgren (lindalundgren): Rollback to 471 Chair for Provost's Office
5. Wed, 08 Nov 2023 23:28:54 GMT  
Tyler Bland (tbland): Rollback to Initiator
6. Thu, 07 Dec 2023 18:07:31 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
7. Thu, 07 Dec 2023 18:09:07 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
8. Thu, 07 Dec 2023 18:24:59 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
9. Tue, 12 Dec 2023 16:47:54 GMT  
Sydney Beal (sbeal): Rollback to Initiator
10. Tue, 12 Dec 2023 18:24:23 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
11. Tue, 12 Dec 2023 18:25:05 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
12. Tue, 12 Dec 2023 18:28:47 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
13. Wed, 13 Dec 2023 19:09:39 GMT  
Sydney Beal (sbeal): Rollback to 20 Dean for Provost's Office
14. Wed, 13 Dec 2023 19:09:57 GMT  
Sydney Beal (sbeal): Approved for 20 Dean
15. Wed, 13 Dec 2023 19:11:05 GMT  
Sydney Beal (sbeal): Approved for V00654458
16. Tue, 19 Dec 2023 18:02:29 GMT  
Brenda Helbling (brenadah): Approved for Provost's Office
17. Thu, 21 Dec 2023 20:04:57 GMT  
Rebecca Frost (rfrost): Approved for Degree Audit Review
18. Thu, 21 Dec 2023 20:31:18 GMT  
Jerry McMurtry (mcmurtry): Approved for Graduate Council Chair

- 19. Tue, 16 Jan 2024 21:16:57 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
- 20. Wed, 17 Jan 2024 16:16:09 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
- 21. Tue, 23 Jan 2024 22:43:56 GMT  
Sydney Beal (sbeal): Approved for UCC
- 22. Thu, 25 Jan 2024 21:50:27 GMT  
Sydney Beal (sbeal): Approved for Post-UCC Registrar

### New Program Proposal

Date Submitted: Tue, 12 Dec 2023 18:12:40 GMT

**Viewing: 540 : Direct-Entry Master of Science in Nursing**

**Last edit: Thu, 25 Jan 2024 21:50:20 GMT**

Changes proposed by: Whitney Vincent

#### Faculty Contact

Faculty Name	Faculty Email
Jeff Seegmiller	jeffreys@uidaho.edu

**Will this request have a fiscal impact of \$250K or greater?**

Yes

#### Academic Level

Graduate

#### College

Graduate Studies

#### Department/Unit:

Graduate Studies

#### Effective Catalog Year

2025-2026

#### Program Title

Direct-Entry Master of Science in Nursing

#### Degree Type

Major

Please note: Majors and Certificates over 30 credits need to have a state form approved before the program can be created in Curriculum.

#### Program Credits

67

#### Attach Program Change

SBOE Academic\_Degree\_and\_Certificate\_Full-Proposal\_Form MSN (1).pdf

#### CIP Code

51.1601 - Nursing/Registered Nurse (RN, ASN, BSN, MSN).

#### Will the program be Self-Support?

No

#### Will the program have a Professional Fee?

Yes

#### Will the program have an Online Program Fee?

No

#### Will this program lead to licensure in any state?

Yes

**Will the program be a statewide responsibility?**

No

## Financial Information

**What is the financial impact of the request?**

Greater than \$250,000 per FY

**Note: If financial impact is greater than \$250,000, you must complete a Program Proposal Form**

**Describe the financial impact**

The MSN program is going to be housed in the College of Graduate Studies at the University of Idaho. A School of Health and Medical Professions is currently being created and processed to eventually house these health care programs, under the College of Graduate Studies.

Based on feedback from policymakers and Idaho business leaders, our request is dedicated to addressing healthcare workforce needs, one of the most pressing issues the state is facing today. We acknowledge the importance of flexibility to adapt to evolving challenges and workforce needs of the future.

The primary beneficiaries, if this program request is granted, are the individuals and communities who will be served by these future Nurses. Thus, the impact could encompass all of Idaho.

**Curriculum:**

See attached Direct-Entry Masters of Science in Nursing Proposal

## Distance Education Availability

To comply with the requirements of the Idaho State Board of Education (SBOE) and the Northwest Commission on Colleges and Universities (NWCCU) the University of Idaho must declare whether 50% or more of the curricular requirements of a program which may be completed via distance education.

**Can 50% or more of the curricular requirements of this program be completed via distance education?**

Yes

**If Yes, can 100% of the curricular requirements of this program be completed via distance education?**

No

Note: Existing programs transitioning from less than 50% of its curricular requirements to 50% or more of its requirements being available via distance education is considered a Group B change and must complete the program proposal formwork before these changes will be processed.

## Geographical Area Availability

**In which of the following geographical areas can this program be completed in person?**

Moscow

Other

**Where?**

Geographical region including Idaho during the clinical rotations.

## Student Learning Outcomes

**List the intended learning outcomes for program component. Use learner centered statements that indicate what will students know, be able to do, and value or appreciate as a result of completing the program.**

See the attached document: The Essentials: Competencies for Nursing Education 2021.

The Competencies for nursing education include competencies and student learning outcomes required for successful program accreditation by the Commission on the Collegiate Nursing Education (CCNE)

These learning outcomes also prepare students for the national board examination for nursing practice (National Council Licensure Examination).

Intended Learning Outcomes for the Nursing Program Component:

1. Knowledge Acquisition and Application: Upon completion of the program component, students will demonstrate a comprehensive understanding of core nursing concepts, theories, and evidence-based practices. They will be able to apply this knowledge to solve complex healthcare challenges.

2. **Clinical Competence:** Students will develop clinical competence in patient care, including assessment, planning, implementation, and evaluation of nursing interventions. They will be capable of delivering safe and effective nursing care across diverse healthcare settings.

3. **Critical Thinking and Problem-Solving:** Graduates will possess strong critical thinking skills, enabling them to analyze clinical situations, identify potential problems, and make informed decisions to optimize patient outcomes.

4. **Communication and Interpersonal Skills:** Students will exhibit effective communication and interpersonal skills, fostering therapeutic relationships with patients, families, and the healthcare team.

5. **Professionalism and Ethical Practice:** Graduates will uphold the highest standards of professionalism and ethics, adhering to legal and ethical guidelines while demonstrating cultural competence, empathy, and respect for patient autonomy.

6. **Leadership and Collaboration:** Students will acquire leadership and collaboration skills, enabling them to work effectively within interdisciplinary healthcare teams, advocate for patients, and contribute to improving healthcare systems.

**Describe the assessment process that will be used to evaluate how well students are achieving the intended learning outcomes of the program component.**

To evaluate how well students are achieving the intended learning outcomes, the following assessment processes will be employed:

1. **Examinations and Quizzes:** Regular assessments will include written examinations and quizzes to evaluate knowledge acquisition and critical thinking skills.

2. **Clinical Skills Assessment:** Clinical skills will be assessed through direct observation, practical examinations, and skills checklists during clinical rotations.

3. **Case Studies and Care Plans:** Students will complete case studies and care plans to demonstrate their ability to apply theoretical knowledge to real-world patient care scenarios.

4. **Reflective Journals and Portfolios:** Students will maintain reflective journals and e-portfolios, providing insights into their personal and professional growth.

5. **Peer and Self-Assessment:** Peer evaluations and self-assessment will be incorporated for group projects and personal reflection on skills development.

**How will you ensure that the assessment findings will be used to improve the program?**

Assessment findings will be used for continuous program improvement through the following mechanisms:

1. **Faculty Meetings:** Regular faculty meetings will involve discussions of assessment results, with a focus on identifying areas of improvement and refining teaching methods and curriculum.

2. **Curriculum Review:** Assessment data will inform curriculum revisions, ensuring alignment with current healthcare trends and best practices.

3. **Faculty Development:** Faculty will receive training and support to enhance assessment techniques and teaching strategies, addressing areas where student performance needs improvement.

4. **Feedback Loops:** Continuous feedback loops will be established with students, incorporating their input to make program enhancements.

**What direct and indirect measures will be used to assess student learning?**

Direct measures include examinations, skills assessments, case studies, and practical evaluations. Indirect measures include student surveys, feedback from clinical preceptors, and analysis of retention and graduation rates.

**When will assessment activities occur and at what frequency?**

Assessment activities will occur throughout the program at various frequencies:

- Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.
- Summative assessments (midterm, final examinations) will occur at the end of relevant courses and following year one and year two. Alumni and industry surveys will be completed two years following graduation.
- Clinical skills assessments and evaluations will be conducted during clinical rotations.
- Case studies, care plans, and projects will be assigned periodically.

## **Student Learning Outcomes**

### **Learning Objectives**

See the attached document: The Essentials: Competencies for Nursing Education 2021.

The Competencies for nursing education include competencies and student learning outcomes required for successful program accreditation by the Commission on the Collegiate Nursing Education (CCNE)

These learning outcomes also prepare students for the national board examination for nursing practice (National Council Licensure Examination).

Intended Learning Outcomes for the Nursing Program Component:

1. Knowledge Acquisition and Application: Upon completion of the program component, students will demonstrate a comprehensive understanding of core nursing concepts, theories, and evidence-based practices. They will be able to apply this knowledge to solve complex healthcare challenges.
2. Clinical Competence: Students will develop clinical competence in patient care, including assessment, planning, implementation, and evaluation of nursing interventions. They will be capable of delivering safe and effective nursing care across diverse healthcare settings.
3. Critical Thinking and Problem-Solving: Graduates will possess strong critical thinking skills, enabling them to analyze clinical situations, identify potential problems, and make informed decisions to optimize patient outcomes.
4. Communication and Interpersonal Skills: Students will exhibit effective communication and interpersonal skills, fostering therapeutic relationships with patients, families, and the healthcare team.
5. Professionalism and Ethical Practice: Graduates will uphold the highest standards of professionalism and ethics, adhering to legal and ethical guidelines while demonstrating cultural competence, empathy, and respect for patient autonomy.
6. Leadership and Collaboration: Students will acquire leadership and collaboration skills, enabling them to work effectively within interdisciplinary healthcare teams, advocate for patients, and contribute to improving healthcare systems.

**A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any.**

Justification:

Rural areas struggle to find adequate numbers of nurses and data shows that there has been a profound urban shift in practicing registered nurses. In 2005, 17% of registered nurses worked in rural areas, but that number dropped to 14.4% by 2018. In 2005, 16.4% of nurses worked in rural hospitals, but in 2018, that figure dropped to 13.4%. The percentage of registered nurses working at rural critical access hospitals in 2018 was 38.5%, but the Covid-19 pandemic accelerated retirement of many older nurses and rural facilities with tight budgets could not compete with better funded urban healthcare centers and the rural nursing workforce dropped even further. Although efforts to train and recruit more nurses are ongoing and projections show enough new nurses to replace retiring baby boomer registered nurses, the replacement distribution is expected to be uneven with urban locales attracting more new nurses than rural regions (National Academies Press, 2021).

Research shows that graduate-level direct-entry nursing students demonstrate discipline and independent learning skills that transfer well to nursing and outperform younger nursing students. With an average age of 26, direct-entry graduate students are motivated, engaged learners who demonstrate emotional maturity well-suited for healthcare employment (Everrett et al., 2013). With calls for educational leadership that meets actual needs by delivering innovative educational programs that harness technology to transform curricular offerings (Thompson, 2016), a direct-entry nursing education program addresses unmet needs for both an able student population and a struggling rural workforce.

Currently, no institution in Idaho offers a Direct Entry Master of Science in Nursing (MSN) and there are only 41 programs of this type in the nation. Idaho students who have already obtained a bachelor's degree in a non-nursing field, must complete a second bachelor's degree, or leave the state if they want to enter the nursing profession. This is an inefficient use of human resources and an obstacle that keeps many nontraditional students from entering the nursing field. The proposed Direct Entry (aka Entry to Practice) MSN program fills this educational gap for Idaho. The proposed MSN Direct Entry program is a full-time accelerated nursing program that prepares students of all academic backgrounds who have a degree in a field other than nursing to become practicing nurses. Upon graduation, students will be prepared to take the nursing licensure exam NCLEX-RN to be licensed as an RN.

Prerequisites include: a bachelor's degree in a non-nursing field with GPA of 3.0 or higher, anatomy with lab (3-4 credits), microbiology (3-4 credits), nutrition (2-3 credits), physiology with lab (3-4 credits), statistics (3 credits). A 3+2 program option will also be available through the University of Idaho in the future for students who want to change their career trajectory before the end of their baccalaureate education.

Mode of Delivery:

1. Campus-based curricula
2. Hybrid-online

4-semester program with three foundational elements:

1. Nursing foundational theory courses. Hybrid-online or on-campus.
2. Nursing skills practicum and simulation. On-site requirement.
3. Nursing clinical rotations. Healthcare facilities. Travel required.

Proposed Curriculum:

The Direct Entry MSN Nursing Curriculum is an accelerated program that requires 67 credit hours of training. Coursework is designed to build knowledge and skills in a stepwise manner in context of patient care. Hybrid mode of course delivery with in-person and online didactic instruction followed by in-person skills labs and clinical immersion experiences.

The department of medical education will add required nursing faculty to accommodate the added workload for nursing. As capacity grows the nursing program will be part of a new department of health professions within a new college of health and medical professions. The workload for nursing operations will be part of expectations within the program.

### Supporting Documents

Essentials-2021.pdf  
Direct-Entry Master of Science in Nursing Proposal.pdf



Org Chart\_Health Professions\_COGS\_SHAMP.pdf  
2023 (FINAL) MSN Budget - Full Proposal Form updated 10-12-23.pdf

**Reviewer Comments**

**Linda Lundgren (lindalundgren) (Wed, 08 Nov 2023 22:22:10 GMT):** Rollback: LL rolled back for revision to online program fee. Email sent to Jeff Seegmiller explaining the online program fee.

**Tyler Bland (tbland) (Wed, 08 Nov 2023 23:28:54 GMT):** Rollback: Rollback

**Sydney Beal (sbeal) (Tue, 12 Dec 2023 16:47:54 GMT):** Rollback: Rolled back per request

**Sydney Beal (sbeal) (Wed, 13 Dec 2023 19:09:39 GMT):** Rollback: Rolled back to add additional workflow step between 20 Dean and Provost's Office

**Sydney Beal (sbeal) (Tue, 23 Jan 2024 22:43:47 GMT):** Approved at UCC pending the successful approval of the associated coursework

Key: 540

**Program Resource Requirements.**

- Indicate all resources needed including the planned FTE enrollment, projected revenues, and estimated expenditures for the first **four** fiscal years of the
- Include reallocation of existing personnel and resources and anticipated or requested new resources.
- Second and third year estimates should be in constant dollars.
- Amounts should reconcile subsequent pages where budget explanations are provided.
- If the program is contract related, explain the fiscal sources and the year-to-year commitment from the contracting agency(ies) or party(ies).
- Provide an explanation of the fiscal impact of any proposed discontinuance to include impacts to faculty (i.e., salary savings, re-assignments).

**I. PLANNED STUDENT ENROLLMENT**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
A. New enrollments		15		15		15		15
B. Shifting enrollments								
<b>Total Enrollment</b>	0	15	0	15	0	15	0	15

**II. REVENUE**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
1. New Appropriated Funding Request	\$417,600.00		\$417,600.00		\$417,600.00		\$417,600.00	
2. Institution Funds	\$212,400.00	\$200,000.00	\$212,400.00		\$212,400.00		\$212,400.00	
3. Federal	\$0.00		\$0.00		\$0.00		\$0.00	
4. New Tuition Revenues from Increased Enrollments	\$375,000.00		\$375,000.00		\$375,000.00		\$375,000.00	
5. Student Fees								
6. Other (i.e., Gifts)								
<b>Total Revenue</b>	<u>\$1,005,000</u>	<u>\$200,000</u>	<u>\$1,005,000</u>	<u>\$0</u>	<u>\$1,005,000</u>	<u>\$0</u>	<u>\$1,005,000</u>	<u>\$0</u>

***Ongoing is defined as ongoing operating budget for the program which will become part of the base.***

***One-time is defined as one-time funding in a fiscal year and not part of the base.***

III. EXPENDITURES

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>A. Personnel Costs</b>								
1. FTE	<u>5.5</u>		<u>5.5</u>		<u>5.5</u>		<u>5.5</u>	
2. Faculty	<u>\$315,000.00</u>		<u>\$315,000.00</u>		<u>\$315,000.00</u>		<u>\$315,000.00</u>	
3. Adjunct Faculty								
4. Graduate/Undergrad Assistants								
5. Research Personnel								
6. Directors/Administrators	<u>200,000</u>		<u>200,000</u>		<u>200,000</u>		<u>200,000</u>	
7. Administrative Support Personnel	<u>115,000</u>		<u>115,000</u>		<u>115,000</u>		<u>115,000</u>	
8. Fringe Benefits	<u>102,600</u>		<u>102,600</u>		<u>102,600</u>		<u>102,600</u>	
9. Other:								
<b>Total Personnel and Costs</b>	<u><u>\$732,600</u></u>	<u><u>\$0</u></u>	<u><u>\$732,600</u></u>	<u><u>\$0</u></u>	<u><u>\$732,600</u></u>	<u><u>\$0</u></u>	<u><u>\$732,600</u></u>	<u><u>\$0</u></u>

FY 25

FY 26

FY 27

FY 28  
September 16, 2021  
Page 2

<b>B. Operating Expenditures</b>	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
	1. Travel	\$25,000.00		\$25,000.00		\$25,000.00		\$25,000.00
2. Professional Services	\$50,000.00		\$50,000.00		\$50,000.00		\$50,000.00	
3. Other Services	\$5,000.00		\$5,000.00		\$5,000.00		\$5,000.00	
4. Communications	\$20,000.00		\$20,000.00		\$20,000.00		\$20,000.00	
5. Materials and Supplies	\$167,400.00		\$167,400.00		\$167,400.00		\$167,400.00	
6. Rentals								
7. Materials & Goods for Manufacture & Resale								
8. Miscellaneous	\$5,000.00		\$5,000.00		\$5,000.00		\$5,000.00	
<b>Total Operating Expenditures</b>	<b>\$272,400</b>	<b>\$0</b>	<b>\$272,400</b>	<b>\$0</b>	<b>\$272,400</b>	<b>\$0</b>	<b>\$272,400</b>	<b>\$0</b>

<b>C. Capital Outlay</b>	<b>FY 25</b>		<b>FY 26</b>		<b>FY 27</b>		<b>FY 28</b>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
1. Library Resources								
2. Equipment		\$200,000.00						
<b>Total Capital Outlay</b>	<b>\$0</b>	<b>\$200,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

FY \_\_\_\_\_

FY \_\_\_\_\_

FY \_\_\_\_\_

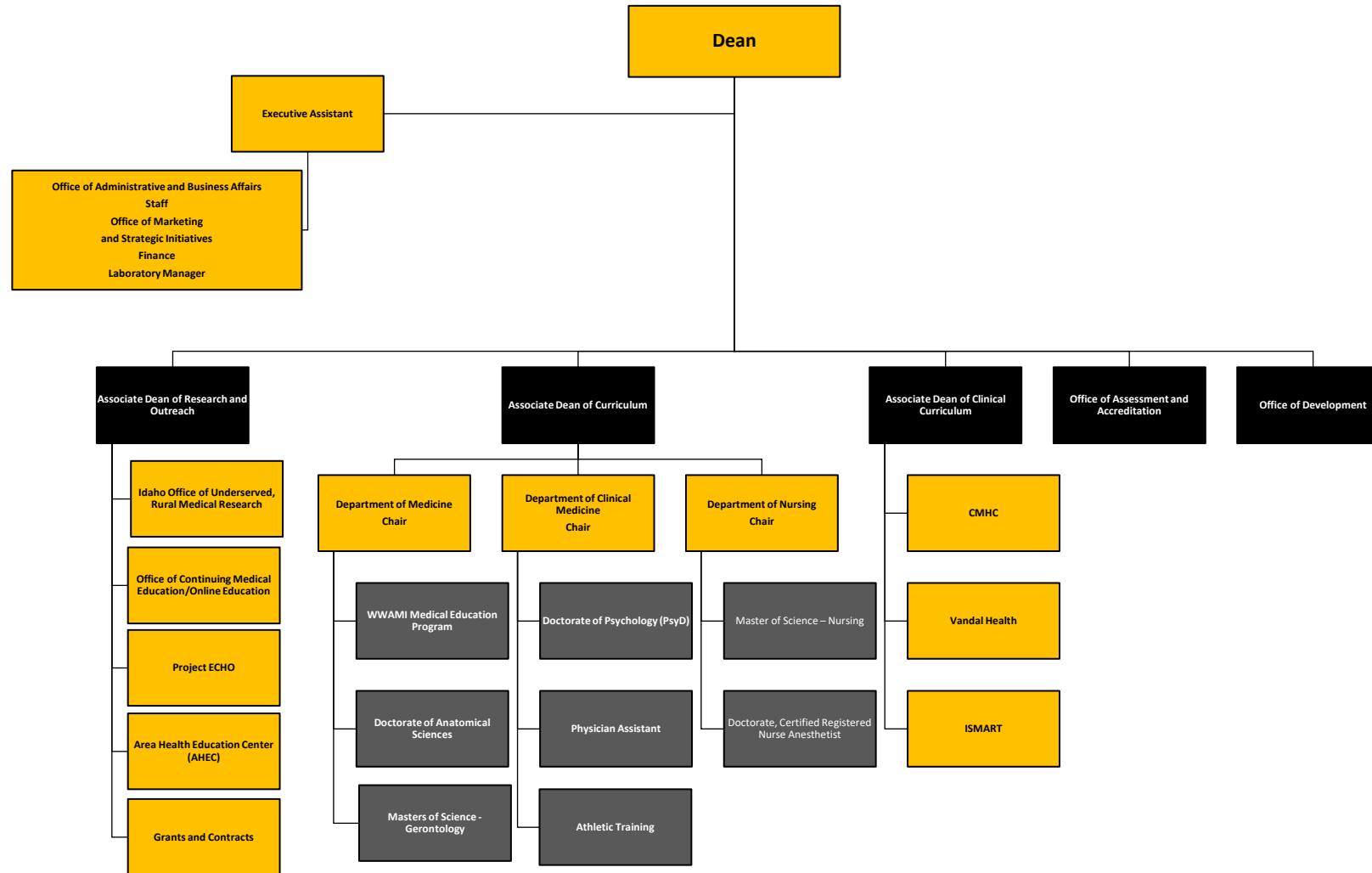
FY \_\_\_\_\_

	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>D. Capital Facilities Construction or Major Renovation</b>								
<b>E. Other Costs</b>								
Utilities								
Maintenance & Repairs								
Other								
<b>Total Other Costs</b>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
<b>TOTAL EXPENDITURES:</b>	<u>\$1,005,000</u>	<u>\$200,000</u>	<u>\$1,005,000</u>	<u>\$0</u>	<u>\$1,005,000</u>	<u>\$0</u>	<u>\$1,005,000</u>	<u>\$0</u>
<b>Net Income (Deficit)</b>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

Budget Notes (specify row and add explanation where needed; e.g., "I.A.,B. FTE is calculated using..."):

II.1	Request for \$417,600 to support the new Masters of Nursing program.
II.1	Institutional funds \$212,400 consecutively will support this program as well.
C.2	Simulation and laboratory equipment

# School of Health and Medical Professions



## **Proposed Nursing Degree: Master of Science in Nursing (MSN)**

### **Justification:**

Rural areas struggle to find adequate numbers of nurses and data shows that there has been a profound urban shift in practicing registered nurses. In 2005, 17% of registered nurses worked in rural areas, but that number dropped to 14.4% by 2018. In 2005, 16.4% of nurses worked in rural hospitals, but in 2018, that figure dropped to 13.4%. The percentage of registered nurses working at rural critical access hospitals in 2018 was 38.5%, but the Covid-19 pandemic accelerated the retirement of many older nurses, and rural facilities with tight budgets could not compete with better funded urban healthcare centers and the rural nursing workforce dropped even further. Although efforts to train and recruit more nurses are ongoing and projections show enough new nurses to replace retiring baby boomer registered nurses, the replacement distribution is expected to be uneven with urban locales attracting more new nurses than rural regions (National Academies Press, 2021).

Research shows that graduate-level direct-entry nursing students demonstrate discipline and independent learning skills that transfer well to nursing and outperform younger nursing students. With an average age of 26, direct-entry graduate students are motivated, engaged learners who demonstrate emotional maturity well-suited for healthcare employment (Everrett et al., 2013). With calls for educational leadership that meets actual needs by delivering innovative educational programs that harness technology to transform curricular offerings (Thompson, 2016), a direct-entry nursing education program addresses unmet needs for both an able student population and a struggling rural workforce.

Currently, no institution in Idaho offers a Direct Entry Master of Science in Nursing (MSN) and there are only 41 programs of this type in the nation. Idaho students who have already obtained a bachelor's degree in a non-nursing field, must complete a second bachelor's degree, or leave the state if they want to enter the nursing profession. This is an inefficient use of human resources and an obstacle that keeps many nontraditional students from entering the nursing field. The proposed Direct Entry (aka Entry to Practice) MSN program fills this educational gap for Idaho. The proposed MSN Direct Entry program is a full-time accelerated nursing program that prepares students of all academic backgrounds who have a degree in a field other than nursing to become practicing nurses. Upon graduation, students will be prepared to take the nursing licensure exam NCLEX-RN to be licensed as an RN.

Prerequisites include a bachelor's degree in a non-nursing field with GPA of 3.0 or higher, anatomy with lab (3-4 credits), microbiology (3-4 credits), nutrition (2-3 credits), physiology with lab (3-4 credits), statistics (3 credits). A 3+2 program option will also be available through the University of Idaho in the future for students who want to change their career trajectory before the end of their baccalaureate education.

Mode of Delivery:

1. Campus-based curricula
2. Hybrid-online

4-semester program with three foundational elements:

1. Nursing foundational theory courses. Hybrid-online or on-campus.
2. Nursing skills practicum and simulation. On-site requirement.
3. Nursing clinical rotations. Healthcare facilities. Travel required.

Proposed Curriculum:

The Direct Entry MSN Nursing Curriculum is an accelerated program that requires 67 credit hours of training. Coursework is designed to build knowledge and skills in a stepwise manner in the context of patient care. Hybrid mode of course delivery with in-person and online didactic instruction followed by in-person skills labs and clinical immersion experiences.

### Semester One

Course	Description	Credits
MSN 506	Foundations of Nursing Practice	3
MSN 507	Health Assessment	2
MSN 508	Health Assessment lab	1
MSN 509	Pathophysiology	3
MSN 510	Integrated Clinical Management 1: concepts and interventions to promote mental health	3
MSN 511	Integrated Clinical Management 1: concepts and interventions to promote mental health clinical	2
MSN 512	Pharmacotherapeutics	3
Total credits		17

### Semester Two

Course	Description	Credits
MSN 513	Nursing Fundamentals and Professional Practices	3
MSN 514	Theoretical Foundations for Nursing Practice	3
MSN 515	Integrated Clinical Management 2: adult and gerontological chronic health alterations	3
MSN 516	Integrated Clinical Management 2: adult and Gerontological Chronic Health Alterations clinical	2
MSN 517	Ethics, Policy, and Health Care Advocacy	3
MSN 518	Health Promotion and Risk Reduction Across the Lifespan	3
Total credits		17



### Semester Three

<b>Course</b>	<b>Description</b>	<b>Credits</b>
MSN 519	Healthcare Research and Evidence-based Practice	3
MSN 520	Interprofessional Collaboration and Population Health	3
MSN 521	Quality and Patient Safety in Health Care	3
MSN 522	Integrated Clinical Management 3: adult and gerontological acute health alterations	3
MSN 523	Integrated Clinical Management 3: adult and Gerontological Acute Health Alterations clinical	2
MSN 524	Informatics, Technology, and Professional Issues	3
Total credits		17

### Semester Four

<b>Course</b>	<b>Description</b>	<b>Credits</b>
MSN 525	Healthcare Organizational and Systems Leadership	3
MSN 526	Integrated Clinical Management 4: Pediatric, Obstetric, and Women's Health	3
MSN 527	Integrated Clinical Management 4: Pediatric, Obstetric, and Women's Health clinical	2
MSN 528	Professional Nursing Practice Capstone Experience	5
MSN 529	Emerging Topics and Transition to Nursing Practice	3
Total credits		16

## COURSE DESCRIPTIONS

### Semester One

Course	Description	Credits
MSN 506	<p><b>Foundations of Nursing Practice</b></p> <p>This foundational course introduces students to core concepts of clinical nursing, including clinical reasoning, professional ethics, therapeutic communication, and activities of daily living. Students will develop the knowledge, skills and attitudes required for safe, high quality, culturally sensitive, person-centered care across the lifespan. Students will also develop beginning competency in fundamental psychomotor and technological skills used by nurses in various health care settings to promote patient health and independence.</p>	3
MSN 507	<p><b>Health Assessment</b></p> <p>This course prepares students to conduct a health history assessment using developmentally and culturally appropriate approaches for individuals across the lifespan. Students will acquire the knowledge and understanding needed to perform, interpret, and communicate a health history using motivational interviewing, identifying obvious deviations from normal in adult, elderly, and pediatric populations.</p>	2
MSN 508	<p><b>Health Assessment lab</b></p> <p>Utilizing a systems approach, basic physical assessment skills will be mastered. Identification and interpretation of abnormalities in the physical exam are emphasized. This course's aim is to provide students with the critical thinking skills needed for the beginning nursing student to perform appropriate health assessments in context of patient history, status, and physical exam data.</p>	1
MSN 509	<p><b>Pathophysiology*</b></p> <p>In this course, students learn pathophysiological processes that contribute to different disease states across the lifespan and human responses to those processes. Students will explore authentic case studies to learn to make selective clinical decisions using current, reliable sources of pathophysiology information.</p>	3
MSN 510	<p><b>Integrated Clinical Management 1: concepts and interventions to promote mental health</b></p> <p>This course explores the biological, psychological, cultural, societal, and environmental factors that affect psychological wellness and illness. Students will gain understanding of mental health issues secondary to physical or psychiatric illness, trauma, or loss.</p>	3

MSN 511	<p><b>Integrated Clinical Management 1: concepts and interventions to promote mental health clinical</b></p> <p>This clinical nursing course will help students gain experience in caring for patients with psychological illnesses. Students will develop beginning competencies in providing nursing care to individuals and families experiencing disruptions in mental health secondary to physical or psychiatric illness, trauma, or loss.</p>	2
MSN 512	<p><b>Pharmacotherapeutics</b></p> <p>Principles of pharmacology will be discussed, including pharmacokinetics, pharmacodynamics, and toxicities. Major drug classifications, pharmacologic agents used to treat common disease states, and prototype drugs are presented. Discussion will include medication safety issues, nursing management of drug therapy including maximizing therapeutic effects, minimizing adverse effects, and patient and family education. These concepts will be reviewed in relation to patient case scenarios.</p>	3

## Semester Two

Course	Description	Credits
MSN 513	<p><b>Nursing Fundamentals and Professional Practices</b></p> <p>This course introduces students to the theories and principles that form the foundation for professional nursing practice. The theoretical foundation of caring and culture care is introduced. The fundamental concepts basic to nursing such as health and wellness, nursing process, therapeutic communication, and holistic health are examined. Historical, legal, professional, cultural, economic, and social factors that influence nursing and health care delivery are studied.</p>	3
MSN 514	<p><b>Integrated Clinical Management 2: adult and gerontological chronic health alterations</b></p> <p>This course explores the biological, psychological, cultural, societal, and environmental factors that affect the development of chronic illnesses. Students will gain an understanding of integrated treatment approaches including behavior change, pharmacologic agents, physical therapy, and other approaches to improve outcomes for patients with chronic health alterations.</p>	3
MSN 515	<p><b>Integrated Clinical Management 2: adult and Gerontological Chronic Health Alterations clinical</b></p>	2

	<p>This clinical nursing course introduces students to concepts central to the effective management of a variety of common chronic illnesses and disabling conditions in a variety of different settings. Students will practice using motivational interviewing techniques to conduct an in-depth health assessment of individuals with chronic conditions that is person-centered and both developmentally and culturally appropriate. They will also learn how to partner with individuals, their families and other health professionals to manage chronic conditions and make desired changes in health behavior to reduce long-term risks.</p>	
MSN 516	<p><b>Theoretical Foundations for Nursing Practice</b>  This course focuses on the philosophical and theoretical bases underlying concepts and operations inherent to nursing. Synthesis of theories from behavioral, natural, social, applied sciences, and nursing is emphasized. Investigation of the intersections between system science and organizational science will be explored. Students will analyze clinical problems integrating ethical concepts, nursing, and scientific theories and incorporate prevention, intervention, and health promotion strategies to create solutions.</p>	3
MSN 517	<p><b>Ethics, Policy, and Health Care Advocacy*</b>  In this course, students will explore ethical frameworks for policy and patient care, explore policy making processes, examine effects of policy on practice, explore relationship between advocacy and policy change, and analyze how policy influences financing of health care, practice, and health outcomes.</p>	3
MSN 518	<p><b>Health Promotion and Risk Reduction Across the Lifespan</b>  This course integrates clinical prevention and population health concepts to develop patient-centered culturally responsive strategies to promote prevention and intervention services to individuals, families, communities, and clinical populations. Students will synthesize global and social determinants of health using principles of genetics, genomics, biostatistics, and epidemiology to design and implement clinical prevention and intervention initiatives.</p>	3

### Semester Three

Course	Description	Credits
MSN 519	<p><b>Healthcare Research and Evidence-based Practice*</b></p> <p>In this course, students will integrate theory, evidence, clinical judgment, research, and advocacy in becoming scholarly clinicians. Students will utilize multiple resources to evaluate evidence to inform patient care and utilize data to inform point-of-care decisions.</p>	3
MSN 520	<p><b>Interprofessional Collaboration and Population Health*</b></p> <p>Improving population health in a complex delivery system requires interprofessional collaboration. Scopes of practice within healthcare teams may overlap, necessitating effective communication, team building, and conflict management skills. Theoretical and applied frameworks for group dynamics, patient-centered care, and leadership will also be explored.</p>	3
MSN 521	<p><b>Quality and Patient Safety in Health Care*</b></p> <p>This interactive course explores quality improvement, research processes, knowledge of healthcare systems, and innovative corrective measures as it relates to safe, effective nursing practice. Evidence-based strategies for building cultures of quality and safety within complex healthcare delivery systems will be explored. Strategies for data management, analysis of errors, and personnel management to reduce fatigue and burnout will also be explored.</p>	3
MSN 522	<p><b>Integrated Clinical Management 3: adult and gerontological acute and complex health alterations</b></p> <p>This theoretical course prepares students to provide comprehensive, patient-centered nursing care for patients with acute or complex illness and injury. Building on previous coursework, this course will focus on building a comprehensive understanding of factors related to acute and complex physiological alterations.</p>	3
MSN 523	<p><b>Integrated Clinical Management 3: adult and gerontological acute and complex health alterations clinical</b></p> <p>This clinical course uses a wide variety of experiential learning activities including simulation, role play and case studies to facilitate the integration of key concepts presented throughout the curriculum. Concepts include communication, person-centered care, ethical decision making, end-of-life decisions, culturally</p>	2

	appropriate care, quality and safety, social justice, and professionalism.	
MSN 524	<p><b>Informatics, Technology, and Professional Issues</b></p> <p>This interprofessional course on technology and innovations in health care will incorporate a multidisciplinary approach including nursing, medicine, social and behavioral sciences, as well as information technology and engineering perspectives to stimulate new thinking in the practice, process, and delivery of health care. The goal of the course is to stimulate thinking about new processes, technologies and strategies designed to improve overall health outcomes.</p>	3

#### Semester Four

Course	Description	Credits
MSN 525	<p><b>Healthcare Organizational and Systems Leadership</b></p> <p>This course explores philosophical and theoretical perspectives of leadership using contemporary approaches and strategies to make data-driven decisions using an ethical framework to promote quality patient care. Focus is placed on specific challenges in health care and leadership at various levels (e.g., unit, organizational, and policy levels), as well as in a variety of organizational settings and environments. Interprofessional communication, teamwork, delegation, supervision, conflict resolution, healthcare finance, and supply chain management will be explored through a combination of individual projects, small and large group discussions, individual reflection, and case studies to explore the complexity of leadership styles in both extraordinarily successful and less successful leaders.</p>	3
MSN 526	<p><b>Integrated Clinical Management 4: Pediatric, Obstetric, and Women's Health</b></p> <p>This course will introduce students to theory and application of evidence-based care for special populations including pediatric, obstetric, and women's health patients. In this nursing specialty course, students will develop a comprehensive understanding of the physiologic, psycho-social, legal, and ethical considerations impacting the nurse's role in caring for these populations. Students will learn about advanced physiologic principles of genetic screening modalities, including first and second trimester screening and testing for Down's syndrome and open neural tube defects. Students will review physiologic principles underlying screening modalities for fetal well-being during pregnancy and the birth process. Ethical considerations, legal and risk management issues for the nurse in clinical practice will be reviewed. Current practice</p>	3

	<p>guidelines from key professional organizations (AWHOHH, ACNM, ACOG, NICHD) will be introduced and analyzed from an evidence-based perspective.</p>	
MSN 527	<p><b>Integrated Clinical Management 4: Pediatric, Obstetric, and Women’s Health clinical</b>  This clinical course will provide introductory experience in a variety of settings with specialty practice for pediatric, obstetric, and gynecologic patients. Case-studies and simulation will be used to include key concepts in quality and safety, including patient advocacy, teamwork and interprofessional communication. Neonatal resuscitation will be introduced with practical application.</p>	2
MSN 528	<p><b>Professional Nursing Practice Capstone Experience</b>  This practicum experience is designed to facilitate transition to professional practice. Students are placed in a healthcare setting with a preceptor with expertise in that area. Most student placements are on adult acute care units, however, there may be limited opportunities for specialty preceptorships including pediatrics, OB, critical care, community/ambulatory care, public health, rural health, and mental health. Emphasis is on the synthesis of previous and concurrent learning, development of independence in nursing practice, skill in clinical decision-making and application of nursing, leadership, and management skills.</p>	5
MSN 529	<p><b>Emerging Topics and Transition to Nursing Practice</b>  This course is designed to facilitate the transition from nursing student to professional nurse. Course concepts include ethical comportment, professional values of social justice, autonomy, advocacy, altruism, human dignity and integrity, current events, and issues within the profession, and NCLEX preparation. Students will be required to pass a mastery exit examination.</p>	3

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# THE ESSENTIALS:

## CORE COMPETENCIES FOR PROFESSIONAL NURSING EDUCATION



American Association  
*of Colleges of Nursing*

*The Voice of Academic Nursing*



***THE ESSENTIALS:***

**CORE COMPETENCIES FOR  
PROFESSIONAL NURSING EDUCATION**

APPROVED BY THE AACN MEMBERSHIP ON APRIL 6, 2021

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***The Essentials: Core Competencies for Professional Nursing Education***  
**April 6, 2021**

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## ***The Essentials: Core Competencies for Professional Nursing Education***

### **Introduction**

Since 1986, the American Association of Colleges of Nursing (AACN) has published the *Essentials* series that provides the educational framework for the preparation of nurses at four-year colleges and universities. In the past, three versions of Essentials were published: *The Essentials of Baccalaureate Education for Professional Nursing Practice*, last published in 2008; *The Essentials of Master’s Education in Nursing*, last published in 2011; and *The Essentials of Doctoral Education for Advanced Nursing Practice*, last published in 2006. Each of these documents has provided specific guidance for the development and revision of nursing curricula at a specific degree level. Given changes in higher education, learner expectations, and the rapidly evolving healthcare system outlined in AACN’s *Vision for Academic Nursing* (2019), new thinking and new approaches to nursing education are needed to prepare the nursing workforce of the future.

*The Essentials: Core Competencies for Professional Nursing Education* provides a framework for preparing individuals as members of the discipline of nursing, reflecting expectations across the trajectory of nursing education and applied experience. In this document competencies for professional nursing practice are made explicit. These *Essentials* introduce 10 domains that represent the essence of professional nursing practice and the expected competencies for each domain (see page 26). The domains and competencies exemplify the uniqueness of nursing as a profession and reflect the diversity of practice settings yet share common language that is understandable across healthcare professions and by employers, learners, faculty, and the public. The competencies accompanying each domain are designed to be applicable across four spheres of care (disease prevention/promotion of health and wellbeing, chronic disease care, regenerative or restorative care, and hospice/palliative/supportive care), across the lifespan, and with diverse patient populations. While the domains and competencies are identical for both entry and advanced levels of education, the sub-competencies build from entry into professional nursing practice to advanced levels of knowledge and practice. The intent is that any curricular model should lead to the ability of the learner to achieve the competencies. The *Essentials* also feature eight concepts that are central to professional nursing practice and are integrated within and across the domains and competencies.

Because this document has been shared with practice partners and with other nursing colleagues, the *Essentials* serve to bridge the gap between education and practice. The core competencies are informed by the expanse of higher education, nursing education, nursing as a discipline, and a breadth of knowledge. The core competencies also are informed by the lived experiences of those deeply entrenched in various areas where nurses practice and the synthesis of knowledge and action intersect. The collective understanding allows all nurses to have a shared vision; promotes open discourse and exchange about nursing practice; and expresses a unified voice that represents the nursing profession.

This introduction provides an overview of the evolution of nursing as a discipline, critical aspects of the profession that serve as a framework, and sufficient depth to inform nursing education across the educational trajectory (entry into practice through advanced education).

Specific citations throughout provide immediate access to pertinent references that substantiate relevancy.

## Foundational Elements

*The Essentials: Core Competencies for Professional Nursing Education* has been built on the strong foundation of nursing as a discipline, the foundation of a liberal education, and principles of competency-based education.

### ***Nursing as a Discipline***

The *Essentials*, as the framework for preparing nursing's future workforce, intentionally reflect and integrate nursing as a discipline. The emergence of nursing as a discipline had its earliest roots in Florence Nightingale's thoughts about the nature of nursing. Believing nursing to be both a science and an art, she conceptualized the whole patient (mind, body, and spirit) as the center of nursing's focus. The influence of the environment on an individual's health and recovery was of utmost importance. The concepts of health, healing, well-being, and the interconnectedness with the multidimensional environment also were noted in her work. Although Nightingale did not use the word "caring" explicitly, the concept of care and a commitment to others were evident through her actions (Dunphy, 2015). In the same era of Florence Nightingale, nurse pioneer Mary Seacole was devoted to healing the wounded during the Crimean war.

Following Nightingale, the nursing profession underwent a period of disorganization and confusion as it began to define itself as a distinct scientific discipline. Early nursing leaders (including Mary Eliza Mahoney, Effie Taylor, Annie Goodrich, Agatha Hodgins, Esther Lucille Brown, and Loretta Ford) sought to define the functions of the nurse (Gunn, 1991; Keeling, Hehman, & Kirchgessner, 2017). Other leaders devoted their efforts to addressing discrimination, advancing policies, and creating a collective voice for the profession. It would be difficult to gain an understanding of this period of the profession's development without considering the work of Lavinia Dock, Estelle Osborne, Mary Elizabeth Carnegie, Ildaura Murillo-Rohde, and many other fearless champions.

Contemporary nursing as it is practiced today began to take shape as a discipline in the 1970s and 1980s. Leaders of this era shared the belief that the discipline of nursing was the study of the well-being patterning of human behavior and the constant interaction with the environment, including relationships with others, health, and the nurse (Rogers, 1970; Donaldson & Crowley, 1978; Fawcett, 1984; Chinn & Kramer 1983, 2018; Chinn, 2019; Roy & Jones, 2007). The concept of caring also was described as the defining attribute of the nursing discipline (Leininger, 1978; Watson, 1985). Newman (1991) spoke to the need to sharpen the focus of the discipline of nursing to better define its social relevance and the nature of its service. Newman, Smith, Pharris, and Jones (2008) affirmed caring as the focus of the discipline, suggesting that relationships were the unifying construct. Smith and Parker (2010) later posited that relationships were built on partnership, presence, and shared meaning.

In a historical analysis of literature on the discipline of nursing, five concepts emerged as defining the discipline: human wholeness; health; healing and well-being; environment-health relationship; and caring. When practicing from a holistic perspective, nurses understand the

dynamic, ongoing body-brain-mind-spirit interactions of the person, between and among individuals, groups, communities, and the environment (Smith, 2019, pp. 9-12). Smith purports that if nursing is to retain its status as a discipline, the explicit disciplinary knowledge must be an integral part of all levels of nursing. Nursing has its own science, and this body of knowledge is foundational for the next generation (Smith, 2019, p.13).

Why consider the past in a document that strives to shape the future? The historical roots of the profession help its members understand how the past has answered complex questions and shapes vital discipline concepts, traditions, policies, and even relationships. D'Antonio, et. al (2010) also emphasize the disciplinary insights gained by considering the different histories that challenge the dominant and accepted historical narrative. Undoubtedly, many experts have contributed to the development of the discipline as it exists today. While the work of early and current theorists is extensive, Green (2018) notes that none have been accepted as completely defining the nature of nursing as a discipline. No doubt, nursing as a discipline will continue to evolve as society and health care evolves.

### ***Advancing the Discipline of Nursing***

The continued development of nursing as a unique discipline requires an intentional approach. Jairath et. al (2018) stated that any further development of the discipline should have the capacity to directly transform the patient's health experience. A new social order may be necessary in which scientists, theorists, and practitioners work together to address questions related to the interplay of big data and nursing theory. Nursing graduates, particularly at the advanced nursing practice level, must be well-prepared to think ethically, conceptually, and theoretically to better inform nursing care. Students must not only be introduced to the knowledge and values of the discipline, but they must be guided to practice from a disciplinary perspective – by seeing patients through the lens of wholeness and interconnectedness with family and community; appreciating how the social, political, and economic environment influences health; attending to what is most important to well-being; developing a caring-healing relationship; and honoring personal dignity, choice, and meaning. Smith and McCarthy (2010) spoke to the need to provide a foundation for practitioners in the knowledge of the discipline. Without this knowledge, the persistent challenge of differentiating nursing and the professional levels of practice will continue.

Knowledge of the discipline grows in graduate education, as students apply and generate nursing knowledge in their advanced nursing roles or develop and test theories as researchers. Nursing practice should be guided by a nursing perspective while functioning within an interdisciplinary arena. To appropriately educate the next generation of nurses, disciplinary knowledge must be leveled to reflect the competencies or roles expected at each level.

### ***The Value of a Liberal Education***

In higher education, every academic discipline is grounded in a unique body of knowledge that distinguishes that discipline. Through the study of the humanities, social sciences, and natural sciences, students develop the capacity to engage in socially valued work and civic leadership in society. Liberal education exposes students to a broad worldview, multiple disciplines, and ways of knowing through specific coursework; however, the richness of perspective and knowledge is woven throughout the nursing curriculum as these are integral to the full scope of nursing



practice (Hermann, 2004). Successful integration of liberal and nursing education provides graduates with knowledge of human cultures, including spiritual beliefs, as well as the physical and natural worlds supporting an approach to practice. The study of history, critical race theories, critical theories of nursing, critical digital studies, planetary health and climate science, politics, public policies, policy formation, fine arts, literature, languages, and the behavioral, biological, and natural sciences are key to the understanding of one's self and others, civil readiness, and engagement and forms the basis for clinical reasoning and subsequent clinical judgments.

A liberal education creates the foundation for intellectual and practical abilities within the context of nursing practice as well as for engagement with the larger community, locally and globally. A hallmark of liberal education is the development of a personal value-system that includes the ability to act ethically regardless of the situation and where students are encouraged to define meaningful personal and professional goals with a commitment to integrity, equity, and social justice. Liberally educated graduates are well prepared to integrate knowledge, skills, and values from the arts, sciences, and humanities to provide safe, quality care; advocate for patients, families, communities, and populations; and promote health equity and social justice. Equally important, nursing education needs to ensure an understanding of the intersection of bias, structural racism, and social determinants with healthcare inequities and promote a call to action.

### ***Competency-Based Education***

Competency-based education is a process whereby students are held accountable to the mastery of competencies deemed critical for an area of study. Competency-based education is inherently anchored to the outputs of an educational experience versus the inputs of the educational environment and system. Students are the center of the learning experience, and performance expectations are clearly delineated along all pathways of education and practice. Across the health professions, curriculum, course work, and practice experiences are designed to promote responsible learning and assure the development of competencies that are reliably demonstrated and transferable across settings. By consistently assessing their own performance, students develop the ability to reflect on their own progress towards the achievement of learning goals and the ongoing attainment of competencies required for practice.

Advances in learning approaches and technologies, understanding of evolving student learning styles and preferences, and the move to outcome-driven education and assessment all point to a transition to competency-based education. This learning approach is linked to explicitly defined performance expectations, based on observable behavior, and requires frequent assessment using diverse methodologies and formats. Designed in this fashion, competency-based education produces learning and behavior that endures, since it encourages conscious connections between knowledge and action. Learners who put knowledge into action grasp the interrelatedness of their learning with both theoretical perspectives and the world of their professional work. Achieving a specific competency gives meaning to the theoretical and assists in understanding and taking on a professional identity.

Further, today's students increasingly are taking responsibility for their own learning and, varied as they are in age and experience, respond to active learning strategies. Active learning involves

making an action out of knowledge—using knowledge to reflect, analyze, judge, resolve, discover, interact, and create. Active learning requires clear information regarding what is to be learned, including guided practice in using that information to achieve a competency. It also requires regular assessment of progress towards mastery of the competency and frequent feedback on successes and areas needing development. Additionally, students must learn how to assess their own performances to develop the skill of continual self-reflection in their own practice.

Stakeholders (employers, students, and the public) expect all nursing graduates to exit their education programs with defined and observable skills and knowledge. Employers desire assurance that graduates have expected competencies—the ability “to know” and also “to do” based on current knowledge. Moving to a competency-based model fosters intentionality of learning by defining domains, associated competencies, and performance indicators for those competencies. Currently, there is wide variability in graduate capabilities. Therefore, there is a need for consistency enabled by a competency-based approach to nursing education.

A standard set of definitions frame competency-based education in the health professions and was adopted for these *Essentials*. Adoption of common definitions allows multiple stakeholders involved in health education and practice to share much of the same language. These definitions are included in the glossary (p. 59).

## **Nursing Education for the 21<sup>st</sup> Century**

In addition to the foundational elements on which the *Essentials* has been developed, other factors have served as design influencers. What does the nursing workforce need to look like for the future, and how do nursing education programs prepare graduates to be “work ready”? Nursing education for the 21<sup>st</sup> century ought to reflect a number of contemporary trends and values and address several issues to shape the future workforce, including diversity, equity, and inclusion; four spheres of care (including an enhanced focus on primary care); systems-based practice; informatics and technology; academic-practice partnerships; and career-long learning.

### ***Diversity, Equity, and Inclusion***

Shifting U.S. population demographics, health workforce shortages, and persistent health inequities necessitate the preparation of nurses able to address systemic racism and pervasive inequities in health care. The existing inequitable distribution of the nursing workforce across the United States, particularly in underserved urban and rural areas, impacts access to healthcare services across the continuum from health promotion and disease prevention, to chronic disease management, to restorative and supportive care. Diversity, equity, and inclusion—as a value—supports nursing workforce development to prepare graduates who contribute to the improvement of access and care quality for underrepresented and medically underserved populations (AACN, 2019). Diversity, equity, and inclusion require intentionality, an institutional structure of social justice, and individually concerted efforts. The integration of diversity, equity, and inclusion in this *Essentials* document moves away from an isolated focus on these critical concepts. Instead, these concepts, defined in competencies, are fully represented and deeply integrated throughout the domains and expected in learning experiences across curricula.

Making nursing education equitable and inclusive requires actively combating structural racism, discrimination, systemic inequity, exclusion, and bias. Holistic admission reviews are recommended to enhance the admission of a more diverse student population to the profession (AACN, 2020). Additionally, an equitable and inclusive learning environment will support the recruitment, retention, and graduation of nursing students from disadvantaged and diverse backgrounds. Diverse and inclusive environments allow examination of any implicit or explicit biases, which can undermine efforts to enhance diversity, equity, and inclusion. When diversity is integrated within inclusive educational environments with equitable systems in place, biases are examined, assumptions are challenged, critical conversations are engaged, perspectives are broadened, civil readiness and engagement are enhanced, and socialization occurs. These environments recognize the value of and need for diversity, equity, and inclusion to achieve excellence in teaching, learning, research, scholarship, service, and practice.

Academic nursing must address structural racism, systemic inequity, and discrimination in how nurses are prepared. Nurse educators are called to critically evaluate policies, processes, curricula, and structures for homogeneity, classism, color-blindness, and non-inclusive environments. Evidence-based, institution-wide approaches focused on equity in student learning and catalyzing culture shifts in the academy are fundamental to eliminating structural racism in higher education (Barber et al., 2020). Only through deconstructive processes can academic nursing prepare graduates who provide high quality, equitable, and culturally competent health care.

Finally, nurses should learn to engage in ongoing personal development towards understanding their own conscious and unconscious biases. Then, acting as stewards of the profession, they can fulfill their responsibility to influence both nursing and societal attitudes and behaviors toward eradicating structural/systemic racism and discrimination and promoting social justice.

### ***Four Spheres of Care***

Historically, nursing education has emphasized clinical education in acute care. Looking at current and future needs, it is becoming increasingly evident that the future of healthcare delivery will occur within four spheres of care: 1) disease prevention/promotion of health and well-being, which includes the promotion of physical and mental health in all patients as well as management of minor acute and intermittent care needs of generally healthy patients; 2) chronic disease care, which includes management of chronic diseases and prevention of negative sequelae; 3) regenerative or restorative care, which includes critical/trauma care, complex acute care, acute exacerbations of chronic conditions, and treatment of physiologically unstable patients that generally requires care in a mega-acute care institution; and 4) hospice/palliative/supportive care, which includes end-of-life care as well as palliative and supportive care for individuals requiring extended care, those with complex, chronic disease states, or those requiring rehabilitative care (Lipstein et al., 2016; AACN, 2019).

Entry-level professional nursing education ensures that graduates demonstrate competencies through practice experiences with individuals, families, communities, and populations across the lifespan and within each of these four spheres of care. The workforce of the future needs to attract and retain registered nurses who choose to practice in diverse settings, including community settings to sustain the nation's health. Expanding primary care into communities will enable our healthcare delivery systems to achieve the Quadruple Aim of improving patient

experiences (quality and satisfaction), improving the health of populations, decreasing per capita costs of health care, and improving care team well-being (Bowles et al., 2018). It is time for nursing education to refocus and move beyond some long-held beliefs such as: primary care content is not important because it is not on the national licensing exam for registered nurses; students only value those skills required in acute care settings; and faculty preceptors only have limited community-based experiences. Recommendations from the Josiah Macy Foundation Conference (2016) on expanding the use of registered nursing in primary care provides a call to education and practice to place more value on primary care as a career choice, effectively changing the culture of nursing and health care. A collaborative effort between academic and practice leaders is needed to ensure this culture change and educate primary care practitioners about the value of the registered nurse role.

### ***Systems-Based Practice***

Integrated healthcare systems that require coordination across settings as well as across the lifespan of diverse individuals and populations are emerging. Healthcare systems are revising strategic goals and reorganizing services to move more care from the most expensive venues – inpatient facilities and emergency departments – to primary care and community settings. Consequently, nurse employment settings also are shifting, creating a change in workforce distribution and the requisite knowledge and skills necessary to provide care in those settings. Knowledge differentiating equity and equality in healthcare systems and systems-based practice is essential. Nurses in the future are needed to lead initiatives to address structural racism, systemic inequity, and discrimination. Equitable healthcare better serves the needs of all individuals, populations, and communities.

Importantly, an understanding of how local, national, and global structures, systems, politics, and rules and regulations contribute to the health outcomes of individual patients, populations, and communities will support students in developing agility and advocacy skills. Factors such as structural racism, cost containment, resource allocation, and interdisciplinary collaboration are considered and implemented to ensure the delivery of high quality, equitable, and safe patient care (Plack et al., 2018).

### ***Informatics and Technology***

Informatics increasingly has been a focus in nursing education, correlating with the advancement in sophistication and reach of information technologies, the use of technology to support healthcare processes and clinical thinking, and the ability of informatics and technology to positively impact patient outcomes. Health information technology is required for person-centered service across the continuum and requires consistency in user input, proper process, and quality management. While different specialty roles in nursing may require varying depth and breadth of informatics competency, basic informatics competencies are foundational to all nursing practice. Much work will be required to achieve full integration of core information and communication technologies competencies into nursing curricula.

### ***Engagement and Experience***

The future consumers of health care are changing. They are transitioning from passive participants in medically focused acute care environments to engaged participants of healthcare services. They actively participate in managing not only their chronic illnesses but also acute

care exacerbations with an increasing focus on prevention and wellness. Thus, nurses need an understanding of consumer engagement and experience across all settings as an essential component of person-centered, quality care.

In today's society, many people seek information and use technology to help make informed decisions about their health. Nurses seek to help patients determine what information to use and how to use it. Individuals want to know about their options when it comes to healthcare services, which extends to using websites to provide information on provider quality and performance, comparing prices for common procedures, and reviewing the effectiveness of treatments and care approaches (Adler-Milstein & Sinaiko, 2019). Gaffney (2015) stated that as consumers shoulder more of the financial responsibility for their health care, they became more educated about available options. Studies have shown that patients who are engaged in decision-making regarding their care have better outcomes and lower costs (Gaffney, 2015).

Meaningful practice experiences in health care start with the individual who is actively engaged in the journey throughout the continuum of care. Each interaction between the recipient of care and the nurse or healthcare provider creates an experience. Practice experience is defined as "the sum of all interactions, shaped by an organization's culture that influence patient perceptions across the continuum of care." (Wolf, Niederhauser, Marshburn, & LaVela, 2014, p. 8). Within that interactive experience, the attitudes and the behaviors of the nurse matter a great deal. Nurses are identified as one of the most trusted professionals in the United States. Mutual trust is foundational to an interactive and ongoing relationship that will enhance a positive experience of care. Those with positive experiences of care often have better outcomes.

Individual engagement has been described as "the blockbuster drug of the 21st century" (Dentzer, 2013). Who better to engage individuals in their care than nurses? Nursing practice has focused consistently on individual care and ongoing communication with family members and care providers. Sherman points to the fact that effective individual/family involvement leads to safer and higher quality care. In addition, individual/patient engagement can be directly correlated with increased reimbursement to hospitals based on achieving health outcomes. Nurses in all settings and across the continuum of care contribute to creating a culture that supports full engagement of individuals in their care and in the development of policies, which will provide guidance to the improvement of individual engagement (Sherman, 2014).

### ***Academic-Practice Partnerships***

Partnerships and collaborative team-based care are the cornerstones of safe, effective care whether it be for individuals, families, communities, or populations. Academic-practice partnerships serve to recruit and retain nurses and to support the practice and academic enterprise in relation to mutual research, leadership development, and a shared commitment to redesign practice environments. Such partnerships also have the potential to facilitate the ability of nurses to achieve educational and career advancement, prepare nurses of the future to practice and lead, provide mechanisms for career-long learning, and provide a structure for transition to practice programs. Successful academic-practice partnerships are predicated on respect, relationship, reciprocity, and co-design.

The 2016 report *Advancing Healthcare Transformation: A New Era for Academic Nursing* identified a path for achieving enhanced partnerships between nursing schools and academic

health centers with the goals of achieving improved healthcare outcomes, fostering new models for innovation, and advancing integrated systems of health care. While focused primarily on academic health centers, the recommendations apply to partnerships between non-academic health centers and schools of nursing as well. The recommendations include enhancing the clinical practice of academic nursing; partnering in the preparation of the nurses of the future; collaborating to develop workforce plans in partnership with the health system; integrating academic nursing into population health initiatives; partnering in the implementation of Accountable Care; and partnering for optimal patient care and healthcare delivery (AACN, 2016).

### ***Career-Long Learning***

Current trends in higher education focus on supplemental methods of awarding credit and recognition for additional learning which has implications for career-long learning. Emerging educational methods should be considered as possible additions in the development of curriculum pathways in contemporary nursing education. For example, the use of e-portfolios, which may be used to record competency achievement and educational milestones and continued throughout one's career, can be used to document personal development plans, badges, certifications, employment appraisals, and reflections on clinical events to establish meaning from various encounters.

Awarding of micro-credentials or badges by academic institutions also is becoming popular. Badges recognize incremental learning in visible ways and can support career development (Educause, 2018). Stackable credentials can be accumulated over time and facilitate one's professional development along a career trajectory (Department of Labor, 2015). Open access courses represent another way to learn a variety of skills or subject matter. All of these are important considerations in basic and advanced nursing education.



## Domains and Concepts

### Domains for Nursing

Domains are broad distinguishable areas of competence that, when considered in the aggregate, constitute a descriptive framework for the practice of nursing. These *Essentials* include 10 domains that were adapted from the interprofessional work initiated by Englander (2013) and tailored to reflect the discipline of nursing.

This document delineates the domains that are essential to nursing practice, including how these are defined, what competencies should be expected for each domain at each level of nursing, and how those domains and competencies both distinguish nursing and relate to other health professions. Each domain has a descriptor (or working definition) and a contextual statement. The contextual statement (presented in the Domain, Competency, Sub-Competency Table found beginning on page 26) provides a framing for what the domain represents in the context of nursing practice – thus providing an explanation for how the competencies within the domain should be interpreted. The domain designations, descriptors, and contextual statements may evolve over time to reflect future changes in healthcare and nursing practice. Although the domains are presented as discrete entities, the expert practice of nursing requires integration of most of the domains in every practice situation or patient encounter, thus they provide a robust framework for competency-based education. The domains and descriptors used in the *Essentials* are listed below.

- *Domain 1: Knowledge for Nursing Practice*  
Descriptor: Integration, translation, and application of established and evolving disciplinary nursing knowledge and ways of knowing, as well as knowledge from other disciplines, including a foundation in liberal arts and natural and social sciences. This distinguishes the practice of professional nursing and forms the basis for clinical judgment and innovation in nursing practice.
- *Domain 2: Person-Centered Care*  
Descriptor: Person-centered care focuses on the individual within multiple complicated contexts, including family and/or important others. Person-centered care is holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate. Person-centered care builds on a scientific body of knowledge that guides nursing practice regardless of specialty or functional area.
- *Domain 3: Population Health*  
Descriptor: Population health spans the healthcare delivery continuum from public health prevention to disease management of populations and describes collaborative activities with both traditional and non-traditional partnerships from affected communities, public health, industry, academia, health care, local government entities, and others for the improvement of equitable population health outcomes.
- *Domain 4: Scholarship for Nursing Discipline*  
Descriptor: The generation, synthesis, translation, application, and dissemination of nursing knowledge to improve health and transform health care.

- *Domain 5: Quality and Safety*  
Descriptor: Employment of established and emerging principles of safety and improvement science. Quality and safety, as core values of nursing practice, enhance quality and minimize risk of harm to patients and providers through both system effectiveness and individual performance.
- *Domain 6: Interprofessional Partnerships*  
Descriptor: Intentional collaboration across professions and with care team members, patients, families, communities, and other stakeholders to optimize care, enhance the healthcare experience, and strengthen outcomes.
- *Domain 7: Systems-Based Practice*  
Descriptor: Responding to and leading within complex systems of health care. Nurses effectively and proactively coordinate resources to provide safe, quality, equitable care to diverse populations.
- *Domain 8: Informatics and Healthcare Technologies*  
Descriptor: Information and communication technologies and informatics processes are used to provide care, gather data, form information to drive decision making, and support professionals as they expand knowledge and wisdom for practice. Informatics processes and technologies are used to manage and improve the delivery of safe, high-quality, and efficient healthcare services in accordance with best practice and professional and regulatory standards.
- *Domain 9: Professionalism*  
Descriptor: Formation and cultivation of a sustainable professional nursing identity, accountability, perspective, collaborative disposition, and comportment that reflects nursing's characteristics and values.
- *Domain 10: Personal, Professional, and Leadership Development*  
Descriptor: Participation in activities and self-reflection that foster personal health, resilience, and well-being, lifelong learning, and support the acquisition of nursing expertise and assertion of leadership.

## Concepts for Nursing Practice

In addition to domains, there are featured concepts associated with professional nursing practice that are integrated within the *Essentials*. A concept is an organizing idea or a mental abstraction that represents important areas of knowledge. A common understanding of each concept is achieved through characteristics and attributes. Many disciplines, like nursing, have numerous concepts. The featured concepts are well-represented in the nursing literature and thus also are found throughout the *Essentials* and verified through a crosswalk analysis. Specifically, the featured concepts are found in the introduction, across the domains (within domain descriptors and contextual statements), and within the competencies and sub-competencies. Although not every concept is found within every domain, each concept is represented in most domains – and all domains have multiple concepts represented.



The featured concepts found within the *Essentials* are not of ‘lesser importance’ than a domain. Each of these concepts serves as a core component of knowledge, facts, and skills across multiple situations and contexts within nursing practice. Each concept functions as a hub for transferable knowledge, thus enhancing learning when learners make cognitive links to other information through mental constructs. The integration of concepts within the competencies and sub-competencies is essential for the application throughout the educational experience. As an example, can you imagine delivering person-centered care without also considering diversity, equity, and inclusion? Can you imagine having a conversation about population health without considering ethics and health policy? These concepts truly are interrelated and interwoven within the domains and competencies, serving as a foundation to students’ learning. The featured concepts are:

- *Clinical Judgment*

As one of the key attributes of professional nursing, clinical judgment refers to the process by which nurses make decisions based on nursing knowledge (evidence, theories, ways/patterns of knowing), other disciplinary knowledge, critical thinking, and clinical reasoning (Manetti, 2019). This process is used to understand and interpret information in the delivery of care. Clinical decision making based on clinical judgment is directly related to care outcomes.

- *Communication*

Communication, informed by nursing and other theories, is a central component in all areas of nursing practice. Communication is defined as an exchange of information, thoughts, and feelings through a variety of mechanisms. The definition encompasses the various ways people interact with each other, including verbal, written, behavioral, body language, touch, and emotion. Communication also includes intentionality, mutuality, partnerships, trust, and presence. Effective communication between nurses and individuals and between nurses and other health professionals is necessary for the delivery of high quality, individualized nursing care. With increasing frequency, communication is delivered through technological modalities. Communication also is a core component of team-based, interprofessional care and closely interrelated with the concept Social Determinants of Health (described below).

- *Compassionate Care*

As an essential principle of person-centered care, compassionate care refers to the way nurses relate to others as human beings and involves “noticing another person’s vulnerability, experiencing an emotional reaction to this, and acting in some way with them in a way that is meaningful for people” (Murray & Tuqiri, 2020). Compassionate care is interrelated with other concepts such as caring, empathy, and respect and is also closely associated with patient satisfaction.

- *Diversity, Equity, and Inclusion*

Collectively, diversity, equity, and inclusion (DEI) refers to a broad range of individual, population, and social constructs and is adapted in the *Essentials* as one of the most visible concepts. Although these are collectively considered a concept, differentiation of each conceptual element leads to enhanced understanding.

Diversity references a broad range of individual, population, and social characteristics, including but not limited to age; sex; race; ethnicity; sexual orientation; gender identity; family structures; geographic locations; national origin; immigrants and refugees; language; any impairment that substantially limits a major life activity; religious beliefs; and socioeconomic status. Inclusion represents environmental and organizational cultures in which faculty, students, staff, and administrators with diverse characteristics thrive. Inclusive environments require intentionality and embrace differences, not merely tolerate them (AACN, 2017; Bloomberg, 2019). Everyone works to ensure the perspectives and experiences of others are invited, welcomed, acknowledged, and respected in inclusive environments. Equity is the ability to recognize the differences in the resources or knowledge needed to allow individuals to fully participate in society, including access to higher education, with the goal of overcoming obstacles to ensure fairness (Kranich, 2001). To have equitable systems, all people should be treated fairly, unhampered by artificial barriers, stereotypes, or prejudices (Cooper, 2016). Two related concepts that fit within DEI include structural racism and social justice. (See the glossary for definitions of structural racism and social justice.)

- *Ethics*

Core to professional nursing practice, ethics refers to principles that guide a person's behavior. Ethics is closely tied to moral philosophy involving the study of or examination of morality through a variety of different approaches (Tubbs, 2009). There are commonly accepted principles in bioethics that include autonomy, beneficence, non-maleficence, and justice (ANA 2015; ACNM, 2015; AANA, 2018; ICN, 2012). The study of ethics as it relates to nursing practice has led to the exploration of other relevant concepts, including moral distress, moral hazard, moral community, and moral or critical resilience.

- *Evidence-Based Practice*

The delivery of optimal health care requires the integration of current evidence and clinical expertise with individual and family preferences. Evidence-based practice is a problem-solving approach to the delivery of health care that integrates best evidence from studies and patient care data with clinician expertise and patient preferences and values (Melnyk, Fineout-Overhold, Stillwell, & Williamson, 2010). In addition there is a need to consider those scientific studies that ask: whose perspectives are solicited, who creates the evidence, how is that evidence created, what questions remain unanswered, and what harm may be created? Answers to these questions are paramount to incorporating meaningful, culturally safe, evidence-based practice (Nursing Mutual Aid, 2020).

- *Health Policy*

Health policy involves goal directed decision-making about health that is the result of an authorized public decision-making process (Keller & Ridenour, 2021). Nurses play critical roles in advocating for policy that impacts patients and the profession, especially when speaking with a united voice on issues that affect nursing practice and health outcomes. Nurses can have a profound influence on health policy by becoming engaged in the policy process on many levels, which includes interpreting, evaluating, and leading policy change.

- *Social Determinants of Health*

Determinants of health, a broader term, include personal, social, economic, and environmental factors that impact health. Social determinants of health, a primary component of determinants of health “are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.”

The social determinants of health contribute to wide health disparities and inequities in areas such as economic stability, education quality and access, healthcare quality and access, neighborhood and built environment, and social and community context (Healthy People, 2030). Nursing practices such as assessment, health promotion, access to care, and patient teaching support improvements in health outcomes. The social determinants of health are closely interrelated with the concepts of diversity, equity, and inclusion, health policy, and communication.

## Competencies and Sub-Competencies

The competencies identified in this *Essentials* document provide a bridge between the current and future needs of practice and the requisite education to prepare a competent practitioner. Competence develops over time, is progressive, and reflects the impact of internal and external factors and experiences of the student. Internal factors include education, experience, knowledge, and professional orientation, among others. External forces include the complexity of the learning experience and professional autonomy. While knowledge is essential to the development of competence, it does not in and of itself validate competence (Currier, 2019). Rather, learners progress to successive levels of competence by demonstrating achievement of expectations across the span of their education and practice experience. Students are successful when they meet and sustain measurable competence at each level of performance expectation and are able to transfer their competence across different practice experiences and settings (Josiah Macy Foundation, 2017).

All competencies, organized within the 10 domains, are broad in scope and cross all levels and areas of nursing practice. The competency is intentionally written as a short statement; therefore, it is necessary to be familiar with the contextual statement within the parent domain to fully understand the competency. In other words, the competency is interpreted as a component within the domain. It also should be noted that there is intentional overlap of competencies in several domains to account for differences in the competency or sub-competency context in different domains.

Each competency statement has multiple sub-competencies written at two levels to reflect learner expectations for entry-level and advanced nursing education. These sub-competencies are designed to ‘paint a picture’ of how the competency is achieved at each level. The sub-competencies are designed to be understandable, observable, and measurable by learner, faculty, and future employers. Competencies mature over time and become more sophisticated with ongoing practice.

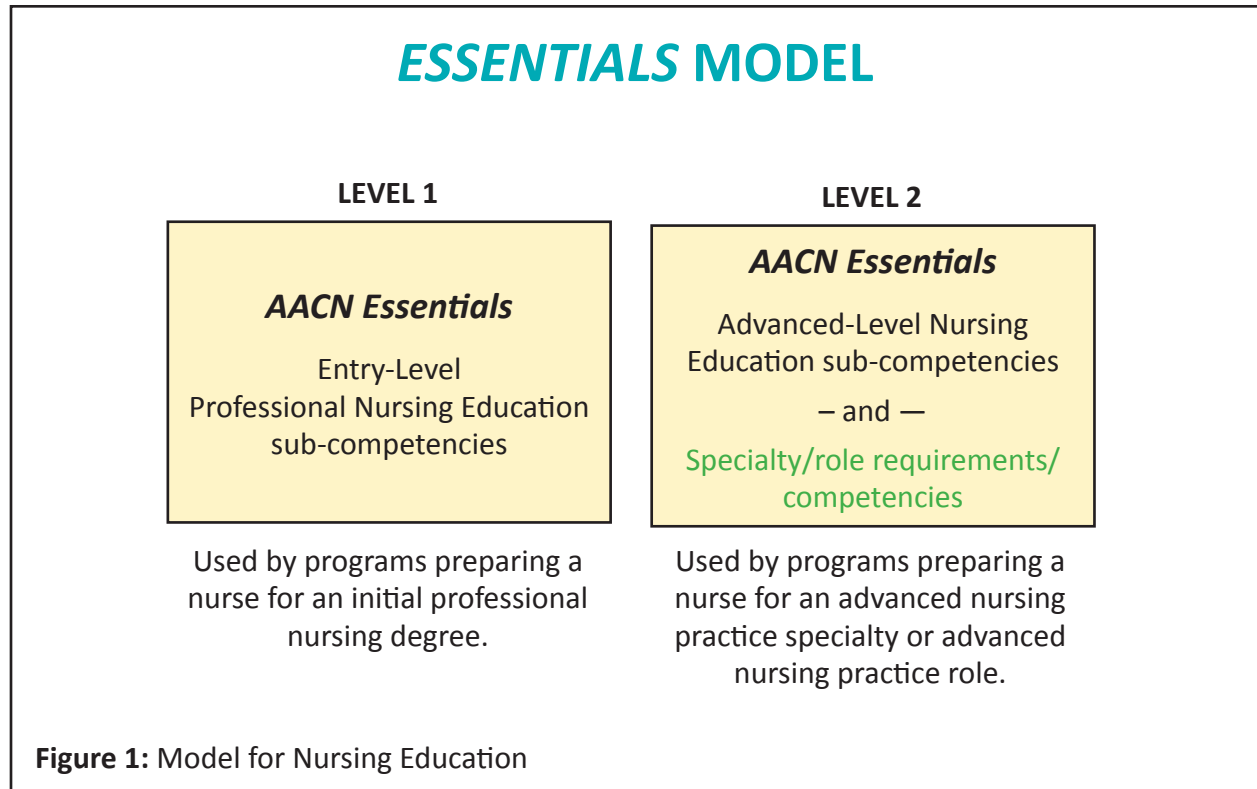
## A New Model for Nursing Education

These *Essentials* represents a new direction for nursing education, influenced by AACN's *Vision for Academic Nursing* (AACN, 2019), setting in place a new model for preparing professional nurses, which includes a transition to competency-based education. This model provides the structure across education programs and provides a mechanism to adapt to future changes within nursing education.

Currently, multiple educational programs and degree pathways exist that prepare nurses for similar roles. As an example, there are several types of programs and degrees that prepare students to become a registered nurse, and there are multiple education programs and paths to prepare a nurse practitioner (NP) and multiple types of NP certification. These multiple program options confuse external stakeholders as well as those within our own discipline regarding differences between an academic degree and a role – as if the academic degree signifies a specific nursing role. The new model is an intentional departure from the previous versions of the *Essentials* that were aligned to an academic degree. Thus, a primary intent of the *Essentials* is to create more consistency in graduate outcomes, influenced by the robustness of the learning experiences and demonstration of competencies. By emphasizing the attainment of competencies within an academic program, employers will have a clear expectation of knowledge and skill sets of nursing graduates.

Two levels of sub-competencies reflect the educational stages of nurses as they enter professional practice and as they return to school to advance their education (see Figure 1). The first level sub-competencies set the foundation for nurses entering professional practice. These level one (entry-level) competencies are used within curricula for prelicensure preparation as well as professional nursing degree completion pathways for nurses with initial preparation at the associate degree or diploma level. Although learning experiences may vary across individual programs, they provide an opportunity for learners to demonstrate attainment of competencies in multiple and authentic contexts over time (not a “one and done”/checklist approach).

The second level sub-competencies build and expand the competence of the nurse seeking advanced education in nursing and broadens the breadth of experiences in context and complexity as compared to graduates of entry-level programs. Advanced nursing education affords the student the opportunity to focus on an advanced nursing practice specialty or advanced nursing practice role. Level 2 sub-competencies form the foundation for all advanced education, and as conceptualized, apply to all advanced nursing practice specialties and advanced nursing practice roles. Referencing Thorne's use of “nursing's angle of vision” reinforces the importance of nurses using the unique knowledge and insight of the profession to inform any practice role and to impact the challenges in health care. Competencies designated for an advanced nursing practice specialty (informatics, administration/practice leadership, public health/population health, health policy) or an advanced practice nursing role (certified nurse practitioner, certified nurse-midwife, certified clinical nurse specialist, certified registered nurse anesthetist) are integrated with and complement the *Essentials* competencies.



These *Essentials* represent an opportunity for a future characterized by greater clarity as it relates to expectations of graduates and a more disciplined approach to nursing education. Competencies are used within the academic program as core expectations, thus setting a common standard. Additional elements within a degree plan will allow schools to differentiate degree paths using the same sub-competencies and to distinguish themselves in alignment with various institutional missions. This model adapts to the current state of nursing education, and perhaps more importantly, provides a path for an evolving trajectory for nursing education. Over time, higher education, stakeholder demands, nursing regulatory standards, and economics are among the many forces that will drive the direction and pace of change for nursing education in the future. This model has been designed to adapt to such future changes, not only for the degrees offered, but also for recognized areas of emphasis at the advanced education level by coupling with specialty competencies and/or certification standards.

The *Essentials* do not apply directly to the preparation of nurse researchers in a PhD (or other nursing research-focused) program. However, the second-level sub-competencies could be used by PhD programs to guide core courses for doctoral nursing, particularly for programs offering baccalaureate to PhD degrees. Additionally, for nursing programs offering both DNP and PhD degrees and/or PhD to DNP or DNP to PhD options, the second-level core sub-competencies could form the basis for shared core courses between the two doctoral degree programs – representing efficiencies in program delivery as well as for more seamless pathways from one degree to the other.

## Implementing the *Essentials*: Considerations for Curriculum

The domains, competencies, and concepts presented in the *Essentials* provide the platform for curriculum design and program assessment with an intent to produce consistency in outcomes expected of graduates. Although these are major elements incorporated within a curriculum for learning and assessment, they are not to be interpreted as representing the curriculum in its entirety. In other words, it is not intended for courses within nursing curricula to mirror the 10 domains and eight concepts. Instead, the elements used as the *Essentials* framework (domains, concepts, and competencies) should be integrated throughout and across the curriculum. A scaffolded approach ensures students interface with competencies in multiple contexts and with increasing complexity. Nursing programs have a great deal of flexibility in the development and design of curricula, thus preserving the ability of nursing programs to be unique or innovative.

Outcomes, when referred to as student learning outcomes, describe the desired outcomes of the graduate at the completion of the program. The student learning outcomes will reflect attainment of all competencies in addition to any relevant specialty/role competencies and other identified expectations. Course design within curricula reflect the expectations of student learning with clear linkage from course objectives/competencies from within and across courses to end of program student learning outcomes, written as course learning outcomes or course competencies. For this reason, course outcomes should link to the *Essentials* competencies and concepts. Intentional teaching strategies are designed and incorporated throughout the curriculum in multiple contexts and with increasing complexity to provide students multiple opportunities for learning and demonstrating competencies. For the foreseeable future, minimum requirements for practicum experiences are deemed important to provide consistent and quality preparation at both the entry- and advanced-levels for professional nursing practice.

Competencies are assessed as the learner progresses throughout the program; therefore, a robust program assessment plan is needed to measure students' achievement of competencies by the end of the program. Some programs may wish to create "progression indicators" at specified points within a program of study to track learners' achievement of competencies. To demonstrate the integration of competencies across multiple domains with increasing complexity, performance assessments should be integrated in the curriculum throughout the program of study. As such, assessments are performance based and serve as both a learning experience and an evaluation tool. Performance assessment is a multidimensional process, integral to learning, that involves observation and judgment of each student's performance on the basis of explicit criteria, with feedback to the student for improving learning and competency.

In the previous section, the *Essentials Model* featuring two levels of professional nursing education (entry and advanced) was introduced. While the domains, competencies, and concepts are identical for both entry and advanced levels of education, *sub-competencies* are used to differentiate expectations for entry (Level 1) and advanced (Level 2) professional nursing education (see Figure 1). These two levels of sub-competencies reflect the educational stages of nurses—as they enter professional nursing practice and as they advance their education—regardless of the program of study they are completing to advance their education. The following sections detail the expectations for curricula at each of these two levels.



## Entry-Level Professional Nursing Education

Programs preparing nurses to enter professional nursing practice (either through prelicensure preparation or through a degree completion pathway for nurses with initial preparation with an associate or diploma degree) use Level 1 sub-competencies within the curriculum. Entry-level professional nursing programs prepare graduates as a generalist for practice across the lifespan and with diverse populations and in four spheres of practice.

## Entry-Level Professional Nursing Degree Options

### *Pre-licensure Programs*

Entry-Level Professional Nursing Education sub-competencies (Level 1) are applied across any curriculum preparing for entry to professional nursing practice. Content learned within prerequisite courses is incorporated into the learning and assessment of the sub-competencies as applicable, and attainment of sub-competencies are applied within prerequisite courses. This does not mean that every sub-competency and concept is applied in every course, but it does mean that sub-competencies are not addressed in one course and then disregarded for the remainder of the program. Outcome measures include evidence of attainment of Level 1 sub-competencies, pass rates on the NCLEX-RN® (for traditional and accelerated tracks), and other institutional requirements.

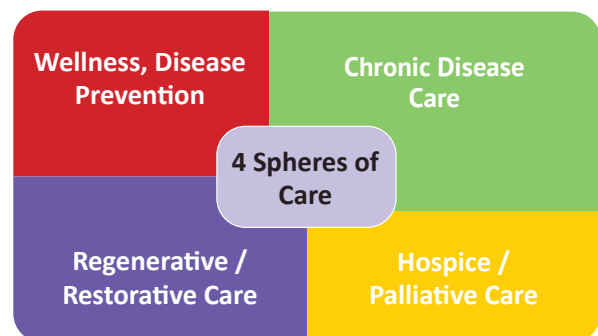
### *Post-Licensure Degree Programs*

Level 1 core sub-competencies also are used in post-licensure or degree completion, first professional programs. Because learners in these programs are already licensed registered nurses, the Level 1 sub-competencies build on knowledge and skills acquired in their initial nursing education program. Verification of prior competency achievement in some domains may result in a shorter timeframe needed to prepare learners in these programs.

*All learners in entry-level professional nursing education programs (pre-licensure and post-licensure [degree-completion] programs) will engage in direct patient care learning activities in all four spheres of care and across the lifespan.*

### **Spheres of Care and Entry-Level Professional Nursing Education**

All entry-level professional nurses need knowledge and proficiencies to practice across a variety of settings. Accordingly, curricula for entry-level professional nursing education prepare the learner for generalist practice across the lifespan and with diverse populations, focusing on four spheres of care: promotion of health and well-being/disease prevention; chronic disease care; regenerative or restorative care; and hospice/palliative/supportive care (AACN, 2019; Lipstein et al., 2016; Figure 2). Didactic, simulated, laboratory, and clinical learning experiences prepare nurses to practice in these diverse settings. Level 1 sub-competencies apply across the spheres of care, requiring learners to



**Figure 2:** Four Spheres of Care



demonstrate competencies in multiple contexts and settings. Demonstration of the Level 1 sub-competencies by the end of the program will enable the new professional nurse to practice as a generalist in any setting with diverse populations and with all ages.

Although all students will have learning experiences across all four spheres of care, entry-level professional programs could create opportunities for students to gain additional education (through immersion experiences, electives, badges, or certificates) in any of the four spheres. Such a path would allow a graduate to have a defined area of emphasis (if desired) upon graduation, and/or to attain a documented area of emphasis in a post-entry level program certificate option.

### ***Clinical Expectations***

Entry-level professional nursing education programs provide rich and varied opportunities for practice experiences (both direct and indirect care experiences) across the four spheres of care, designed to assist the graduate to achieve Level 1 sub-competencies upon completion of the program. Theoretical learning becomes a reality as students are coached to make cognitive connections between the cases or situations presented in the classroom, simulation, or laboratory and in actual practice settings. Clinical experiences also assist the graduate to develop proficiency in cognitive, psychomotor, and affective learning. Clinical experiences are essential for students to care for a variety of individuals, families, groups, and populations across the lifespan and across the four spheres of care. Clinical learning provides opportunities for a student to enhance the provision of care and gain the skills needed to be an effective member of an interprofessional team; thus, interprofessional experiences in a variety of practice settings are essential.

Graduates of all types of entry-level professional nursing education programs need sufficient practice experiences (both direct and indirect care experiences) to demonstrate end-of-program learning outcomes inclusive of all Level 1 sub-competencies. *All learners in entry-level professional nursing education programs (pre-licensure and post-licensure [degree-completion] programs) will engage in direct patient care learning activities in all four spheres of care and across the life span and provide clear evidence of student (Level 1) competency achievement.*

### ***Clinical Sites***

Nursing programs are responsible for ensuring clinical placements are safe, supportive, and conducive for learning by individual students or groups of students. The program is responsible for providing sufficient and appropriate clinical sites/placements for students to demonstrate attainment of Level 1 sub-competencies. The program faculty assesses clinical sites to determine that, on the aggregate, clinical experiences provide students learning opportunities to foster interprofessional team practice and to provide care within the four spheres of care and with care recipients from diverse backgrounds and cultures, from different genders and age groups and with different religious and spiritual practices, including those who may be considered most vulnerable. Programs are responsible for informing clinical educators or preceptors about the specific learning that is expected and occurring in didactic and laboratory settings and provide appropriate learning opportunities across settings to reinforce learning as well as demonstrate achievement of competencies (Level 1 sub-competencies) across the 10 *Essentials* domains.

### ***Simulation***

Simulation experiences represent an important component of clinical education, serving as a valuable augmentation to direct and indirect care within healthcare settings. Laboratory and simulation experiences provide an effective, safe environment for learning and demonstrating competencies. However, care experiences with actual individuals or groups continue to be the most important component of clinical education. A landmark study conducted by the National Council of State Boards of Nursing concluded that for pre-licensure students “substituting high-quality simulation experiences for up to half of traditional clinical hours produces comparable end-of-program educational outcomes” (Hayden et al., 2014, p. S3). Simulation cannot substitute for all direct care practice experiences in any one sphere or for any one age group. Also, simulation learning experiences should align with best practice standards such as those developed by the International Nursing Association for Clinical Simulation and Learning (INACSL) or the Society for Simulation in Healthcare (SSH). The use of simulation in the curriculum as a replacement of direct patient clinical/practice hours or experiences is also determined by requirements of regulatory entities (i.e., licensing and accrediting bodies).

### ***Practice Synthesis Experience/Immersion***

Development of competency attainment is facilitated through use of focused and sustained practice experiences. Immersion experiences provide the learner with the opportunity to integrate the Level 1 sub-competencies. Entry-level professional nursing programs (pre-and post-licensure) must develop immersion or synthesis experiences that allow students to integrate learning and gain experience that facilitates transition into practice. Such experiences provide opportunities to enact principles of the nursing discipline and for building clinical reasoning, management of care, and assessment of clinical outcomes. These opportunities increase the student’s self-confidence, professional identity, and sense of belonging within the profession. Immersion experiences also allow students to integrate previous learning and demonstrate competencies in more complex situations and contexts. Immersion experiences may afford the student an opportunity to focus on a population of interest and clinical role. The immersion experience may occur towards the end of the program as a culminating synthesis experience; and/or there may be one or more immersion experiences at various points in a curriculum. The key is to provide for a concentrated practice experience that approximates professional practice expectations (Fowler et al., 2018; Tratnack et al., 2011).

### **Advanced-Level Nursing Education**

Nursing programs preparing nurses to advance their education beyond entry-level professional nursing practice will incorporate advanced-level nursing education (Level 2) sub-competencies. Advanced-level nursing education programs (degree granting and advanced nursing practice post-graduate certificate programs) intentionally build on Level 1 sub-competencies. Although Level 2 sub-competencies have been written with doctoral education in mind, the actual differentiator for the degree attained does not lie within the sub-competencies themselves, but rather the degree/program requirements – such as the DNP project (described below), role/specialty requirements, and other requirements set by the faculty and institution. While it is not expected that every sub-competency and concept will be applied in every course, sub-competencies are not to be isolated in one or two courses and then disregarded for the rest of the program.

Advanced-level nursing education programs prepare graduates for practice in an advanced nursing practice specialty (informatics, administration/practice leadership, public health/population health, health policy) or an advanced practice nursing role (certified nurse practitioner, certified nurse-midwife, certified clinical nurse specialist, certified registered nurse anesthetist). Advanced-level nursing education programs focus on providing specialty knowledge for graduates to enact specific advanced practice nursing roles or assume advanced nursing specialty practice within the healthcare system. For this reason, specialty competencies, defined by nationally recognized, specialty organizations, represent a major component of advanced-level nursing education programs. Specialty competencies complement and build upon the Level 2 sub-competencies. All graduates of an advanced nursing education program are prepared and eligible for national, advanced nursing practice specialty certification or advanced nursing practice role certification when available. It is noteworthy that specialties evolve over time and new specialties may emerge.

All DNP programs (post-baccalaureate and post-master's) demonstrate that graduates attain and integrate Level 2 sub-competencies and competencies for at least one advanced nursing practice specialty or advanced nursing practice role.

Individuals should seek to advance disciplinary expertise in a chosen nursing specialty or advanced nursing practice role. This expertise is critical to advancing the profession, to expand the influence of the profession for the transformation of health care, and to ensure an informed disciplinary perspective for teaching in the discipline. Advancing education in nursing with the emphasis on teaching and learning alone does not fulfill the achievement of disciplinary expertise. Excellence as an educator is achieved by the collective enterprise for faculty teaching and learning afforded by institutions and applied to discipline-specific teaching.

### ***Advanced Level Practicum Experiences***

Advanced-level nursing education programs provide rich and varied opportunities for practice experiences (both direct and indirect care experiences) to prepare graduates with the Level 2 sub-competencies as well as applicable advanced nursing practice specialty/advanced nursing practice role competencies and requirements. Practice experiences build on Level 1 sub-competency achievement and are designed to assist the graduate to achieve Level 2 sub-competencies and applicable specialty competencies upon completion of the program. Practice experiences are required to integrate didactic learning, promote innovative thinking, and test new potential solutions to clinical practice or system issues. Therefore, the development of new skills and practice expectations can be facilitated through use of creative learning opportunities in diverse settings.

All graduates of advanced-level nursing education programs have structured, faculty-designed practice experiences, which may include precepted experiences with faculty oversight and/or experiences with direct faculty supervision. The program is responsible for providing sufficient and appropriate clinical sites/placements for students to demonstrate attainment of Level 2 sub-competencies and applicable specialty competencies. Clinical/practice learning experiences may be accomplished through diverse methodologies, including simulation and virtual technology, and assist the graduate to develop greater proficiency in these competencies, including cognitive, psychomotor, and affective competencies. Use of simulation should align with specialty requirements.

All advanced education practicum experiences must have faculty oversight and be verified and documented as a component of a formal course or plan of study. Programs provide practice placements that are safe, supportive, and conducive for learning. The nursing program faculty determine and assess practice sites to ensure that the site supports student learning with the intended population or scope of practice. Faculty, students, and preceptors must be well informed about the specific competencies that are integrated in the didactic, laboratory, and practice experiences and the method(s) to assess the achievement of the competencies.

### ***Competency Attainment and Practice Experiences***

All learners in advanced nursing education programs engage in practice learning activities (both direct and indirect care experiences). Graduates of all advanced nursing education programs need sufficient clinical/practice experiences to demonstrate end-of-program student outcomes, Level 2 sub-competencies, and competencies required by applicable national, specialty organizations and/or for national advanced nursing practice specialty or advanced nursing practice role certification. Programs document clear evidence of competency achievement.

### ***Advanced Education Clinical/Practice Hours***

The application of competency-based education to prepare advanced nursing professionals inherently calls to question the role of more traditional time-based requirements. In this *Essentials* model, there is an emphasis on ensuring that all nurses pursuing advanced education attain Level 2 sub-competencies as well as competencies required for an advanced nursing practice specialty or advanced nursing practice role being pursued. The number of required practice (direct and indirect care) hours vary based on advanced specialty/role requirements. These *Essentials* represent a commitment that required hours prepare a consistent product in terms of breadth of preparation and quality to reinforce confidence in our graduates by nursing practice colleagues, other health professionals, and consumers.

Some learners will achieve select competency outcomes more quickly than others. “One and done,” however, does not demonstrate the progressive and consistent nature of competency attainment and the assessment necessary in nursing professional education. Repetition plays a role in reinforcing previously acquired knowledge, skills, values, and attitudes. Repetition also allows for intentional and unintentional complexities and context nuances to be introduced, thus building on minimum competency thresholds. Given the paucity of evidence to support specific experience quantities, case numbers, or hourly requirements that should be achieved, a minimum threshold of hours of practice engagement remains necessary at this time.

The specific clinical/practice experiences and number of practice hours and/or credit hours required depends on these *Essentials*, advanced nursing practice specialty and advanced nursing practice role requirements, and regulatory standards for specialty certifications and licensure. The program must include adequate experiences (in terms of time, diversity, depth, and breadth) to allow attainment and demonstration of all relevant competencies (Level 2 sub-competencies and applicable specialty/role competencies and other requirements) and successful transition to practice demonstrated through program outcomes. The number of in-person practice hours will vary based on student needs and curriculum design. ***Participation in a minimum of 500 practice hours in the discipline of nursing, post entry-level education, and attainment of Level 1 sub-competencies is required for demonstration of the advanced***

**level sub-competencies.** Some students may require more. These practice hours also provide a foundation for the additional time-based requirements set by specialty organizations or external licensing/certifying bodies, which will require additional practice time for preparation in advanced nursing specialties or advanced nursing practice roles. Hours of practice do not necessarily need to be delineated by competency type (*Essentials* or specialty/role). Some, but not all, Level 2 sub-competencies and/or specialty/role competencies may be demonstrated and assessed concurrently. It is expected that faculty create clinical/practice learning experiences that provide for active learning, repetition, interprofessional engagement, and successive levels of difficulty. As the strength of evidence to support valid and reliable assessment techniques builds, the role of practice experiences and number of hours (e.g., time-based requirements) may evolve in the future.

### ***Immersion Practicum Experiences***

Development of competency attainment is facilitated through use of focused and sustained practice experiences. Immersion experiences, expected in advanced nursing education programs, provide the learner with the opportunity to integrate the advanced level sub-competencies and applicable specialty competencies. An immersion also provides an opportunity for the learner to focus on a population of interest, an advanced nursing role, or specialty area of study. Placement of integrated or immersion experiences may vary and depend upon the program's design, curriculum, and specialty requirements.

### ***Simulation***

Simulation experiences represent an important component of clinical/practice education, serving as a valuable augmentation to direct clinical care or practice within healthcare settings. Laboratory and simulation experiences provide an effective, safe environment for learning and demonstrating competencies, particularly high-risk and low-frequency experiences. However, practice experiences in actual practice settings continue to represent the most important component of nursing practice education and are required in advanced nursing programs for the learning and demonstration of the Level 2 sub-competencies and integration of specialty competencies. Simulation learning experiences align with best practice standards such as those developed by the International Nursing Association for Clinical Simulation and Learning (INACSL) or the Society for Simulation in Healthcare (SSH). The use of simulation in the curriculum as a replacement of direct patient clinical/practice hours or experiences is also determined by requirements of national specialty education, certification entities, and regulatory entities.

Practice experiences may include simulated experiences for the attainment of a portion of the Level 2 sub-competencies, particularly for experiences that are high risk and low frequency or may not be available to all students, and in accordance with requirements set forth by specialty organizations and/or licensing/certifying bodies. Regardless of the design of the experiences, programs are expected to document attainment of these sub-competencies through varied and comprehensive assessment methods across the curriculum.

### ***DNP Scholarly Project/Product***

There are many past, present, and projected healthcare dilemmas that call for healthcare transformation. Nurses, as members of the healthcare team, are expected to assume a prominent role in addressing these dilemmas. Nurses cannot be expected to significantly



impact healthcare transformation unless their educational preparation provides them with opportunities to learn and employ scholarship, leadership, and teamwork skills to advance practice. *A scholarly work that aims to improve clinical practice, therefore, is required of students completing a practice doctorate in nursing.* Collaboration with practice partners whenever possible will maximize the impact of the student experience.

The scholarly work may take on various final forms depending on the academic institution's requirements and the student's area (specialty or role) of study/practice. Key elements of the scholarly work include problem identification; a search, analysis, and synthesis of the literature and evidence; translating evidence to construct a strategy or method to address a problem; designing a plan for implementation and actual implementation when possible, and an evaluation of the outcomes, process, and/or experience. Faculty may identify additional elements deemed necessary to meet the expected outcomes of the curriculum. Programs are encouraged to support innovation in the design and dissemination of the final project without reducing the substantive nature of the work. A literature review that lacks applicability to affect a practice improvement or the other elements identified above would not constitute a scholarly work that aligns with this *Essentials* model. Similarly, a portfolio may be used as a tool to enhance the development and presentation of a project but may not be the sole deliverable product of the student's scholarly work.

The scholarly work should not be a separate disaggregated part of the plan of study. Instead, faculty should consider how the development of the scholarly work is integrated throughout the curriculum, allowing for dissemination of the results prior to program completion. The intent is that this scholarly work reflects the longitudinal attainment of advanced level sub-competencies, going across the curriculum and allowing for the evolution of ideas. There also is a need to ensure an understanding by the student of the connection between the scholarly work and application to future practice. This will promote integration of advanced nursing education competencies into future practice.

Dissemination methods for the scholarly work are determined by the student in consultation with the faculty and may include a variety of methods. Dissemination may include a final written product that is presented to a defined group of stakeholders, such as members of the practice and/or university community or participants at a local, state, or national professional meeting. Other possible examples of dissemination include poster presentations, a manuscript under review and/or submission for publication, an educational presentation, or a podcast.

Faculty with appropriate specialty and academic credentials are involved in the planning, formation, and evaluation of the student's scholarly work. In some instances, additional experts/mentors/ partners/facilitators can be formal or informal collaborators and provide intermittent or limited support throughout the project phases as needed. Evaluation of the student's scholarly work may include a combination of methods, including faculty, expert, and/or peer evaluation. Programs tailor scholarly work evaluation and approval processes per institution's, the program's, and/or appropriate committee's requirements. Evaluation of the final DNP project is the responsibility of the faculty.

In summary:

- These program requirements do not modify any additional requirements for any advanced specialty or role preparation, including the requirement for all Advanced Practice Registered Nurse (APRNs) education to include three graduate-level courses delineated in *The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education* (2006; see glossary).
- All graduates of an advanced-level nursing education program are prepared for practice in an advanced nursing specialty (informatics, administration/practice leadership, public health/population health, or health policy) or for an advanced nursing practice role (nurse practitioner, certified nurse-midwife, certified clinical nurse specialist, certified registered nurse anesthetist).
- All DNP students will complete a scholarly project/product, which will be evaluated by faculty; DNP students will demonstrate the attainment and integration of the Level 1 sub-competencies, Level 2 sub-competencies, and advanced specialty/role competencies into practice.

# Domains, Competencies, and Sub-Competencies for Entry-level Professional Nursing Education and Advanced-level Nursing Education

## Domain 1: Knowledge for Nursing Practice

**Descriptor:** Integration, translation, and application of established and evolving disciplinary nursing knowledge and ways of knowing, as well as knowledge from other disciplines, including a foundation in liberal arts and natural and social sciences. This distinguishes the practice of professional nursing and forms the basis for clinical judgment and innovation in nursing practice.

**Contextual Statement:** Knowledge for Nursing Practice provides the context for understanding nursing as a scientific discipline. The lens of nursing, informed by nursing history, knowledge, and science, reflects nursing’s desire to incorporate multiple perspectives into nursing practice, leading to nursing’s unique way of knowing and caring.

Preparation in both liberal arts and sciences and professional nursing coursework provides graduates with the essential abilities to function as independent, intellectually curious, socially responsible, competent practitioners (Tobbell, 2018). A liberal education creates the foundation for the development of intellectual and practical abilities within the context of nursing. Further, liberal education is the key to understanding self and others; contributes to safe, quality care; and informs the development of clinical judgment.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>1.1 Demonstrate an understanding of the discipline of nursing’s distinct perspective and where shared perspectives exist with other disciplines</b>	
1.1a Identify concepts, derived from theories from nursing and other disciplines, which distinguish the practice of nursing.	1.1e Translate evidence from nursing science as well as other sciences into practice.
1.1b Apply knowledge of nursing science that develops a foundation for nursing practice.	1.1f Demonstrate the application of nursing science to practice.
1.1c Understand the historical foundation of nursing as the relationship developed between the individual and nurse.	1.1g Integrate an understanding of nursing history in advancing nursing’s influence in health care.
1.1d Articulate nursing’s distinct perspective to practice.	
<b>1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences.</b>	
1.2a Apply or employ knowledge from nursing science as well as the natural, physical, and social sciences to build an understanding of the human experience and nursing practice.	1.2f Synthesize knowledge from nursing and other disciplines to inform education, practice, and research.



1.2b Demonstrate intellectual curiosity.	1.2g Apply a systematic and defensible approach to nursing practice decisions.
1.2c Demonstrate social responsibility as a global citizen who fosters the attainment of health equity for all.	1.2h Employ ethical decision making to assess, intervene, and evaluate nursing care.
1.2d Examine influence of personal values in decision making for nursing practice.	1.2i Demonstrate socially responsible leadership.
1.2e Demonstrate ethical decision making.	1.2j Translate theories from nursing and other disciplines to practice.
<b>1.3 Demonstrate clinical judgment founded on a broad knowledge base.</b>	
1.3a Demonstrate clinical reasoning.	1.3d Integrate foundational and advanced specialty knowledge into clinical reasoning.
1.3b Integrate nursing knowledge (theories, multiple ways of knowing, evidence) and knowledge from other disciplines and inquiry to inform clinical judgment.	1.3e Synthesize current and emerging evidence to influence practice.
1.3c Incorporate knowledge from nursing and other disciplines to support clinical judgment.	1.3f Analyze decision models from nursing and other knowledge domains to improve clinical judgment.

## Domain 2: Person-Centered Care

**Descriptor:** Person-centered care focuses on the individual within multiple complicated contexts, including family and/or important others. Person-centered care is holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate. Person-centered care builds on a scientific body of knowledge that guides nursing practice regardless of specialty or functional area.

**Contextual Statement:** Person-centered care is the core purpose of nursing as a discipline. This purpose intertwines with any functional area of nursing practice, from the point of care where the hands of those that give and receive care meet, to the point of systems-level nursing leadership. Foundational to person-centered care is respect for diversity, differences, preferences, values, needs, resources, and the determinants of health unique to the individual. The person is a full partner and the source of control in team-based care. Person-centered care requires the intentional presence of the nurse seeking to know the totality of the individual’s lived experiences and connections to others (family, important others, community). As a scientific and practice discipline, nurses employ a relational lens that fosters mutuality, active participation, and individual empowerment. This focus is foundational to educational preparation from entry to advanced levels irrespective of practice areas.

With an emphasis on diversity, equity, and inclusion, person-centered care is based on best evidence and clinical judgment in the planning and delivery of care across time, spheres of care, and developmental levels. Contributing to or making diagnoses is one essential aspect of nursing practice and critical to an informed plan of care and improving outcomes of care (Olson et al., 2019). Diagnoses at the system-level are equally as relevant, affecting operations that impact care for individuals. Person-centered care results in shared meaning with the healthcare team, recipient of care, and the healthcare system, thus creating humanization of wellness and healing from birth to death.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>2.1 Engage with the individual in establishing a caring relationship.</b>	
2.1a Demonstrate qualities of empathy.	2.1d Promote caring relationships to effect positive outcomes.
2.1b Demonstrate compassionate care.	2.1e Foster caring relationships.
2.1c Establish mutual respect with the individual and family.	
<b>2.2 Communicate effectively with individuals.</b>	
2.2a Demonstrate relationship-centered care.	2.2g Demonstrate advanced communication skills and techniques using a variety of modalities with diverse audiences.
2.2b Consider individual beliefs, values, and personalized information in communications.	2.2h Design evidence-based, person-centered engagement materials.

2.2c Use a variety of communication modes appropriate for the context.	2.2i Apply individualized information, such as genetic/genomic, pharmacogenetic, and environmental exposure information in the delivery of personalized health care.
2.2d Demonstrate the ability to conduct sensitive or difficult conversations.	2.2j Facilitate difficult conversations and disclosure of sensitive information.
2.2e Use evidence-based patient teaching materials, considering health literacy, vision, hearing, and cultural sensitivity.	
2.2f Demonstrate emotional intelligence in communications.	
<b>2.3 Integrate assessment skills in practice.</b>	
2.3a Create an environment during assessment that promotes a dynamic interactive experience.	2.3h Demonstrate that one's practice is informed by a comprehensive assessment appropriate to the functional area of advanced nursing practice.
2.3b Obtain a complete and accurate history in a systematic manner.	
2.3c Perform a clinically relevant, holistic health assessment.	
2.3d Perform point of care screening/diagnostic testing (e.g. blood glucose, PO2, EKG).	
2.3e Distinguish between normal and abnormal health findings.	
2.3f Apply nursing knowledge to gain a holistic perspective of the person, family, community, and population.	
2.3g Communicate findings of a comprehensive assessment.	
<b>2.4 Diagnose actual or potential health problems and needs.</b>	
2.4a Synthesize assessment data in the context of the individual's current preferences, situation, and experience.	2.4f Employ context driven, advanced reasoning to the diagnostic and decision-making process.
2.4b Create a list of problems/health concerns.	2.4g Integrate advanced scientific knowledge to guide decision making.
2.4c Prioritize problems/health concerns.	

2.4d Understand and apply the results of social screening, psychological testing, laboratory data, imaging studies, and other diagnostic tests in actions and plans of care.	
2.4e Contribute as a team member to the formation and improvement of diagnoses.	
<b>2.5 Develop a plan of care.</b>	
2.5a Engage the individual and the team in plan development.	2.5h Lead and collaborate with an interprofessional team to develop a comprehensive plan of care.
2.5b Organize care based on mutual health goals.	2.5i Prioritize risk mitigation strategies to prevent or reduce adverse outcomes.
2.5c Prioritize care based on best evidence.	2.5j Develop evidence-based interventions to improve outcomes and safety.
2.5d Incorporate evidence-based intervention to improve outcomes and safety.	2.5k Incorporate innovations into practice when evidence is not available.
2.5e Anticipate outcomes of care (expected, unexpected, and potentially adverse).	
2.5f Demonstrate rationale for plan.	
2.5g Address individuals' experiences and perspectives in designing plans of care.	
<b>2.6 Demonstrate accountability for care delivery.</b>	
2.6a Implement individualized plan of care using established protocols.	2.6e Model best care practices to the team.
2.6b Communicate care delivery through multiple modalities.	2.6f Monitor aggregate metrics to assure accountability for care outcomes.
2.6c Delegate appropriately to team members.	2.6g Promote delivery of care that supports practice at the full scope of education.
2.6d Monitor the implementation of the plan of care.	2.6h Contribute to the development of policies and processes that promote transparency and accountability.
	2.6i Apply current and emerging evidence to the development of care guidelines/tools.
	2.6j Ensure accountability throughout transitions of care across the health continuum.

<b>2.7 Evaluate outcomes of care.</b>	
2.7a Reassess the individual to evaluate health outcomes/goals.	2.7d Analyze data to identify gaps and inequities in care and monitor trends in outcomes.
2.7b Modify plan of care as needed.	2.7e Monitor epidemiological and system-level aggregate data to determine healthcare outcomes and trends.
2.7c Recognize the need for modifications to standard practice.	2.7f Synthesize outcome data to inform evidence-based practice, guidelines, and policies.
<b>2.8 Promote self-care management.</b>	
2.8a Assist the individual to engage in self-care management.	2.8f Develop strategies that promote self-care management.
2.8b Employ individualized educational strategies based on learning theories, methodologies, and health literacy.	2.8g Incorporate the use of current and emerging technologies to support self-care management.
2.8c Educate individuals and families regarding self-care for health promotion, illness prevention, and illness management.	2.8h Employ counseling techniques, including motivational interviewing, to advance wellness and self-care management.
2.8d Respect individuals and families' self-determination in their healthcare decisions.	2.8i Evaluate adequacy of resources available to support self-care management.
2.8e Identify personal, system, and community resources available to support self-care management.	2.8j Foster partnerships with community organizations to support self-care management.
<b>2.9 Provide care coordination.</b>	
2.9a Facilitate continuity of care based on assessment of assets and needs.	2.9f Evaluate communication pathways among providers and others across settings, systems, and communities.
2.9b Communicate with relevant stakeholders across health systems.	2.9g Develop strategies to optimize care coordination and transitions of care.
2.9c Promote collaboration by clarifying responsibilities among individual, family, and team members.	2.9h Guide the coordination of care across health systems.
2.9d Recognize when additional expertise and knowledge is needed to manage the patient.	2.9i Analyze system-level and public policy influence on care coordination.
2.9e Provide coordination of care of individuals and families in collaboration with care team.	2.9j Participate in system-level change to improve care coordination across settings.

### Domain 3: Population Health

**Descriptor:** Population health spans the healthcare delivery continuum from public health prevention to disease management of populations and describes collaborative activities with both traditional and non-traditional partnerships from affected communities, public health, industry, academia, health care, local government entities, and others for the improvement of equitable population health outcomes. (Kindig & Stoddart, 2003; Kindig, 2007; Swartout & Bishop, 2017; CDC, 2020).

**Contextual Statement:** A population is a discrete group that the nurse and others care for across settings at local, regional, national, and global levels. Population health spans the healthcare delivery continuum, including public health, acute care, ambulatory care, and long-term care. Population health also encompasses collaborative activities among stakeholders – all relevant individuals and organizations involved in care, including patients and communities themselves - for the improvement of a population’s health status. The purpose of these collaborative activities, including development of interventions and policies, is to strive towards health equity and improved health for all. Diversity, equity, inclusion, and ethics must be emphasized and valued. Accountability for outcomes is shared by all, since outcomes arise from multiple factors that influence the health of a defined group. Population health includes population management through systems thinking, including health promotion and illness prevention, to achieve population health goals (Storfjell, Wehtle, Winslow, & Saunders, 2017). Nurses play a critical role in advocating for, developing, and implementing policies that impact population health globally and locally. In addition, nurses respond to crises and provide care during emergencies, disasters, epidemics, or pandemics. They play an essential role in system preparedness and ethical response initiatives. Although each type of public health emergency will likely require a unique set of competencies, preparedness for responding begins with a population health perspective and a particular focus on surveillance, prevention, and containment of factors contributing to the emergency.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>3.1 Manage population health.</b>	
3.1a Define a target population including its functional and problem-solving capabilities (anywhere in the continuum of care).	3.1j Assess the efficacy of a system’s capability to serve a target sub-population’s healthcare needs.
3.1b Assess population health data.	3.1k Analyze primary and secondary population health data for multiple populations against relevant benchmarks.
3.1c Assess the priorities of the community and/or the affected clinical population.	3.1l Use established or evolving methods to determine population-focused priorities for care.
3.1d Compare and contrast local, regional, national, and global benchmarks to identify health patterns across populations.	3.1m Develop a collaborative approach with relevant stakeholders to address population healthcare needs, including evaluation methods.

3.1e Apply an understanding of the public health system and its interfaces with clinical health care in addressing population health needs.	3.1n Collaborate with appropriate stakeholders to implement a sociocultural and linguistically responsive intervention plan.
3.1f Develop an action plan to meet an identified need(s), including evaluation methods.	
3.1g Participate in the implementation of sociocultural and linguistically responsive interventions.	
3.1h Describe general principles and practices for the clinical management of populations across the age continuum.	
3.1i Identify ethical principles to protect the health and safety of diverse populations.	
<b>3.2 Engage in effective partnerships.</b>	
3.2a Engage with other health professionals to address population health issues.	3.2d Ascertain collaborative opportunities for individuals and organizations to improve population health.
3.2b Demonstrate effective collaboration and mutual accountability with relevant stakeholders.	3.2e Challenge biases and barriers that impact population health outcomes.
3.2c Use culturally and linguistically responsive communication strategies.	3.2f Evaluate the effectiveness of partnerships for achieving health equity.
	3.2g Lead partnerships to improve population health outcomes.
	3.2h Assess preparation and readiness of partners to organize during natural and manmade disasters.
<b>3.3 Consider the socioeconomic impact of the delivery of health care.</b>	
3.3a Describe access and equity implications of proposed intervention(s).	3.3c Analyze cost-benefits of selected population-based interventions.
3.3b Prioritize patient-focused and/or community action plans that are safe, effective, and efficient in the context of available resources.	3.3d Collaborate with partners to secure and leverage resources necessary for effective, sustainable interventions.
	3.3e Advocate for interventions that maximize cost-effective, accessible, and equitable resources for populations.
	3.3f Incorporate ethical principles in resource allocation in achieving equitable health.

<b>3.4 Advance equitable population health policy.</b>	
3.4a Describe policy development processes.	3.4f Identify opportunities to influence the policy process.
3.4b Describe the impact of policies on population outcomes, including social justice and health equity.	3.4g Design comprehensive advocacy strategies to support the policy process.
3.4c Identify best evidence to support policy development.	3.4h Engage in strategies to influence policy change.
3.4d Propose modifications to or development of policy based on population findings.	3.4i Contribute to policy development at the system, local, regional, or national levels.
3.4e Develop an awareness of the interconnectedness of population health across borders.	3.4j Assess the impact of policy changes.
	3.4k Evaluate the ability of policy to address disparities and inequities within segments of the population.
	3.4l Evaluate the risks to population health associated with globalization.
<b>3.5 Demonstrate advocacy strategies.</b>	
3.5a Articulate a need for change.	3.5f Appraise advocacy priorities for a population.
3.5b Describe the intent of the proposed change.	3.5g Strategize with an interdisciplinary group and others to develop effective advocacy approaches.
3.5c Define stakeholders, including members of the community and/or clinical populations, and their level of influence.	3.5h Engage in relationship-building activities with stakeholders at any level of influence, including system, local, state, national, and/or global.
3.5d Implement messaging strategies appropriate to audience and stakeholders.	3.5i Demonstrate leadership skills to promote advocacy efforts that include principles of social justice, diversity, equity, and inclusion.
3.5e Evaluate the effectiveness of advocacy actions.	
<b>3.6 Advance preparedness to protect population health during disasters and public health emergencies.</b>	
3.6a Identify changes in conditions that might indicate a disaster or public health emergency.	3.6f Collaboratively initiate rapid response activities to protect population health.



3.6b Understand the impact of climate change on environmental and population health.	3.6g Participate in ethical decision making that includes diversity, equity, and inclusion in advanced preparedness to protect populations.
3.6c Describe the health and safety hazards of disasters and public health emergencies.	3.6h Collaborate with interdisciplinary teams to lead preparedness and mitigation efforts to protect population health with attention to the most vulnerable populations.
3.6d Describe the overarching principles and methods regarding personal safety measures, including personal protective equipment (PPE).	3.6i Coordinate the implementation of evidence-based infection control measures and proper use of personal protective equipment.
3.6e Implement infection control measures and proper use of personal protective equipment.	3.6j Contribute to system-level planning, decision making, and evaluation for disasters and public health emergencies.

## Domain 4: Scholarship for the Nursing Discipline

**Descriptor:** The generation, synthesis, translation, application, and dissemination of nursing knowledge to improve health and transform health care (AACN, 2018).

**Contextual Statement:** Nursing scholarship informs science, enhances clinical practice, influences policy, and impacts best practices for educating nurses as clinicians, scholars, and leaders. Scholarship is inclusive of discovery, application, integration, and teaching. While not all inclusive, the scholarship of discovery includes primary empirical research, analysis of large data sets, theory development, and methodological studies. The scholarship of practice interprets, draws together, applies, and brings new insight to original research (Boyer, 1990; AACN 2018).

Knowledge of the basic principles of the research process, including the ability to critique research and determine its applicability to nursing’s body of knowledge, is critical. Ethical comportment in the conduct and dissemination of research and advocacy for human subjects are essential components of nursing’s role in the process of improving health and health care. Whereas the research process is the generation of new knowledge, evidence-based practice (EBP) is the process for the application, translation, and implementation of best evidence into clinical decision-making. While evidence may emerge from research, EBP extends beyond just data to include patient preferences and values as well as clinical expertise. Nurses, as innovators and leaders within the interprofessional team, use the uniqueness of nursing in nurse-patient relationships to provide optimal care and address health inequities, structural racism, and systemic inequity.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>4.1 Advance the scholarship of nursing.</b>	
4.1a Demonstrate an understanding of different approaches to scholarly practice.	4.1h Apply and critically evaluate advanced knowledge in a defined area of nursing practice.
4.1b Demonstrate application of different levels of evidence.	4.1i Engage in scholarship to advance health.
4.1c Apply theoretical framework(s)/models in practice.	4.1j Discern appropriate applications of quality improvement, research, and evaluation methodologies.
4.1d Demonstrate an understanding of basic elements of the research process.	4.1k Collaborate to advance one’s scholarship.
4.1e Participate in scholarly inquiry as a team member.	4.1l Disseminate one’s scholarship to diverse audiences using a variety of approaches or modalities.
4.1f Evaluate research.	4.1m Advocate within the interprofessional team and with other stakeholders for the contributions of nursing scholarship.
4.1g Communicate scholarly findings.	

<b>4.2 Integrate best evidence into nursing practice.</b>	
4.2a Evaluate clinical practice to generate questions to improve nursing care.	4.2f Use diverse sources of evidence to inform practice.
4.2b Evaluate appropriateness and strength of the evidence.	4.2g Lead the translation of evidence into practice.
4.2c Use best evidence in practice.	4.2h Address opportunities for innovation and changes in practice.
4.2d Participate in the implementation of a practice change to improve nursing care.	4.2i Collaborate in the development of new/revised policy or regulation in the light of new evidence.
4.2e Participate in the evaluation of outcomes and their implications for practice.	4.2j Articulate inconsistencies between practice policies and best evidence.
	4.2k Evaluate outcomes and impact of new practices based on the evidence.
<b>4.3 Promote the ethical conduct of scholarly activities.</b>	
4.3a Explain the rationale for ethical research guidelines, including Institutional Review Board (IRB) guidelines.	4.3e Identify and mitigate potential risks and areas of ethical concern in the conduct of scholarly activities.
4.3b Demonstrate ethical behaviors in scholarly projects including quality improvement and EBP initiatives.	4.3f Apply IRB guidelines throughout the scholarship process.
4.3c Advocate for the protection of participants in the conduct of scholarly initiatives.	4.3g Ensure the protection of participants in the conduct of scholarship.
4.3d Recognize the impact of equity issues in research.	4.3h Implement processes that support ethical conduct in practice and scholarship.
	4.3i Apply ethical principles to the dissemination of nursing scholarship.

## Domain 5: Quality and Safety

**Descriptor:** Employment of established and emerging principles of safety and improvement science. Quality and safety, as core values of nursing practice, enhance quality and minimize risk of harm to patients and providers through both system effectiveness and individual performance.

**Contextual Statement:** Provision of safe, quality care necessitates knowing and using established and emerging principles of safety science in care delivery. Quality and safety encompass provider and recipient safety and the recognition of synergy between the two. Quality or safety challenges are viewed primarily as the result of system failures, as opposed to the errors of an individual. In an environment fostering quality and safety, caregivers are empowered and encouraged to promote safety and take appropriate action to prevent and report adverse events and near misses. Fundamental to the provision of safe, quality care, providers of care adopt, integrate, and disseminate current practice guidelines and evidence-based interventions.

Safety is inclusive of attending to work environment hazards, such as violence, burnout, ergonomics, and chemical and biological agents; there is a synergistic relationship between employee safety and patient safety. A safe and just environment minimizes risk to both recipients and providers of care. It requires a shared commitment *to create and maintain* a physically, psychologically, secure, and just environment. Safety demands an obligation to remain non-punitive in detecting, reporting, and analyzing errors, possible exposures, and near misses when they occur.

Quality and safety are interdependent, as safety is a necessary attribute of quality care. For quality health care to exist, care must be safe, effective, timely, efficient, equitable, and person-centered. Quality care is the extent to which care services improve desired health outcomes and are consistent with patient preferences and current professional knowledge (IOM, 2001). Additionally, quality care includes collaborative engagement with the recipient of care in assuming responsibility for health promotion and illness treatment behaviors. Quality care both improves desired health outcomes, and prevents harm (IOM, 2001). Addressing contributors and barriers to quality and safety, at both individual and system levels, are necessary. Essentially, everyone in health care is responsible for quality care and patient safety. Nurses are uniquely positioned to lead or co-lead teams that address the improvement of quality and safety because of their knowledge and ethical code (ANA Code of Ethics, 2015). Increasing complexity of care has contributed to continued gaps in healthcare safety.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>5.1 Apply quality improvement principles in care delivery.</b>	
5.1a Recognize nursing’s essential role in improving healthcare quality and safety.	5.1i Establish and incorporate data driven benchmarks to monitor system performance.
5.1b Identify sources and applications of national safety and quality standards to guide nursing practice.	5.1j Use national safety resources to lead team-based change initiatives.

5.1c Implement standardized, evidence-based processes for care delivery.	5.1k Integrate outcome metrics to inform change and policy recommendations.
5.1d Interpret benchmark and unit outcome data to inform individual and microsystem practice.	5.1l Collaborate in analyzing organizational process improvement initiatives.
5.1e Compare quality improvement methods in the delivery of patient care.	5.1m Lead the development of a business plan for quality improvement initiatives.
5.1f Identify strategies to improve outcomes of patient care in practice.	5.1n Advocate for change related to financial policies that impact the relationship between economics and quality care delivery.
5.1g Participate in the implementation of a practice change.	5.1o Advance quality improvement practices through dissemination of outcomes.
5.1h Develop a plan for monitoring quality improvement change.	
<b>5.2 Contribute to a culture of patient safety.</b>	
5.2a Describe the factors that create a culture of safety.	5.2g Evaluate the alignment of system data and comparative patient safety benchmarks.
5.2b Articulate the nurse’s role within an interprofessional team in promoting safety and preventing errors and near misses.	5.2h Lead analysis of actual errors, near misses, and potential situations that would impact safety.
5.2c Examine basic safety design principles to reduce risk of harm.	5.2i Design evidence-based interventions to mitigate risk.
5.2d Assume accountability for reporting unsafe conditions, near misses, and errors to reduce harm.	5.2j Evaluate emergency preparedness system-level plans to protect safety.
5.2e Describe processes used in understanding causes of error.	
5.2f Use national patient safety resources, initiatives, and regulations at the point of care.	

<b>5.3 Contribute to a culture of provider and work environment safety.</b>	
5.3a Identify actual and potential level of risks to providers within the workplace.	5.3e Advocate for structures, policies, and processes that promote a culture of safety and prevent workplace risks and injury.
5.3b Recognize how to prevent workplace violence and injury.	5.3f Foster a just culture reflecting civility and respect.
5.3c Promote policies for prevention of violence and risk mitigation.	5.3g Create a safe and transparent culture for reporting incidents.
5.3d Recognize one's role in sustaining a just culture reflecting civility and respect.	5.3h Role model and lead well-being and resiliency for self and team.

## Domain 6: Interprofessional Partnerships

**Descriptor:** Intentional collaboration across professions and with care team members, patients, families, communities, and other stakeholders to optimize care, enhance the healthcare experience, and strengthen outcomes.

**Contextual Statement:** Professional partnerships that include interprofessional, intraprofessional, and paraprofessional partnerships, build on a consistent demonstration of core professional values (altruism, excellence, caring, ethics, respect, communication, and shared accountability) in the provision of team-based, person-centered care. Nursing knowledge and expertise uniquely contributes to the intentional work within teams and in concert with patient, family, and community preferences and goals. Interprofessional partnerships require a coordinated, integrated, and collaborative implementation of the unique knowledge, beliefs, and skills of the full team for the end purpose of optimized care delivery. Effective collaboration requires an understanding of team dynamics and an ability to work effectively in care-oriented teams. Leadership of the team varies depending on needs of the individual, community, population, and context of care.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>6.1 Communicate in a manner that facilitates a partnership approach to quality care delivery.</b>	
6.1a Communicate the nurse’s roles and responsibilities clearly.	6.1g Evaluate effectiveness of interprofessional communication tools and techniques to support and improve the efficacy of team-based interactions.
6.1b Use various communication tools and techniques effectively.	6.1h Facilitate improvements in interprofessional communications of individual information (e.g. EHR).
6.1c Elicit the perspectives of team members to inform person-centered care decision making.	6.1i Role model respect for diversity, equity, and inclusion in team-based communications.
6.1d Articulate impact of diversity, equity, and inclusion on team-based communications.	6.1j Communicate nursing’s unique disciplinary knowledge to strengthen interprofessional partnerships.
6.1e Communicate individual information in a professional, accurate, and timely manner.	6.1k Provide expert consultation for other members of the healthcare team in one’s area of practice.
6.1f Communicate as informed by legal, regulatory, and policy guidelines.	6.1l Demonstrate capacity to resolve interprofessional conflict.
<b>6.2 Perform effectively in different team roles, using principles and values of team dynamics.</b>	
6.2a Apply principles of team dynamics, including team roles, to facilitate effective team functioning.	6.2g Integrate evidence-based strategies and processes to improve team effectiveness and outcomes.

6.2b Delegate work to team members based on their roles and competency.	6.2h Evaluate the impact of team dynamics and performance on desired outcomes.
6.2c Engage in the work of the team as appropriate to one's scope of practice and competency.	6.2i Reflect on how one's role and expertise influences team performance.
6.2d Recognize how one's uniqueness (as a person and a nurse) contributes to effective interprofessional working relationships.	6.2j Foster positive team dynamics to strengthen desired outcomes.
6.2e Apply principles of team leadership and management. performance to improve quality and assure safety.	
6.2f Evaluate performance of individual and team to improve quality and promote safety.	
<b>6.3 Use knowledge of nursing and other professions to address healthcare needs.</b>	
6.3a Integrate the roles and responsibilities of healthcare professionals through interprofessional collaborative practice.	6.3d Direct interprofessional activities and initiatives.
6.3b Leverage roles and abilities of team members to optimize care.	
6.3c Communicate with team members to clarify responsibilities in executing plan of care.	
<b>6.4 Work with other professions to maintain a climate of mutual learning, respect, and shared values.</b>	
6.4a Demonstrate an awareness of one's biases and how they may affect mutual respect and communication with team members.	6.4e Practice self-assessment to mitigate conscious and implicit biases toward other team members.
6.4b Demonstrate respect for the perspectives and experiences of other professions.	6.4f Foster an environment that supports the constructive sharing of multiple perspectives and enhances interprofessional learning.
6.4c Engage in constructive communication to facilitate conflict management.	6.4g Integrate diversity, equity, and inclusion into team practices.
6.4d Collaborate with interprofessional team members to establish mutual healthcare goals for individuals, communities, or populations.	6.4h Manage disagreements, conflicts, and challenging conversations among team members.
	6.4i Promote an environment that advances interprofessional learning.



## Domain 7: Systems-Based Practice

**Descriptor:** Responding to and leading within complex systems of health care. Nurses effectively and proactively coordinate resources to provide safe, quality, and equitable care to diverse populations.

**Contextual Statement:** Using evidence-based methodologies, nurses lead innovative solutions to address complex health problems and ensure optimal care. Understanding of systems-based practice is foundational to the delivery of quality care and incorporates key concepts of organizational structure, including relationships among macro-, meso-, and microsystems across healthcare settings. Knowledge of financial and payment models relative to reimbursement and healthcare costs is essential. In addition, the impact of local, regional, national, and global structures, systems, and regulations on individuals and diverse populations must be considered when evaluating patient outcomes. As change agents and leaders, nurses possess the intellectual capacity to be agile in response to continually evolving healthcare systems, to address structural racism and other forms of discrimination, and to advocate for the needs of diverse populations. Systems-based practice is predicated on an ethical practice environment where professional and organizational values are aligned, and structures and processes enable ethical practice by all members of the institution.

Integrated healthcare systems are highly complex, and gaps or failures in service and delivery can cause ineffective, harmful outcomes. These outcomes also span individual through global networks. Cognitive shifting from focused to big picture is a crucial skill set. Similarly, the ability for nurses to predict change, employ improvement strategies, and exercise fiscal prudence are critical skills. System awareness, innovation, and design also are needed to address such issues as structural racism and systemic inequity.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>7.1 Apply knowledge of systems to work effectively across the continuum of care.</b>	
7.1a Describe organizational structure, mission, vision, philosophy, and values.	7.1e Participate in organizational strategic planning.
7.1b Explain the relationships of macrosystems, mesosystems, and microsystems.	7.1f Participate in system-wide initiatives that improve care delivery and/or outcomes.
7.1c Differentiate between various healthcare delivery environments across the continuum of care.	7.1g Analyze system-wide processes to optimize outcomes.
7.1d Recognize internal and external system processes that impact care coordination and transition of care.	7.1h Design policies to impact health equity and structural racism within systems, communities, and populations.
<b>7.2 Incorporate consideration of cost-effectiveness of care.</b>	
7.2a Describe the financial and payment models of health care.	7.2g Analyze relevant internal and external factors that drive healthcare costs and reimbursement.

7.2b Recognize the impact of health disparities and social determinants of health on care outcomes.	7.2h Design practices that enhance value, access, quality, and cost-effectiveness.
7.2c Describe the impact of healthcare cost and payment models on the delivery, access, and quality of care.	7.2i Advocate for healthcare economic policies and regulations to enhance value, quality, and cost-effectiveness.
7.2d Explain the relationship of policy, regulatory requirements, and economics on care outcomes.	7.2j Formulate, document, and disseminate the return on investment for improvement initiatives collaboratively with an interdisciplinary team.
7.2e Incorporate considerations of efficiency, value, and cost in providing care.	7.2k Recommend system-wide strategies that improve cost- effectiveness considering structure, leadership, and workforce needs.
7.2f Identify the impact of differing system structures, leadership, and workforce needs on care outcomes.	7.2l Evaluate health policies based on an ethical framework considering cost-effectiveness, health equity, and care outcomes.
<b>7.3 Optimize system effectiveness through application of innovation and evidence-based practice.</b>	
7.3a Demonstrate a systematic approach for decision-making.	7.3e Apply innovative and evidence-based strategies focusing on system preparedness and capabilities.
7.3b Use reported performance metrics to compare/monitor outcomes.	7.3f Design system improvement strategies based on performance data and metrics.
7.3c Participate in evaluating system effectiveness.	7.3g Manage change to sustain system effectiveness.
7.3d Recognize internal and external system processes and structures that perpetuate racism and other forms of discrimination within health care.	7.3h Design system improvement strategies that address internal and external system processes and structures that perpetuate structural racism and other forms of discrimination in healthcare systems.

## Domain 8: Informatics and Healthcare Technologies

**Descriptor:** Information and communication technologies and informatics processes are used to provide care, gather data, form information to drive decision making, and support professionals as they expand knowledge and wisdom for practice. Informatics processes and technologies are used to manage and improve the delivery of safe, high-quality, and efficient healthcare services in accordance with best practice and professional and regulatory standards.

**Contextual Statement:** Healthcare professionals interact with patients, families, communities, and populations in technology-rich environments. Nurses, as essential members of the healthcare team, use information and communication technologies and informatics tools in their direct and indirect care roles. The technologies, the locations in which they are used, the users interacting with the technology, the communication occurring, and the work being done all impact the data collected, information formed, decisions made, and the knowledge generated. Additionally, the utilization of information and communication technologies in healthcare settings changes how people, processes, and policies interact. Using these tools in the provision of care has both short- and long-term consequences for the quality of care, efficiency of communications, and connections between team members, patients, and consumers. It is essential that nurses at all levels understand their role and the value of their input in health information technology analysis, planning, implementation, and evaluation. With the prevalence of patient-focused health information technologies, all nurses have a responsibility to advocate for equitable access and assist patients and consumers to optimally use these tools to engage in care, improve health, and manage health conditions.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations.</b>	
8.1a Identify the variety of information and communication technologies used in care settings.	8.1g Identify best evidence and practices for the application of information and communication technologies to support care.
8.1b Identify the basic concepts of electronic health, mobile health, and telehealth systems for enabling patient care.	8.1h Evaluate the unintended consequences of information and communication technologies on care processes, communications, and information flow across care settings.
8.1c Effectively use electronic communication tools.	8.1i Propose a plan to influence the selection and implementation of new information and communication technologies.
8.1d Describe the appropriate use of multimedia applications in health care.	8.1j Explore the fiscal impact of information and communication technologies on health care.
8.1e Demonstrate best practice use of social networking applications.	8.1k Identify the impact of information and communication technologies on workflow processes and healthcare outcomes.

8.1f Explain the importance of nursing engagement in the planning and selection of healthcare technologies.	
<b>8.2 Use information and communication technology to gather data, create information, and generate knowledge.</b>	
8.2a Enter accurate data when chronicling care.	8.2f Generate information and knowledge from health information technology databases.
8.2b Explain how data entered on one patient impacts public and population health data.	8.2g Evaluate the use of communication technology to improve consumer health information literacy.
8.2c Use appropriate data when planning care.	8.2h Use standardized data to evaluate decision-making and outcomes across all systems levels.
8.2d Demonstrate the appropriate use of health information literacy assessments and improvement strategies.	8.2i Clarify how the collection of standardized data advances the practice, understanding, and value of nursing and supports care.
8.2e Describe the importance of standardized nursing data to reflect the unique contribution of nursing practice.	8.2j Interpret primary and secondary data and other information to support care.
<b>8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings.</b>	
8.3a Demonstrate appropriate use of information and communication technologies.	8.3g Evaluate the use of information and communication technology to address needs, gaps, and inefficiencies in care.
8.3b Evaluate how decision support tools impact clinical judgment and safe patient care.	8.3h Formulate a plan to influence decision-making processes for selecting, implementing, and evaluating support tools.
8.3c Use information and communication technology in a manner that supports the nurse-patient relationship.	8.3i Appraise the role of information and communication technologies in engaging the patient and supporting the nurse-patient relationship.
8.3d Examine how emerging technologies influence healthcare delivery and clinical decision making.	8.3j Evaluate the potential uses and impact of emerging technologies in health care.
8.3e Identify impact of information and communication technology on quality and safety of care.	8.3k Pose strategies to reduce inequities in digital access to data and information.

<p>8.3f Identify the importance of reporting system processes and functional issues (error messages, mis-directions, device malfunctions, etc.) according to organizational policies and procedures.</p>	
<p><b>8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels.</b></p>	
<p>8.4a Explain the role of communication technology in enhancing clinical information flows.</p>	<p>8.4e Assess best practices for the use of advanced information and communication technologies to support patient and team communications.</p>
<p>8.4b Describe how information and communication technology tools support patient and team communications.</p>	<p>8.4f Employ electronic health, mobile health, and telehealth systems to enable quality, ethical, and efficient patient care.</p>
<p>8.4c Identify the basic concepts of electronic health, mobile health, and telehealth systems in enabling patient care.</p>	<p>8.4g Evaluate the impact of health information exchange, interoperability, and integration to support patient-centered care.</p>
<p>8.4d Explain the impact of health information exchange, interoperability, and integration on health care.</p>	
<p><b>8.5 Use information and communication technologies in accordance with ethical, legal, professional, and regulatory standards, and workplace policies in the delivery of care.</b></p>	
<p>8.5a Identify common risks associated with using information and communication technology.</p>	<p>8.5g Apply risk mitigation and security strategies to reduce misuse of information and communication technology.</p>
<p>8.5b Demonstrate ethical use of social networking applications.</p>	<p>8.5h Assess potential ethical and legal issues associated with the use of information and communication technology.</p>
<p>8.5c Comply with legal and regulatory requirements while using communication and information technologies.</p>	<p>8.5i Recommend strategies to protect health information when using communication and information technology.</p>
<p>8.5d Educate patients on their rights to access, review, and correct personal data and medical records.</p>	<p>8.5j Promote patient engagement with their personal health data.</p>
<p>8.5e Discuss how clinical judgment and critical thinking must prevail in the presence of information and communication technologies.</p>	<p>8.5k Advocate for policies and regulations that support the appropriate use of technologies impacting health care.</p>
<p>8.5f Deliver care using remote technology.</p>	<p>8.5l Analyze the impact of federal and state policies and regulation on health data and technology in care settings.</p>

## Domain 9: Professionalism

**Descriptor:** Formation and cultivation of a sustainable professional identity, including accountability, perspective, collaborative disposition, and comportment, that reflects nursing’s characteristics and values.

**Contextual Statement:** Professionalism encompasses the development of a nursing identity embracing the values of integrity, altruism, inclusivity, compassion, courage, humility, advocacy, caring, autonomy, humanity, and social justice. Professional identity formation necessitates the development of emotional intelligence to promote social good, engage in social justice, and demonstrate ethical comportment, moral courage, and assertiveness in decision making and actions. Nursing professionalism is a continuous process of socialization that requires the nurse to give back to the profession through the mentorship and development of others.

Professional identity, influenced by one’s personal identity and unique background, is formed throughout one’s education and career. Nursing identity flourishes through engagement and reflection in multiple experiences that is defined by differing perspectives and voices. As a result, nurses embrace the history, characteristics, and values of the discipline and think, act, and feel like a nurse. Professional identity formation is not a linear process but rather one that responds to challenges and matures through professional experiences as one develops confidence as a nurse.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>9.1 Demonstrate an ethical comportment in one’s practice reflective of nursing’s mission to society.</b>	
9.1a Apply principles of professional nursing ethics and human rights in patient care and professional situations.	9.1h Analyze current policies and practices in the context of an ethical framework.
9.1b Reflect on one’s actions and their consequences.	9.1i Model ethical behaviors in practice and leadership roles.
9.1c Demonstrate ethical behaviors in practice.	9.1j Suggest solutions when unethical behaviors are observed.
9.1d Change behavior based on self and situational awareness.	9.1k Assume accountability for working to resolve ethical dilemmas.
9.1e Report unethical behaviors when observed.	
9.1f Safeguard privacy, confidentiality, and autonomy in all interactions.	
9.1g Advocate for the individual’s right to self-determination.	

<b>9.2 Employ participatory approach to nursing care.</b>	
9.2a Employ the use of intentional presence to facilitate shared meaning of the experience between nurse and recipient of care.	9.2h Foster opportunities for intentional presence in practice.
9.2b Facilitate health and healing through compassionate caring.	9.2i Identify innovative and evidence-based practices that promote person-centered care.
9.2c Demonstrate empathy to the individual's life experience.	9.2j Advocate for practices that advance diversity, equity, and inclusion.
9.2d Advocate for practices that advance diversity, equity, and inclusion.	9.2k Model professional expectations for therapeutic relationships.
9.2e Demonstrate cultural sensitivity and humility in practice.	9.2l Facilitate communication that promotes a participatory approach.
9.2f Apply principles of therapeutic relationships and professional boundaries.	
9.2g Communicate in a professional manner.	
<b>9.3 Demonstrate accountability to the individual, society, and the profession.</b>	
9.3a Engage in advocacy that promotes the best interest of the individual, community, and profession.	9.3i Advocate for nursing's professional responsibility for ensuring optimal care outcomes
9.3b Demonstrate the moral courage to report concerns related to actual or potential hazards and/or errors.	9.3j Demonstrate leadership skills when participating in professional activities and/or organizations.
9.3c Demonstrate professional and personal honesty and integrity.	9.3k Address actual or potential hazards and/or errors.
9.3d Take responsibility for one's roles, decisions, obligations, actions, and care outcomes.	9.3l Foster a practice environment that promotes accountability for care outcomes.
9.3e Engage in professional activities and/or organizations.	9.3m Advocate for policies/practices that promote social justice and health equity.
9.3f Demonstrate adherence to a culture of civility.	9.3n Foster strategies that promote a culture of civility across a variety of settings.
9.3g Advocate for social justice and health equity, including addressing the health of vulnerable populations.	9.3o Lead in the development of opportunities for professional and interprofessional activities.
9.3h Engage in peer evaluation.	

<b>9.4 Comply with relevant laws, policies, and regulations.</b>	
9.4a Advocate for policies that promote health and prevent harm.	9.4d Advocate for polices that enable nurses to practice to the full extent of their education.
9.4b Adhere to the registered nurse scope and standards of practice.	9.4e Assess the interaction between regulatory agency requirements and quality, fiscal, and value-based indicators.
9.4c Adhere to regulatory requirements and workplace policies consistent with one's educational preparation.	9.4f Evaluate the effect of legal and regulatory policies on nursing practice and healthcare outcomes.
	9.4g Analyze efforts to change legal and regulatory policies that improve nursing practice and health outcomes.
	9.4h Participate in the implementation of policies and regulations to improve the professional practice environment and healthcare outcomes.
<b>9.5 Demonstrate the professional identity of nursing.</b>	
9.5a Describe nursing's professional identity and contributions to the healthcare team.	9.5f Articulate nursing's unique professional identity to other interprofessional team members and the public.
9.5b Demonstrate the core values of professional nursing identity.	9.5g Evaluate practice environment to ensure that nursing core values are demonstrated.
9.5c Demonstrate sensitivity to the values of others.	9.5h Identify opportunities to lead with moral courage to influence team decision-making.
9.5d Demonstrate ethical comportment and moral courage in decision making and actions.	9.5i Engage in professional organizations that reflect nursing's values and identity.
9.5e Demonstrate emotional intelligence.	
<b>9.6 Integrate diversity, equity, and inclusion as core to one's professional identity.</b>	
9.6a Demonstrate respect for diverse individual differences and diverse communities and populations	9.6d Model respect for diversity, equity, and inclusion for all team members.
9.6b Demonstrate awareness of personal and professional values and conscious and unconscious biases.	9.6e Critique one's personal and professional practices in the context of nursing's core values.



9.6c Integrate core principles of social justice and human rights into practice.	9.6f Analyze the impact of structural and cultural influences on nursing's professional identity.
	9.6g Ensure that care provided by self and others is reflective of nursing's core values.
	9.6h Structure the practice environment to facilitate care that is culturally and linguistically appropriate.
	9.6i Ensure self and others are accountable in upholding moral, legal, and humanistic principles related to health.

## Domain 10: Personal, Professional, and Leadership Development

**Descriptor:** Participation in activities and self-reflection that foster personal health, resilience, and well-being; contribute to lifelong learning; and support the acquisition of nursing expertise and the assertion of leadership.

**Contextual Statement:** Competency in personal, professional, and leadership development encompasses three areas: 1) development of the nurse as an individual who is resilient, agile, and capable of adapting to ambiguity and change; 2) development of the nurse as a professional responsible for lifelong learning and ongoing self-reflection; and 3) development of the nurse as a leader proficient in asserting control, influence, and power in professional and personal contexts, which includes advocacy for patients and the nursing profession as leaders within the healthcare arena. Development of these dimensions requires a commitment to personal growth, sustained expansion of professional knowledge and expertise, and determined leadership practice in a variety of contexts.

Graduates must develop attributes and skills critical to the viability of the profession and practice environments. The aim is to promote diversity and retention in the profession, self-awareness, avoidance of stress-induced emotional and mental exhaustion, and re-direction of energy from negative perceptions to positive influence through leadership opportunities.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
<b>10.1 Demonstrate a commitment to personal health and well-being.</b>	
10.1a Demonstrate healthy, self-care behaviors that promote wellness and resiliency.	10.1c Contribute to an environment that promotes self-care, personal health, and well-being.
10.1b Manage conflict between personal and professional responsibilities.	10.1d Evaluate the workplace environment to determine level of health and well-being.
<b>10.2 Demonstrate a spirit of inquiry that fosters flexibility and professional maturity.</b>	
10.2a Engage in guided and spontaneous reflection of one's practice.	10.2g Demonstrate cognitive flexibility in managing change within complex environments.
10.2b Integrate comprehensive feedback to improve performance.	10.2h Mentor others in the development of their professional growth and accountability.
10.2c Commit to personal and professional development.	10.2i Foster activities that support a culture of lifelong learning.
10.2d Expand personal knowledge to inform clinical judgment.	10.2j Expand leadership skills through professional service.
10.2e Identify role models and mentors to support professional growth.	

10.2f Participate in ongoing activities that embrace principles of diversity, equity, inclusion, and anti-discrimination.	
<b>10.3 Develop capacity for leadership.</b>	
10.3a Compare and contrast leadership principles and theories.	10.3j Provide leadership to advance the nursing profession.
10.3b Formulate a personal leadership style.	10.3k Influence intentional change guided by leadership principles and theories.
10.3c Demonstrate leadership behaviors in professional situations.	10.3l Evaluate the outcomes of intentional change.
10.3d Demonstrate self-efficacy consistent with one's professional development.	10.3m Evaluate strategies/methods for peer review.
10.3e Use appropriate resources when dealing with ambiguity.	10.3n Participate in the evaluation of other members of the care team.
10.3f Modify one's own leadership behaviors based on guided self-reflection.	10.3o Demonstrate leadership skills in times of uncertainty and crisis.
10.3g Demonstrate self-awareness of one's own implicit biases and their relationship to one's culture and environment.	10.3p Advocate for the promotion of social justice and eradication of structural racism and systematic inequity in nursing and society.
10.3h Communicate a consistent image of the nurse as a leader.	10.3q Advocate for the nursing profession in a manner that is consistent, positive, relevant, accurate, and distinctive.
10.3i Recognize the importance of nursing's contributions as leaders in practice and policy issues.	

## Glossary

**Accountability:** Obligation or willingness to accept responsibility or to account for one's actions.

**Advanced nursing practice role:** One of the four Advanced Practice Registered Nurse (APRN) roles – certified registered nurse anesthetist, certified nurse-midwife, certified clinical nurse specialist, and certified nurse practitioner.

**Advanced nursing practice specialty:** See Specialty.

**Advanced Practice Registered Nurse (APRN):** Designation given to one of four nursing roles: certified registered nurse anesthetists, certified nurse-midwives, certified clinical nurse specialists, and certified nurse practitioners. An APRN is a nurse who has 1.) completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles; 2.) passed a national certification examination that measures APRN role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program; 3.) acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; 4.) built on the competencies of registered nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy; 5.) been educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; 6.) clinical experience of sufficient depth and breadth to reflect the intended license; and 7.) obtained a license to practice in one of the four APRN roles (APRN Consensus Work Group & NCSBN APRN Advisory Committee, 2008).

**APRN Core:** APRN education programs include at a minimum, three separate comprehensive graduate-level courses in: Advanced physiology and pathophysiology, which includes general principles that apply across the lifespan; Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents (APRN Consensus Work Group & NCSBN APRN Advisory Committee, 2008).

**Advocacy:** The act or process of supporting a cause or proposal: the act or process of advocating. Advocacy is a pillar of nursing. Nurses instinctively advocate for their patients, in their workplaces, and in their communities; but legislative and political advocacy is equally important to advancing patient care.

**Analytic approach:** Any method based on breaking down a complex process into its parts so as to better understand the whole.

**Authentic or intentional presence:** Being fully present in the moment This extends to possessing an awareness of when you drift and how to intentionally bring yourself back to the interaction (Altman, 2014).

**Care:** A focused attention on, and when possible, engagement with a patient to determine a person's particular needs and the use of clinical judgment to meet those needs (Grace, 2018).

**Care outcomes:** Harris (1991) defined outcomes as the end points of care, substantial changes in the health condition of a patient, and changes in patient behavior caused by medical interventions. Given these definitions, outcomes related to clinical practice are any change that resulted from health care.

**Caring relationship:** Caring constitutes the essence of what it is to be human, having a profound effect on well-being and recovery, being at ease, and being healed. When hospitality is received, patients feel a connection, they begin to trust, and their healing begins.

**Clinical immersion:** A brief, structured, intense nursing practicum where the entire focus is in a particular clinical setting without the distraction of other academic classes (Tratnack, et al., 2011).

**Clinical judgment:** The skill of recognizing cues regarding a clinical situation, generating and weighing hypotheses, taking action, and evaluating outcomes for the purpose of arriving at a satisfactory clinical outcome. Clinical judgment is the observed outcome of two unobserved underlying mental processes, critical thinking and decision making (NCSBN, 2018).

**Clinical reasoning:** Thought processes that allow healthcare providers to arrive at a conclusion.

**Cognitive flexibility:** A critical executive function involving the ability to adapt behaviors in response to changes in the environment. Cognitive flexibility generally refers to the ability to adapt flexibly to a constantly changing environment.

**Complex systems:** Systems whose behavior is intrinsically difficult to model due to the dependencies, competitions, relationships, or other types of interactions between their parts or between a given system and its environment. Complex systems have distinct properties that arise from these relationships, such as nonlinearity, emergence, spontaneous order, adaptation, and feedback loops, among others.

**Competence:** The array of abilities (knowledge, skills, and attitudes) across multiple domains or aspects of performance in a certain context. Competence is multi-dimensional and dynamic (Frank, Snell, Cate, et al., 2010).

**Competency:** An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition (Frank, Snell, Cate, et al., 2010).

**Competency framework:** An organized and structured representation of a set of interrelated and purposeful competencies (Englander et al., 2013, p. 1089).

**Competency list:** The delineation of the specific competencies within a competency framework (Englander, et al., 2013, p.1089).

**Concepts:** A concept is an organizing idea or mental construct represented by common attributes. Rodgers (1989, p. 332) describes concepts as "an abstraction that is expressed in some form."

**Core values:** In nursing, core nursing values include human dignity, integrity, autonomy, altruism, and social justice.

**Core disciplinary knowledge:** The intellectual structures within which the discipline delineates its unique focus of vision and social mandate. AACN has identified core disciplinary knowledge as having three components: historic and philosophic foundations to the development of nursing knowledge; existing and evolving substantive nursing knowledge; and methods and processes of theory/knowledge development (AACN, 2002, p. 289).

**Cost effectiveness:** A way to examine both the costs and health outcomes of one or more interventions; it compares one intervention to another (or the status quo) by estimating how much it costs to gain a unit of a health outcome, like a life year gained or a death prevented.

**Critical thinking:** The skill of using logic and reasoning to identify the strengths and weaknesses of alternative healthcare solutions, conclusions, or approaches to clinical or practice problems.

**Cultural awareness:** The deliberate self-examination and in-depth exploration of one's biases, stereotypes, prejudices, assumptions, and "isms" that one holds regarding individuals and groups who are different from them (Campinha-Bacote, 1998).

**Cultural competence:** The ability to effectively work within the client's cultural context. Structural competence is recognition of the economic and political conditions that produce health inequalities in the first place. It is the ability to understand how institutions, markets, or healthcare delivery systems shape symptom presentations and to mobilize for correction of health and wealth inequalities in society (Drevdahl, 2018; Metzl et al., 2018; Metzl et al., 2020).

**Cultural and linguistic competence:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross et al., 1989). Cultural competence is a developmental process that evolves over an extended period.

**Culturally sensitive:** "The ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage" (DHHS, OMH, 2001, p. 131).

**Cultural humility:** A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but also examines her/his own beliefs and cultural identities.

**Determinants of health:** The range of personal, social, economic, and environmental factors that interrelate to determine individual and population health. These factors include policymaking, social factors, health services, individual behaviors, and biology and genetics. Determinants of health reach beyond the boundaries of traditional health care and public health sectors. Sectors such as education, housing, transportation, agriculture, and environment can be important allies in improving population health (*Healthy People 2020*).

**Diagnose:** To identify the nature of an illness or other problem by examination of the symptoms.

**Diversity:** A broad range of individual, population, and social characteristics, including but not limited to age; sex; race; ethnicity; sexual orientation; gender identity; family structures; geographic locations; national origin; immigrants and refugees; language; any impairment that substantially limits a major life activity; religious beliefs; and socioeconomic status. Inclusion represents environmental and organizational cultures in which faculty, students, staff, and administrators with diverse characteristics thrive. Inclusive environments require intentionality and embrace differences, not merely tolerate them. Everyone works to ensure the perspectives and experiences of others are invited, welcomed, acknowledged, and respected in inclusive environments.

**Domains of competence:** Broad distinguishable areas of competence that in the aggregate constitute a general descriptive framework for a profession (Englander et al., 2013, p. 1089).

**Emotional intelligence:** The ability to perceive, appraise and express emotion, access and process emotional information, generate feelings, understand emotional knowledge and regulate emotions for emotional and intellectual growth (Mayer, et al, 1997, p. 10). Emotional intelligence, like academic intelligence, can be learned, increases with age, and is predictive of how emotional processing contributes to success in life (Mayer et al., 2004).

**Equity:** The ability to recognize the differences in the resources or knowledge needed to allow individuals to fully participate in society, including access to higher education, with the goal of overcoming obstacles to ensure fairness (Kranich, 2001). To have equitable systems, all people should be treated fairly, unhampered by artificial barriers, stereotypes, or prejudices (Cooper, 2016).

**Ethical comportment:** The way in which nurses embody the ability to relate to others respectfully and responsively (Benner, 2009). Ethical comportment consists of four critical attributes: 1) embodiment, 2) skilled relational know-how, 3) caring, and 4) salience (Hardin, 2018).

**Ethical competence:** The ability to recognize an ethical situation/issue (awareness/sensitivity), the ability to determine a justifiable action (reflection/decision-making), and have the motivation, knowledge, and skills to implement a decision (comportment and action) (ANA Scope & Standards, 2021).

**Evidence-based practice:** A conscientious, problem-solving approach to clinical practice that incorporates the best evidence from well-designed studies, patient values and preferences, and a clinician's expertise in making decisions regarding a patient's care. Being knowledgeable about evidence-based practice and levels of evidence is important for clinicians to be confident about how much emphasis they should place on a study, report, practice alert or practice guideline when making decisions about a patient's care.

**Explicit biases:** Conscious positive or negative feelings and/or thoughts about groups or identity characteristics. Because these attitudes are explicit in nature, they are espoused openly, through overt and deliberate thoughts and actions (Harrison et al., 2019; Wilson et al., 2000)



**Family:** An individual’s closest support structure that is inclusive of birth family, single parent families, blended families, families with stepparents, and families with homosexual parents to name a few. The concept of the contemporary family has evolved into a fluid ideology that is constantly shifting and changing throughout society.

**Health disparities:** “A particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” (US Department of Health and Human Services (2010).

**Health equity:** When every person has an opportunity to attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances (National Academies of Sciences, Engineering, and Medicine, 2017). Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

**Health inequity:** The distribution and allocation of power and resources differentially, which manifest in unequal social, economic, and environmental conditions (National Academies of Sciences, Engineering, and Medicine, 2017).

**Health Information Technology (HIT):** The electronic systems healthcare professionals and patients use to store, share, and analyze health information. HIT consists of many types of applications such as Electronic Health Records, personal health records, electronic prescribing, mobile applications, social networks, monitors, wearables, nanotechnology, genomics, and robotics (Office of the National Coordinator for Health Information Technology [ONC], 2018).

**Healthcare team:** The collective of individuals who contribute to the care and treatment of an individual, family, group, or population.

**Healthy lifestyle:** A way of living that lowers the risk of being seriously ill or dying early. Scientific studies have identified certain types of behavior that contribute to the development of noncommunicable diseases and early death. Health is not only just about avoiding disease. It involves physical, mental and social wellbeing.

**Holistic admissions review:** An admissions strategy that assesses an applicant’s unique experiences alongside traditional measures of academic achievement, such as grades and test scores. This process is used to help schools consider a broad range of factors reflecting the applicant’s academic readiness, contribution to the incoming class, and potential for success both in school and later as a professional.

**Holistic nursing:** “All nursing practice that has healing the whole person as its goal” (American Holistic Nurses’ Association, 1998).



**Implicit and unconscious biases:** The tendency to process information based on unconscious associations and feelings, even when these are contrary to one’s conscious or declared beliefs. They are automatically activated and may occur unconsciously (Metzl et al., 2018, 2020; Van Ryn et al. 2011).

**Inclusive environments:** Environmental and organizational cultures in which faculty, students, staff, and administrators with diverse characteristics thrive. Inclusive environments require intentionality and embrace differences, not merely tolerate them. Everyone works to ensure the perspectives and experiences of others are invited, welcomed, acknowledged, and respected.

**Inequities:** Characterized by a lack of equity, injustice, unfairness.

**Informatics:** The intersection between the work of stakeholders across the health and healthcare delivery system who seek to improve outcomes, lower costs, increase safety and promote the use of high-quality services. It is frequently confused with data science, big data, health information management and data analytics, informatics is the overarching field of study that pulls all these subdomains into one discipline focused on improving health and healthcare. Emerging topics like artificial intelligence and machine learning are incorporating in the field of informatics (AMIA, 2021).

**Information and Communications Technologies (ICT):** Technologies that provide access to information through telecommunications, including the internet, telephones, cell phones, wireless signals, networks, satellite systems, telehealth/telenursing, and video conferencing.

**Innovation:** A great idea to develop and deliver new or improved health policies, systems, products and technologies, and services and delivery methods that improve people’s health (WHO Health Innovation Group, 2021).

**Integration:** An experience designed to provide the student with an opportunity to synthesize the knowledge and skills acquired during previous and current coursework and learning experiences.

**Intentional change theory:** The essential components and processes of desirable, sustainable change in one’s behavior, thoughts, feelings, and perceptions. The “change” maybe in a person’s actions, habits, competencies, or aspirations as well as in the way one feels in certain situations or around certain people. The change may impact how one looks at events at work or in life. The change is “desired” in that person wishes it so or would like to occur and is “sustainable” in that it endures and lasts a relatively long time (Boyatzis, 2006).

**Interdisciplinary:** Refers to a group of healthcare providers with various areas of expertise who work together toward the goals of their clients.

**Interoperability:** The ability of different information systems, devices, and applications (systems) to access, exchange, integrate, and cooperatively use data in a coordinated manner, within and across organizational, regional, and national boundaries to provide timely and seamless portability of information and optimize the health of individuals and populations globally. Health data exchange architectures, application interfaces, and standards enable data to be accessed and shared appropriately and securely across the complete spectrum of care, within all applicable settings and with relevant stakeholders, including the individual.

**Interprofessional:** Engagement involving two or more professions or professionals.

**Interprofessional team:** The cooperation, coordination, and collaboration expected among members of different professions in delivering patient-centered care collectively.

**Just culture:** Balances the need for an open and honest reporting environment with a quality learning environment and culture. All individuals within this environment are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to system design and management of the behavioral choices of all employees.

**Lifelong learning:** The provision or use of both formal and informal learning opportunities throughout one's life to foster the continuous development and improvement of the knowledge and skills needed for employment and personal fulfillment.

**Macrosystem:** The highest system level represents the whole of the organization and is led by senior leaders such as the CEO, chief operations officer (COO), chief nursing officer (CNO), and chief information officer (CIO) and is guided by a board of trustees (Nelson, et al., 2007).

**Managing disease:** To improve the health of persons with chronic conditions and reduce associated costs from avoidable complications by identifying and treating chronic conditions more quickly and more effectively, thus slowing the progression of diseases.

**Mesosystem:** The interrelated units and clinical leadership that provide care to certain populations (McKinley et al., 2008).

**Microsystem:** Small, functional frontline units that provide the most health care to most people (Nelson et al., 2007, p.3). A clinical microsystem is a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. These units have clinical and business aims, linked processes, and a shared information environment, and focus on producing performance outcomes. Microsystems are complex adaptive systems, and as such they must do the primary work associated with core aims, meet the needs of internal staff, and maintain themselves over time as clinical units (Nelson, et al., 2002).

**Mitigation:** The action of reducing the severity, seriousness, or painfulness of something.

**Mobile health (mHealth):** The use of mobile and wireless technologies to support the achievement of health objectives. The expanding use of mobile health is driven rapid advances in mobile technologies and applications, a rise in new opportunities for the integration of mobile health into existing eHealth services, and the continued growth in coverage of mobile cellular networks.

**Moral courage:** The willingness of individuals to take hold of, and fully support, ethical responsibilities essential to professional values (Day, 2007). This highly esteemed trait is displayed by individuals, who, despite adversity and personal risk, decide to act upon their ethical values to help others during difficult ethical dilemmas. Moral courage entails doing the right thing, even when others choose less ethical behavior, which may include taking no action at all (Lachman, 2009; 2007a; 2007b; Sekerka & Bagozzi, 2007).

**Moral ethical behaviors:** Prevailing standards of behavior used to judge right and wrong.

**Nurse sensitive indicators:** Reflect three aspects of nursing care: structure, process, and outcomes. Structural indicators include the supply of nursing staff, the skill level of nursing staff, and the education and certification levels of nursing staff. Process indicators measure methods of patient assessment and nursing interventions. Nursing job satisfaction is also considered a process indicator. Outcome indicators reflect patient outcomes that depend on the quantity or quality of nursing care (e.g., pressure ulcers and falls).

**Nursing informatics:** The specialty that integrates nursing science with multiple information and analytical sciences to identify, define, manage, and communicate data, information, knowledge, and wisdom in nursing practice (HIMSS, 2021).

**Participatory approach:** Calls for involving stakeholders, particularly the participants in a program or those affected by a given policy, in specific aspects of the evaluation process. The approach covers a wide range of different types of participation, and stakeholders can be involved at any stage of the impact evaluation process, including its design, data collection, analysis, reporting, and managing a study.

**Partnerships:** Close cooperation between parties having specified and joint rights and responsibilities.

**Patient:** The recipient of a healthcare service or intervention at the individual, family, community, or aggregate level. Patients may function in independent, interdependent, or dependent roles, and may seek or receive nursing interventions related to disease prevention, health promotion, or health maintenance, as well as illness and end-of-life care (AACN, 2006).

**Person-Centered Care:** “Empowering people to take charge of their own health rather than being passive recipients of services” (WHO, 2021). This care strategy is based on the belief that patient views, input, and experiences can help improve overall health outcomes.

**Point of Care:** Where care is delivered, including in diverse settings where individuals live, learn, work, play, and worship.

**Population:** A collection of individuals who have one or more personal or environmental characteristics in common.

**Practice:** Any form of nursing intervention that influences healthcare outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and healthcare organizations, and the development and implementation of health policy (AACN, 2004). Practice includes both direct and indirect care experiences (defined below).

**Direct Care/Indirect Care:**

- Direct care refers to a professional encounter between a nurse and an actual individual or family, either face to face or virtual, that is intended to achieve specific health goals or achieve selected health outcomes. Direct care may be provided in a wide range of settings, including acute and critical care, long term care, home health, community-based settings, and telehealth. (AACN, 2004, 2006; Suby, 2009; Upenieks, Akhavan, Kotlerman et al., 2007).

- Indirect care refers to nursing decisions, actions, or interventions that are provided through or on behalf of individuals, families, or groups. These decisions or interventions create the conditions under which nursing care or selfcare may occur. Nurses might use administrative decisions, population or aggregate health planning, or policy development to affect health outcomes in this way. Nurses who function in administrative capacities are responsible for direct care provided by other nurses. Their administrative decisions create the conditions under which direct care is provided. Public health nurses organize care for populations or aggregates to create the conditions under which improved health outcomes are more likely to occur. Health policies create broad scale conditions for delivery of nursing and health care (AACN, 2004, 2006; Suby, 2009; Upenieks et al., 2007).

**Preparedness:** The readiness of the nation’s medical and public health infrastructure to respond to and recover from disasters and public health emergencies. Preparedness requires collaboration with hospitals, healthcare coalitions, biotech firms, community members, state, local, tribal, and territorial governments, and other partners across the country to improve readiness and response capabilities.

**Primary and secondary data:** Primary data is collected by an investigator for a specific purpose. Secondary data is collected by someone else for another purpose (but being utilized by the investigator for another purpose).

**Profession:** An occupation (e.g., nursing, medicine, law, teaching) that is not mechanical or agricultural and requires special education.

**Professional agility:** The power to move quickly and easily; the ability to think and draw conclusions quickly drawing on intellectual acuity.

**Professional development:** Taking purposeful action to engage in structured activities to advance career development, education, leadership, program management, and/or compliance initiatives.

**Professional identity:** The representation of self, achieved in stages over time during which the characteristics, values, and norms of a profession are internalized, resulting in an individual thinking, acting, and feeling like a member of the profession (Cruess et al., 2014).

**Quality Improvement (QI):** A process that uses data to monitor the outcomes of care processes. QI uses improvement methods to design and test changes to continuously improve the quality and safety of health care systems (Cronenwett et al., 2007).

**Resilience:** The ability to survive and thrive in the face of adversity. Resilience can be developed and internalized as a measure to improve retention and reduce burnout. Building positive relationships, maintaining positivity, developing emotional insight, creating work-life balance, and reflecting on successes and challenges are effective strategies for resilience building.

**Response and recovery in an emergency/disaster:** Identifying resources and expertise in advance and planning how these can be used in a disaster. Preparedness, however, is only one phase of emergency management. There are four phases of emergency management: mitigation, preparedness, response, and recovery.

**Responsibility:** The state or fact of being responsible, answerable, or accountable for something within one's power, control, or management.

**Return on investment (ROI):** A performance measure used to evaluate the efficiency of an investment or compare the efficiency of a number of different investments. ROI seeks to directly measure the amount of return on a particular investment, relative to the investment's cost. To calculate ROI, the benefit (or return) of an investment is divided by the cost of the investment. The result is expressed as a percentage or a ratio.

**Risk assessment:** A process to identify potential hazards and analyze what could happen if a hazard occurs. To assess risk, organizations often consider possible scenarios that could unfold and what the potential impacts may be.

**Scholarship:** The generation, synthesis, translation, application, and dissemination of knowledge that aims to improve health and transform health care. Scholarship is the communication of knowledge generated through multiple forms of inquiry that inform clinical practice, nursing education, policy, and healthcare delivery. Scholarship is inclusive of discovery, integration, application, and teaching (Boyer, 1990). The hallmark attribute of scholarship is the cumulative impact of the scholar's work on the field of nursing and health care.

**Self-care:** The act of attending to one's physical or mental health, generally without medical or other professional consultation.

**Self-management:** The management of or by oneself; the taking of responsibility for one's own behavior and well-being.

**Service:** is the action of helping or doing work for someone.

**Simulation:** A technique that creates a situation or environment to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions (AHRQ, 2020).

**Social Determinants of Health:** See Determinants of Health

**Social Justice:** The expectation that everyone deserves equal economic, political, and social rights and opportunities. Equity, access, participation, and human rights are four principles of social justice including to ensure fair distribution of available resources across society, to ensure all people have access to goods and services regardless of age, gender, race, ethnicity etc.; to enable people to participate in decisions that affect their lives, and to protect individual liberties to information about circumstances and decisions affecting them and to appeal decisions believed to be unfair (Morgaine, 2014; Nemetchek, 2019).

**Social Responsibility:** An ethical theory in which individuals are accountable for fulfilling their civic duty, and the actions of an individual must benefit the whole of society. This typically involves a balance between economic growth and the welfare of society and the environment. (Pachchamama Alliance, 2021)

**Specialty:** The pursuit, area of study, or skill to which someone has devoted much time and effort and in which they are expert. Nursing specialization involves focusing on nursing practice in an identified specific area within the discipline of professional nursing. A defined specialty scope of practice statement and standards of professional practice, with accompanying competencies, are unique to each nursing specialty. These documents help assure continued understanding and recognition of nursing's diverse professional contributions (Finnell, et al, 2015).

- **Advanced nursing practice specialties:** Currently, advanced nursing practice specialties include informatics, administration/practice leadership, public health/population health, and health policy. Specialties may evolve over time to address future healthcare needs.

**Spheres of Care:** Encompass the healthcare needs of individuals, families, populations, and the care/services required to address these needs and promote desired health outcomes. In this document, four spheres of care are delineated 1) disease prevention/promotion of health and well-being, which includes the promotion of physical and mental health in all patients as well as management of minor acute and intermittent care needs of generally healthy patients; 2) chronic disease care, which includes management of chronic diseases and prevention of negative sequelae; 3) regenerative or restorative care, which includes critical/trauma care, complex acute care, acute exacerbations of chronic conditions, and treatment of physiologically unstable patients that generally requires care in a mega-acute care institution; and, 4) hospice/palliative/supportive care which includes end-of-life care as well as palliative and supportive care for individuals requiring extended care or those with complex, chronic disease states or those requiring rehabilitative care (Lipstein, et al, 2016; AACN, 2019).

**Standardized data:** The process of ensuring that one data set can be compared to other data sets. In statistics, standardized data is the process of putting different variables on the same scale. This process allows one to compare scores between different types of variables.

**Stress management:** A range of strategies to help one better deal with stress and difficulty (adversity). Managing stress can help an individual lead a more balanced, healthier life. Stress is an automatic physical, mental and emotional response to a challenging event. Stress management approaches include learning skills such as problem-solving, prioritizing tasks, and time management to enhance the ability to cope with adversity.

**Structural racism:** A complex system of conferring social benefits in some groups and imposing burdens on others resulting in segregation, poverty, and denial of opportunity for people of color. Structural racism comprises cultural beliefs, historical legacies, and institutions, policies within and among public and private organizations that interweave to create drastic racial disparities in life outcomes (Wiecek, 2011).

**Support care:** Treatment given to prevent, control, or relieve complications and side effects and to improve the patient's comfort and quality of life.

**System decision:** A computerized program used to support determinations, judgments, and courses of action in an organization or a business. A system decision sifts through and analyzes massive amounts of data, compiling comprehensive information that can be used to solve problems and in decision-making.



**Systemic inequity:** A condition where one category of people is attributed an unequal status in relation to other categories of people. This relationship is perpetuated and reinforced by a confluence of unequal relations in roles, functions, decisions, rights, and opportunities.

**Systemic racism (also known as institutionalized racism):** Terms similar to structural racism which focuses more on the historical, cultural and social psychological aspects of the currently racialized society. The term institutional racism may be used to differentiate “access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there is no identifiable perpetrator. Institutionalized racism is often evident as inaction in the face of need” (Jones, 2000).

**Systems:** A set of elements or components working together as parts of a mechanism or an interconnecting network.

**Systems-based practice:** An analytic tool and a way of viewing the world, which can make caregiving and change efforts more successful. The focus is on understanding the interdependencies of a system or series of systems and the changes identified to improve care that can be made and measured in the system.

**Team-based care:** The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care (Naylor, 2010; NAM, 2012; AANP, 2020).

**Telehealth systems:** The use of a technology-based virtual platform to deliver various aspects of health information, prevention, monitoring, and medical care.

**Translation:** The process of turning observations in the laboratory, clinic, and community into interventions that improve the health of individuals and the public — from diagnostics and therapeutics to medical procedures and behavioral changes.

**Translational science:** The field of investigation focused on understanding the scientific and operational principles underlying each step of the translational process. Translational scientists are innovative and collaborative, searching for ways to break down barriers in the translation process and ultimately deliver more treatments to more patients more quickly.

**Wellness and well-being:** A state of being marked by emotional stability (e.g., coping effectively with life and creating satisfying relationships) and physical health (e.g., recognizing the need for physical activity, healthy foods, and sleep).

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## Essentials Task Force

### Essentials Leadership Team

Jean Giddens, PhD, RN, FAAN  
Co-Chair of the Essentials Task Force  
Virginia Commonwealth University

Cynthia McCurren, PhD, RN  
Co-Chair of the Essentials Task Force  
University of Michigan-Flint

John McFadden, PhD, CRNA  
Co-Chair of the Essentials Task Force  
Barry University

Lin Zhan, PhD, RN, FAAN  
AACN Board Liaison  
University of Memphis

Jean Bartels, PhD, RN  
Consultant

Linda Caldwell, DNSc, ANP-BC  
Consultant

Nancy DeBasio, PhD, RN, FAAN  
Consultant

### Essentials Task Force Members

Angela Amar, PhD, RN, ANEF, FAAN  
University of Nevada Las Vegas

Jacklyn Barber, EdD, RN, CNL, CNS  
Morningside College

Carol Buck-Rolland, EdD, APRN  
University of Vermont

Jill Case-Wirth, MHA, BSN, RN  
WellStar Health System (Practice)

Lori Escallier, PhD, RN, CPNP-PC, FAAN  
SUNY Downstate Health Sciences University

Eileen Fry-Bowers, PhD, JD, RN, CPNP, FAAN  
University of San Diego

Vincent Hall, PhD, RN, CNE  
Walden University

Beverly Foster, PhD, MN, MPH, RN  
University of North Carolina – Chapel Hill

Jacqueline Hill, PhD, RN  
Bowie State University

Erica Hooper-Arana, DNP, RN, PHN, CNS, CNL  
University of San Francisco

Kristin Lee, PhD, MSN, RN, CNE  
University of Missouri-Kansas City

Kim Litwack, PhD, RN, FAAN, APNP  
University of Wisconsin-Milwaukee

Mary Morin, MSN, RN, NEA-BC  
Sentara Healthcare (Practice)

Connie Miller, DNP, RNC-OB, CNE  
University of Arizona

Susan Mullaney, DNP, APRN, GNP-BC,  
GS-C, FAANP  
UnitedHealth Group (Practice)

Susan Ruppert, PhD, RN, FNP-C,  
ANP-BC, FCCM, FNAP, FAANP, FAAN  
University of Texas Health Science Center  
at Houston

Marcella Rutherford, PhD, MBA, MSN, RN  
Nova Southeastern University

Martha Scheckel, PhD, MSN, RN  
University of St Thomas

Jenny Schuessler, PhD, RN, CNE  
University of West Georgia



Casey Shillam, PhD, RN  
University of Portland

Mary Stachowiak, DNP, RN, CNL  
Rutgers School of Nursing

Rachel Start, MSN, RN, NEA-BC, FAAN  
Rush University Medical Center (Practice)

Allison Squires, PhD, RN, FAAN  
New York University

Susan Swider, PhD, PHNA-BC, FAAN  
Rush University

Marjorie Splaine Wiggins, DNP, MBA, RN,  
NEA-BC, FAAN  
Maine Health System (Practice)

Marisa Wilson, DNSc, MHSc, RN, CPHIMS,  
RN-BC, FAMIA, FAAN  
University of Alabama-Birmingham

Danuta Wojnar, PhD, RN, MN, MED,  
IBCLC, FAAN  
Seattle University

Geraldine Young, DNP, MSN, APRN, FNP-BC,  
CDCES, FAANP  
Frontier Nursing University

#### **AACN Staff Liaisons**

Joan Stanley, PhD, NP, FAAN, FAANP  
Chief Academic Officer

Shirin Samimi-Farr  
Project Manager

Rick García, PhD, RN  
Director of Nursing Education

Krisi Yosifova  
Nursing Education Coordinator

Kathy McGuinn, MSN, RN  
Director of Interprofessional Education and  
Practice Partnerships

*Approved by the AACN Membership on April 6, 2021.*



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# 548: DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

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## In Workflow

1. 276 Chair (mcmurtry@uidaho.edu)
2. 20 Curriculum Committee Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
3. 20 Dean (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
4. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
5. Degree Audit Review (rfrost@uidaho.edu)
6. Graduate Council Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
7. Registrar's Office (none)
8. Ready for UCC (disable)
9. UCC (none)
10. Post-UCC Registrar (none)
11. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
12. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
13. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
14. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
15. Theodore Unzicker (tunzicker@uidaho.edu)

## Approval Path

1. Mon, 09 Oct 2023 23:50:08 GMT  
Tyler Bland (tbland): Approved for 471 Chair
2. Mon, 09 Oct 2023 23:55:44 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Curriculum Committee Chair
3. Mon, 09 Oct 2023 23:56:12 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Dean
4. Thu, 19 Oct 2023 22:56:31 GMT  
Linda Lundgren (lindalundgren): Rollback to Initiator
5. Thu, 07 Dec 2023 22:03:40 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
6. Thu, 07 Dec 2023 22:04:06 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
7. Thu, 07 Dec 2023 22:04:40 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
8. Sat, 09 Dec 2023 01:13:36 GMT  
Gwen Gorzelsky (gwen): Approved for Provost's Office
9. Thu, 21 Dec 2023 20:04:19 GMT  
Rebecca Frost (rfrost): Approved for Degree Audit Review
10. Thu, 21 Dec 2023 20:31:24 GMT  
Jerry McMurtry (mcmurtry): Approved for Graduate Council Chair
11. Tue, 16 Jan 2024 21:08:48 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
12. Wed, 17 Jan 2024 16:16:39 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
13. Tue, 23 Jan 2024 22:44:21 GMT  
Sydney Beal (sbeal): Approved for UCC
14. Thu, 25 Jan 2024 21:51:07 GMT  
Sydney Beal (sbeal): Approved for Post-UCC Registrar

## New Program Proposal

Date Submitted: Thu, 07 Dec 2023 21:48:08 GMT

**Viewing: 548 : Doctor of Psychology in Clinical Psychology**

**Last edit: Thu, 25 Jan 2024 21:51:04 GMT**

Changes proposed by: Whitney Vincent

**Faculty Contact**

Faculty Name	Faculty Email
Thomas J. Farrer, PhD, ABPP	tfarrer@uidaho.edu

**Will this request have a fiscal impact of \$250K or greater?**

Yes

**Academic Level**

Graduate

**College**

Graduate Studies

**Department/Unit:**

Graduate Studies

**Effective Catalog Year**

2025-2026

**Program Title**

Doctor of Psychology in Clinical Psychology

**Degree Type**

Major

Please note: Majors and Certificates over 30 credits need to have a state form approved before the program can be created in Curriculum.

**Program Credits**

120-125

**Attach Program Change**

PsyD\_Budget-Proposal-Form\_final\_9-16-2021-1 (1).xlsx  
SBOE\_App\_PsyD\_Academic\_Degree\_and\_Certificate\_Full-Proposal\_Form.pdf

**CIP Code**

42.2801 - Clinical Psychology.

**Will the program be Self-Support?**

No

**Will the program have a Professional Fee?**

No

**Will the program have an Online Program Fee?**

No

**Will this program lead to licensure in any state?**

Yes

**Will the program be a statewide responsibility?**

No

**Financial Information**

**What is the financial impact of the request?**

Greater than \$250,000 per FY

**Note: If financial impact is greater than \$250,000, you must complete a Program Proposal Form**

**Discribe the financial impact**

The Idaho WWAMI Medical Education program, in collaboration with the UI Counseling & Mental Health Center (CMHC) and the UI Psychology and Communication Department, proposes the development of a Doctor of Psychology program (PsyD) in clinical

psychology. As such, the new program is a shared endeavor. It will not replace any existing programs. This is a substantive change, with a new program offering, requiring the addition of clinical faculty and additional courses not currently offered at the University of Idaho.

The PsyD Program will be housed in the College of Graduate Studies at the University of Idaho. A School of Health and medical Professions is currently being created and processed to eventually house this and other health care programs, under the College of Graduate Studies.

Based on feedback from policymakers and Idaho business leaders, our request is dedicated to addressing healthcare workforce needs, one of the most pressing issues the state is facing today. We acknowledge the importance of flexibility to adapt to evolving challenges and workforce needs of the future.

The primary beneficiaries, if this program request is granted, are the individuals and communities who will be served by these future Nurses. Thus, the impact could encompass all of Idaho.

#### **Curriculum:**

See attached SBOE Full Proposal Form

### **Distance Education Availability**

To comply with the requirements of the Idaho State Board of Education (SBOE) and the Northwest Commission on Colleges and Universities (NWCCU) the University of Idaho must declare whether 50% or more of the curricular requirements of a program which may be completed via distance education.

#### **Can 50% or more of the curricular requirements of this program be completed via distance education?**

No

Note: Existing programs transitioning from less than 50% of its curricular requirements to 50% or more of its requirements being available via distance education is considered a Group B change and must complete the program proposal formwork before these changes will be processed.

### **Geographical Area Availability**

#### **In which of the following geographical areas can this program be completed in person?**

Moscow

### **Student Learning Outcomes**

**List the intended learning outcomes for program component. Use learner centered statements that indicate what will students know, be able to do, and value or appreciate as a result of completing the program.**

Intended learning outcomes for PsyD clinical psychology graduates are detailed in the accreditation requirements for the American Psychological Association. The curriculum will be based on profession-wide competencies as outlined by the APA, which include the following: I. Research; II. Ethical and Legal Standards; III. Individual and Cultural Diversity; IV. Professional Values, Attitudes, and Behaviors; V. Communication and Interpersonal Skills; VI. Assessment; VII. Intervention; VIII. Supervision; IX. Consultation and Interprofessional/Interdisciplinary Skills.

These profession-wide competencies are expected of all graduates and are partially demonstrated via the following learning outcomes:

- I. Research: Successful completion of coursework related to methods and statistics, as well as completion of the dissertation, participation in faculty-supervised research, and completion of a manuscript to be submitted for possible publication in a peer-reviewed journal.
- II. Ethical and Legal Standards: Successful completion of coursework related to ethics and legal standards, demonstration of ethical practice in practicum and as assessed by faculty supervisor.
- III. Individual and Cultural Diversity: Successful completion of coursework related to culture and diversity, as well as by designing and implementing culturally sensitive interventions based on the unique needs and perspectives of their patient/client for whom they are providing assessment or therapy while demonstrating evidence-based practice under the supervision of a licensed psychologist.
- IV. Professional Values, Attitudes, and Behaviors: Outcomes for this area of competencies will be demonstrated by the successful completion of practicum, supervision, and case conferences.
- V. Communication and Interpersonal Skills: The student will demonstrate effective active listening, empathetic responses, and clear communication in therapeutic interactions with clients, and via supervision and obtaining feedback from supervisors.
- VI. Assessment: Successful completion of coursework related to Assessment, as well as completion of practicum and supervision. Next, they will successfully complete their comprehensive examination on assessment. They will also demonstrate competence in assessment via the one-year APA-accredited clinical internship, which is required for graduation.
- VII. Intervention: Successful completion of coursework related to Intervention, as well as completion of practicum and supervision. Next, they will successfully complete their comprehensive examination on therapy and intervention. They will also demonstrate competence in intervention via the one-year APA-accredited clinical internship, which is required for graduation.

VIII. Supervision: Learning outcomes are based on the completion of a supervised practicum. Additionally, students in their 3rd and 4th years of training will have the opportunity to provide mentored supervision to 1st and 2nd year students (i.e., “supervised supervision”).

IX. Consultation and Interprofessional/Interdisciplinary Skills: Students will actively participate in interdisciplinary case conferences, contributing meaningful insights and recommendations, and receiving positive evaluations from colleagues and supervisors for their contributions.

These profession-wide competencies are expected of all graduates and are partially demonstrated via:

- Coursework: Students will obtain a grade of B or higher.
- Other didactics: attendance and participation in case conferences and other periodic seminars.
- Successful completion of supervised clinical practica (therapy and assessment experiences).
- Completion of dissertation
- Completion of comprehensive examinations
- Completion of a one-year APA accredited clinical internship (APA requirement).

**Describe the assessment process that will be used to evaluate how well students are achieving the intended learning outcomes of the program component.**

To evaluate how well students are achieving the intended learning outcomes, the following assessment processes will be employed:

1. Examinations and Quizzes: Regular assessments will include written examinations and quizzes to evaluate knowledge acquisition and critical thinking skills.
2. Clinical Skills Assessment: Clinical skills will be assessed through direct observation, practical examinations, and skills checklists during clinical rotations.
3. Case Studies and Care Plans: Students will complete case studies and care plans to demonstrate their ability to apply theoretical knowledge to real-world patient care scenarios.
4. Reflective Journals and Portfolios: Students will maintain reflective journals and e-portfolios, providing insights into their personal and professional growth.
5. Peer and Self-Assessment: Peer evaluations and self-assessment will be incorporated for group projects and personal reflection on skills development.

**How will you ensure that the assessment findings will be used to improve the program?**

1. Faculty Meetings: Regular faculty meetings will involve discussions of assessment results, with a focus on identifying areas of improvement and refining teaching methods and curriculum.
2. Curriculum Review: Assessment data will inform curriculum revisions, ensuring alignment with current healthcare trends and best practices.
3. Faculty Development: Faculty will receive training and support to enhance assessment techniques and teaching strategies, addressing areas where student performance needs improvement.
4. Feedback Loops: Continuous feedback loops will be established with students, incorporating their input to make program enhancements.

**Assessment Activity Timing:**

Assessment activities will occur throughout the program at various frequencies:

- Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.
- Summative assessments (midterm, final examinations) will occur at the end of relevant courses and following year one and year two. Alumni and industry surveys will be completed two years following graduation.
- Clinical skills assessments and evaluations will be conducted during clinical rotations.
- Case studies, care plans, and projects will be assigned periodically.

**What direct and indirect measures will be used to assess student learning?**

Direct measures include examinations, skills assessments, case studies, and practical evaluations. Indirect measures include student surveys, feedback from instructors, and analysis of retention and graduation rates.

**When will assessment activities occur and at what frequency?**

Assessment activities will occur throughout the program at various frequencies:

- Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.
- Summative assessments (midterm, final examinations, term projects, reflection essays) will occur at the end of relevant courses and following at the end of each year. Alumni and industry surveys will be completed two years following graduation.
- Case studies, teaching plans, and projects will be assigned periodically.

## **Student Learning Outcomes**

### **Learning Objectives**

Intended learning outcomes for PsyD clinical psychology graduates are detailed in the accreditation requirements for the American Psychological Association (APA). The curriculum will be based on profession-wide competencies as outlined by the APA, which

include the following: I. Research; II. Ethical and Legal Standards; III. Individual and Cultural Diversity; IV. Professional Values, Attitudes, and Behaviors; V. Communication and Interpersonal Skills; VI. Assessment; VII. Intervention; VIII. Supervision; IX. Consultation and Interprofessional/Interdisciplinary Skills.

These profession-wide competencies are expected of all graduates and are partially demonstrated via the following learning outcomes:

- I. Research: Successful completion of coursework related to methods and statistics, as well as completion of the dissertation, participation in faculty-supervised research, and completion of a manuscript to be submitted for possible publication in a peer-reviewed journal.
- II. Ethical and Legal Standards: Successful completion of coursework related to ethics and legal standards, demonstration of ethical practice in practicum and as assessed by faculty supervisor.
- III. Individual and Cultural Diversity: Successful completion of coursework related to culture and diversity, as well as by designing and implementing culturally sensitive interventions based on the unique needs and perspectives of their patient/client for whom they are providing assessment or therapy while demonstrating evidence-based practice under the supervision of a licensed psychologist.
- IV. Professional Values, Attitudes, and Behaviors: Outcomes for this area of competencies will be demonstrated by the successful completion of practicum, supervision, and case conferences.
- V. Communication and Interpersonal Skills: The student will demonstrate effective active listening, empathetic responses, and clear communication in therapeutic interactions with clients, and via supervision and obtaining feedback from supervisors.
- VI. Assessment: Successful completion of coursework related to Assessment, as well as completion of practicum and supervision. Next, they will successfully complete their comprehensive examination on assessment. They will also demonstrate competence in assessment via the one-year APA-accredited clinical internship, which is required for graduation.
- VII. Intervention: Successful completion of coursework related to Intervention, as well as completion of practicum and supervision. Next, they will successfully complete their comprehensive examination on therapy and intervention. They will also demonstrate competence in intervention via the one-year APA-accredited clinical internship, which is required for graduation.
- VIII. Supervision: Learning outcomes are based on the completion of a supervised practicum. Additionally, students in their 3rd and 4th years of training will have the opportunity to provide mentored supervision to 1st and 2nd year students (i.e., "supervised supervision").
- IX. Consultation and Interprofessional/Interdisciplinary Skills: Students will actively participate in interdisciplinary case conferences, contributing meaningful insights and recommendations, and receiving positive evaluations from colleagues and supervisors for their contributions.

Other general learning outcomes expected of students:

- Coursework: Students will obtain a grade of B or higher.
- Other didactics: attendance and participation in case conferences and other periodic seminars.
- Successful completion of supervised clinical practica (therapy and assessment experiences).
- Completion of a dissertation
- Completion of comprehensive examinations
- Completion of a one-year APA-accredited clinical internship (APA requirement).

**A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any.**

#### Introduction

According to the Idaho Behavioral Health Alliance<sup>1</sup>, there is a critical shortage of mental health providers in Idaho and there are not enough providers to meet the needs of Idaho citizens with mental health conditions. Fewer than half of Idahoans with mental health conditions receive appropriate care. Idaho is also the second highest in the nation for suicide and has a high rate of accidental deaths associated with substance abuse.

The Idaho Behavioral Health Alliance also suggests that Idaho has spent significant funding on developing crisis management rather than having continuous adequate health care. In other words, individuals with mental health difficulties are only being treated through crisis management rather than having continuous adequate health care between crises. Having health care only at the point of crisis rather than adequate health care between crises leads to poor health management over time and expense of healthcare costs. According to the Idaho Behavioral Health Alliance, "half of all claims submitted to the state catastrophic fund in 2018 involved a mental health diagnosis." This organization also suggests that one of the strategies to improve mental health healthcare in Idaho is to "implement policy to bolster behavioral health workforce and encourage retention, especially in rural areas..."

#### Current State of Behavioral Healthcare in Idaho

Mental health providers support people from early childhood through cognitive decline and other conditions associated with aging. Idaho currently lacks mental health resources to support the existing and growing needs of the state. The entire state of Idaho (100% of counties) is a mental health shortage area (HSPA) according to the Idaho Department of Health & Welfare<sup>2</sup>. Additionally, Idaho has the lowest number of psychiatrists per capita, lowest number of child and adolescent psychiatrists, lowest number of geriatric psychiatrists and no addiction psychiatrists. Considering overall mental health care needs more broadly including providers such as clinical psychologists, Mental Health America<sup>3</sup> (MHA 2023 report) ranks Idaho 44th out of 51 (including D.C.) in adult care, 47th in youth care, while ranking 48th in the prevalence of mental illness. Across all the metrics assessed by MHA, Idaho ranks 47th, indicating an imbalance between the prevalence of mental illness in the state and access to care. The same 2023 MHA report



revealed that 51% of adults in the state receive no treatment for mental illness and 32% have unmet mental health needs (Idaho ranked 41st in the nation). 47% of Idaho's youth with a major depressive episode do not receive mental health services. Lastly, Idaho ranks 34th in mental health workforce availability. These dire statistics are further enumerated by the Kaiser Family Foundation (KFF) data on mental health needs in Idaho6.

This general lack of behavioral health workforce has an economic impact on residents and improving access and mental health care in Idaho will have a positive impact on the economy as job numbers increase in mental health and as health care costs decline with better health care coverage for mental health needs.

#### Current Supply and Demand for Psychologists in Idaho

Idaho currently has a foundation that can be built upon to address these deficiencies by developing a PsyD program at the University of Idaho. The University of Idaho currently has a strong undergraduate psychology program with over 500 students, the school's largest major. Additionally, there are currently only two clinical psychology doctorate programs in Idaho, one longstanding program housed at Idaho State University and a second relatively new program at Northwest Nazarene University (NNU). Given that NNU's program is new and housed in a private institution, data from NNU are not enumerated here. ISU's program is accredited by the American Psychological Association (APA). However, this university turns away 90-95% of their applicants. From 2017 – 2022, there were a total of 585 applicants to ISU's program, but only 34 enrolled in the program, which is 5.8% enrollment from the applicant pool. In other words, in the past 6 application cycles at ISU, 551 individual applications were turned away. While some of these applicants may not be an adequate fit for a clinical psychology role, many of them likely are. If they continue their pursuit of obtaining a doctoral degree, they will ultimately have to leave the state to do so.

Similarly, there are very few APA-accredited clinical psychology doctoral programs regionally.

Montana: 1  
Wyoming: 1  
Alaska: 1  
New Mexico: 1  
Utah: 2  
Arizona: 3  
Washington: 4  
Oregon: 4  
Colorado: 5

Additionally, the Idaho Business for Education (IBE) reported that in August 2022, there were over 9,000 healthcare job vacancies in Idaho, with mental health being an important sector5 (e.g., on average, we have one school counselor for every 400 students).

#### Plan

The University of Idaho will develop a new Doctor of Psychology (PsyD) in Clinical Psychology to help fill the mental and behavioral health needs in Idaho. While the clinical degree will be housed in WWAMI, it will be in partnership with the UI Counseling and Mental Health Center (CMHC; formerly the Counseling and Testing) and the Psychology and Communication Department.

This partnership is currently supported by the following:

1. Dr. Jeff Seegmiller, Regional Dean and Director, WWAMI
2. Dr. Thomas J. Farrer, Associate Program Director, WWAMI
3. Dr. Benjamin Barton, Professor and Department Chair, Psychology and Communication Department.
4. Dr. Sean Quinlan, Dean, College of Letters, Arts and Social Sciences (CLASS)
5. Dr. Traci Craig, Professor and Associate Dean for Research and Faculty Affairs for CLASS
6. Dr. Greg Lambeth, Executive Director, UI Counseling & Mental Health Center (CMHC)
7. Dr. Martha Kitzrow, Training Director of APA-accredited internship, UI Counseling & Mental Health Center (CMHC)

#### Citations:

Idaho Behavioral Health Alliance: "Idaho's Behavioral Health Workforce Shortage" Retrieved 9/24/2023 from <https://www.idahobha.org/wp-content/uploads/2019/09/Idaho-Behavioral-Health-Workforce-Shortage-REVISE-8-22.pdf>

Idaho Department of Health and Welfare. Rural Health and Underserved Areas. Health Professional Shortage Areas (HSPA). Retrieved 9/24/2023 from <https://healthandwelfare.idaho.gov/providers/rural-health-and-underserved-areas/rural-health-and-underserved-areas>

Mental Health American. Retrieved 9/24/2023 from <https://mhanational.org/mhamapping/mha-state-county-data>

Idaho State University (ISU) Doctor of Philosophy in Clinical Psychology, Student Admissions, Outcomes, and Other Data. Retrieved 9/24/2023 from <https://www.isu.edu/psych/graduate-programs/clinical-phd-program/#d.en.239881>

Idaho Business for Education Report, August 2022. Retrieved 9/24/2023 from <http://idahobe.org/wp-content/uploads/2022/08/HEALTH-CARE-SUMMIT-WHITE-PAPER-3.0.pdf>

Kaiser Family Foundation, Mental Health in Idaho, retrieved 9/24/2023 from [https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/idaho/#:~:text=Prior%20to%20the%20pandemic%2C%20in,6.2%25%20\(15.4%20million\)](https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/idaho/#:~:text=Prior%20to%20the%20pandemic%2C%20in,6.2%25%20(15.4%20million))

#### Supporting Documents

548 Program Description Doctor of Psychology in Clinical Psychology.pdf  
Org Chart\_Health Professions\_COGS\_SHAMP.pdf



**Reviewer Comments**

**Linda Lundgren (lindalundgren) (Thu, 12 Oct 2023 19:19:01 GMT):** Program Description for #548 attached.

**Linda Lundgren (lindalundgren) (Thu, 19 Oct 2023 22:55:24 GMT):** LL rolled back to department for corrections. Email sent to Dr. Farrer to address specific to corrections to CIM and Full Proposal form.

**Linda Lundgren (lindalundgren) (Thu, 19 Oct 2023 22:56:31 GMT):** Rollback: LL sent email to Dr. Farrer to address corrections to State Full proposal form and CIM.

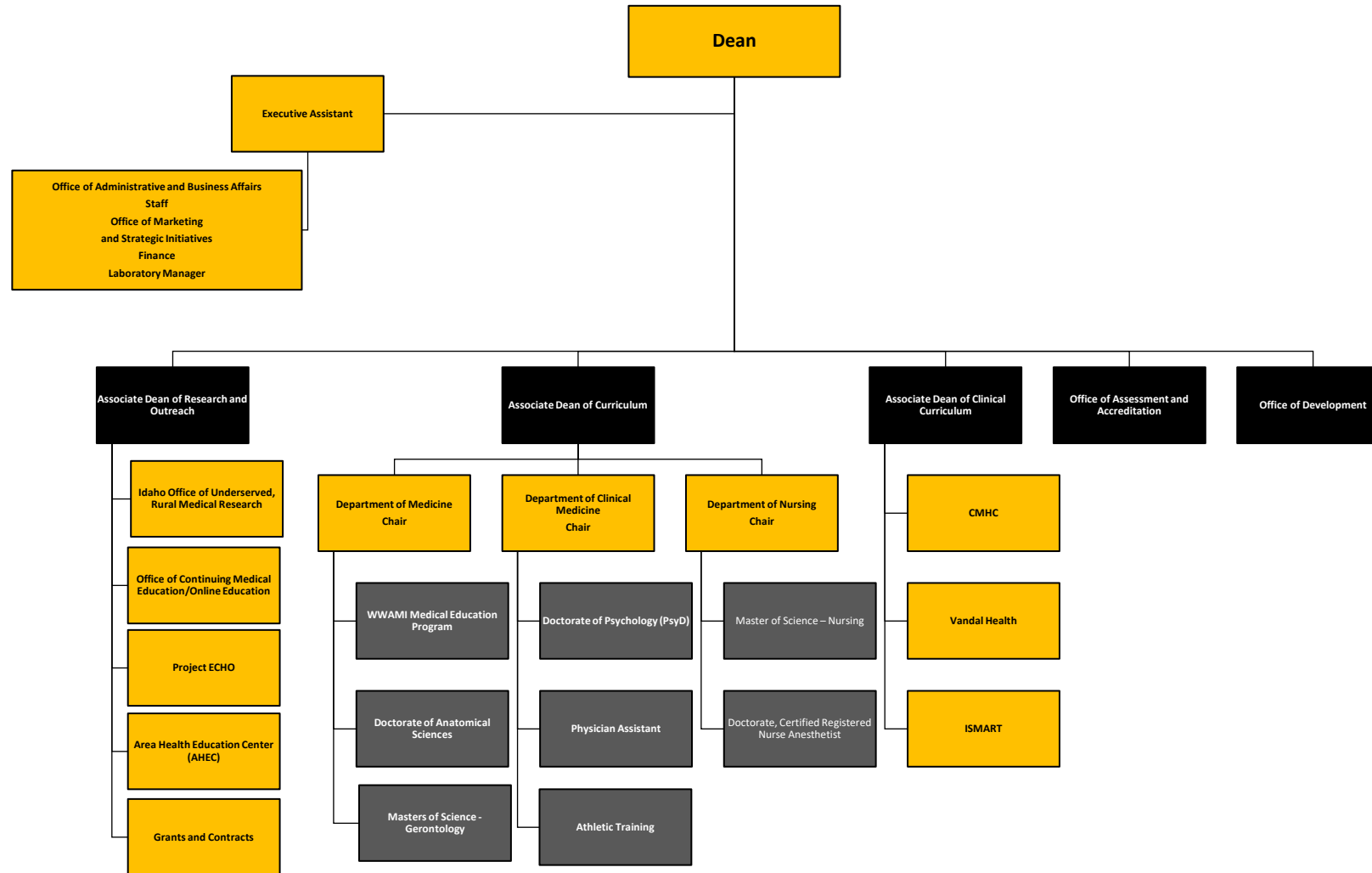
**Sydney Beal (sbeal) (Tue, 23 Jan 2024 22:44:18 GMT):** Approved at UCC pending the successful approval of the associated coursework

Key: 548

## Program Description #548

The Doctor of Psychology (PsyD) program in Clinical Psychology offers comprehensive instruction in assessment and diagnosis, evidence-based intervention and therapy techniques, professionalism, and ethics, with a practitioner-scholar framework. With a lifespan and generalist series of courses and mentored clinical experiences, students will be well-prepared to obtain licensure and independently practice clinical psychology.

# School of Health and Medical Professions



# 550: MASTER OF PHYSICIAN ASSISTANT STUDIES

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## In Workflow

1. 276 Chair (mcmurtry@uidaho.edu)
2. 20 Curriculum Committee Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
3. 20 Dean (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
4. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
5. Degree Audit Review (rfrost@uidaho.edu)
6. Graduate Council Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
7. Registrar's Office (none)
8. Ready for UCC (disable)
9. UCC (none)
10. Post-UCC Registrar (none)
11. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
12. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
13. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
14. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brenadah@uidaho.edu)
15. Theodore Unzicker (tunzicker@uidaho.edu)

## Approval Path

1. Mon, 16 Oct 2023 21:01:42 GMT  
Tyler Bland (tbland): Approved for 471 Chair
2. Mon, 16 Oct 2023 21:35:44 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Curriculum Committee Chair
3. Mon, 16 Oct 2023 21:36:22 GMT  
Jeffrey Seegmiller (jeffreys): Approved for 22 Dean
4. Tue, 07 Nov 2023 01:04:59 GMT  
Linda Lundgren (lindalundgren): Rollback to 471 Chair for Provost's Office
5. Wed, 08 Nov 2023 01:50:54 GMT  
Tyler Bland (tbland): Rollback to Initiator
6. Wed, 06 Dec 2023 23:38:10 GMT  
Jerry McMurtry (mcmurtry): Approved for 276 Chair
7. Thu, 07 Dec 2023 16:26:04 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
8. Thu, 07 Dec 2023 17:20:51 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Dean
9. Fri, 08 Dec 2023 00:39:24 GMT  
Gwen Gorzelsky (gwen): Approved for Provost's Office
10. Thu, 21 Dec 2023 20:04:46 GMT  
Rebecca Frost (rfrost): Approved for Degree Audit Review
11. Thu, 21 Dec 2023 20:31:29 GMT  
Jerry McMurtry (mcmurtry): Approved for Graduate Council Chair
12. Tue, 16 Jan 2024 21:10:30 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
13. Wed, 17 Jan 2024 16:16:43 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
14. Tue, 23 Jan 2024 22:45:19 GMT  
Sydney Beal (sbeal): Approved for UCC
15. Thu, 25 Jan 2024 21:51:54 GMT  
Sydney Beal (sbeal): Approved for Post-UCC Registrar

## New Program Proposal

Date Submitted: Wed, 06 Dec 2023 23:37:17 GMT

**Viewing: 550 : Master of Physician Assistant Studies**

**Last edit: Thu, 25 Jan 2024 21:51:51 GMT**

Changes proposed by: Whitney Vincent

**Faculty Contact**

Faculty Name	Faculty Email
Russell Baker	russellb@uidaho.edu

**Will this request have a fiscal impact of \$250K or greater?**

Yes

**Academic Level**

Graduate

**College**

Graduate Studies

**Department/Unit:**

Graduate Studies

**Effective Catalog Year**

2025-2026

**Program Title**

Master of Physician Assistant Studies

**Degree Type**

Major

Please note: Majors and Certificates over 30 credits need to have a state form approved before the program can be created in Curriculum.

**Program Credits**

108

**Attach Program Change**

SBOE\_Academic\_Degree\_and\_Certificate\_Full-Proposal\_Form\_PA.pdf

**CIP Code**

51.0912 - Physician Assistant.

**Will the program be Self-Support?**

No

**Will the program have a Professional Fee?**

Yes

**Will the program have an Online Program Fee?**

No

**Will this program lead to licensure in any state?**

Yes

**Will the program be a statewide responsibility?**

No

**Financial Information**

**What is the financial impact of the request?**

Greater than \$250,000 per FY

**Note: If financial impact is greater than \$250,000, you must complete a Program Proposal Form**

**Discribe the financial impact**

The WWAMI Medical Education Program has recently submitted a request for Fiscal Year 2025 to the State of Idaho for educational support to create a new School of Health and Medical Professions (SHAMP). Under this will be the Direct Entry Master of Physician Assistant Studies degree. Based on feedback from policymakers and Idaho business leaders, our request is dedicated to addressing

healthcare workforce needs, one of the most pressing issues the state is facing today. We acknowledge the importance of flexibility to adapt to evolving challenges and workforce needs of the future. The primary beneficiaries, if this program request is granted, are the individuals and communities who will be served by these future healthcare providers.

#### **Curriculum:**

See Attached SBOE Document

### **Distance Education Availability**

To comply with the requirements of the Idaho State Board of Education (SBOE) and the Northwest Commission on Colleges and Universities (NWCCU) the University of Idaho must declare whether 50% or more of the curricular requirements of a program which may be completed via distance education.

#### **Can 50% or more of the curricular requirements of this program be completed via distance education?**

No

Note: Existing programs transitioning from less than 50% of its curricular requirements to 50% or more of its requirements being available via distance education is considered a Group B change and must complete the program proposal formwork before these changes will be processed.

### **Geographical Area Availability**

#### **In which of the following geographical areas can this program be completed in person?**

Moscow

### **Student Learning Outcomes**

#### **List the intended learning outcomes for program component. Use learner centered statements that indicate what will students know, be able to do, and value or appreciate as a result of completing the program.**

The Physician Assistant program's learning outcomes and expectations are based on the Competencies for the Physician Assistant Profession as developed jointly by the National Commission on Accreditation of Physician Assistants (NCCPA), the American Academy of Physician Assistants (AAPA), the Accreditation Review Commission for Education of the Physician Assistant (ARC-PA), and the Physician Assistant Education Association (PAEA).

Our graduates will demonstrate entry-level proficiency as PAs in the following program-defined learning outcomes:

#### **Medical Knowledge for Practice**

Demonstrate knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care. PAs should be able to:

Demonstrate investigative and critical thinking in clinical situations.

Access and interpret current and credible sources of medical information.

Apply principles of epidemiology to identify health problems, risk factors, treatment strategies, resources, and disease prevention/health promotion efforts for individuals and populations.

Differentiate among acute, chronic, and emergent disease states.

Apply principles of clinical sciences to diagnose disease and utilize therapeutic decision-making, clinical problem-solving, and other evidence-based practice skills.

Adhere to standards of care, and to relevant laws, policies, and regulations that govern the delivery of care in the United States.

Consider cost-effectiveness when allocating resources for individual patients or population-based care.

Work effectively and efficiently in various healthcare delivery settings and systems relevant to the PA's clinical specialty.

Identify and address social determinants that affect access to care and deliver high-quality care in a value-based system.

Participate in surveillance of community resources to determine if they are adequate to sustain and improve health.

Utilize technological advancements that decrease costs, improve quality, and increase access to sustain and improve healthcare.

#### **Interpersonal and Communication Skills**

Demonstrate interpersonal and communication skills (verbal, nonverbal, written, and electronic) that result in the effective exchange of information and collaboration with patients, their families, and health professionals. PAs should be able to:

Establish meaningful therapeutic relationships with patients and families to ensure that patients' values and preferences are addressed and that needs and goals are met to deliver patient-centered care.

Provide effective, equitable, understandable, respectful, quality, and culturally competent care that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Accurately and adequately document information regarding care for medical, legal, quality, and financial purposes.

Demonstrate sensitivity, honesty, and compassion in all conversations.

Demonstrate emotional resilience, stability, adaptability, flexibility, and tolerance of ambiguity.

Recognize communication barriers and provide solutions.

#### Patient-centered Care

Provide person-centered care that includes patient- and setting-specific assessment, evaluation, and management and healthcare that is evidence-based, supports patient safety, and advances in health equity. PAs should be able to:

Accumulate accurate and essential information about patients through history-taking, physical examination, and diagnostic testing.

Develop, implement, and monitor effectiveness of patient management plans.

Maintain proficiency to perform safely all medical, diagnostic, and surgical procedures considered essential for primary care.

Counsel, education, and empower patients and their families to participate in their care and enable shared decision-making.

Refer patients appropriately, ensure continuity of care throughout transitions between providers or settings and follow-up on patient progress and outcomes.

Provide health care service to patients, families, and communities to prevent health problems and to maintain health.

#### Professionalism

Adhere to the standards of care in the role of the PA in the health care team.

Demonstrate responsiveness to patient needs that supersedes self-interest.

Demonstrate a high level of responsibility, ethical practice, and adherence to legal and regulatory requirements.

Demonstrate sensitivity to a diverse patient population by identifying the socio-cultural, familial, psychological, economic, environmental, and spiritual factors impacting health care and health care delivery; and responding to these factors by planning and advocating the appropriate course of action at both the individual and the community level.

#### Practice-based Learning and Improvement

Demonstrate the ability to learn and implement quality improvement practices by engaging in critical analysis of one's own practice experience, the medical literature, and other information resources of the purpose of self-evaluation, lifelong learning, and practice management. PAs should be able to:

Use practice performance data and metrics to identify areas for improvement.

Critically evaluate the medical literature in order to use current practice guidelines and apply the principles of evidence-based medicine to patient care.

#### Society and Population Health

Recognize and understand the influences of the ecosystem of person, family, population, environment, and policy on health of patients and integrate knowledge of these determinants of health into patient care decisions. PAs should be able to:

Apply principles of social-behavioral sciences by assessing the impact of psychosocial and cultural influences on health, disease, care seeking, and compliance.

Improve the health of patient populations through recognition of the influences of genetic, socioeconomic, environmental, and other determinants on the health of the individual and the community.

Demonstrate accountability, responsibility, and leadership for removing barriers to health.

### **Describe the assessment process that will be used to evaluate how well students are achieving the intended learning outcomes of the program component.**

Student success in achieving the intended learning outcomes of the program will be monitored throughout the program's didactic and clinical phases. The program's faculty and clinical preceptors will evaluate students through a variety of assessment tools, including but not limited to multiple-choice examinations, collaborative group projects, objective structured clinical examinations (OSCEs), and clinical performance evaluations.

### **How will you ensure that the assessment findings will be used to improve the program?**

Assessment findings will be used in compliance with external program accreditation requirements to ensure program-self-study and improvement is occurring regularly. Student board exam performance and external accreditation requirements will be assessed annually to examine program performance

### **What direct and indirect measures will be used to assess student learning?**

Examinations and Quizzes

Clinical Skills Assessment

Case Studies and Care Plans

Reflective Journals and Portfolios.

Preceptor, Peer, and Self-Assessment

Board Examinations

### **When will assessment activities occur and at what frequency?**

Assessment findings will be used for continuous program improvement through the following mechanisms:

Faculty Meetings: Regular faculty meetings will involve discussions of assessment results, with a focus on identifying areas of improvement and refining teaching methods and curriculum.

Curriculum Review: Assessment data will inform curriculum revisions, ensuring alignment with current healthcare trends and best practices.

Faculty Development: Faculty will receive training and support to enhance assessment techniques and teaching strategies, addressing areas where student performance needs improvement.

Feedback Loops: Continuous feedback loops will be established with students, incorporating their input to make program enhancements.

Assessment Activity Timing (assessment activities will occur throughout the program at various frequencies):

Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.

Summative assessments (midterm, final examinations) will occur at the end of relevant courses and following year one and year two. Alumni and industry surveys will be completed two years following graduation.

Clinical skills assessments and evaluations will be conducted during clinical rotations.

Case studies, care plans, and projects will be assigned periodically.

## Student Learning Outcomes

### Learning Objectives

Our graduates will demonstrate entry-level proficiency as PAs in the following program-defined outcomes:

#### Medical Knowledge for Practice

- Demonstrate knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care. PAs should be able to:
- Demonstrate investigative and critical thinking in clinical situations.
- Access and interpret current and credible sources of medical information.
- Apply principles of epidemiology to identify health problems, risk factors, treatment strategies, resources, and disease prevention/health promotion efforts for individuals and populations.
- Differentiate among acute, chronic, and emergent disease states.
- Apply principles of clinical sciences to diagnose disease and utilize therapeutic decision-making, clinical problem-solving, and other evidence-based practice skills.
- Adhere to standards of care, and to relevant laws, policies, and regulations that govern the delivery of care in the United States.
- Consider cost-effectiveness when allocating resources for individual patients or population-based care.
- Work effectively and efficiently in various health care delivery settings and systems relevant to the PA's clinical specialty.
- Identify and address social determinants that affect access to care and deliver high quality care in a value-based system.
- Participate in surveillance of community resources to determine if they are adequate to sustain and improve health.
- Utilize technological advancements that decrease costs, improve quality, and increase access to sustain and improve healthcare.

#### Interpersonal and Communication Skills

- Demonstrate interpersonal and communication skills (verbal, nonverbal, written, and electronic) that result in the effective exchange of information and collaboration with patients, their families, and health professionals. PAs should be able to:
- Establish meaningful therapeutic relationships with patients and families to ensure that patients' values and preferences are addressed and that needs and goals are met to deliver patient-centered care.
- Provide effective, equitable, understandable, respectful, quality, and culturally competent care that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Accurately and adequately document information regarding care for medical, legal, quality, and financial purposes.
- Demonstrate sensitivity, honesty, and compassion in all conversations.
- Demonstrate emotional resilience, stability, adaptability, flexibility, and tolerance of ambiguity.
- Recognize communication barriers and provide solutions.

#### Patient-centered Care

- Provide person-centered care that includes patient- and setting-specific assessment, evaluation, and management and healthcare that is evidence-based, supports patient safety, and advances in health equity. PAs should be able to:
- Accumulate accurate and essential information about patients through history-taking, physical examination, and diagnostic testing.
- Develop, implement, and monitor effectiveness of patient management plans.
- Maintain proficiency to perform safely all medical, diagnostic, and surgical procedures considered essential for primary care.
- Counsel, education, and empower patients and their families to participate in their care and enable shared decision-making.
- Refer patients appropriately, ensure continuity of care throughout transitions between providers or settings and follow-up on patient progress and outcomes.
- Provide health care service to patients, families, and communities to prevent health problems and to maintain health.



### Professionalism

- Adhere to the standards of care in the role of the PA in the health care team.
- Demonstrate responsiveness to patient needs that supersedes self-interest.
- Demonstrate a high level of responsibility, ethical practice, and adherence to legal and regulatory requirements.
- Demonstrate sensitivity to a diverse patient population by identifying the socio-cultural, familial, psychological, economic, environmental, and spiritual factors impacting health care and health care delivery; and responding to these factors by planning and advocating the appropriate course of action at both the individual and the community level.

### Practice-based Learning and Improvement

- Demonstrate the ability to learn and implement quality improvement practices by engaging in critical analysis of one's own practice experience, the medical literature, and other information resources of the purpose of self-evaluation, lifelong learning, and practice management. PAs should be able to:
- Use practice performance data and metrics to identify areas for improvement.
- Critically evaluate the medical literature in order to use current practice guidelines and apply the principles of evidence-based medicine to patient care.

### Society and Population Health

- Recognize and understand the influences of the ecosystem of person, family, population, environment, and policy on health of patients and integrate knowledge of these determinants of health into patient care decisions. PAs should be able to:
- Apply principles of social-behavioral sciences by assessing the impact of psychosocial and cultural influences on health, disease, care seeking, and compliance.
- Improve the health of patient populations through recognition of the influences of genetic, socioeconomic, environmental, and other determinants on the health of the individual and the community.
- Demonstrate accountability, responsibility, and leadership for removing barriers to health.

**A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any.**

#### Rationale:

Idaho has been one of the fastest growing states for 5 consecutive years: our population increased by 11.1% since 2016 and is expected to grow 10.5% between 2021 and 2026. The population increase in Idaho substantially outpaced the national growth rate of 1.8% by 13.5%. Additionally, Idaho's percentage of the population over the age of 65 has grown from 15% (2015) to 16% (2021). The rapid population growth and increased percentage of an aging population further burden a struggling healthcare system, exacerbating the industry need for expansion of healthcare services in Idaho.

Idaho is facing a severe healthcare workforce crisis; for example, in June of 2022, Idaho had 9,000 health care jobs that could not be filled. While a shortage of healthcare professionals is not unique to Idaho, the worsening shortages nationwide, and Idaho population increases has resulted in a need for more healthcare professionals and a decrease in the per capita healthcare provider ratio. This change in our population and a decrease in the healthcare provider ratio justifies seeking new solutions to increase the number of health care professionals who will care for the people of Idaho.

Currently, Idaho ranks at the bottom of all the states for number of practicing physicians per capita. The Idaho Department of Health and Welfare data indicates 98% of the state has a shortage of primary care physicians and 100% of the state has a shortage of mental health professionals. Further, 41% of Idaho physicians are age 55 or older, with higher populations of older physicians in Idaho's rural communities. Physician assistants can fill these gaps in the Idaho healthcare system, especially in rural communities; thus, our state has an immediate need and rising demand for physician assistants. The increasing shortage of health care professionals is an Idaho issue that needs to be addressed by higher education institutions within the state.

Certified Physician Assistants/Associates (PA-Cs) are essential members of the healthcare workforce and play a crucial role in expanding access to quality healthcare for Idaho's most rural communities. PAs are qualified to work in just about every area of clinical medicine, from family medicine to surgical specialties. The three top specialties for PAs are family medicine (30.6%), emergency medicine (14.8%), and urgent care (10.1%). This versatility allows for PAs to be employed wherever a physician might be employed; by educating more PAs in Idaho, we can serve Idaho citizens with healthcare who may not receive it otherwise due to the physician shortage.

The PA program at UI will serve baccalaureate prepared students from a variety of backgrounds who may enroll directly after completion of their undergraduate degree or as is often the case, after working in another health care field for a variable length of time. Our goal is to find qualified Idaho residents for at least two-thirds of the available seats in the program. We intend to attract individuals who want to serve their communities as providers of quality health care with an emphasis on evidence-based medicine. To that end, we will make a concerted effort to attract and accept a diverse student body to create a student-centered educational environment that engages individuals to become compassionate, competent physician assistants who possess the clinical skills to contribute positively to the dynamic health care needs of rural and underserved Idaho communities.

The Idaho Department of Labor predicts a 23% growth rate for PA positions in Idaho through 2030. Currently, Idaho State University runs the only PA program in the state, with cohorts enrolled in three locations: Pocatello, Meridian, and Caldwell. It is a distance learning model that leverages the talents of faculty at all locations to serve students. Seventy-two students are admitted each year (out of ~650 to 900 applications), and the applicant pool of students not accepted has a large portion of Idaho residents (e.g., the ISU applicant 'alternate list' has been made up 40% or more Idaho residents in 3 of the past 4 years). A comparable PA program at

the University of Utah has similar PA production (i.e., 60-68 students per cohort out of ~2500 applicants; self-reports a 3% admission rate for the PA program). In short, more than 90% of applicants are not accepted to either of these programs and the regional admissions data supports a great student desire to pursue a career as a PA that is not being met. Further, there is a great demand for PA graduates in the healthcare system. The student and healthcare system demand are greater than ISU can meet, and establishing a program at UI allows for students to be trained and prepared to meet the needs of northern Idaho and our rural communities (e.g., not training students in the Treasure Valley who are likely to remain in the Treasure Valley for clinical practice). The U of I's expansion into PA education, especially since our program will focus on recruitment from – and training in – Northern Idaho is needed for our students and our state.

A clearly stated rationale for this proposal must be included or the University Curriculum Committee will return the proposal for completion of this section. The rationale should provide a detailed summary of the proposed change(s). In addition, include a statement in the rationale regarding how the department will manage the added workload, if any:

### Supporting Documents

Program Description for Master of Physician Assistant.pdf  
 University of Idaho PA Curriculum.pdf  
 Budget-Proposal-Form\_PA Program.pdf

### Reviewer Comments

**Linda Lundgren (lindalundgren) (Thu, 26 Oct 2023 15:54:16 GMT):** 10/25/23: Program Description attached.

**Linda Lundgren (lindalundgren) (Tue, 07 Nov 2023 01:04:49 GMT):** 11/6/23: LL rolling back to dept. Email sent to Dr. Russel Baker outlining revisions that need to be done in proposal.

**Linda Lundgren (lindalundgren) (Tue, 07 Nov 2023 01:04:59 GMT):** Rollback: 11/6/23: LL rolling back to dept. Email sent to Dr. Russel Baker outlining revisions that need to be done in proposal.

**Tyler Bland (tbland) (Wed, 08 Nov 2023 01:50:54 GMT):** Rollback: Rollback

**Sydney Beal (sbeal) (Tue, 23 Jan 2024 22:45:16 GMT):** Approved at UCC pending the successful approval of the associated coursework

Key: 550

## University of Idaho PA Curriculum Draft: Didactic Year

First Semester (18 credits):

1. Anatomy (4 credits):
  - a. This course provides students with exposure to human anatomy. Students will learn the structure of the human body through active participation in the classroom, interactive software programs, and in the planning, dissection, and presentation of findings in the laboratory setting. Students will apply this foundational, anatomical knowledge to diseases and disorders in humans.
2. Physiology (2 credits separate or part of anatomy)
  - a. The basic concepts and principles that are essential to comprehending the fundamental mechanisms of human physiology at the cellular, tissue and organ levels and the requirements for the maintenance of homeostatic control. This course lays the foundation for understanding the underlying principles of the etiology, management, and prevention of human disease processes.
3. Foundations of Medical Science (4 credits)
  - a. This course provides students with exposure to the basic sciences related to the practice of medicine. Students will learn select topics in physiology, microbiology, pharmacology, laboratory studies, infectious disease and immunology and be introduced to diagnostic imaging (e.g., point of care ultrasound, magnetic resonance imaging). Students will apply this foundational, science knowledge to diseases and disorders in humans.
4. Introduction to Patient Care (5 credits)
  - a. This course provides students with the tools to conduct a comprehensive medical interview and introduces skills to assist in performing a physical examination to support patient evaluation and management. Students will learn effective methods for obtaining and documenting historical information, developing communication skills with patients and health care providers, and providing patient counseling. Further, students will learn critical thinking skills, physical examination techniques, and interpretation and documentation of medical findings. Students will learn through lectures, case discussions, laboratory sessions and patient simulations, and small group discussions.
5. Introduction to Epidemiology & Biostatistics (2 credits)
  - a. This course provides students with exposure to the basic concepts of descriptive and analytic epidemiology. Students will learn to read and interpret medical literature as it relates to disease frequency, probability, study design, sample size, hypothesis testing, test significance, measures of data quality and bias, multivariate models, survival analysis, and causality for the practice of evidence-based medicine. Students will develop these skills through lectures, journal article discussions, assignments, readings, and projects.
6. Humanism & Ethics in Health Care (1 credit)
  - a. This course is designed to provide an exposure to ethical principles and practice in healthcare, while also service as a foundation for PA students to appreciate and apply humanism in health and healthcare in their professional practice. Topics covered in this course include ethical theories, the history and future of humanism in medicine, medicalization and over diagnosis, the science of empathy, and the intersection of marginalization, otherness and cultural competency. Students will engage with multiple learning modalities such as articles, videos, interactive group activities, and short written reflections and quizzes.

Second Semester (18 credits):

1. Patient Assessment and Diagnosis I (5 credits)
  - a. The first class in a series that provides preparation on history-taking, physical examination techniques, counseling, documentation and presenting clinical information, the practical application of these clinical skills, along with the essentials of ordering, interpreting, and performing diagnostic studies used in the screening, diagnosis, management, and monitoring of common diseases. Emphasis is placed on acquiring the skills, knowledge and sensitivity needed to communicate and intervene effectively in a wide variety of patient encounters. Teaching methods include lectures, small group demonstrations and hands-on laboratory and practice sessions as well as clinical assignments to examine and/or interview standardized patients and patients in hospital, and outpatient settings. Students also access standardized patients in a controlled setting. Audiovisuals and asynchronous learning are also used. The topics of this course will be sequenced with the other content areas (e.g., clinical medicine, pharmacology) in the curriculum.
2. Clinical Medicine I (5 credits)
  - a. The first course of a sequence of courses to explore the essentials of diagnosis and management of the most common clinical problems seen by primary care practitioners using an organ systems and life stages approach. Clinical information is presented in lectures, small group learning experiences, modules, and practicums. Content covered in this course is correlated with preceding courses on physiology, anatomy, and basic medical science to build upon and develop a learner's foundational understanding of pathophysiology and related mechanisms of health and disease. This course supports the development of clinical reasoning and problem-solving skills applied to inform preventative, emergent, chronic, and rehabilitative care. Patient cases are used in modules, practicums, and small group settings to enhance readings and lectures. These core courses serve as the foundation of clinical medicine and most other courses are organized and built around the curricular content provided.
3. Pharmacology I (2 credits)
  - a. The essentials of basic pharmacological principles and disease process therapeutics. Topics for this course are sequenced with Clinical Medicine I, II and III (PHYASST 220, 221, 222) and are provided in lecture format.
4. Foundations in Community and Social Medicine (2 credits)
  - a. This course provides students with an understanding of the social, economic, and environmental factors that impact the health of populations and communities. Students will learn about social determinants of health, implicit bias and how to engage patients as upstanders for patient and community health.
5. Evidence-based Medicine I (1 credit)
  - a. A lecture and seminar course that provides a practical approach to making sound medical decisions based on current evidence in medical literature. Through a series of didactic presentations, group exercises, and reading, students will learn the basic principles of evidence-based medicine. Basic skills in using MEDLINE and other medical databases will be emphasized and practiced. Research principles, research ethics, and basic statistical review are introduced.
6. Practice and the Health System I (1 credit)
  - a. Provide an overview of the U.S. health care system with a focus on the PA profession. An interprofessional faculty will provide lectures and lead conversations on various aspects of PA practice and the health care system, including topics such as: the history of the PA profession, population health, health disparities, and health policy. The first part of the course sequence (PHS 1) will focus on sociocultural influences on health, wellness, and health care.
7. Complementary Medicine and Nutrition (2 credits)
  - a. This course provides an overview of the importance of and role of the human lifestyle in healthcare, and the principles for maintaining good health through nutrition, sleep, exercise, stress, risky behavior reduction, and social connection. It will address the health hazards associated with dietary deficiencies including obesity, fad dieting, food contamination, and diet management of selected diseases. It will address the use of therapeutic lifestyle interventions as a primary modality to both prevent and treat chronic diseases including, but not limited to, cardiovascular disease, type 2 diabetes, and obesity.

Third Semester (18 credits):

1. Patient Assessment and Diagnosis II (5 credits)
  - a. The second class in a series that provides preparation on history-taking, physical examination techniques, counseling, documentation and presenting clinical information, the practical application of these clinical skills, along with the essentials of ordering, interpreting, and performing diagnostic studies used in the screening, diagnosis, management, and monitoring of common diseases. Emphasis is placed on acquiring the skills, knowledge and sensitivity needed to communicate and intervene effectively in a wide variety of patient encounters. Teaching methods include lectures, small group demonstrations and hands-on laboratory and practice sessions as well as clinical assignments to examine and/or interview standardized patients and patients in hospital, and outpatient settings. Students also access standardized patients in a controlled setting. Audiovisuals and asynchronous learning are also used. The topics of this course will be sequenced with the other content areas (e.g., clinical medicine, pharmacology) in the curriculum.
2. Clinical Medicine II (5 credits)
  - a. The second course of a sequence of courses to explore the essentials of diagnosis and management of the most common clinical problems seen by primary care practitioners using an organ systems and life stages approach. Clinical information is presented in lectures, small group learning experiences, modules, and practicums. Content covered in this course is correlated with preceding courses on physiology, anatomy, and basic medical science to build upon and develop a learner's foundational understanding of pathophysiology and related mechanisms of health and disease. This course supports the development of clinical reasoning and problem-solving skills applied to inform preventative, emergent, chronic, and rehabilitative care. Patient cases are used in modules, practicums, and small group settings to enhance readings and lectures. These core courses serve as the foundation of clinical medicine and most other courses are organized and built around the curricular content provided.
3. Pharmacology II (2 credits)
  - a. The essentials of basic pharmacological principles and disease process therapeutics. Topics for this course are sequenced with Clinical Medicine I, II and III (PHYASST 220, 221, 222) and are provided in lecture format.
4. Evidence-based Medicine II (1 credit)
  - a. A lecture and seminar course that provides a practical approach to making sound medical decisions on the basis of current evidence in the medical literature. Through a series of didactic presentations, group exercises, and reading, students will learn the basic principles of evidence-based medicine. Basic skills in using MEDLINE and other medical databases will be emphasized and practiced. Research principles, research ethics, and basic statistical review are introduced.
5. Practice and the Health System II (1 credit)
  - a. Provide an overview of the U.S. health care system with a focus on the PA profession. An interprofessional faculty will provide lectures and lead conversations on various aspects of PA practice and the health care system, including topics such as: the history of the PA profession, population health, health disparities, and health policy. The second portion of the course sequence (PHS II) will continue discussion of the PA professional role, including interactions in the health care system and health policy, and practical application of content in professional settings.
6. Fundamentals of Surgery II (3 credits)
  - a. The course focuses on the basic surgical concepts needed for the PA to function in primary care settings as well as major surgical areas. The course emphasizes surgical concepts, topics and surgical technique. A substantial part of this course consists of essential hands-on laboratory exercises emphasizing surgical skills required in a primary care setting.
7. Electrocardiography (ECG) and Life Support Procedures and Skills (1 credit)
  - a. This course provides the basics for learning to interpret normal ECG tracings and applying those principles to interpret the ECG tracings of common cardiac disease. This course will also introduce the principles of advanced life support utilized in medical and surgical emergencies. Includes a review of the most common emergency situations encountered and provides hands-on practical training that will assist the clinician in developing the skills required to stabilize patients with life threatening conditions. Includes certification in Basic (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS).

Fourth Semester (18 credits):

1. Patient Assessment and Diagnosis III (5 credits)
  - a. The third class in a series that provides preparation on history-taking, physical examination techniques, counseling, documentation and presenting clinical information, the practical application of these clinical skills, along with the essentials of ordering, interpreting, and performing diagnostic studies used in the screening, diagnosis, management, and monitoring of common diseases. Emphasis is placed on acquiring the skills, knowledge and sensitivity needed to communicate and intervene effectively in a wide variety of patient encounters. Teaching methods include lectures, small group demonstrations and hands-on laboratory and practice sessions as well as clinical assignments to examine and/or interview standardized patients and patients in hospital, and outpatient settings. Students also access standardized patients in a controlled setting. Audiovisuals and asynchronous learning are also used. The topics of this course will be sequenced with the other content areas (e.g., clinical medicine, pharmacology) in the curriculum.
2. Clinical Medicine III (5 credits)
  - a. The third course of a sequence of courses to explore the essentials of diagnosis and management of the most common clinical problems seen by primary care practitioners using an organ systems and life stages approach. Clinical information is presented in lectures, small group learning experiences, modules, and practicums. Content covered in this course is correlated with preceding courses on physiology, anatomy, and basic medical science to build upon and develop a learner's foundational understanding of pathophysiology and related mechanisms of health and disease. This course supports the development of clinical reasoning and problem-solving skills applied to inform preventative, emergent, chronic, and rehabilitative care. Patient cases are used in modules, practicums, and small group settings to enhance readings and lectures. These core courses serve as the foundation of clinical medicine and most other courses are organized and built around the curricular content provided.
3. Pharmacology III (2 credits)
  - a. The essentials of basic pharmacological principles and disease process therapeutics. Topics for this course are sequenced with Clinical Medicine I, II and III (PHYASST 220, 221, 222) and are provided in lecture format.
4. Evidence-based Medicine III (3 credits):
  - a. During this course PA students complete an evidence-based review paper on a clinical question of interest. Students will present their findings to faculty and student colleagues.
5. Practice and the Health System III (1 credit):
  - a. The Practice & the Health System courses (PHS I, II, and III) provide an overview of the U.S. health care system with a focus on the PA profession. PHS III is the culmination of the course sequence. An interprofessional faculty approach provides lectures and leads discussions on various aspects of PA practice and the health care system, including topics such as: transition to professional practice, social and cultural determinants of health, medical billing and coding, advanced clinical medicine, licensure and certification, medication-assisted therapy training (MAT), professional ethics, team skills and communication, leadership development, and prescription writing/medication errors. The program's final summative evaluation is part of this course, which also serves as preparation for the PA National Certifying Examination (PANCE).
6. The Pathway to Patient Care (2 credits)
  - a. This two-week course provides physician assistant students with preparation to begin the clinical year rotations. Topics covered include preceptor expectations, self-care, electronic medical records access, professionalism and formative and summative assessment of readiness to enter the clinical training environment.

## University of Idaho PA Curriculum Draft: Clinical Year (36 credits)

1. General Surgery (4 credits)
  - a. This required 4-week clinical clerkship provides the student with exposure to the principles and practices of general surgery. Emphasis is placed on the management of patients who present with surgical issues. The students will participate in the pre-operative evaluation of patients, including history taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. They will assist in the operating room, learn to write pre and post-operative notes, care for the post-operative patient, and report to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and perform bedside procedures. They will develop an understanding of how to function as part of the surgical team, develop effective communication with the patient, the healthcare team, and the patient's family.
2. Emergency Medicine (4 credits)
  - a. This required 4-week clinical clerkship provides the student with exposure to the principles and practice of emergency medicine. Emphasis is placed on caring for patients presenting to the emergency department. Students will participate in the assessment of patient acuity, disease state, and appropriate management within the setting of the emergency department. They will participate in history-taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and bedside procedures. Students will develop an understanding of how to function as part of the medical team, develop effective communication with the patient, the healthcare team, and the patient's family.
3. Obstetrics and Gynecology (4 credits)
  - a. This required 4-week clinical clerkship provides students with exposure to the principles and practice of obstetrics and gynecology, including health maintenance and screening. Emphasis is placed on caring for female patients across their life span, including menarche, family planning, childbearing years, perimenopause, menopause, and post-menopause. Students will learn how to recognize and treat sexually transmitted diseases, ovarian, breast, and uterine cancer, and evaluate and treat common ambulatory gynecologic problems. Students will learn prenatal counseling and care and may have exposure to labor and delivery. They will participate in history-taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and perform bedside procedures. They will develop an understanding of how to function as part of the medical team, improve effective communication with the patient, the healthcare team, and the patient's family.
4. Pediatrics (4 credits)
  - a. This required 4-week clinical clerkship provides the student with exposure to the principles and practice of pediatric medicine in the ambulatory setting. Students will gain experience caring for neonates, infants, children, and adolescents, providing parental education and guidance, recognizing the appropriate milestone, preventing illness, injury, and accidents, and providing care unique to the pediatric patient. Students will participate in history-taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and perform bedside procedures. They will develop an understanding of how to function as part of the medical team, improve effective communication with the patient, the healthcare team, and the patient's family.
5. Internal Medicine (4 credits)
  - a. This required 4-week clinical clerkship provides students with exposure to the principles and practice of internal medicine. Emphasis is placed on caring for the acutely and chronically ill adult patient who requires hospitalization. Students will participate in admission history taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in

inpatient rounds; provide patient presentations to clinical team members, and perform bedside procedures. Students will develop an understanding of how to function as part of the medical team, develop effective communication with the patient, the healthcare team, and the patient's family.

6. Family Medicine (4 credits)

- a. This required 4-week clinical clerkship provides the student with exposure to the principles and practice of family medicine. Emphasis is placed on disease prevention and health maintenance in adults and children. The students will develop an increased understanding of the social, economic, and environmental factors related to caring for the patient and extended family. They will participate in history-taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and perform bedside procedures. Students will develop an understanding of how to function as part of the medical team, develop effective communication with the patient, the healthcare team, and the patient's family.

7. Primary Care Directive (4 credits)

- a. This required 4-week clinical clerkship provides students with further exposure to the principles and practice of Primary Care. Emphasis is placed on caring for patients with general medical problems in the outpatient or the inpatient setting. Students will participate in taking medical histories, physical examination, assessment and formulation of a plan and problem list, ordering, and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in rounds; provide patient presentations to clinical team members and perform procedures. Students will develop an understanding of how to function as part of the medical team, develop effective communication with the patient, the healthcare team, and the patient's family.

8. Clinical Elective I (4 credits)

- a. These elective 4-week clinical clerkships provide the student with the opportunity to gain additional experience in one of the core clerkship areas or to supplement the foundational core clerkships with specialty disciplines in medicine and surgery. Emphasis is placed on the management of patients within the specialty discipline. Students will utilize these electives to better understand how a primary care provider should manage a patient presenting with a disease/condition prior to specialty referral and upon follow up. They will participate in history-taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and perform bedside procedures. Students will develop an understanding of how to function as part of the medical team, develop effective communication with the patient, the healthcare team, and the patient's family.

9. Clinical Elective II (4 credits)

- a. These elective 4-week clinical clerkships provide the student with the opportunity to gain additional experience in one of the core clerkship areas or to supplement the foundational core clerkships with specialty disciplines in medicine and surgery. Emphasis is placed on the management of patients within the specialty discipline. Students will utilize these electives to better understand how a primary care provider should manage a patient presenting with a disease/condition prior to specialty referral and upon follow up. They will participate in history-taking, physical examination, assessment and formulation of a plan and problem list, ordering and interpreting diagnostic tests, proper medical documentation, and reporting to the healthcare team as appropriate for the clerkship. During this clerkship, students may additionally participate in inpatient rounds, provide patient presentations to clinical team members, and perform bedside procedures. Students will develop an understanding of how to function as part of the medical team, develop effective communication with the patient, the healthcare team, and the patient's family.



### Program Description:

The Master of Physician Assistant Studies is an entry-level program designed to empower aspiring healthcare professionals to become physician assistants (PAs). PAs are adept and compassionate healthcare providers who collaborate closely with physicians to deliver comprehensive patient care services. Within this program, students will acquire the essential skills to take complete medical histories, perform thorough physical examinations, interpret diagnostic studies, including laboratory tests and x-rays, and make informed diagnoses and treatment decisions. By doing so, our graduates contribute significantly to enhancing healthcare accessibility for underserved communities, both in urban and rural settings.

**Program Resource Requirements.**

- Indicate all resources needed including the planned FTE enrollment, projected revenues, and estimated expenditures for the firstfour fiscal years of the
- Include reallocation of existing personnel and resources and anticipated or requested new resources.
- Second and third year estimates should be in constant dollars.
- Amounts should reconcile subsequent pages where budget explanations are provided.
- If the program is contract related, explain the fiscal sources and the year-to-year commitment from the contracting agency(ies) or party(ies).
- Provide an explanation of the fiscal impact of any proposed discontinuance to include impacts to faculty (i.e., salary savings, re-assignments).

**I. PLANNED STUDENT ENROLLMENT**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
A. New enrollments		20		25		30		35
B. Shifting enrollments								
<b>Total Enrollment</b>	0	20	0	45	0	55	0	65

**II. REVENUE**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
1. New Appropriated Funding Reques	\$507,600.00	\$500,000.00	\$507,600.00		\$507,600.00		\$507,600.00	
2. Institution Funds								
3. Federal								
4. New Tuition Revenues from Increased Enrollments	\$1,052,160.00		\$2,359,983.00		\$2,900,817.00		\$3,412,143.00	
5. Student Fees								
6. Other (i.e., Gifts)								
<b>Total Revenue</b>	\$1,559,760	\$500,000	\$2,867,583	\$0	\$3,408,417	\$0	\$3,919,743	\$0

*Ongoing is defined as ongoing operating budget for the program which will become part of the base.*

*One-time is defined as one-time funding in a fiscal year and not part of the base.*

**III. EXPENDITURES**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>A. Personnel Costs</b>								
1. FTE	5.5		5.5		7.5		8.5	
2. Faculty	\$240,000.00		\$240,000.00		\$480,000.00		\$600,000.00	
3. Adjunct Faculty								
4. Graduate/Undergrad Assistants								
5. Research Personnel								
6. Directors/Administrators	275000		275000		275000		275000	
7. Administrative Support Personnel	115000		115000		115000		115000	
8. Fringe Benefits	102600		102600		140800		159900	
9. Other:								
<b>Total Personnel and Costs</b>	<b>\$732,600</b>	<b>\$0</b>	<b>\$732,600</b>	<b>\$0</b>	<b>\$1,010,800</b>	<b>\$0</b>	<b>\$1,149,900</b>	<b>\$0</b>

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>B. Operating Expenditures</b>								
1. Travel	\$20,000.00		\$20,000.00		\$20,000.00		\$20,000.00	
2. Professional Services	\$10,000.00		\$10,000.00		\$10,000.00		\$10,000.00	
3. Other Services								
4. Communications	\$20,000.00		\$20,000.00		\$20,000.00		\$20,000.00	
5. Materials and Supplies	\$25,000.00		\$25,000.00		\$25,000.00		\$25,000.00	

6. Rentals								
7. Materials & Goods for Manufacture & Resale								
8. Miscellaneous	\$15,000.00		\$15,000.00		\$15,000.00		\$15,000.00	
<b>Total Operating Expenditures</b>	<b>\$90,000</b>	<b>\$0</b>	<b>\$90,000</b>	<b>\$0</b>	<b>\$90,000</b>	<b>\$0</b>	<b>\$90,000</b>	<b>\$0</b>

	<b>FY 25</b>		<b>FY 26</b>		<b>FY 27</b>		<b>FY 28</b>	
<b>C. Capital Outlay</b>	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
1. Library Resources								
2. Equipment		\$500,000.00	\$25,000.00		\$25,000.00		\$25,000.00	
<b>Total Capital Outlay</b>	<b>\$0</b>	<b>\$500,000</b>	<b>\$25,000</b>	<b>\$0</b>	<b>\$25,000</b>	<b>\$0</b>	<b>\$25,000</b>	<b>\$0</b>

	<b>FY _____</b>		<b>FY _____</b>		<b>FY _____</b>		<b>FY _____</b>	
<b>D. Capital Facilities Construction or Major Renovation</b>	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>E. Other Costs</b>								
Utilites								
Maintenance & Repairs								
Other								

<b>Total Other Costs</b>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
<b>TOTAL EXPENDITURES:</b>	<u>\$822,600</u>	<u>\$500,000</u>	<u>\$847,600</u>	<u>\$0</u>	<u>\$1,125,800</u>	<u>\$0</u>	<u>\$1,264,900</u>	<u>\$0</u>
<b>Net Income (Deficit)</b>	<u>\$737,160</u>	<u>\$0</u>	<u>\$2,019,983</u>	<u>\$0</u>	<u>\$2,282,617</u>	<u>\$0</u>	<u>\$2,654,843</u>	<u>\$0</u>

Budget Notes (specify row and add explanation where needed; e.g., "I.A.,B. FTE is calculated using..."):

I.A.B.	20 students in the first year and a 5 student increase in cohort size each subsequent year.
II.4	Based on projected enrollment with 75% of the cohort being in state students and 25% being out-of-state students.
III.B	Conference travel for professional development; professional services; program communciations; accreditation costs; program supplies.
III.C	Training equipment and simulation equipment purchases; subsequent upgrades and maintenance. (see request under Revenue II.1 for \$500,000)
	to cover this one time expenditure.

# 99: SCHOOL OF HEALTH AND MEDICAL PROFESSIONS

## In Workflow

1. Registrar's Office (none)
2. 20 Curriculum Committee Chair (mcmurtry@uidaho.edu; slthomas@uidaho.edu)
3. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brendah@uidaho.edu)
4. Registrar's Office (none)
5. Ready for UCC (disable)
6. UCC (none)
7. Post-UCC Registrar (none)
8. Faculty Senate Chair (mstout@uidaho.edu; jvalkovic@uidaho.edu; cari@uidaho.edu; csparker@uidaho.edu)
9. Provost's Office (kudas@uidaho.edu; mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brendah@uidaho.edu)
10. State Approval (mstout@uidaho.edu; jvalkovic@uidaho.edu; gwen@uidaho.edu; cari@uidaho.edu; brendah@uidaho.edu)
11. NWCCU (panttaja@uidaho.edu; mstout@uidaho.edu; cari@uidaho.edu; brendah@uidaho.edu)
12. Catalog Update (sbeal@uidaho.edu)

## Approval Path

1. Tue, 10 Oct 2023 16:19:22 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
2. Wed, 08 Nov 2023 23:13:43 GMT  
Linda Lundgren (lindalundgren): Rollback to Initiator
3. Wed, 06 Dec 2023 22:21:36 GMT  
Theodore Unzicker (tunzicker): Approved for Registrar's Office
4. Thu, 14 Dec 2023 23:53:25 GMT  
Jerry McMurtry (mcmurtry): Approved for 20 Curriculum Committee Chair
5. Tue, 16 Jan 2024 21:56:41 GMT  
Brenda Helbling (brendah): Approved for Provost's Office
6. Thu, 18 Jan 2024 19:22:48 GMT  
Sydney Beal (sbeal): Approved for Registrar's Office
7. Thu, 18 Jan 2024 19:23:11 GMT  
Sydney Beal (sbeal): Approved for Ready for UCC
8. Tue, 23 Jan 2024 22:42:51 GMT  
Sydney Beal (sbeal): Approved for UCC
9. Thu, 25 Jan 2024 21:52:57 GMT  
Sydney Beal (sbeal): Approved for Post-UCC Registrar

## New Proposal

Date Submitted: Wed, 06 Dec 2023 22:01:01 GMT

## Viewing: School of Health and Medical Professions

Last edit: Thu, 25 Jan 2024 21:52:53 GMT

Changes proposed by: Marlane Martonick

## Faculty Contact

Faculty Name	Faculty Email
Jeffrey G. Seegmiller	jeffreys@uidaho.edu

## Request Type

Add/Drop a Department/School/Unit/College

## Effective Catalog Year

2025-2026

## Title

School of Health and Medical Professions

## Request Details

Please see attached State Forms.

**Attach State Form**

Instructional\_Administrative\_Unit-Form-FINAL-1.pdf

**Supporting Documents**

School of Health and Medical Professions - Org Chart SHAMP.pdf  
Budget-Proposal-Form\_final\_9-16-2021 (2).pdf

**Reviewer Comments**

**Linda Lundgren (lindalundgren) (Thu, 19 Oct 2023 23:49:06 GMT):** Per Jeff Seegmiller, updated Instructional\_Admin form to shows Fall 2025 as implementation date.

**Linda Lundgren (lindalundgren) (Wed, 08 Nov 2023 23:13:43 GMT):** Rollback: Per email from Whitney Vincent on 11/8/23, at Marlane Martonick's request, Linda Lundgren asking rolled #99, College of Health and Medical Professions proposal. The college is no longer asking for a new college at this time but rather a new School of Health and Medical Professions so rolled back for verbiage to be revised on all proposals. Let me know if you have any questions, Thank you! Whitney WHITNEY VINCENT Academic Coordinator Idaho WWAMI Medical Education Program 208-885-1686 (O) 208-885-7910 (F) 121 W. Sweet Ave, Office 147 Moscow, ID 83844

Key: 99



# Idaho State Board of Education

## PROPOSAL FORM

Instructional and Administrative Units

Date of Proposal Submission:	09/26/2023
Institution Submitting Proposal:	University of Idaho
Name of School, School, or Division:	The School of Health and Medical Professions
Name of Department(s) or Area(s):	Department of Medicine, Department of Clinical Medicine, Department of Nursing
Title of Proposed Unit	School of Health and Medical Professions
Proposed Implementation Date:	FY26 (Fall of 2025)

**Indicate whether this request is either of the following:**

New Administrative Unit

New Instructional Unit

Jeffrey G. Seemiller, Ed.D.  10/9/23  
 \_\_\_\_\_  
 Dean Date

Christopher Nomura, VP for Research  
 \_\_\_\_\_  
 Vice President for Research (as applicable) Date

Jerry McMurtry, Dean, College of Grad Studies  
 \_\_\_\_\_  
 Graduate Dean (as applicable) Date

Patty Sanchez, OSBE Program Manager  
 \_\_\_\_\_  
 OSBE Program Manager/IDCTE Director, Program Services Date

Brian Foisy, VP for Finance and Administration  
 \_\_\_\_\_  
 FVP/Chief Fiscal Officer Date

Jenn Thompson, Chief Policy/Govt. Affairs Officer  
 \_\_\_\_\_  
 State Administrator, IDCTE Date

Torrey Lawrence, Provost/Exec. Vice President  
 \_\_\_\_\_  
 Provost/VP for Instruction Date

Patrick Coulson, Chief Financial Officer  
 \_\_\_\_\_  
 Chief Financial Officer, OSBE Date

Scott Green, President  
 \_\_\_\_\_  
 President Date

T.J. Bliss, Chief Academic Officer  
 \_\_\_\_\_  
 Chief Academic Officer, OSBE Date



Matt Freeman, Executive Director

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SBOE/Executive Director or Designee Approval

Date

1. What are the goals and objectives for the new unit?

As a unit of the University of Idaho, we intend to establish the School of Health and Medical Professions (SHAMP) which will provide the citizens of the State of Idaho an opportunity to fill a critical workforce shortage in healthcare. Idaho's population has been growing at an exceptional rate for five consecutive years, surpassing the national growth rate by a substantial margin. The mission of SHAMP is to improve the health of the people of Idaho by developing a robust academic health care delivery system that will educate and set forth a skilled workforce of healthcare professionals to attack this critical healthcare shortage.

To fulfill our mission, the following goals and objectives are set forth:

- To create educational opportunities to train the citizens of the State of Idaho in healthcare professions which will in turn expand and strengthen the healthcare services in Idaho.
- Expand health care academic programs to address the critical workforce shortage.
- Addressing Idaho's rural health care needs which often face the brunt of workforce shortages.
- Developing academic programs to help train and retain healthcare professionals, ensuring that even the most remote areas receive adequate medical and mental health services.
- Meeting the needs of the future which shows a continual population growth both in Idaho and nationally. This underscores the importance of establishing healthcare academic programs now to meet future workforce needs and reduce reliance on out-of-state recruitment.
- To build the school upon the highest quality, basic, applied, and clinical research available at the University of Idaho.

2. What is the relationship of the unit to the university's mission and priorities? Is the unit involved in instruction and if so, to what extent?

The mission of the University of Idaho is to shape the future through innovative thinking, community engagement and transformative education. The School of Health and Medical Professions stands firm in this mission by providing educational offerings that will transform the lives of our students through engaged learning and self-reflection. Our teaching and learning will include graduate, professional and continuing education offered through face-to-face instruction, technology-enabled delivery and hands-on experience. Our educational programs will strive for excellence and will be enriched by the knowledge, collaboration, diversity and creativity of our faculty, students and staff. The programs listed below have been identified as areas of workforce development to help meet the needs of the healthcare shortage.

The School of Health and Medical Professions will be the foundation on which our programs will grow. The school will be located within the College of Graduate Studies. Please note that the bulk of these specific programs are currently not being offered in our state institutions, except for the Physician's Assistant Program. Program Proposals for each of these academic programs are included in this School/Program proposal submission.

**Doctorate Psychology (PsyD) program**

The entire state of Idaho is a mental health shortage area and Idaho has the lowest number of psychiatrists per capita. Considering overall mental health care, Mental Health America ranks Idaho 49th out of 51 (including D.C.) in adult care, 45th in youth care, while ranking 50th (second highest) in the prevalence of mental illness (19% average). The University of Idaho has a foundation of faculty and facilities that can be leveraged to develop a doctorate in this clinical psychology program that will address deficiencies in mental health care. Once implemented,

graduates will be able to focus on mental health needs related to early childhood development, adolescent, and young adult care needs, such as suicide prevention, substance use disorder and mental health counseling, and geriatric care.

#### **Direct-Entry Master of Science in Nursing (MSN)**

The University of Idaho has a foundation of faculty and facilities that can be leveraged to develop a Master of Science in Nursing (MSN). The MSN prepares the graduate for a position as a Registered Nurse, as well as a leadership role in varied settings such as hospitals, health department, clinics, among other practice areas.

#### **Doctorate - Anatomical Science Education (DAS)**

Expert knowledge of the anatomical sciences is central to diagnosis and treatment of disease and as such in-depth coursework in this area has long been the foundation of health sciences curricula. Despite this, health sciences programs nationwide are facing an increasing shortage of highly trained anatomy educators. The Doctoral of Anatomical Sciences program is designed to train individuals to become fully qualified educators in all of the anatomical disciplines and conduct educational scholarly research for promotion and tenure.

#### **Master of Science, Gerontology**

The Master of Science in Gerontology prepares graduates to assume major leadership roles in the field of aging, primarily in the planning, administration, and evaluation of programs in the private and public sectors, as well as executive positions in the delivery of direct services to older people and their families and in the instruction of older adults and service providers.

#### **Certified Registered Nurse Anesthetist (CRNA) Doctorate**

The practice of anesthesia is a recognized specialty in nursing. Considered an essential role to the health care workforce, nurse anesthetists provide anesthesia and related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures. They also provide pain management and emergency services such as airway management.

#### **Physician Assistant (PA) - Masters**

Working interdependently with physicians, PAs (Physician Assistant) provide diagnostic and therapeutic patient care in virtually all medical specialties and settings. They take patient histories, perform physical examinations, order laboratory and diagnostic studies, prescribe medications, and develop patient treatment plans. Their job descriptions are as diverse as those of their supervising physicians, and include clinical practice, patient education, team leadership, medical education, health administration, and research.

### 3. What is the demand for the unit's services? What population will the unit serve?

Idaho's population has been growing at an exceptional rate for five consecutive years, surpassing the national growth rate by a substantial margin.

This population surge has strained the state's healthcare system, underscoring the necessity for expanding healthcare services within Idaho. For example, Idaho ranks at the bottom among all states in terms of practicing physicians per capita. Moreover, a significant percentage of the state's physicians are approaching retirement age, further exacerbating the shortage.

Furthermore, it is quite evident that we simply do not have enough health care workers to take care of us and the situation could get worse if we do not act. The Idaho Business for Education

sponsored a Health Care Summit in June of 2022 to address the workers' healthcare crisis. In the report, they explored why we have a crisis, how it affects our health care professionals and their patients, and it recommends specific ways our leaders can help solve it. One of the chief ways to solve this crisis is ramping up educational opportunities for the citizens in the State of Idaho. Please see following white paper from the Idaho Business for Education: <http://idahobe.org/wp-content/uploads/2022/08/HEALTH-CARE-SUMMIT-WHITE-PAPER-3.0.pdf>

Healthcare jobs in Idaho are projected to be the fastest growing professions this decade, with nearly 10,000 new jobs being projected, according to the Idaho Department of Labor. The population that the new School will serve encompasses a broad demographic from the classroom to the bedside, by training a healthcare workforce who will in turn provide essential healthcare services to the people of Idaho.

Based on this important need, we propose to create the School of Health and Medical Professions at the University of Idaho which will provide the citizens of the State of Idaho an opportunity to fill this critical workforce shortage. The school will include three new departments and six new programs, along with existing programs such as the WWAMI Medical Education program and the Athletic Training program. The areas of justification include the following:

- **Critical Workforce Shortage:** Idaho's healthcare workforce shortage poses a significant threat to public health and access to quality care. Expanding healthcare academic programs is essential to address this urgent need.
- **Enhancing Access to Care:** Building on the success of the WWAMI medical program and partnerships, this budget request will allow the University of Idaho to initiate new healthcare programs within the School of Health and Medical Professions.
- **Addressing Rural Healthcare Needs:** Rural communities often face the brunt of workforce shortages. Developing academic programs will help train and retain healthcare professionals, ensuring that even the most remote areas receive adequate medical and mental health services.
- **Future Demand:** Projected growth in demand for healthcare professionals, both in Idaho and nationally, underscores the importance of establishing healthcare academic programs now to meet future workforce needs and reduce reliance on out-of-state recruitment.

4. Describe the proposed unit's organizational structure.

The new School of Health and Medical Professions located within the College of Graduate Studies will be supported by the many excellent administrative and academic units at the University of Idaho main campus (Financial Services, Human Resources, Risk Management, Facilities Management, and Business & Administrative services). The Dean for the School of Health and Medical Professions provides leadership to the Administration and Business Affairs division, which includes an executive assistant, support staff in finance, marketing and strategic initiatives, and laboratory management. The dean will oversee five academic and business divisions. We are currently proposing the new school and six new programs under three departments (Department of Medicine, Department of Clinical Medicine and the Department of Nursing). Our Idaho WWAMI Medical Education program is also included in this organizational structure and is under the Department of Medicine.

- 1) Department of Medicine
  - a) WWAMI Medical Education Program
  - b) Doctorate of Anatomical Sciences
  - c) Masters of Science – Gerontology

- 2) Department of Clinical Medicine
  - a) Doctorate of Psychology
  - b) Physician Assistant
  - c) Athletic Training

- 3) Department of Nursing
  - a) Masters of Science – Nursing
  - b) Doctorate, Certified Registered Nurse Anesthetist

We are working closely with the College of Education, Health and Human Sciences to transition their Athletic Training Programs into the new School as shown on the following organizational chart. In addition, our future strategic plan is to improve healthcare for all on-campus students and create “Vandal Health” which will provide hands-on experience and training for our students in these healthcare programs. Note: Please see attached organizational chart.

5. What targets have been set to assess the proposed unit’s success in achieving objectives?

GOAL 1: A WELL, EDUCATED CITIZENRY – Continuously improve access to health and medical education for individuals of all backgrounds, ages, abilities, and economic means.

GOAL 2: CRITICAL THINKING AND INNOVATION - SHAMP will provide an environment for the development of innovative ideas, and practical and theoretical knowledge to foster the development of healthcare workers (psychologists, gerontologists, physician assistants, nurses, anatomists, and future physicians) who contribute to the health and wellbeing of Idaho’s people and communities.

GOAL 3: Effective and Efficient Delivery Systems – Deliver health and medical education, training, research, and service in a manner which makes efficient use of resources and contributes to the successful completion of our health and medical education program goals for Idaho.

6. Briefly describe the processes that will demonstrate the quality of the unit.

1. Set School and program performance measures as a series of goals to meet over time.
2. Define goals and objectives of the school and its programs and evaluate.
3. Report and use the evaluation findings to improve the school, programs, and its courses.
4. Each program will have an assessment process to be used for continuous program improvement through the following mechanisms:

- To evaluate how well students are achieving the intended learning outcomes, the following assessment processes will be employed:
- Examinations and Quizzes: Regular assessments will include written examinations and quizzes to evaluate knowledge acquisition and critical thinking skills.
- Clinical Skills Assessment: Clinical skills will be assessed through direct observation, practical examinations, and skills checklists during clinical rotations.
- Case Studies and Care Plans: Students will complete case studies and care plans to demonstrate their ability to apply theoretical knowledge to real-world patient care scenarios.
- Reflective Journals and Portfolios: Students will maintain reflective journals and e-portfolios, providing insights into their personal and professional growth.
- Peer and Self-Assessment: Peer evaluations and self-assessment will be incorporated for group projects and personal reflection on skills development.

Assessment findings will be used for continuous program improvement through the following mechanisms:

- Faculty Meetings: Regular faculty meetings will involve discussions of assessment results, with a focus on identifying areas of improvement and refining teaching methods and curriculum.
- Curriculum Review: Assessment data will inform curriculum revisions, ensuring alignment with current healthcare trends and best practices.
- Faculty Development: Faculty will receive training and support to enhance assessment techniques and teaching strategies, addressing areas where student performance needs improvement.
- Feedback Loops: Continuous feedback loops will be established with students, incorporating their input to make program enhancements.

Assessment Activity Timing - Assessment activities will occur throughout the program at various frequencies:

- Formative assessments (quizzes, in-class discussions) will be ongoing throughout each semester.
- Summative assessments (midterm, final examinations) will occur at the end of relevant courses and following year one and year two. Alumni and industry surveys will be completed two years following graduation.
- Clinical skills assessments and evaluations will be conducted during clinical rotations.
- Case studies, care plans, and projects will be assigned periodically.

7. Indicate the number of students, businesses, industries, and/or other clients to be served by this unit. Include a description of faculty participation and student involvement in the unit if applicable.

Entering Enrollment	Program/Degree Title
15	Direct Entry - Masters Degree, Nursing (MSN)
20	Doctorate – Anatomical Science Education (DAS) - Self Support
20	Masters of Science – Gerontology – Self Support
10	Certified Registered Nurse Anesthetist (CRNA) - Self Support

20	Physician Assistant	
15	Doctorate of Psychology (PsyD)	
Academic Personnel		Description
11	Fulltime Faculty	
4.5	Parttime Faculty	
7	Administration and Staff	
Hospital/Clinic Training Sites		Location
Gritman Medical Center and Medical Clinics		Moscow, Idaho
St. Joseph Regional Medical Center		Lewiston, Idaho
Tri State Hospital and Medical Clinics		Clarkston, Washington
Whitman Hospital and Medical Clinics		Colfax, Washington
Pullman Regional Hospital and Medical Clinics		Pullman, Washington
Kootenai Medical Center		Coeur d'Alene, Idaho
Bonner General Health		Sandpoint, Idaho
North Idaho Acute Care Hospital		Post Falls, Idaho

8. Financial Impact: Using the **budget template**, provide a narrative budget summarizing the needs and requirements for implementing the new unit.

The WWAMI Medical Education Program has recently submitted a request for Fiscal Year 2025 to the State of Idaho for educational support to create a new School of Health and Medical Professions (SHAMP). Based on feedback from policy makers and Idaho business leaders, our request is dedicated to addressing healthcare workforce needs, one of the most pressing issues the state is facing today. We acknowledge the importance of flexibility to adapt to evolving challenges and workforce needs of the future. The budget summary is as follows:

Positions will be full-time, and part-time and most will be benefit eligible.

Healthcare Workforce – this request for the new School includes the programs that will require State support (Doctorate in Psychology, Physician Assistant, along with state support for the new School which includes Associate Dean of Curriculum, Associate Dean of Clinical Curriculum, Associate Dean of Admissions and Assessment, as well as department chairs and program coordinators. (Requesting 3.5 FTP; \$539,200 total General Fund PC funding with benefits). In addition to the state support, SHAMP will match the FTE and salary for a total personnel cost of \$946,700 (includes fringe benefits) for 7.0 FTE.

All personnel costs are based on market data and costs for comparable positions as per the University of Idaho's Market-based Compensation model.

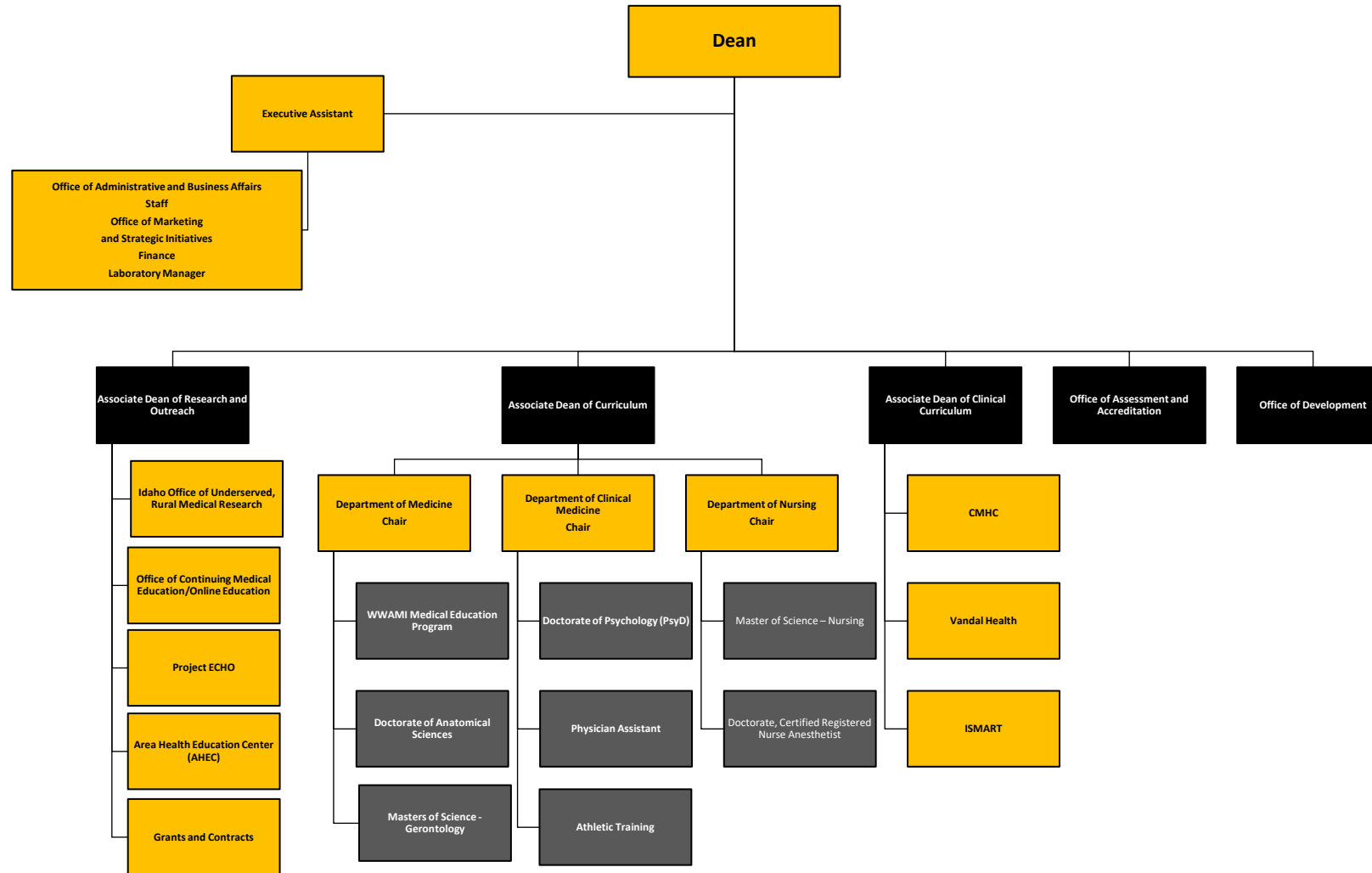
The budget included in this proposal not only includes the budget request for FTE, salary and benefits that were submitted to the State of Idaho for FY25. It is necessary to include various expenditures to support the School and its programs. Therefore, the budget for this proposal includes \$100,000 in operating expenditures, as well as a one-time request for \$200,000 in capital outlay for equipment costs. The total amount for the FY25 budget is \$1,046,700.00. Each following year includes a 5% inflation added to the budget for all expenditures.

Current staff and faculty will be re-directed. Faculty and staff within WWAMI will be redirected to the new School of Health and Medical Professions. Please see the organizational chart under supportive documentation.

In conclusion, the primary beneficiaries, if this request is granted, are the individuals and communities who will be served by future PAs or Nurses, Clinical Psychologists and other graduates of the new School of Health and Medical Professions. Thus, the impact could encompass all of Idaho.



# School of Health and Medical Professions



**Program Resource Requirements.**

- Indicate all resources needed including the planned FTE enrollment, projected revenues, and estimated expenditures for the first **four** fiscal years of
- Include reallocation of existing personnel and resources and anticipated or requested new resources.
- Second and third year estimates should be in constant dollars.
- Amounts should reconcile subsequent pages where budget explanations are provided.
- If the program is contract related, explain the fiscal sources and the year-to-year commitment from the contracting agency(ies) or party(ies).
- Provide an explanation of the fiscal impact of any proposed discontinuance to include impacts to faculty (i.e., salary savings, re-assignments).

**I. PLANNED STUDENT ENROLLMENT**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
A. New enrollments								
B. Shifting enrollments								
<b>Total Enrollment</b>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

**II. REVENUE**

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
1. New Appropriated Funding Request	<u>\$589,200.00</u>	<u>\$100,000.00</u>	<u>\$618,660.00</u>		<u>\$649,593.00</u>		<u>\$682,072.00</u>	
2. Institution Funds	<u>\$457,500.00</u>	<u>\$100,000.00</u>	<u>\$480,375.00</u>		<u>\$504,393.00</u>		<u>\$529,613.00</u>	
3. Federal								
4. New Tuition Revenues from Increased Enrollments								
5. Student Fees								
6. Other (i.e., Gifts)								
<b>Total Revenue</b>	<u>\$1,046,700</u>	<u>\$200,000</u>	<u>\$1,099,035</u>	<u>\$0</u>	<u>\$1,153,986</u>	<u>\$0</u>	<u>\$1,211,685</u>	<u>\$0</u>

***Ongoing is defined as ongoing operating budget for the program which will become part of the base.***

***One-time is defined as one-time funding in a fiscal year and not part of the base.***

### III. EXPENDITURES

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>A. Personnel Costs</b>								
1. FTE	7.0		7.0		7.0		7.0	
2. Faculty								
3. Adjunct Faculty								
4. Graduate/Undergrad Assistants								
5. Research Personnel								
6. Directors/Administrators	695000		729750		766237		804549	
7. Administrative Support Personnel	120000		126000		132300		138915	
8. Fringe Benefits	131700		138285		145199		152459	
9. Other:								
<b>Total Personnel and Costs</b>	<b>\$946,700</b>	<b>\$0</b>	<b>\$994,035</b>	<b>\$0</b>	<b>\$1,043,736</b>	<b>\$0</b>	<b>\$1,095,923</b>	<b>\$0</b>

	<u>FY 25</u>		<u>FY 26</u>		<u>FY 27</u>		<u>FY 28</u>	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>B. Operating Expenditures</b>								
1. Travel	\$20,000.00		\$21,000.00		\$22,050.00		\$23,152.00	
2. Professional Services	\$10,000.00		\$10,500.00		\$11,025.00		\$11,576.00	
3. Other Services								
4. Communications	\$20,000.00		\$21,000.00		\$22,050.00		\$23,152.00	
5. Materials and Supplies	\$40,000.00		\$42,000.00		\$44,100.00		\$46,305.00	

6. Rentals								
7. Materials & Goods for Manufacture & Resale								
8. Miscellaneous	\$10,000.00		\$10,500.00		\$11,025.00		\$11,577.00	
<b>Total Operating Expenditures</b>	<u>\$100,000</u>	<u>\$0</u>	<u>\$105,000</u>	<u>\$0</u>	<u>\$110,250</u>	<u>\$0</u>	<u>\$115,762</u>	<u>\$0</u>

	FY _____		FY _____		FY _____		FY _____	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>C. Capital Outlay</b>								
1. Library Resources								
2. Equipment		\$200,000.00						
<b>Total Capital Outlay</b>	<u>\$0</u>	<u>\$200,000</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

	FY _____		FY _____		FY _____		FY _____	
	On-going	One-time	On-going	One-time	On-going	One-time	On-going	One-time
<b>D. Capital Facilities Construction or Major Renovation</b>								

<b>E. Other Costs</b>								
Utilities								
Maintenance & Repairs								

Other								
<b>Total Other Costs</b>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
<b>TOTAL EXPENDITURES:</b>	<u>\$1,046,700</u>	<u>\$200,000</u>	<u>\$1,099,035</u>	<u>\$0</u>	<u>\$1,153,986</u>	<u>\$0</u>	<u>\$1,211,685</u>	<u>\$0</u>
<b>Net Income (Deficit)</b>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

Budget Notes (specify row and add explanation where needed; e.g., "I.A.,B. FTE is calculated using..."):

D24-D26	Salary costs are split 50/50 between Appropriation and Institutional funds. State supports all fringe benefit
D49	FTE - 3.5 Appropriation / 3.5 Institution
D94	Operating expenditures - these were not included in the budget request to the State of Idaho for FY25, but are necessary to support the Schd
F104	Capital Outlay - Equipment - Computers, components, software (one time)
Note	Inflation of 5% added each FY to salary and expenditures



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### Faculty Staff Handbook (FSH)

Addition  Revision\*  Deletion\*  Interim  Minor Amendment

Policy Number & Title: **FSH 3440 Compensation of Classified Employees**

### Administrative Procedures Manual (APM)

Addition  Revision\*  Deletion\*  Interim  Minor Amendment

Policy Number & Title:

\*Note: If revision or deletion, request original document from [ui-policy@uidaho.edu](mailto:ui-policy@uidaho.edu). All changes must be made using "track changes."

**Policy originator: Brandi Terwilliger, Director of Human Resources**

**Policy sponsor, if different from originator: Brian Foisy, VPFA**

**Reviewed by General Counsel:  Yes  No** Name & Date: Kim Rytter, 12/27/23

**Comprehensive review?  Yes  No**

- 1. Policy/Procedure Statement:** Briefly explain the reason for the proposed change.  
With the establishment of a market-based compensation system, this revision is necessary to replace the previous language which was based on the previous pay grade system. The primary compensation principles remain intact.
- 2. Fiscal Impact:** What fiscal impact, if any, will this change have?  
None
- 3. Related Policies/Procedures:** Describe other UI policies or procedures related or similar to this proposed change, or that will be impacted by it.  
FSH 3260
- 4. Effective Date:** This policy shall be effective on July 1, or January 1, whichever arrives first after final approval (see FSH 1460 H) unless otherwise specified.

3440

COMPENSATION OF ~~CLASSIFIED EMPLOYEES~~ ~~Staff~~ ~~CLASSIFIED~~ STAFF EMPLOYEES

**CONTENTS:**

- A. General ~~p~~Policy
- B. Authority for ~~Establishing establishing Compensation-compensation Policy-policy~~ for UI ~~Classified-classified~~ ~~Employeesemployees~~
- C. Administration of ~~UI-the University of Idaho Compensation-compensation Plan-plan~~ ~~[ed. 7-00]~~
- D. In-Grade Salary ~~Increasesincreases~~
- E. ~~Annual Salary Increases~~
- FE. Compensation for ~~Night-night Workwork~~
- GF. Additional ~~Compensation-for Classified~~ ~~pay for Staff-staff~~ for ~~Secondary-secondary Work-work Assignments~~ ~~assignments~~ ~~[add. 12-04, ren. 7-08]~~
- HG. Questions ~~About-about Salary-salary Equityequity~~
- H. Voluntary salary reductions ~~[ren. 7-08]~~

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**A. GENERAL POLICY:**

A-1. The University of Idaho seeks to provide a high level of responsive service in meeting the needs of students, faculty and staff and the general public. To accomplish this mission, it is the policy of the University of Idaho to provide a total compensation system that attracts and retains employees. Recognizing and rewarding employees for performance in the achievement of service delivery goals and objectives through a market-based salary model is thea foundation of this system. This policy addresses only the salary component of the university's total compensation system as it relates to staff employees; it does not address other components. Other factors that are part of total compensation system such as health insurance and retirement plans are not the subject of this policy.

A-2. Compensation practices should be consistent throughout the university, yet flexible to adapt to specific needs. To this end, employees are compensated from according to a base pay salary structure schedule based on market salary data and weighted factors for 1) education beyond the minimum required for the position, 2) prior experience directly related substantively similar to the position, 3) time -in -service, and 4) time -in -responsibility. Together with market salary data, (These weighted factors produce a target salary. Flexibility is provided through supervisory oversight regarding employee performance and budget constraints. Actual salary may differ from target salary due to performance or budget constraints. that provides pay grades with open ranges.

A-3. The University of Idaho seeks to pay competitive job market average salaries and intends that classified employees with at least satisfactory performance evaluations of "meets/exceeds requirements" should expect to advance according to the base pay salary structure within the salary range for the pay grade assigned to a classification. [rev. 7-03]

A-4. Advancement within the base pay salary structure will be predicated on satisfactory performance performance evaluations of "meets/exceeds requirements" salary range shall be based on performance criteria, as recorded assessed in the annual performance evaluation process, and the ability to achieve the goals and objectives of the particular position. [rev. 7-03]

**B. AUTHORITY FOR ESTABLISHING COMPENSATION POLICY FOR UNIVERSITY OF IDAHO**

**CLASSIFIED EMPLOYEES.** Salary and wage increases for University of Idaho classified employees are made in conformity with state legislation. An annual plan is established by the president in accordance with guidelines issued by the Board of Regents, RGP V.B.1. Initial appointments, promotions, classifications, and pay grades compensation, and other matters related to classified employees, are the responsibility of the president or designee. Oversight of the University of Idaho staff personnel system is within the administrative area of the Division of Finance and Administration, which reports to the financial vice president Vice President for Finance and Administration. [rev. 7-03]

## UI FACULTY-STAFF HANDBOOK

### Chapter III: EMPLOYMENT INFORMATION CONCERNING FACULTY AND STAFF Section 3440: Compensation of Classified Employees

**C. ADMINISTRATION OF THE UNIVERSITY OF IDAHO COMPENSATION PLAN.** The ~~assistant vice president senior for Human Resources (HR) executive~~ is responsible for maintaining the compensation plan for UI classified employees in conformity with Board of Regents' policy. No classified employee is to be paid at a rate that is not within the salary range for the class, except as noted in C-5 below. The current base pay salary structure schedule will be maintained by the HR office. For information on the base pay salary structure, see the APM 50.40 and the Information is available from the HR office of Human Resources website.  ~~(rev. 7-02, 7-03, 12-04, ed. 7-08, 6-09)~~

**C-1.** The classification and pay grade factors of the base pay structure will be maintained through coordination and of classified positions are established by Employment Services in consultation with the department administrator and are subject to the with approval of the dean, director, or vice president. The base pay factors include:

~~a. Market Rate. The market rate is determined from a review of the duties, responsibilities, and qualifications for the position. It is assigned by HR in consultation with the management of the position. Market rates are based on salary data published annually by the Bureau of Labor Statistics (BLS) and the College and University Professional Association (CUPA).~~

~~1. The market rate may include the addition of a discount or premium of the actual average rate when a specific match between the position and market data cannot be found; to create career ladders around a single market rate; or to create a basis for internal equity between similar but different positions. The discount or premium is referred to as "relative value."~~

~~b. Target Compa Ratio (CR%). The target CR% is determined by five factors that, when multiplied by the market rate, will determine an employee's target salary.~~

~~1. Minimum CR%. The minimum CR% for staff positions is 80% of the determined market rate. The minimum CR% may be increased when the salary data indicates that entry level salaries for a specific rate is higher than 80%. Such an increase is reviewable every year.~~

~~2. Education beyond the minimum requirement. When an employee has received an academic degree beyond that which is required an additional 2% will be added to the minimum CR%. This education credit may only be assigned for the first degree beyond the required degree.~~

~~3. Prior Experience. An employee's prior experience prior to the current hire date in the same or substantially similar position as the position currently held will add an additional 1% per year to the minimum CR% though the accumulated total CR% may not exceed 100%.~~

~~4. Time in Service (TIS). Counted from the current hire date maintained in the personnel database, an additional 1% per year will be added to the accumulated target CR% up to 100%. After the 100% total is reached, TIS years will continue to be counted at an additional .5% per year.~~

~~5. Time in Responsibility (TIR). Counted from the date assigned to the position maintained in the personnel database, an additional 1% per year will be added to the accumulated target CR% up to 100%. After the 100% total is reached, TIR years will continue to be counted at an additional .5% per year.~~

~~6. The maximum target CR% is 120%.~~

~~c. Target Salary. The target salary is the result of the application of the above mentioned factors. While the target salary represents the most equitable result of our salary determination process, there is no guarantee that employee's will be paid the target salary. There may be budget limitations or performance factors that prevent us from reaching the target salary. Target salaries will be the primary basis for salary decisions.~~

~~(rev. 7-02, 7-03)~~

**C-2.** The entrance salary for new appointees in any class ~~employees~~ is ordinarily set between the minimum rate and the calculated target salary for the individual employee ~~market~~ for that class. In unusual circumstances, and when supported by acceptable reasons, appointment at a higher rate may be authorized by the respective vice president or

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## UI FACULTY-STAFF HANDBOOK

### Chapter III: EMPLOYMENT INFORMATION CONCERNING FACULTY AND STAFF Section 3440: Compensation of Classified Employees

~~provost, director of employment services and the dean or director. Otherwise, all new appointments are made within the entrance salary range. [rev. 7-02, 7-03]~~

~~C-3. When an employee is reinstated in a previously held position or transferred to another position in the same classification, he or she is generally paid at the same salary. Salary adjustments may be agreed upon by the employee, the department administrator, and the director of employment services. [rev. 7-02, 7-03]~~

~~C-4. The pay grade market rate of a classified position may be changed upon review of the duties and responsibilities of the position. This action may be initiated by Human Resources, the supervisor, or the manager or management team responsible for the work unit by any of the following actions:~~

- ~~a. "Reallocation." A change of an entire class of positions from the current pay grade in the compensation schedule to another pay grade of either higher or lower entrance salary.~~
- ~~b. "Reclassification." A change of a single position from the current class to another class to properly reflect the duties and responsibilities assigned to that position.~~
- ~~c. "Refactoring." A change in the number of Hay Points assigned to a class or position.~~

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~~C-5. When a market rate is decreased for a particular class or position is reallocated or reclassified to a lower pay grade, the salaries of incumbent employees who are being paid at a rate higher than the target salary maximum provided in the new grade will not be reduced as a result of the reallocation or reclassification. However, the salaries of such employees will generally be held constant and not be increased thereafter so long as they exceed that maximum rate target salary. At the discretion of the dean or director respective vice president or provost and in consultation with the assistant vice president senior HR executive for human resources, exemplary performance by such employees may be recognized through a bonus adjustment to salary, effective for one fiscal year only or an increase based on performance. An employee whose position receives a new market rate has been reallocated or reclassified is not required to complete a new six-month probationary period. [rev. 7-02]~~

~~C-6. When a particular class or position is reallocated to a higher pay grade receives an increased market rate resulting in a new target salary, the employee will receive a salary equivalent to or higher than his or her current hourly rate. An employee whose position has been reallocated is not required to complete a new six-month probationary period be considered for a salary increase adjustment. Supervisors must also consider internal equity and funding availability in such cases.~~

~~C-7. When the position of an employee is reclassified to a higher pay grade, the employee will be assigned a salary in the range of the higher grade that provides a salary increase of not less than five percent. Salary increases outside of the annual salary adjustment cycle must have dean or vice president level approval. The reclassified employee is not required to complete a new six-month probationary period. The employee's department unit is responsible for providing the funding necessary for the required requested salary increase. [ed. 7-02, rev. 7-03, 12-04]~~

~~C-8. When an employee applies and is selected for a new position in a higher pay grade, he or she may negotiate the starting pay within the pay grade for the new position [see C-2 above]. Each promoted employee must successfully complete a six-month probationary period in his or her for the new position unless the employee was previously certified in that classification. (For the effect of demotion on salary see 3360 C 4; for the effect on salary of a recommendation for a merit increase in the previously held position, see B-3.) [rev. 7-03, rev. 12-04]~~

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#### **D. IN-GRADE SALARY INCREASES.**

~~D-1. In-grade advancement Salary increases are not a vested right. While employees should expect to advance within their assigned pay range in salary based upon acceptable satisfactory performance and increases in the target salary, advancement is within the discretion of the university. Such advancements are considered as a part of the overall UI budget-setting process and are effective at the beginning of the fiscal year. An employee may advance within the salary range only if certified as meeting the satisfactory service requirements on a written documented~~

**UI FACULTY-STAFF HANDBOOK**  
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Section 3440: Compensation of Classified Employees

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~~performance evaluation on file in HR and approved for the purpose by the president or the president's designee. Normally, an employee receives only one salary increase per year for satisfactory service. [See also 3380 E.]~~

~~D-2. Employees who are in probationary status may be recommended for merit increases at the discretion of the department unit administrator and with the approval of the dean or director; however, merit increases which have been authorized for employees in probationary status are not effective or awarded until the probationary period has been satisfactorily completed. [ed. 7-02]~~

**DE. ANNUAL SALARY INCREASES.** ~~Salary increases are not a right. While employees should expect to advance in salary based upon satisfactory performance and increases in the target salary, advancement is within the discretion of the University. Such advancements are considered as a part of the overall UI budget-setting process and are effective at the beginning of the fiscal year. An employee may advance within the salary range only if certified as meeting the satisfactory service requirements on a documented performance evaluation on file in HR and approved for the purpose by the president or the president's designee. Normally, an employee receives only one salary increase per year for satisfactory performance service. [See also 3380 E.]~~

Changes in employee compensation (CEC) are considered annually by the legislature. Salary adjustments reflecting some or all of the following factors may be approved and implemented in accordance with guidelines for UI classified salary adjustments issued annually by the president:

**DE-1.** Changes in the cost of living;

**DE-2.** Fluctuations in the market cost of different types of labor, which are reflected in ~~payline~~ adjustments ~~reallocating some classifications to different pay grades to the position market rates and employee target salaries;~~

**DE-3.** ~~Equity; and, Changes to target salaries as a result of updated market rates. The use of updated market rates and resulting target salaries;~~

**DE-34.** Merit increases based on individual employee performance as documented by ~~written—the~~ performance evaluation ~~on file in HR and.~~

~~**D-54a.** Classified employees who are in their hiring probationary status may be recommended for merit increases at the discretion of the unit administrator and with the approval of the dean or director. [ed. 7-02].~~

**FE. COMPENSATION FOR NIGHT WORK.** A full-time classified employee whose work schedule requires at least 50 percent of ~~his or her the~~ scheduled working hours during a given pay period to be performed between the hours of 7 p.m. and 4 a.m. is paid an additional shift differential of 5 percent of the employee's hourly rate. ~~The department unit administrator or designee submits an Electronic "Personnel Action Form" to effect the additional payment. [ed. 7-02, 7-03]~~

**GF. ADDITIONAL PAY FOR ~~CLASSIFIED~~ STAFF FOR SECONDARY WORK ASSIGNMENTS.**

**GF-1. Classified staff additional appointments.** ~~A member of the e~~Classified staff must be paid overtime for any work that results in the employee working over 40 hours per week, including a secondary work assignment that is not within ~~his/her the~~ current job description and is outside the scope of ~~his/her the~~ primary appointment and classification. The secondary work assignment must be performed on a temporary basis beyond the regularly scheduled work week, and be limited in scope (for example, if a senior programmer teaches a special course on a one-time basis; or if an administrative support staff provides assistance one weekend with a special research project in another unit or college). Per federal law, ~~the~~ classified employees must be paid at least 1.5 times ~~his or her their~~ regular hourly rate for each hour that is worked over 40 hours per week. The secondary hiring authority may not offer compensatory time in lieu of cash payment of overtime. The secondary hiring authority is responsible for tracking the hours the employee has worked and

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coordinating with the primary hiring authority for processing the employee's pay via a timesheet, in PHAHOOR. If the employee's wage for the secondary work assignment is set at more than time and a half, the employee should be paid via a Temporary Help – PERSI eligible (T)IP appointment. If the employee is less than full time, contact all Employment Services at 885-3638728 for additional information. *[add. 12-04, ren. & ed. 7-08]*

**H**  
**GF.2. – Exempt staff.** The president or designee can authorize payments in addition to regular salary and these must be reported to the regents in a semi-annual report. See RGP II.C.4., RGP II.F.2., RGP II.G.2. Deans and other administrative officers are responsible for ensuring that required approvals have been granted for employees receiving additional compensation for service that is not part of the employee's position description. See the HR website for additional compensation procedures.

**Gf.3. -Staff (Temporarily working at a higher market rate, e—Supervisors may request a temporary salary increase in pay for classified staff, or additional compensation for exempt staff temporarily performing duties at a higher level than their current permanent position. See the HR website for pay at a higher market rate procedures.**

**HGH. QUESTIONS ABOUT SALARY EQUITY.** An employee who believes that his or their compensation is not equitable first should first consult with his or their supervisor, and then with the department-unit administrator and senior HR executive, and/or the director of employment services. In certain situations, the employee also has recourse through the Director of Human Rights, Access and Inclusion Office of Civil Rights and Investigation, the Ombuds-office or to through the grievance procedure for staff employees. [See 3210 A and 3860 A.] *[ed. 7-02, 12-04, 7-08, 6-09, rev. 7-03, ren. 7-08]*

**JH. VOLUNTARY SALARY REDUCTIONS.** As our compensation efforts are pointed toward providing market-based and equitable salary rates, individual requests to reduce one's salary or to reject an increased salary adjustment based on the individual's target salary are discouraged. Reductions for salaries paid at less than 100% of the employee's target salary will not be considered. Should employees whose salaries exceed their target salary request a salary reduction, make such a request, they must provide a clearly stated reason and the reduction must be approved by the President. The approved salary will not fall below 100% of the target salary.

## Version History

**Amended 2024.** Extensively revised to align with current practices.

**Amended July 2021.** Editorial changes.

**Amended July 2009.** Editorial changes to C and H.

**Amended July 2008.** The policy was revised to remove reference to classified exempt no longer used at the university.

**Amended January 2005.** Section G was rewritten to create sections G & H, and H became section I.

**Amended July 2003.** Revised A-3, A-4, B, C, C-1, C-2, C-3, C-7, C-8, and H. Editorial changes to F.

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**Amended July 2002.** Revised C, C-1, C-2, C-3, and C-5. Editorial changes to C-7, D-2, F and H.

**Amended July 1994.**

**Adopted 1979.**

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**Faculty Staff Handbook (FSH)**

Addition  Revision\*  Deletion\*  Interim  Minor Amendment  
Policy Number & Title:

**Administrative Procedures Manual (APM)**

Addition  Revision\*  Deletion\*  Interim  Minor Amendment  
Policy Number & Title: **APM 50.51 Requests for Job Reclassification**

\*Note: If revision or deletion, request original document from [ui-policy@uidaho.edu](mailto:ui-policy@uidaho.edu). All changes must be made using “track changes.”

**Policy originator: Brandi Terwilliger, Director of Human Resources**

**Policy sponsor, if different from originator: Brian Foisy, VPFA**

**Reviewed by General Counsel:  Yes  No** Name & Date: Kim Rytter, 12/28/23

**Comprehensive review?  Yes  No**

1. **Policy/Procedure Statement:** Briefly explain the reason for the proposed change. Information contained in this item is now maintained on the HR website.
  
2. **Fiscal Impact:** What fiscal impact, if any, will this change have?  
None
  
3. **Related Policies/Procedures:** Describe other UI policies or procedures related or similar to this proposed change, or that will be impacted by it.  
  
None
  
4. **Effective Date:** This policy shall be effective on July 1, or January 1, whichever arrives first after final approval (see FSH 1460 H) unless otherwise specified.

## **50.51—Requests for Job Reclassifications**

Last updated November 7, 2006

**A. General.** The classification of a position determines the pay grade to which it is assigned. UI, and other state agencies, follow the Hay System when analyzing the duties of non-faculty positions to determine the classification. Classification decisions are not based on an employee's job performance or on a comparison to the work that other employees perform. At UI, classification reviews are performed in Employment Services in Human Resources (HR). Reclassification decisions may be appealed. Procedures for requesting a reclassification appear in section C-1, procedures for appealing reclassifications appear in C-2.

The reclassification process is for classified (CL) employees only. For exempt (EX) employees, the promotion process found in the Faculty Staff Handbook 3370 should be followed. *[ed. 11-06]*

**B. Process.** The classification analyst will perform a job analysis to determine the appropriate classification at the time the position is established, or subsequently when an approved request is received in HR. Reasons for reclassification may include: a significant change in job responsibilities and tasks either requiring higher level knowledge, skills and abilities (upward reclassification), a significant change in job responsibilities and tasks requiring the same level of knowledge, skills and abilities but a change in title (lateral reclassification), or a significant change in job responsibilities and tasks requiring a lower level knowledge, skills and abilities (downward reclassification. Note: The downward reclassification is not tied to job performance. See APM 50.21 for information regarding demotion of Classified employees.) The employee must be performing the new duties for six months or more prior to the submission of the reclassification paperwork. The division or unit submitting a request for reclassification provides the funds for any necessary salary increase that results from the review. Implementation of reclassifications is normally effective at the beginning of the fiscal year. Departments may implement changes retroactively to the date following the six-month period the incumbent has been performing within the new classification. Classification decisions may be appealed. *[rev. 11-06]*

### **C. Procedure:**

**C-1. Procedure for requesting job reclassification.** The following procedures should be followed in requesting a job reclassification for university employees:

- i) **Obtain Reclassification Packet.** After the employee has been performing the new duties for at least six months, obtain the reclassification packet from the HR website: <http://www.hr.uidaho.edu/default.aspx?pid=5632> or call HR at (208) 885-3611 for directions.
- ii) **Complete Job Description.** Complete a results-oriented job description on the form provided and attach a copy of the previous job description on file, together with an organization chart showing where the position fits in the department or administrative unit. The job description may be sent for review prior to submission of the reclassification, however, additional changes may be requested upon review of the reclassification questionnaire. *[rev. 11-06]*
- iii) **Complete Questionnaire.** Complete the Position Review Reclassification Questionnaire.
- iv) **Obtain Authorizing Signatures and Submit Completed Packet.** Obtain the required signatures of the supervisor, dean or director, and appropriate provost or vice president. Submit to Employment Services the entire packet of material for reclassification evaluation. Materials in this packet should include:
  - a) Proposed new results-oriented job description.
  - b) Copy of the previous job description.
  - c) Organization chart.
  - d) Position Review Reclassification Questionnaire.

e) Completed signature sheet with appropriate sign-offs indicating the source of funds (budget number) from which the upgrade would be funded.

v) **Email Revised Job Description.** E-mail an electronic copy of the new results-oriented job description (see iv. a) to Employment Services at [melissad@uidaho.edu](mailto:melissad@uidaho.edu). [~~ed. 11-06~~]

vi) **Desk Audit.** A classification analyst from Employment Services may conduct a desk audit of the position by meeting in person or over the telephone with the incumbent to review the reclassification questionnaire and job description. The analyst may also meet in person or over the telephone with the supervisor to obtain additional information and confirm concurrence with responses provided by the incumbent.

vii) **Calculation of Hay Points.** A comprehensive analysis of the position is completed and the position is Hay point factored by the analyst to determine job value based on the knowledge, problem solving, accountability and working conditions of the position.

viii) **Written Recommendation.** A written recommendation is sent to the dean or director of the unit with copies to the supervisor, Affirmative Action Coordinator, and incumbent attached for appropriate distribution. [~~ed. 11-06~~]

ix) **Action by Department.** Within 30 days of receiving the reclassification recommendations from Employment Services, the dean or director has the responsibility to take one of the following courses of action. Allowing the employee to continue working out of classification is not an acceptable option.

a) Make the decision to implement the recommendation; or

b) Return the recommendation to the analyst in Employment Services asking which duties should be pulled in order to sustain the current title and pay grade; or

c) Determine which duties should be added to be able to upgrade the position; or

d) Return the recommendations to the analyst in Employment Services to consider a different classification.

Once approval of funds to support the position reclassification is received from the appropriate provost/vice president, the department will need to initiate a Personnel Action Form (EPAF) on the University Banner HR system to start the new rate on the Sunday of a new pay period, and **forward the new signed job description to HR for the incumbent's personnel file.**

## C-2. **Procedure for appealing a reclassification.**

i) **Notice of Appeal.** If after having a follow up meeting with the classification analyst, the supervisor and the employee do not agree with the final classification decision made by HR, then the classification appeal process can be initiated. Appeals of Employment Services classification decisions are submitted directly to the vice president of finance and administration. A *Notice of Appeal* form must be filed with the vice president for finance and administration, with a copy to the Classified Position Appeals Board (CPAB) chair, within thirty calendar days of the date the notice of the Employment Services decision was received by the supervisor and by the affected employee.

ii) **Hearing Schedule.** The vice president for finance and administration will notify the director of Employment Services that a *Notice of Appeal* form has been received and that an advisory opinion is being requested from the CPAB. The vice president will request that Employment Services supply seven copies of available documentation to the CPAB chair within 10 working days. CPAB will schedule a hearing at the earliest time convenient for all parties.

iii) **Hearing.** The director of Employment Services, the classification analyst, the employee, and his or her supervisor will be notified of the date, time, and place of the hearing by the CPAB chair. The hearing will proceed as follows: the analyst from Employment Services will present the basis for the recommendation that was made; the employee or supervisor, or both, will present

reasons for disagreement; the classification analyst will be given time for closing comments as will the employee and the supervisor. The board may ask questions for further clarification after the presentations. The board will then meet in closed session for deliberation and to develop a recommendation to be submitted to the vice president.

iv) **Decision.** The CPAB will forward its recommendation to the vice president for finance and administration. The vice president will review the recommendation, make a decision, and notify the employee, the employee's supervisor, the director of employment services, the classification analyst and the CPAB chair of the final decision.

D. **Information.** Information regarding position classification procedures, requests for reclassifications, and appeals of classifications may be obtained from Human Resources, (208) 885-3611 or [employment@uidaho.edu](mailto:employment@uidaho.edu).





## POLICY COVER SHEET

For instructions on policy creation and change, please see  
<https://www.uidaho.edu/governance/policy>

All policies must be reviewed, approved, and returned by the policy sponsor, with a cover sheet attached, to [ui-policy@uidaho.edu](mailto:ui-policy@uidaho.edu).

### Faculty Staff Handbook (FSH)

Addition  Revision\*  Deletion\*  Interim  Minor Amendment

Policy Number & Title:

### Administrative Procedures Manual (APM)

Addition  Revision\*  Deletion\*  Interim  Minor Amendment

Policy Number & Title: **APM 45.16 SPONSORED PROJECT PAYMENT MANAGEMENT**

\*Note: If revision or deletion, request original document from [ui-policy@uidaho.edu](mailto:ui-policy@uidaho.edu). All changes must be made using "track changes."

**Policy originator:** Sarah Martonick

**Policy sponsor, if different from originator:** Chris Nomura, VPRED

**Reviewed by General Counsel:**  Yes  No Name & Date: Manisha Wilson, 12/29/23

**Comprehensive review?**  Yes  No

- 1. Policy/Procedure Statement:** Briefly explain the reason for the proposed change.  
Rewritten to clarify processes to match Chart V (Banner) updates and to update format.
- 2. Fiscal Impact:** What fiscal impact, if any, will this change have?  
None
- 3. Related Policies/Procedures:** Describe other UI policies or procedures related or similar to this proposed change, or that will be impacted by it.
- 4. Effective Date:** This policy shall be effective on July 1, or January 1, whichever arrives first after final approval (see FSH 1460 H) unless otherwise specified.

## 45.16 -- Sponsored Project Payment Management

**A. Purpose.** To define the general policy for submitting requests to sponsored for payments and the associated internal controls.

**B. Scope.** This policy applies to all sponsored projects where payments must be requested from the sponsor.

### C. Definitions

**C-1. Cost reimbursable.** Any projects whereby the agreement specifies that payment will be made after costs have been incurred as outlined in the agreement's terms and conditions.

**C-2. Scheduled pay.** Any projects where the agreement terms specify that the sponsor will be invoiced or make automatic payments based on scheduled amounts. Such projects may or may not be fixed price.

Unless otherwise specified in a grant or contract agreement, all payments are requested on a cost-reimbursable basis.

### D. Policy

**D-1. Individuals authorized to request sponsored project payment.** The Authorized Organizational Representative (AOR), the supervisor of the OSP Financial Unit, and the employees of that unit are the only individuals authorized to request sponsored project payments on behalf of the university.

**D-2. Timeliness of payment requests.** The following schedule will be used for requesting payments on cost-reimbursable sponsored projects:

- a. **Letters of credit.** Biweekly coinciding with the payroll cycle, and at the end of each calendar quarter.
- b. **Other cost reimbursable.** Monthly or quarterly as per internal policies on minimum billing, or as otherwise delineated by the agreement terms.
- c. **Fixed-price scheduled billing.** The Financial Unit staff will run the Financial Unit Due Date report by event code LS% for the following month and send invoices to the sponsor by the deadline listed in the report. At the end of each month the Financial Unit staff will run the Fixed-Price Setup report and audit for any missed billing. The Financial Unit supervisor will run this report periodically to check for completeness of the billing and inform staff of any missed billing.

**E. Procedure.** To ensure timeliness, accuracy, and allowability of payment requests, the following internal control procedures are to be used:

**E-1. Report of unbilled charges and undistributed cash.** Prior to issuing an invoice a report of unbilled charges and undistributed cash must be run to ensure that the amount of the payment request matches the total of the unbilled charges, net of any prior overpayments.

**E-2. Letter-of-credit drawdowns.** Each letter of credit payment request shall be done by different individuals on a rotating schedule and the draws will be reconciled periodically by the Financial Unit supervisor.

**F. Contact information.** For additional information please contact [osp-billing@uidaho.edu](mailto:osp-billing@uidaho.edu), [osp@uidaho.edu](mailto:osp@uidaho.edu) or 208-885-6651.



## POLICY COVER SHEET

For instructions on policy creation and change, please see <https://sitecore.uidaho.edu/governance/policy>.

All policies must be reviewed, approved, and returned by the policy sponsor, with a cover sheet attached, to [ui-policy@uidaho.edu](mailto:ui-policy@uidaho.edu).

**Faculty Staff Handbook (FSH)**

Addition  Revision\*  Deletion\*  Emergency  Minor Amendment  
Policy Number & Title:

**Administrative Procedures Manual (APM)**

Addition  Revision\*  Deletion\*  Emergency  Minor Amendment  
Policy Number & Title: **APM 45.17 FIXED-PRICE SPONSORED PROJECTS**

\*Note: If revision or deletion, request original document from [ui-policy@uidaho.edu](mailto:ui-policy@uidaho.edu). All changes must be made using “track changes.”

**Originator: Sarah Martonick**

**Policy Sponsor, if different from Originator: Chris Nomura, VPRED**

**Reviewed by General Counsel**     Yes  No                      Name & Date: Manisha Wilson,  
12/29/23

1.    **Policy/Procedure Statement:** Briefly explain the reason for the proposed addition, revision, and/or deletion.  
Updating for current processes in Chart V as well as new CFR regulations governing fixed-price sponsored funding.
2.    **Fiscal Impact:** What fiscal impact, if any, will this addition, revision, or deletion have?  
  
None- no change to how fixed-price agreements are processed.
3.    **Related Policies/Procedures:** Describe other UI policies or procedures related or similar to this proposed change, or that will be impacted by it.  
  
None – only updating for current systems and regulations.
4.    **Effective Date:** This policy shall be effective on July 1, or January 1, whichever arrives first after final approval (see FSH 1460 D) unless otherwise specified in the policy.

## 45.17 Fixed-Price ~~Contracts/Grants~~Sponsored Projects

~~Created April 11, 2008~~

**A. Purpose.** This document states University policy on, and provides associated procedures for, the actions to be taken upon the completion of externally funded fixed-price ~~contracts/grants~~sponsored projects, especially when such ~~contracts/grants~~sponsored projects are concluded with a residual cash balance.

**B. Scope.** This policy applies to all fixed-price sponsored projects.

### **CB. Definitions:**

**CB-1. Fixed-pPrice ~~Contract/Grant~~Sponsored Pproject.** A fixed-price ~~contract/grants~~sponsored project (also known as a firm-fixed-price, firm-price, ~~or fee-for-service~~fixed-price contract/grant) requires a recipient to perform the work necessary to produce deliverables (i.e., services or property) as specified in the ~~contract/grant~~agreement for an established dollar amount and, usually, withinby a defined time frame. Under such an ~~agreement~~-~~contract/grant~~, the fundingprice is not subject to adjustment on the basis of the recipient's actual expenditures ~~cost~~-~~experience~~ in performing the ~~contract/grants~~sponsored project, and-payment for performance of the ~~contract/grants~~sponsored project remains constant despite the actual costs associated with the work ~~that might be~~ required to fulfill the terms of the ~~contract/grant~~agreement, including any overages or underages.

**CB-2. Residual fFunds.** Residual funds are the monies remaining at the completion of a ~~fixed-price sponsored~~ project-~~contract/grant~~, after all costs incurred in performing the work and fulfilling the deliverables in the agreement ~~contract/grant~~ have been paid and all ~~external funding has~~payments have been received.

**CB-3. Significant rResidual fFund bBalance (or sSignificant bBalance).** A significant residual fund balance is defined by the University as residual funds equal to or greater than ~~ten (10) percent~~ 10% of the total ~~contract/grants~~sponsored project price.

### **DC. ~~REQUIREMENTS OF FIXED-PRICE CONTRACTS/GRANTS~~Policy:**

**DC-1. ~~When to use a fFixed-pPrice Contract/Grant~~agreement.** ~~The~~A fixed-price ~~contract/grant~~agreement mechanism offers benefits to both project sponsors and Principal Investigators (PIs). Because the final cost of a product or service provided under a fixed-price ~~contract/grants~~sponsored project is established and accepted prior to the performance of the ~~contract/grants~~sponsored project, a project sponsor is relieved of the risk that its cost for the deliverable(s) identified in the ~~contract/grant~~agreement may exceed its expectations and budget. ~~Principal Investigators~~PIs, as recipients of a fixed-price ~~contract/grants~~sponsored project, perform under a minimal administrative burden, which is delimited primarily by the periodic reporting on progress toward any defined benchmarks. In most circumstances, if the costs incurred to complete the project are less than the price paid by the sponsor for the performance of the ~~contract/grant, agreement,~~ the recipient institution retains the difference. In cases where a sponsor imposes a restriction on residual funds, the University will be obligated to comply with the terms and conditions in the fixed-price agreement.

### **ED-2. ~~Considerations for aAll fFixed-pPrice Contracts/Grants-sSponsored pProjects~~**

**a. Compensation.** The University must ensure that it is properly compensated for all allowable direct and indirect costs incurred under a fixed-price

~~contract/grant agreement~~, but due to the University's status as a non-profit entity it must-should also avoid generating a residual balance. Entering into a fixed-price ~~contract/grant agreement~~ for deliverables intended for the direct benefit or use of the sponsor may also make the University appear to have an unfair competitive advantage over for-profit businesses providing the same or a similar product or service at a higher cost.

**b. Unrelated Business Income Tax (UBIT) ~~r~~Review.** ~~+~~ -If the University receives funds for work that is regularly undertaken for the benefit of a sponsor and that is not consistent with the research, education, other sponsored activity, instruction, or public service missions of the University as a non-profit institution, the Internal Revenue Service may declare these funds to be unrelated trade or business income and, therefore, subject to unrelated business income tax. ~~The~~ Office of Sponsored Programs (OSP) shall consult with Business and Accounting Services regarding any agreement that has UBIT potential.

**c. Federal ~~r~~Requirements.** ~~+~~ -The University must ensure observance of the terms and conditions of the ~~contracts/grants sponsored projects;~~ must adhere to and consistently apply established cost principles and accounting standards; ~~and~~ must fulfill its obligations under federal and state compliance and audit regulations. ~~(2 CFR Part 200 Subpart E – Cost Principles and 2 CFR Part 200 Subpart F – Audit Requirements.) (See OMB Circular A-21).~~ Among the laws that inform University contracting policy is the Anti-Kickback Act of 1986. Consistent with this statute, the University prohibits any employee from soliciting, accepting, or attempting to accept a kickback—money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, for the purpose of improperly obtaining or rewarding favorable treatment in relation to a sponsored project contract/grant involving federal funds. ~~(See Anti-Kickback Act of 1986).~~

Compensation principles established by the federal government require that salary on sponsored programs be expressed in relation to the entirety of an individual's professional effort. ~~(2 CFR 200.430.) (See OMB Circular A-21).~~ The University demonstrates its conformance to these compensation principles, ensuring that compensation for sponsored programs accurately reflects the effort expended, by requiring the periodic verification of effort for ~~anyone~~ all non-temporary help employees with salary directly charged or cost shared to externally funded sponsored programs. ~~(See APM 45.09, Effort Commitment and Reporting).~~ The University, therefore, requires that faculty or staff report effort on a fixed-price ~~contract/grants sponsored project;~~ when if they have salary charged or committed as cost sharing to it. If no salary is charged or cost shared to the fixed-price ~~contract/grants sponsored project,~~ the effort put toward the performance the ~~grant/contracts sponsored project must be included in the report, as is voluntary uncommitted cost sharing, in as part of the calculation of~~ the total activities in which an employee has engaged in (and is compensated for) as part of ~~his or her~~ their University university appointment.

**d. Tracking of ~~e~~Expenditures.** ~~+~~ -The University must document project expenditures under a fixed-price ~~contract/grants sponsored project~~ in order to show that sponsor funds have been used as specified by the ~~contract/grant agreement~~ and that costs are fully and properly expensed. If unable to adequately demonstrate during the course of an audit that sponsor funds were used in the manner allowed by the ~~contract/grant agreement~~ and applicable policies and regulations, project costs may be disallowed and the University required to return them to the sponsor. Repeated audit findings related to fixed-price

~~contracts/grants sponsored projects~~ may compromise the ability of the University to enter into these agreements with state and federal agencies.

## **ED. Review and Approval of Fixed-Price Contracts/grants Procedure**

**E-1. Pre-aAward rReview and aApproval.** All ~~contract/grants sponsored project~~ proposals, including proposals for fixed-price ~~contracts/grants sponsored projects~~, must be presented by the Principal Investigator to the Office of Sponsored Programs for review of the proposal materials, terms and conditions, and assessment of the proposed project budget and scope of work prior to submission to the sponsor. The project budget should take into account all direct and indirect costs associated with the performance of the project and should include sufficient detail to make accurate accounting practicable. The ~~contract/grant agreement~~ must be approved and signed by the individual with signature authority for such documents ~~under APM Section 60.20~~.

**E-2. Closeout of Fixed-Price Agreements- Closeout of fixed-price agreements.** Upon completion of the work to be performed under a fixed-price contract/grant, the ~~Principal Investigator PI~~ must provide the following information to the Office of Sponsored Programs:

- Substantiation that all work required under the contract/grant has been completed
- Confirmation that no outstanding expense items remain open or in question with the sponsor and that all allocable and allowable costs have been charged to the project funding
- Certification that all required deliverables and reports have been provided to and accepted by the sponsor

The final account balance will be determined only after the final payment from the sponsor has been received, all salaries and outstanding invoices have been paid, and all F&A costs have been recovered by the University.

**E-3F. Contract/grant cCloseout with rResidual fFunds.** In the event that the ~~Principal Investigator PI~~ completes the required work for less than the ~~contract/grant agreement~~ price, the ~~Principal Investigator PI~~ may request that the project account be closed and ~~that~~ the residual funds be distributed to the College or non-academic unit in which ~~she or he the PI~~ is a faculty member. These residual funds are considered deferred revenue of the University, and F&A costs and unrelated business income tax (if applicable) will be assessed against them prior to their distribution. ~~The remaining funds will then be disbursed in accordance with the University procedure for the distribution of earned F&A.~~ The sponsored project account will be closed only after the transfer of the residual funds. A College-unit receiving such funds may use them for any permissible use in support of the research, education, or public service missions of the University.

If there is significant residual fund balance, at the completion of work for the contract/grants sponsored project (i.e., an amount greater than or equal to ~~ten (10) percent~~ 10% of the ~~contract/grants sponsored project~~ price), ~~at the completion of work for the contract/grant~~, the ~~Principal Investigator PI~~ must provide a written explanation for the substantial discrepancy between the ~~cost expenses needed~~ to perform the ~~contract/grants sponsored project~~ and the costing that led to the contract/grants sponsored project price. This explanation should be supplied by the ~~Principal Investigator PI~~ to the Office of Sponsored Programs, which will use it along with the information that the ~~Principal Investigator PI~~ is required to provide upon closeout of the agreement (section under E. Closeout of Fixed-Price Agreements E-2) as the basis for an audit of the project.

Residual funds will be distributed to the college or non-academic unit College of the Principal Investigator PI upon the satisfactory conclusion of the audit and by per the distribution allocation as approved of the Vice President for Research, ~~or the Vice President for Research~~ or their designee.