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Establishing a Structured Mentorship Program for Novice Advanced Practice Registered Nurses in the Veterans Health Care System

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ESTABLISHING A STRUCTURED MENTORSHIP PROGRAM FOR NOVICE ADVANCED PRACTICE REGISTERED NURSES IN THE VETERANS HEALTH CARE SYSTEM

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Abstract

Background. Mentorship is an age-old strategy still widely sought after to increase integration into the workforce. Employers of new APRNs must be aware that newly graduated APRNs are inexperienced. To maximize the employers' investment, training on proper integration should be a high priority. This Doctor of Nursing Practice (DNP) project addressed this quality improvement issue through the implementation of a structured mentorship program to improve the overall transitioning of newly hired APRNs in the Veterans Health Care System (VHCS). ***Problem.*** The VHCS lacks a formalized, structured mentorship program for newly graduated APRNs entering the VA System. ***Intervention.*** Seven APRN mentors and 10 newly hired APRN mentees in their first 8 to 10 weeks of employment were identified for the APRN mentorship program. The participants met monthly face to face and weekly by email. Monthly goals, objectives, strengths, and weaknesses were identified. Project objectives were: 1) All NPs within the VHCS who met mentor criteria would be identified, 2) Fifty percent of identified NPs would be recruited as mentors, 3) All newly hired NPs would be assigned a mentor, 4) All mentor-mentee pairs would establish at least one short-term goal with objectives, 5) Eighty percent of mentees would meet short-term goal, and 6) Fifty percent of mentor-mentee pairs would establish a second short-term goal. The Mentor Competency Assessment (MCA) and the Centers of Excellence in Primary Care Education (CoEPCE) were used to measure progress. ***Results.*** Mentor Competency Assessment scores increased from a median value of 5.88 (moderately skilled) in May to 6.65 (extremely skilled) in July. Composite scores from the Centers of Excellence in Primary Care Education (CoEPCE) assessment improved during the study period, increasing from a mean value of 275.5 in May to 327.1 in July. Mentees' self-reported satisfaction scores increased from a mean of 4.44 in May to 4.94 in July. ***Implications for***

***Practice*.** This quality improvement initiative provides a promising basis for improving the transition of newly hired APRNs in the VHCS, thereby improving overall retention of these providers.

Keywords: mentor, mentee, mentorship, APRN, transition

Establishing a Structured Mentorship Program for Novice Advanced Practice Registered Nurses in the Veterans Health Care System

The role of a registered nurse (RN) has expanded throughout many arenas of the nursing profession. RNs have directly and indirectly influenced health care by having the flexibility to adapt and evolve to meet the needs of the health care industry. More than 270,000 advanced practice registered nurses (APRNs) are licensed to practice in the United States, and nearly 30,000 graduate annually (American Association of Nurse Practitioners [AANP], 2019). APRNs help to significantly address the shortage of primary care providers (PCPs) and the critically low numbers of providers in some specialties in the United States. Although this contribution is presumed to be an excellent opportunity for RNs, it has major internal flaws. One of the flaws that has been recognized and highlighted is the challenge associated with the transitioning of the RN to the APRN role (Barnes, 2015). Transition is defined as a process of changing from one state or condition to another (Oxford University Press, 2012). As health systems aim to ensure optimal patient outcomes, professional satisfaction, and provider retention, the transition of the RN to the APRN role needs attention from organizations that employ APRNs.

Transitioning from the RN to the APRN role can be stressful for new APRNs with varying amounts of experience and a lack of formal orientation tailored to clinical requirements (Barnes, 2015). A poor transitioning process from RN to APRN has led to fatigue and burnout, causing many nurses to leave the profession (Dyrbye et al., 2019). Also, according to Dyrbye et al. (2019), the burnout of APRNs is common and typically due to sympathy exhaustion, physical or passionate weariness, stress, and depersonalization. Additionally, Dyrbye and colleagues found that of the nurse practitioners (NPs) and physician assistants (PAs) surveyed in their study, those who scored as having a low mental quality of life (QOL), also had extreme fatigue, recent

suicidal ideation, or burnout, and had less favorable Well-Being Index Scores (Dyrbye et al., 2019).

In Hart and Bowen's (2016) study of new NPs in which the researchers assessed perceptions of preparedness for the transition into practice, the researchers showed that some APRNs felt ill prepared in mental health management, medical coding, billing, EKG and X-ray interpretation, and office procedures. Employers of new APRNs must be cognizant that newly graduated APRNs are inexperienced, and in order to maximize the employers' investment (i.e., professional development, enhancing organization culture, improving organizational communication), proper integration training should be a high priority. In return, integration training will better promote well-informed diagnoses while improving patient outcomes through greater transparency. Also, employment training strategies for APRNs, such as mentorship, have the potential to set practical expectations that will limit or reduce the anxiety of RNs transitioning into their new roles as APRNs.

Mentoring is defined as a nurturing process with the aim of promoting professional and personal development, in which a more skilled and experienced person, acting as a role model, teaches, encourages, counsels, and befriends a novice (Anderson & Shannon, 1988). Mentorship is an age-old strategy still widely sought after to increase overall integration into the workforce. However, unfortunately, this strategy is not routinely used in nursing. For example, in most cases, APRN training involves graduate programs and employment orientation but little more, if anything. Importantly, APRN mentorship bridges gaps between graduate programs, new-hire orientation, and the transition into practice.

The evidence is clear that mentorship programs have been successful in assimilating new-hire nurses into their roles and responsibilities and have resulted in positive patient outcomes.

Gazaway et al. (2019) explored the impact of the mentorship process on beginner clinical nurse leaders (CNL). The research results included that various mentors should be used to develop the clinical competencies of nurse leaders. The novice CNLs in the study described the importance of various mentors throughout their focus on patient care. In addition, this focus motivated them to become competent clinicians. This Doctor of Nursing Practice (DNP) project will attempt to address the issue of mentoring by researching, planning, and implementing a mentorship program to improve the transition for newly hired APRNs in a Veterans health care system in Central Texas.

Statement of the Problem

Background and Significance

The transition into practice for a novice APRN can be extremely challenging without a dedicated mentorship program to support the growth of the APRN. According to the Academy of Medical-Surgical Nurses (AMSN, 2012), mentoring is a shared and cooperative learning connection between a mentor and mentee but may also include various mentors along the novice's professional journey to obtain expert status. Both the novice and the expert bond over mutual goals to further the learning outcomes and strengthen the process for a successful transition. Furthermore, the AMSN (2012) states that mentoring can guide nurses in their professional, personal, and interpersonal growth.

Twine (2017), in a review of the NP transition experience, documented factors that influence the overall transition to practice. These factors include role transition, perception of NP preparedness, and perceived challenges. Twine also identified that many times when an APRN novice assumes a new professional role, the person might not be fully prepared to assume a primary care provider (PCP) role without mentorship (Twine, 2017).

The results of a study by Rugen et al. (2018) provided a foundation to assess the new NP's feelings about and perceptions of their level of competency and included findings that support the need for an additional onboarding for novice NPs to promote independent practice. Such a mentorship program will soon be available throughout the Veterans Affairs Centers of Excellence in Primary Care Education (VA CoEPCE). Currently, the Veterans Health Care System (VHCS) that is the focus of this project lacks a formalized, structured mentorship program for novice APRNs within Veterans Affairs (VA).

The requirement for APRNs to practice as independent PCPs is vital to supporting and extending health care services within the VHCS. Mentorship can encourage APRNs to expand their hierarchical responsibility in primary care. Although mentorship has been examined as a system to advance the hierarchical responsibilities of nursing personnel, no studies or projects have been identified that examine the effect of APRN mentorships in a primary care environment.

Assessment

For nearly 30 years, Dr. William Bridges (1991), a renowned change and transition expert, has discussed the difference between change and transition from an organizational perspective. His information continues to be implemented either as an organizational approach or as a self-improvement strategy for professionals seeking a better understanding of change and transition. Bridges broadened the understanding of change and transition by simply implying that it isn't the changes that do you in, it's the transitions (Bridges, 1991). The transition from the RN role to the APRN role can be awkward and overwhelming. This transition is a dynamic change for APRNs, as they begin to shed their previous role as RNs.

A mentorship program is a facilitating approach that promotes successful transitions for

the APRNs and is a critical component for them to fully grow into their new roles, responsibilities, and professional environment. A structured and detailed mentorship program is an asset for a health care institution and its health care providers to produce special bonds through growth while creating greater autonomy in the workplace (Vatan, 2016). Moreover, the VHCS exemplifies a health care establishment in need of an APRN mentorship program to provide greater nurturing for APRNs, a close relationship between mentees and mentors, and a professional environment in which to grow.

The target VHCS is a multifaceted, Joint Commission–licensed, Level 1-A health care system serving veterans in 39 districts in Central Texas. The VHCS has two medical centers situated in Temple and Waco; an independent multispecialty facility in Austin; five network-based outpatient facilities in Brownwood, Cedar Park, College Station, Palestine, and La Grange; two community-living centers situated in Temple and Waco; a domiciliary in Temple; a rehabilitation unit for the blind in Waco (one of just 12 in the country); rehabilitation units in Waco for the treatment of posttraumatic stress disorder and for life enhancement for the seriously mentally ill; a 40-bed psychosocial residential rehabilitation treatment program in Waco (the only one in Texas); and a private 8-bed women's trauma rehabilitation unit (one of just four in the country; U.S. Department of Veterans Affairs, 2019).

Throughout this VHCS, a total of 82 APRNs work in primary care and specialty clinics. APRNs are listed under the medical department just as physicians are, not under the nursing department. Also, APRNs are not under the direction of a specific doctor or nursing executive. However, who APRNs are accountable to depends on the area to which they are assigned—the primary care clinic or specialty clinic. Furthermore, little oversight exists regarding APRN proficiency, continuing education, or reprimand, and the only supervision for APRNs are their

assigned departments and the VHCS human resources department.

A decade ago, there were approximately 20 to 30 APRNs employed at the VHCS. Today, newly hired APRNs continue to enter into the VHCS, but many also exit from the system.

However, the human resources department has little data on how many APRNs leave and why. In the past, no one was assigned to track the numbers of APRNs hired as well as those resigning (or being terminated) from the VHCS. In addition, no substantial reasons have been recorded for why APRNs have chosen the VHCS or why they have resigned or have been terminated.

Organization's Readiness for Change

In May 2019, a small committee of master's degree–prepared nurses and APRNs proposed an NP residency coupled with mentorship to provide a well-rounded clinical assimilation process. Another goal of the proposed mentorship program was to assess new APRNs' perceptions of preparedness and readiness to transition into practice. A VHCS mentorship program has been in place since 2016, but APRN mentees have not been receptive to the program. Seven APRN mentors were enrolled in the initial mentorship program before this project, but no mentees registered for the program even though the program was visible on the VA Pulse website (https://www.vapulse.va.gov), the VA's employee social media website.

The VHCS has demonstrated a sustained commitment to the development of nurses at all levels of their careers. As a learning organization, the VHCS strives to maintain strong relationships with its academic partners to ensure a successful transition into practice.

Historically, the VHCS has embraced the role of the APRN but has had difficulty recruiting and integrating NPs into the primary care clinics. NPs hired into primary care practice areas generally have been new graduates, or they have had limited experience with the veteran

population. Several RN staff members in the VHCS are currently pursuing advanced degrees in NP programs. Many are receiving VA scholarships and have an intent-to-hire agreement with the VA to work as NPs within the system upon graduation.

The key VHCS stakeholders throughout this mentorship program project are target VHCS, APRNs, patients, physicians, nursing administration, and coordinators of APRN educational programs. Administration and nursing leaders place great emphasis on APRNs being able to assume the pertinent roles of health care provider and leader in primary care or specialty clinics. However, newly hired VHCS APRNs face many obstacles that impede their ability to function at their full capacity.

Project Identification

Purpose

The purpose of this DNP project is to establish a formalized, structured mentorship program for newly hired APRNS entering the Central Texas Veterans Health Care System. It is anticipated that mentee participation in the mentorship program will increase by 100% and that 80% of mentees will establish and meet monthly short-term goals while participating in the program.

Objectives

The objectives for this program are the following:

Objective 1: All (100%) NPs at the VA who meet mentor criteria will be identified.

Objective 2: At least 50% of identified NPs will be recruited as mentors.

Objective 3: All (100%) newly hired NPs will be assigned a mentor.

Objective 4: All (100%) mentor-mentee pairs will establish at least one short-term goal with objectives to improve practice using the provided worksheet.

Objective 5: At least 80% of mentees will meet the objectives of their established short-term goal within the identified time frame.

Objective 6: At least 50% of mentor-mentee pairs will establish their second short-term goal after the first one has been reached.

Anticipated Outcomes

A well-developed mentorship program is among the best evidence-based practices that can influence the APRN profession and promote good patient outcomes. During the orientation phase, the new hires received informative lectures and initial surveys to discuss their potential barriers to participating in the mentorship program. Moreover, mentors and mentees were able to address both short-term and long-term outcomes for a successful transition.

Short-Term Outcomes

1. NPs with mentors will have someone to ask questions.
2. NPs who participate in the mentor program will have a smoother transition into the VHCS than previous APRNs who struggled to acclimate to their new role.
3. NPs participating in the program will acclimate to the VHCS smoothly.

Long-Term Outcomes

1. NPs who participate in the mentor program will provide better patient care.
2. Patients of NPs who participate in the program will have better health outcomes.
3. NPs will choose to stay within the VHCS.

Summary and Strength of the Evidence

According to Faraz (2017), the imminent APRN workforce is confronting a vast and developing lack of PCPs. By 2030, it was projected that there would be a deficit of 20,400 PCPs,

accompanied by an 81% increase in demand for PCPs (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2013). Various studies have revealed that residency and training programs in addition to mentorships for APRNs facilitate a smoother transition into the APRN role with less provider burnout/fatigue (Barnes, 2015; Hart & Bowen, 2016; Patterson et al., 2019; Robeano et al., 2019). Health care facilities looking to invest in APRNs as a primary care resource will need to use standardized onboarding coupled with standardized orientation and interprofessional mentorship to groom novice APRNs for their new roles (Faraz, 2017; Rugen et al., 2018). Robeano et al. (2019) discussed the facilitation of the novice APRN's movement to independent practice through transitional support. The interventional approach of onboarding was used in this research. The onboarding process for APRNs was observed in five distinct phases: (a) offer acceptance, (b) pre-arrival, (c) first 30 days after start, (d) beyond 30 days, and (e) end of the first year.

In a study of the primary care NP residency and NP perceptions of competency development during a yearlong immersion in primary care, the VA found significant improvement as demonstrated in APRNs' self-rating of their overall performance in the competency domains and ratings of their mentors (Rugen et al., 2018). By the end of the 12 months, APRN mentors rated mentees as able to practice without direction. All of the competency domains were rated high and included such domains as shared decision-making and sustained relationships during the 12 months (Rugen et al., 2018).

In a Department of Veterans Affairs initiative involving the five VA CoEPCE locations, personnel are exploring options to improve overall structure, integrity, and educational models that foster the transformation of health care training (Rugen et al., 2018). From 2012 through 2015, the VA CoEPCE established APRN residency programs across the five centers; 38 NPs

participated in the standardized program (Rugen et al., 2018). Rugen et al. (2018) evaluated NP residents' self-perceived areas of strength, need for improvement, goals, opportunities, and obstacles in the first year as they transitioned to independent practice. Upon completion of the residency, NPs involved in the program reported strengths in patient-centered care and interprofessional teamwork.

Mentorship studies have been applied to multiple skill sets in nursing. Gazaway et al. (2019) explored the influence of mentoring relationships on novice CNLs within the first year. The study used quantitative and qualitative methods in order to assess the outcomes of seven CNLs. The authors discussed the impact of multiple mentors on the novice CNLs. Furthermore, the mentorships contributed to the new CNLs' increase in confidence, comfort, and competence with nursing skills while transitioning into a new role (Gazaway et al., 2019).

A web-based survey on the transition of NPs into clinical practice was conducted by Hart and Bowen (2016), and it consisted of 81 multiple-choice items, nearly 30 demographic items, and six open-ended questions. The survey spanned a total of 5 years and addressed NPs' perceptions of preparation for clinical practice and transition into practice. A total of 698 NPs completed the survey, and they were predominately women approximately 40 years of age. The results reflected the NPs who felt they were most and least prepared to practice. Most of the NPs lacked formal mentors, but participants agreed that mentoring and a formal orientation were essential to a successful transition for new NPs (Hart & Bowen, 2016).

Fleming et al. (2013) investigated psychometric properties regarding mentors and mentees participating in a trial of a mentoring curriculum. The sample size consisted of 283 mentors and mentees from 16 universities. It was concluded that the Mentoring Competency Assessment (MCA) tool supports the evaluation of research mentors. Also, the reliability and

validity of the MCA tool were confirmed as they relate to the primary mentor; the research also showed that the tool works with multiple mentors (Fleming et al., 2013).

Method

Project Intervention

During the past 4 years, the VHCS has shown readiness to address the concerns related to APRNs' lag in transitioning into practice. One of its initiatives is the approval of the APRNs' shared governance committee and the mentorship program. The mentorship program's intended purpose is to guide novice APRNs through a smoother transition to practice (Benner, 1984). The program is modeled on Benner's (1984) novice-to-expert conceptual model. The VHCS goal is patient-centered care, and in order to meet that goal, it is important to ensure that providers are appropriately trained.

Dr. Patricia Benner (1984) encourages educators to be aware of the student's level of proficiency to support advancements and improvements in their knowledge and skills. Knowledge gained is used to build and expand new knowledge, as is consistent with the concept of constructivism. In constructivism, learning is viewed as the building of knowledge in order to make sense and meaning from experiences (Benner, 1984). For example, novice APRNs are more task driven because of their limited understanding of the profession and clinical competency. In contrast, proficient and expert APRNs have mastered an understanding of the profession and clinical competency through their experiences at a higher level of critical thinking and intuitive skills. Novice APRNs see the burden of the task, whereas experts anticipate the impending health concerns and put action into place. Although Benner advises that it often takes about 5 years to move from novice to expert, some learners get stuck at the lower stages.

For the current project, the first step in preparation for the mentorship program intervention was meeting with the APRN shared governance council to initiate the intervention timeline. The APRN shared governance council addresses specific issues surrounding APRN practice and employment in addition to promoting standards of APRN practice. During this meeting, the presentation included an overview of the VHCS mentorship program booklet (Appendix A) with instructions and tools. Several tools inside the workbook, such as the MCA tool, information about the Centers of Excellence in Primary Care Education (CoEPCE) evaluation tool, and the mentoring program satisfaction survey were used to assist in rating the effectiveness and satisfaction regarding the mentorship program.

The second step of preparation was to identify APRNs with 4 or more years of experience in the VHCS. Barnes (2015) suggests that there is little relevance of the RN experience when transitioning from RN to an APRN due the difference in the roles. APRNs with continuous experience over 4 years without a break in practice are typically competent or proficient in their roles (Benner, 1984).

In the third step of the preparation, all potential mentors were to be contacted via an email asking them to sign up to be a mentor through the VHCS's SharePoint. This approach was taken because the VHCS is a large, complex health care system serving veterans in 39 districts throughout Central Texas. APRNs are also widespread throughout these facilities. In order to maximize the mentorship program, it was determined that this strategy would be better to serve all APRNs within the 39 districts.

In step four, the recruited mentors completed a self-assessment on clinical practice strengths and weaknesses. Although APRNs are licensed and credentialed, they may not have

been practicing in family medicine or in the specialty clinics where the new APRNs have been hired. The identified strengths and weaknesses of the mentors assisted with pairing mentors and mentees. These questionnaires are located inside the VHCS mentorship program booklet (see Appendix A).

Lastly, a 90-minute, interactive group in-service titled “Paying It Forward” was also conducted. It discussed the benefits of mentorship programs, the role of the mentor, the role of the mentee, how mentors lessen the burden of transition to practice, and how patient outcomes are improved with mentorships. The in-service began with a public service announcement (PSA) video advertising mentorship. A PowerPoint presentation was then used for the remainder of the session and was delivered in an open format to solicit questions regarding the mentorship program. The content of the PowerPoint presentation addressed Dr. Benner’s (1984) clinical competence theories on the levels of expertise: novice, advanced beginner, competent, proficient, and expert.

Intervention

The primary intervention was to develop and establish a formalized, structured mentorship program for NPs entering the VHCS that will improve the transition to practice, increase confidence, and promote patient outcomes with well-informed diagnoses. The interventions for this DNP project were the following:

1. VHCS NPs with at least 4 years of NP experience in the VA system were identified from the roster of NPs to invite to be mentors.
2. An email was sent to all identified potential mentors through the VA Pulse system to invite them to sign up to be a mentor.
3. All potential NP mentors who responded to the invitation completed a self-assessment on

clinical practice strengths and weaknesses.

4. All newly hired NPs completed a self-assessment to identify their perceived strengths and weaknesses (see Appendix A).
5. After reviewing the self-assessments, the Chief NP matched pairs based on attributes such as age, years of experience, gender, and ethnicity.
6. Mentor and mentee pairs met and established one or two realistic, measurable short- term goals, using the CoEPCE form provided (see Appendix A), that could be accomplished within 1 to 2 months. They emailed the form to the project coordinator.
7. The mentor and mentee pairs scheduled meetings no less than monthly and were to touch base weekly.
8. The project coordinator periodically checked in with the pairs to assess their progress toward meeting the established goal(s).
9. The mentor and mentee pairs evaluated the goal and objectives at the end of the established time frame and completed the goal form (see Appendix A).
10. The mentor emailed the completed goal form to the project coordinator.
11. The completed goal form was filed in the mentee's education file.
12. The mentor and mentee pairs then established their next short-term goal.
13. Satisfaction questionnaires were completed quarterly by mentor and mentee (see Appendix B).

Timing of Interventions

The VHCS allocated positions for eight new APRNs who started orientation in May and June 2020. These new hires were automatically enrolled in the new mentorship program. The administration and nursing leadership place great emphasis on ensuring that newly hired APRNs

have a smooth transition into practice to assume the pertinent role as PCPs or specialty providers.

Implementation Plan

Implementation was initiated during the new hire orientation. APRNs attending this orientation received an in-service about the mentorship program and were given a full explanation of requirements and incentives. The mentees completed a survey related to their perceptions of transition to practice, preconceived barriers to mentorship, and how the APRNs would like to influence patient outcomes before and during the mentorship program. Next, the newly hired APRNs were paired with a mentor who had expressed interest on the VA Pulse/Shared Point website. VA Pulse, which is an internal social media platform similar to current sites such as Facebook, Instagram, and LinkedIn, had the biographies of the mentors, which included the APRN mentor's education, work location, personal hobbies, previous projects, and contact information. Some of the information on the VA Pulse profile was already available for mentees to read to become familiar with the backgrounds of the mentors, such as their definition of leadership, mentoring style, their professional passions, and a valuable life lesson they have carried forward.

Planned Changes

The DNP project will assist the VHCS by increasing participation and enrollment of APRN mentees and mentors, by improving patient outcomes, and by addressing novice APRNs' perceptions of their transition to practice. The first change to accomplish this was to use the new-hire orientation as a time to recruit newly hired APRNs for the mentorship program. The second change was to recruit new mentors using VA Pulse. This provided the VHCS with an excellent pilot program with sustainability and opportunities to further streamline the process.

The third change was to educate the newly hired and experienced APRNs about the

benefits of participation in the APRN mentorship program. Several media interventions were used throughout the VHCS, including VA Pulse, PSA announcements, an in-service about the mentorship program, and an email introduction about the program.

APRNs may have certain barriers that may inhibit enrollment and participation in the mentorship program, including unfamiliarity with the VA health care system, a lack of understanding of why mentorship is important, and the inability to be paired with the right mentor. As the VHCS APRN mentorship participants went through the program, they listed barriers to their participation. The fourth change was a survey on the potential barriers that may reduce participation in the program.

At the end of the program, the project coordinator evaluated the participants' perceptions of practice and how the perceptions might have influenced patient outcomes before and during the mentorship program. The CoEPCE survey was used in the intervention (see Appendix A). In 2011, the CoEPCE survey was designed and implemented to teach health care trainees to work, lead, and improve patient-centered care, through team-based care within primary care settings (Rugen et al., 2018). The interventional survey is comprehensive, overviewing seven sections of clinical competencies while soliciting overall perceptions of practice throughout a 12-month program. The survey was adapted and applied from the first month of the project through the third month.

Setting and Population

The DNP project was restricted to the VHCS in Central Texas; no other VA facilities outside the region participated in this project. As mentioned previously, the Central Texas VHCS consists of two hospitals located in Temple and Waco; one stand-alone outpatient clinic in Austin; four community-based outpatient clinics in Brownwood, Cedar Park, College Station,

and Palestine; two nursing homes in Temple and Waco; one domiciliary in Temple, a rehabilitation unit for the blind in Waco; and two patient rehabilitation units in Waco for life enhancement for those with posttraumatic stress disorder and severe mental illness.

Seven of the 82 APRNs who were invited to participate agreed to participate as mentors in the mentorship program (U.S. Department of Veterans Affairs, 2019). Ten newly hired, novice APRNs were asked to enroll and participate in the mentorship program. The newly hired APRNs were recruited to participate in the program because they completed the VA scholarship program and because they had less than 1 year of experience. The mentees and mentors came from various disciplines such as primary care, neurology, sleep lab, and endocrinology.

Organizational Barriers and Facilitators

Organizational Barriers

Several organizational barriers served as challenges to the project. The time for boarding and credentialing was excessive, from 60 to 100 days and even longer in some cases. The VHCS credentialing department reported delays due to the time of program graduation, surges in the number of APRNs needing to obtain authorization to test, and other delays in licensing/credentialing.

Additionally, although seven volunteer mentors were vetted and certified through the VA mentorship program, mentors' unforeseen professional or personal events had the potential to lead to a lack of participation in the mentorship program. Such events included the mentor's change in position, resignation, retirement, or termination.

The VHCS human resource department also projected untimely delays in the hiring process. The delays centered around pregnancy, births, sickness, deaths, or better job offers outside of the VHCS. Fanay Henderson, an HR representative for APRNs, reports that 15% to

25% of new hires change their minds because of the lengthy wait to get into the VA system (F. Henderson, personal communication, February 4, 2020). Ms. Henderson also reports that, on average, it takes about 100 to 120 days to begin orientation, which has led to losing qualified APRNs (F. Henderson, personal communication, February 4, 2020).

Facilitators

Several key administrators gave their support to proceed with the project. On September 7, 2019, a meeting was scheduled with Ms. Kathy Lee, RN, MSN, clinical faculty/student coordinator, who oversees graduate-level projects. The mentorship project was discussed and approved by the Clinical Faculty/Student Coordinator department at that time. Ms. Lee referred the project to the nurse recruiter/nursing excellence coordinator, Ms. LaVeeta Springer, MSN/MBA, RN, who was the main project facilitator. May Tanay MSN, FNP-C, a geriatric and extended care provider, was the project mentor for the DNP student project coordinator (Appendix C). Both nurses have been employed at the VHCS for a combined time of approximately 20 years. Ms. Springer was a part of a small committee of APRNs who submitted a grant to provide the funding for the previously mentioned APRN residency. Ms. Tanay is an approved mentor in the VHCS mentorship training program and agreed to become a mentor during this mentorship project. They were excellent resources throughout this project.

The fact that there were already seven APRNs who had been trained and recognized as mentors was also a facilitator to making this project viable. All seven mentors had received training as mentors through the VA's mentorship training program and were eager to participate in the newly developed program.

Ethical Considerations

The approval form for the institutional review board (IRB) at the University of the

Incarnate (UIW) was submitted in October 2019. The project was deemed to pose no risk to human subjects and was classified as exempt from IRB review (see Appendix D).

All hard copy data collected were securely filed confidentially in a sealed and locked box in an area accessible only to the project lead. During analysis, data were de-identified, entered, and then stored on a password-protected computer. The evaluation results were shared only with the project advisor, champion, and mentor throughout the 8 to 10 weeks of the mentorship program. Participants were not financially compensated but were given formal letters of appreciation that can be used on their annual performance proficiencies evaluation. Participants were reassured that the outcome of the mentorship program would not affect their employment status and that confidentiality would be maintained.

Project Evaluation

To evaluate the impact of the project, an analysis of enrollment, participation, barriers, transition to practice, and patient outcomes was conducted before and after the mentorship program. The objective was to describe the mentorship program in regard to enrollment, participation, barriers, transition to practice, and patient outcomes before and during the mentorship program. These descriptive analyses were performed using Intellectus Statistics, a software program that allows analyses without requiring statistical expertise.

One way the effectiveness of the mentorship program was measured was with the Mentor Competency Assessment (MCA) tool. Fleming et al. (2013) documented the validity (statistical data) and reliability (results) of the MCA tool. This tool aligns six mentor competencies: communication, expectations, understanding, independence, diversity, and professional development, in addition to 26 additional mentoring skills (Fleming et al., 2013; see Appendix E).

The competency assessment tool used for VA NPs was the CoEPCE which is composed of 69 items within seven domains: clinical, leadership, interprofessional collaboration, patient-centered care, shared decision-making, sustained relationships, and performance improvement/population management. The rating scale is used within the VHCS with the level of supervision needed to carry out the activity (Rugen et al., 2018). Permission to use the CoEPCE was requested and granted (Appendix F).

Results

The implementation of the mentorship project met some obstacles with the spread of coronavirus disease 2019 (COVID-19). On March 11, 2020, the World Health Organization (WHO) declared a global pandemic based on the severity of the coronavirus outbreak. This disease rapidly spread with debilitating effects. COVID-19 limited and halted project data responses and collection. VHCS facilities closed daily operations for nonessential personnel, which included volunteers, temporary staff, and students.

The unavoidable circumstances surrounding the implementation of the project were unforeseeable, but such barriers and limitations should be anticipated during data collection in order to identify alternative approaches. The examination of data is a significant part of the project since the data provide information on how the mentees and mentors responded to the execution of the mentorship program, and the examination is used to decide if the data were useful. As Jones (2017) and Davis and Maisano (2016) referenced, the examination of information is not always flawless as proposed; underlying analysis looks for a better understanding of the specific answer. In short, nothing goes as planned; therefore, collection of data must continue despite the circumstances.

Although the project was limited and timelines needed to be adjusted from the original

dates, the project was implemented. The VHCS was on lockdown for safety; therefore, changes were made to some of the methods to meet the needs of the facilities. All APRN mentors were working via telehealth, and new hires were halted until restrictions were lifted. Meanwhile, all seven trained mentors were emailed their initial welcome email with a mentorship program memorandum of agreement and expectations, first meeting checklist, SMART goal evaluation form, and a demographic survey (see Appendix A). Also, instead of capturing new hire data, an HR employment scan was conducted to review how many APRNs were newly hired within the previous 6 months. From October 2019 to May 2020, a total of seven APRNs were hired while another three successfully completed veteran health care educational programs and were awaiting licensing and credentialing. Due to the small number of recent new hires, the definition of *new hires* was redefined as those hired in the past 0 to 180 days. Since most newly hired APRNs had assumed routine work schedules and had some experience navigating Central Texas VHCS but acquired further integration, they were selected for the mentorship program. To not overwhelm the mentors, the three mentees awaiting licensing and credentialing were paired with more experienced mentors.

Demographic Survey

Among the survey participants, the mentors ranged in age from 29 to 58 years old and had 4 to 18 years of APRN experience (see Table 1), and the mentees ranged in age from 26 to 53 years old and had 3 to 26 years of nursing experience (see Table 2). Among the 10 mentees, one had a bachelor's degree in nursing, and three had a master's degree in nursing. Of the seven mentors, two had a master's degree in nursing, and five had a master's and post-master's certificate in nursing (see Table 3). Both categories of participants showed a wide variety of medical experience, including work experience in the intensive care unit, emergency department,

orthopedic department, day surgery, and psychiatric substance abuse facility. The novice APRNs may have been experts in their previous units, but they were now novices in their advanced practice assignments.

Table 1

Demographic Information for Mentors

Variable	Minimum	Maximum
Age, y	29	58
APRN years of experience	4	18

Note. *N* = 7. APRN = Advanced Practice Registered Nurse

Table 2

Demographic Information for Mentees

Variable	Minimum	Maximum
Age, y	26	53
RN years of experience	3	22

Note. *N* = 10. RN = Registered Nurse

Table 3

Smart Goals Evaluation Meetings

Mentees	May	June	July	Total
APRN 1	2	1	3	6
APRN 2	1	2	2	5
APRN 3	1	2	2	5
APRN 4	2	1	1	4
APRN 5	1	2	2	5
APRN 6	0	3	2	5
APRN 7	4	1	2	7
APRN 8*	1	2	2	5
APRN 9*	0	1	2	3
APRN 10*	3	2	2	7
Total	15	17	20	52

Note. * indicates the mentees with 6 months of experience paired with experienced mentors.

Smart Goals Implementation and Evaluation

The purpose of the monthly meeting was to identify strengths, the areas in need of improvement, monthly goals, recommendations, or any issues that may have arisen. The mentor could provide recommendations based on knowledge, skills, and attitudes observed from the mentee throughout the month. Comments and recommendations were documented in a secured encrypted file and analyzed monthly throughout the project.

It was observed throughout the project that meeting frequency increased amongst both mentors/mentees, reflecting higher survey scores. This steady increase appears to be due to the increased frequency of monthly meetings, starting with 21 meetings the first month and ending with a total of 95 meetings, overall. The inundation of technology services was a part of mentor-mentee day-to-day interaction.

Mentoring Competency Assessment

The mentees evaluated mentors before and after the implementation of the program. Six mentor competencies were measured—communication, expectations, understanding, independence, diversity, and professional development (Fleming et al., 2013). The MCA scores were summed, and the mean score was estimated. Overall, mean composite MCA scores were lowest in May (5.98; moderately skilled) and highest in July (6.63; extremely skilled). Details of the mean, median, and range of the scores are presented in Table 4.

Table 4

Summary Statistics Table for MCA Composite Score by Month

Month	*M*	*SD*	*n*	Min	Max	*Mdn*
May	5.98	0.19	10	5.77	6.31	5.88
June	6.35	0.10	10	6.19	6.54	6.35
July	6.63	0.11	10	6.42	6.77	6.65

Note. Max = Maximum; MCA = Mentoring Competency Assessment; Min = Minimum.

Centers of Excellence in Primary Care Education Assessment

In 2011, the CoEPCE initiative established a yearlong APRN residency program rooted inside an interprofessional primary care educational milieu (Rugen et al., 2018). The CoEPCE comprises 69 items in seven domains, which include clinical competency and management of care, leadership, interprofessional team collaboration, patient centered-care, shared decision-making, sustained relationships, quality improvement, and population management (Rugen et al., 2018; see Appendix A). The rating scale depends on trusting the supervising mentors to fairly assess the professional development of the mentees. The levels are as follows: 0-not performed/not observed, 1-observes task only, 2-needs full supervision, 3-needs supervision periodically, 4-is able to perform without supervision, and 5-able to supervise others (see Appendix A).

The CoEPCE composite construct scores are each reported separately in Table 5, whereas the monthly mean aggregate and mean composite scores are reported in Figure 1 and Figure 2, respectively. For each construct and overall, the scores were lowest in May and highest in June. Aggregate CoEPCE scores increased from 275.50 in May to 302.0 in June and 327.1 in July (Figure 2). Mean MCA composite scores increased from 5.98 in May to 6.35 in June and 6.63 in July (Figure 3).

The highest composite score obtainable on the Clinical Competency in Planning and

Managing Care (CCPMC) construct was 135 (a score of 5 on all 27 items). The median score increased from 100.5 (range, 90.0–113.0) in May to 125.0 (range, 121.0–126.0) in July. The highest composite score on the Leadership construct was 35 (a score of 5 on all 7 items). The median score increased from 26.5 (range, 23.0–31.0) in May to 32.0 (range, 32.0–34.0) in July. The highest composite score on the Interprofessional Team Collaboration construct was 45 (a score of 5 on all 9 items). The median score increased from 38.0 (range, 34.0–41.0) in May to 42.0 (range, 40.0–44.0) in July. Details on the mean, median, and ranges for each composite score on all constructs are presented in Table 5.

Satisfaction Survey

Mentorship programs are beneficial for education, professional development, and meeting unforeseen challenges. Mentoring newly hired APRNs can be fulfilling, with great satisfaction experienced with the successful growth of mentees and the knowledge that the mentors played a part in making it happen. The mentoring program satisfaction survey assesses eight degrees of satisfaction, with each item being rated on a 1-to-5 scale with optional comments (see Appendix B). Permission to use the survey was sought and granted (Appendix G). Satisfaction in each construct measured by the survey is represented in Table 6, and overall satisfaction is shown in Figure 3. In both cases,

satisfaction reported by the mentees increased from May through July, consistently.

Mentee mean satisfaction scores increased from 4.44 in May to 4.70 in June and 4.94 in July (Figure 3).

Table 5

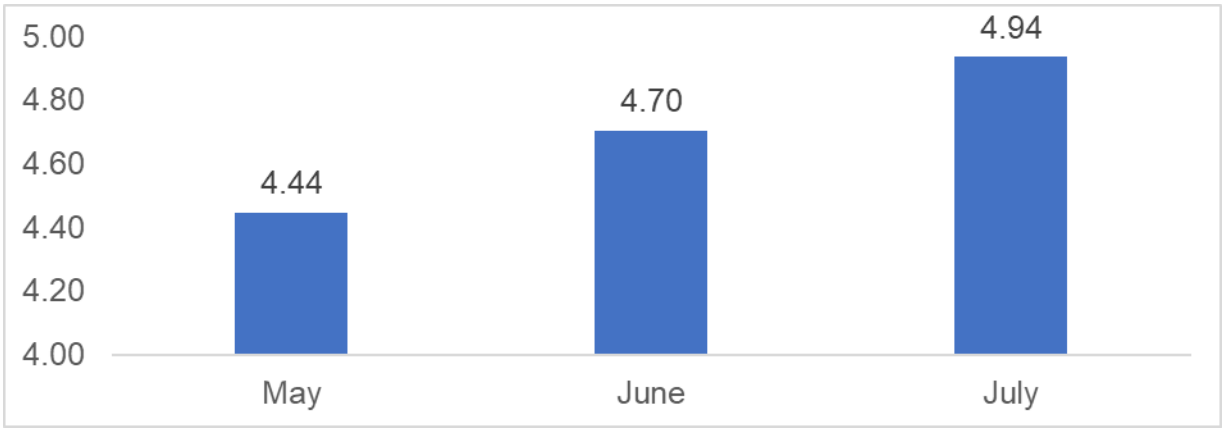
Summary Statistics Table for CoEPCE Constructs (Composite Scores) by Month

Variable	*M*	*SD*	*n*	Min	Max	*Mdn*
CCPMC						
May	100.80	7.47	10	90.00	113.00	100.50
June	113.90	1.73	10	112.00	118.00	113.00
July	124.40	1.65	10	121.00	126.00	125.00
Leadership						
May	26.90	2.88	10	23.00	31.00	26.50
June	29.90	1.10	10	29.00	32.00	29.50
July	32.60	0.84	10	32.00	34.00	32.00
Interprofessional Team Collaboration						
May	38.00	2.36	10	34.00	41.00	38.00
June	39.80	1.69	10	37.00	43.00	40.00
July	42.30	1.25	10	40.00	44.00	42.00
Patient-Centered Care						
May	29.40	2.12	10	26.00	32.00	29.50
June	31.00	1.05	10	30.00	33.00	31.00
July	33.50	0.71	10	32.00	34.00	34.00
Shared Decision-Making						
May	28.20	2.25	10	25.00	32.00	27.50
June	30.30	1.34	10	29.00	33.00	30.00
July	32.90	0.74	10	32.00	34.00	33.00
Sustained Relationships						
May	33.20	3.97	10	27.00	39.00	32.50
June	35.60	2.22	10	33.00	40.00	35.00
July	38.10	1.37	10	36.00	40.00	38.00
Quality Improvement / Population Management						
May	19.00	2.45	10	16.00	22.00	18.00
June	21.50	1.27	10	20.00	24.00	21.00
July	23.30	0.95	10	22.00	25.00	23.00

Note. CCPMC = Clinical Competency in Planning and Managing Care; CoEPCE = Centers of Excellence in Primary Care Education; Max = Maximum; Min = Minimum.

Figure 1

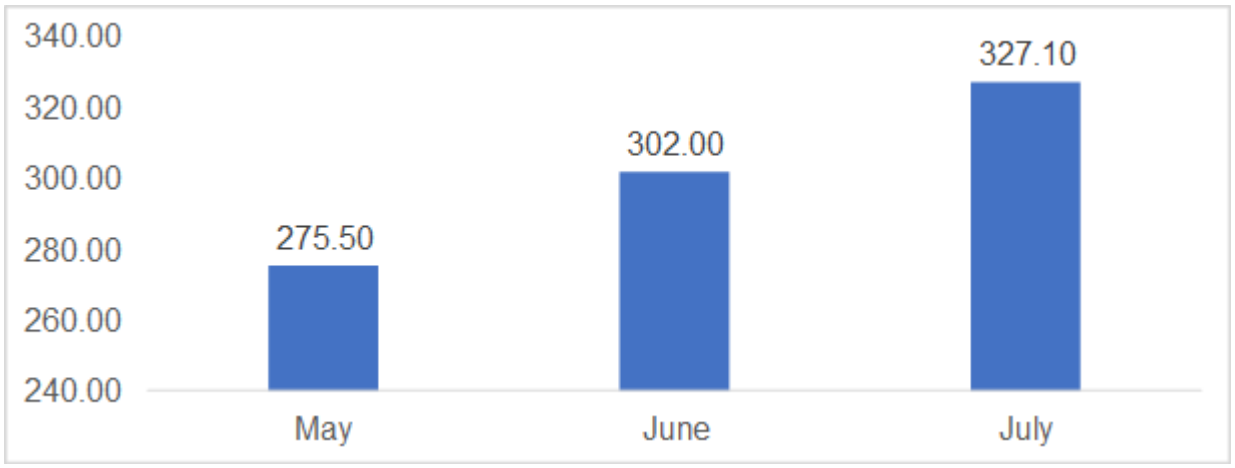
Mentee Mean Satisfaction Scores by Month



Note. MCA = Mentoring Competency Assessment.

Figure 2

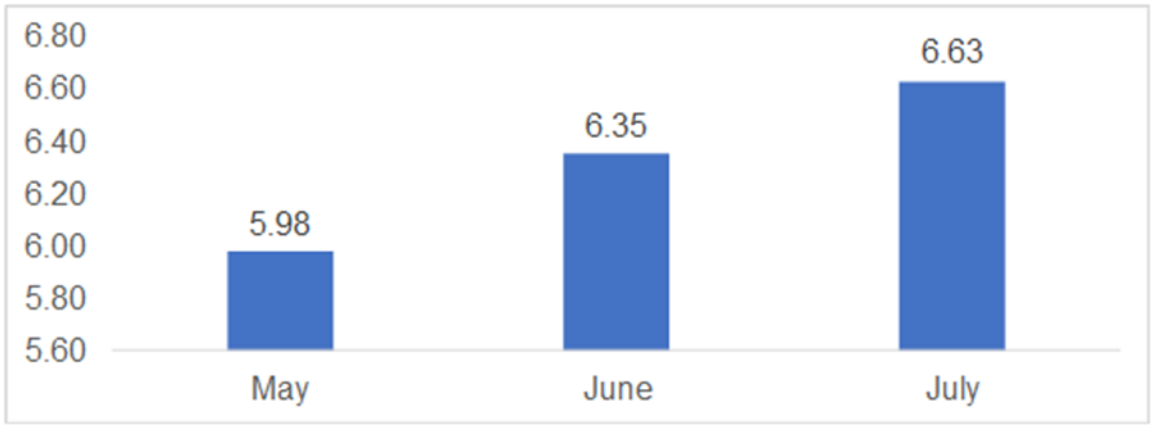
Mean CoEPCE Aggregate Scores by Month



Note. CoEPCE = Centers of Excellence in Primary Care Education.

Figure 3

MCA Mean Composite Scores by Month



Note. MCA = Mentoring Competency Assessment.

Discussion

The APRN mentorship program was successfully implemented in the target VHCS. There were 10 mentee participants and seven mentors. Additionally, three VHS APRN residents were not a part of this project but benefited from the program. During the midpoint of the project, one of the mentees was transferred to another VHCS due to COVID demand. Despite the unexpected change, the mentee maintained virtual communication with their mentor. While there were positive correlations between the mentee group and the mentor group with the use of technology for meetings due to workplace constraints, these findings were not statistically significant. Because of the nature of the global pandemic, the mentees' varying work schedules, and being in different settings, technology use facilitated consults with mentors. It was observed throughout the project that increased use of multiple technology services, such as Skype, Microsoft Teams, and Zoom, were a part of the day-to-day means of communication between the mentors and mentees. The fact that the services were readily available increased meeting frequency amongst both mentors and mentees, reflecting higher MCA, CoEPCE, and satisfaction

Table 6

Summary Statistics Table for Mentee Satisfaction Scores by Month

Variable	*M*	*SD*	*n*	Min	Max	*Mdn*
Personal Relationships						
May	4.30	0.48	10	4.00	5.00	4.00
June	4.80	0.42	10	4.00	5.00	5.00
July	5.00	0.00	10	5.00	5.00	5.00
Professional Growth						
May	4.20	0.42	10	4.00	5.00	4.00
June	4.33	0.50	9	4.00	5.00	4.00
July	4.80	0.42	10	4.00	5.00	5.00
Personal Growth						
May	4.50	0.53	10	4.00	5.00	4.50
June	4.80	0.42	10	4.00	5.00	5.00
July	5.00	0.00	10	5.00	5.00	5.00
Ability to Communicate						
May	4.40	0.52	10	4.00	5.00	4.00
June	4.40	0.52	10	4.00	5.00	4.00
July	4.70	0.48	10	4.00	5.00	5.00
Ability to Problem-Solve						
May	4.40	0.52	10	4.00	5.00	4.00
June	4.80	0.42	10	4.00	5.00	5.00
July	4.80	0.42	10	4.00	5.00	5.00
Communication with Mentor						
May	4.60	0.52	10	4.00	5.00	5.00
June	4.70	0.48	10	4.00	5.00	5.00
July	5.00	0.00	10	5.00	5.00	5.00
Meetings with Mentor						
May	4.40	0.52	10	4.00	5.00	4.00
June	4.80	0.42	10	4.00	5.00	5.00
July	5.00	0.00	10	5.00	5.00	5.00
Program Helpfulness						
May	4.60	0.52	10	4.00	5.00	5.00
June	4.80	0.42	10	4.00	5.00	5.00
July	5.00	0.00	10	5.00	5.00	5.00
Overall Satisfaction						
May	4.60	0.52	10	4.00	5.00	5.00
June	4.80	0.42	10	4.00	5.00	5.00
July	5.00	0.00	9	5.00	5.00	5.00

Note. Max = Maximum; Min = Minimum.

survey scores. Based on the analysis of the data collected using the descriptive surveys, results revealed that from May through July, each of the outcomes improved consistently. As presented previously, the mean MCA composite scores increased from 5.98 in May to 6.35 in June and 6.63 in July. Overall, the mentee scored the mentors higher than the previous month. This steady increase appears to be due to the increased frequency of monthly meetings, starting with 21 meetings the first month and ending with a total of 95 meetings, overall.

The mentorship project produced a sturdy foundation and served as a powerful tool to help the mentors and novice APRNs succeed. The fostered relationships among mentees and mentors assisted with aligning overall expectations, including teaching, professional development, autonomy, support, and role modeling. These relationships strengthened the commitment of both parties to perform to their fullest potential. The VHCS APRNs, patients, family members, and the institution will benefit from the mentorship program and its opportunities. Anecdotally, three NP residents shadowed this project but were not included in this study. However, the NP residents expressed great interest in the project and made connections with unintentional mentors—mentors who serve the function of a mentor without even knowing it. Typically, formalized mentorships are paired professionally through an organizational program, but unintentional mentors' relationships can be valuable and beneficial to the growth of the mentee.

The influence of mentorship on the quality of care provided by the VHCS supports the excellent reputation of the nursing profession because experienced APRNs are a support system for novice APRNs who transition into VHCS. The mentees' evaluations reinforce the results reported in the Jones (2017) article where several positive gains were witnessed during the mentorship program such as optimism, self-assertiveness, efficiency, and effectiveness. Mentors

create positive patient outcomes through education, encouragement, empowerment, growth challenges, and support of transitioning novice APRNs for them to perform to their optimal potential. The mentors also offer hands-on education that is based on current VHCS policies. Importantly, the APRN mentorship program has led to fortifying the entire APRN profession by providing solutions that strengthen the confidence of newly hired APRNs by fostering independence, professional development, relationship building, and open lines of communication for novice providers.

Relation to Other Evidence

The novice-to-expert theoretical model created by Dr. Patricia Benner (1984) offered a foundational framework for newly hired novice APRNs in VHCS. Benner rationalizes that the transition to practice is experienced in five steps: novice, advanced beginner, competent, proficient, and expert (Benner, 1984). The AMSN, CoEPCE, and MCA are similar to Benner's theory, which builds upon a foundation of growth over time. The mentee grows from this relationship where shared knowledge and expertise bring about an ambitious desire to master competencies (AMSN, 2012). In the comparison of evidence, Benner's theory shows similarities with research by Fleming et al. (2013), Rugen et al. (2018), and Gazaway et al. (2019). These studies report that mentees with fewer than 2 years of experience need impactful relationships with mentors, whether formal or informal. A mentee's sense of empowerment is gained through more experience, which in return, fosters independence while promoting professional development as the mentee transitions from novice to expert. Through a shared vision and purpose, mentorship programs blend unique qualities and create synergistic relationships, which help these programs raise positive expectations and overall success rates (AMSN, 2012).

Limitations

Several limitations were encountered during the implementation process. One significant limitation was the spread of COVID-19, which was declared a global pandemic by the WHO in March 2020. This delayed implementation and project data collection for nearly 3 weeks. During this time, all mentor participants were limited to telehealth, making traditional mentoring a challenge. Additionally, miscommunication concerning access to Pulse social media and the transition to SharePoint caused confusion. The Pulse link was discontinued, and the remaining files, demographics, and program descriptions needed to be uploaded to the new VA SharePoint server, causing delays.

Another obstacle was the VHCS mentor training program being postponed due to COVID-19. The mentor training program is a federal training course that allows mentors to become certified to train mentees and receive credit for performance proficiency ratings. Lastly, the VHCS was closed to nonessential personnel, which included new hires and students, which delayed newly hired APRNs from enrolling in the program.

Once the mentorship program was up and running, another limitation encountered was scheduling conflicts with APRNs who had at least 6 months on the job. Due to the small number of recent new hires at the beginning of the project, new hires were redefined as those hired in the past 0 to 180 days. This redefining of who was considered a new hire allowed APRNs who were already in the system to qualify for the mentoring program. Since the majority of these individuals had assumed routine work schedules with little flexibility, face-to-face meetings between the mentee and mentor were challenging. Additionally, the pairing of these three additional mentees placed more responsibility upon the trained mentors because of taking on an additional mentee.

The last limitation that was encountered dealt with the surveys. Initially, the 10 mentee participants did not answer all the questions on the survey, which limited the findings and produced a burden in completing this project. A structured survey would not have allowed the omission of questions needed for more substantial results. Approximately 60% of the surveys (n = 6) were completed thoroughly and turned in on time, while the remaining 40 % (n = 4) were not completed by the due date but 12 days later and only after repeated prompting by the project coordinator.

Recommendations

Future recommendations include analysis of the use of technology effectiveness concerning APRN mentees' barriers and limitations to advanced skills training such as suturing, telehealth examinations, and follow-up procedures. Importantly, it should be considered whether technology aids, hinders, slows down, or accelerates an APRN's transition to practice within the VHCS. The inundation of technological advancements has been extremely helpful throughout the pandemic, which should be explored more thoroughly.

As alluded to earlier, the project coordinator will consider reducing the number of questions included and the structure of the surveys so that participants are able to respond to all questions. Mentees and mentors alike commented on the length of many of the surveys. A web-based electronic survey taking less than 15 minutes to complete would increase the probably that each participant answers all the questions and would increase the likelihood of more accurate data for analysis.

In order to reduce the time required in collecting and analyzing data, it is recommended that a Microsoft Excel spreadsheet be developed that automatically transfers data over to the master spreadsheet. The master spreadsheet modification will make it possible to gather and

collect long-term data, including evaluating each mentee's first 24 months as the novice transitions to beginner. Ensuring all data are collected on time and customizing the survey tools specifically for the VHCS mentees will also reduce project error.

Implications for Practice

The newly developed mentorship program provides a promising basis for improving the transition of newly hired APRNs in the VHCS, thereby improving overall retention of these providers. A structured, standardized orientation and mentorship program for novice APRNs entering the VHCS must move the mentee along the novice-to-expert continuum. Through orientation and mentorship, this mentorship program builds a valuable, clinically based experience that will ensure professional development. Novice APRNs battle to satisfy the needs of their new position by following directives and guidelines placed upon them while simultaneously becoming familiar with their new role as a health care provider. As mentees move from novice APRNs to beginners, the positive impacts provided by a structured mentorship program are critical for successful integration into the VHCS.

More than 270,000 APRNs are licensed to practice in the United States, and nearly 30,000 graduate annually (AANP, 2019). APRNs help to significantly address the shortage of PCPs and the critically low numbers of providers in some specialties in the United States. APRNs are a beneficial and valuable solution to a variety of health care delivery needs (AANP, 2019).

The influence of mentorship on novice APRNs generates a positive reputation for the nursing profession because experienced nurses invest within the social construct of grooming the next generation. Twine (2017) identified that, many times, when an APRN novice assumes a new professional role, the person might not be fully prepared to assume this role without

mentorship. A mentorship program creates those positive outcomes by way of bridging the gap in the novice APRN's complicated first 6 months on the job.

The VHCS administration and the APRN shared governance committee decided to continue the mentorship program for future novice and advance beginners. The number of APRNs practicing within VHCS will continue to increase, and the novice APRN mentorship program will continue to offer this valuable structured mentorship experience. It is encouraging that several seasoned APRNs have displayed an interest in being trained to become mentors and to facilitate the growth of novice APRN mentees in the VHCS.

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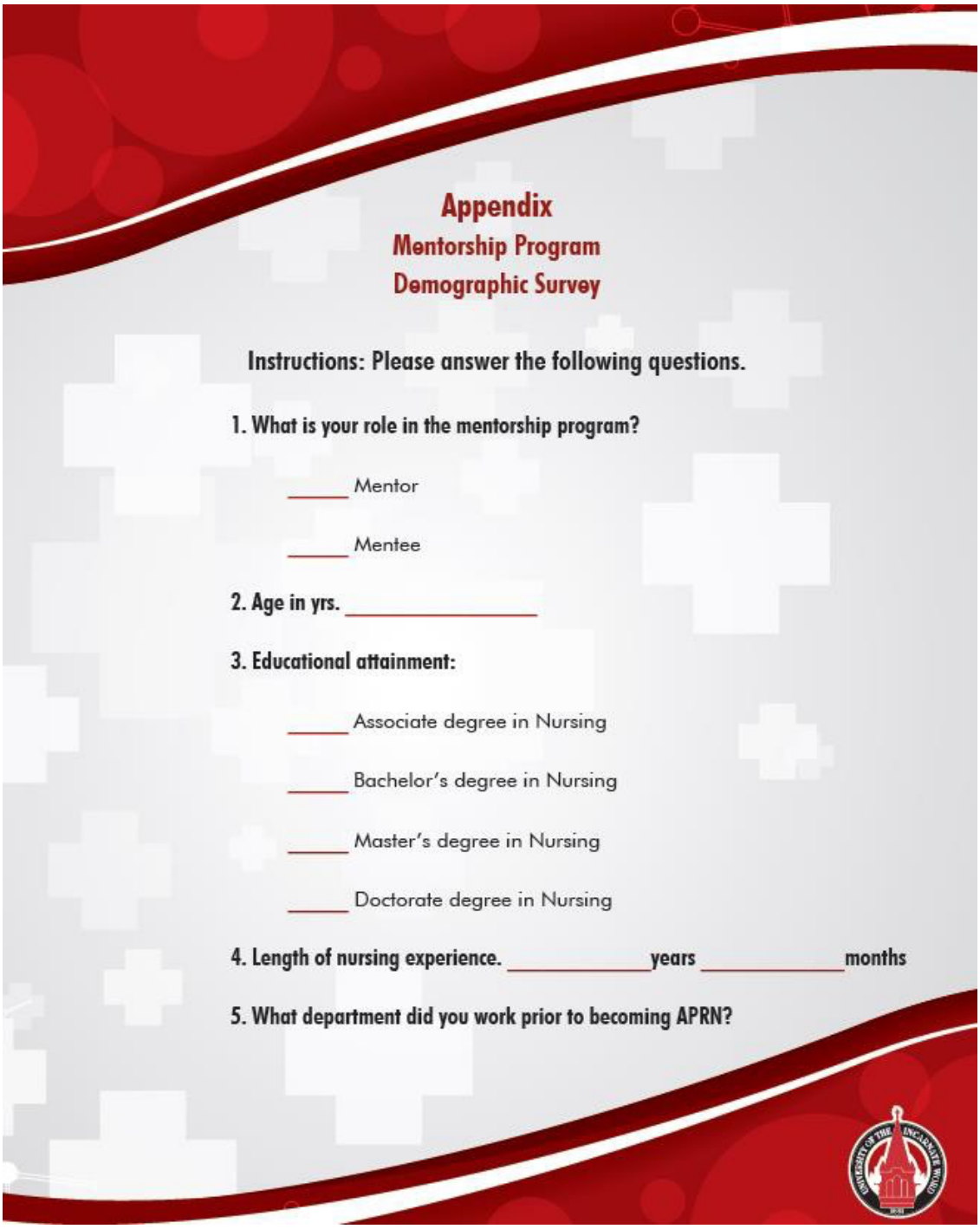
Appendix A

Program Booklet

Demographic Survey



Appendix
Mentorship Program
Demographic Survey

Instructions: Please answer the following questions.

1. What is your role in the mentorship program?

_____ Mentor

_____ Mentee

2. Age in yrs. _____

3. Educational attainment:

_____ Associate degree in Nursing

_____ Bachelor's degree in Nursing

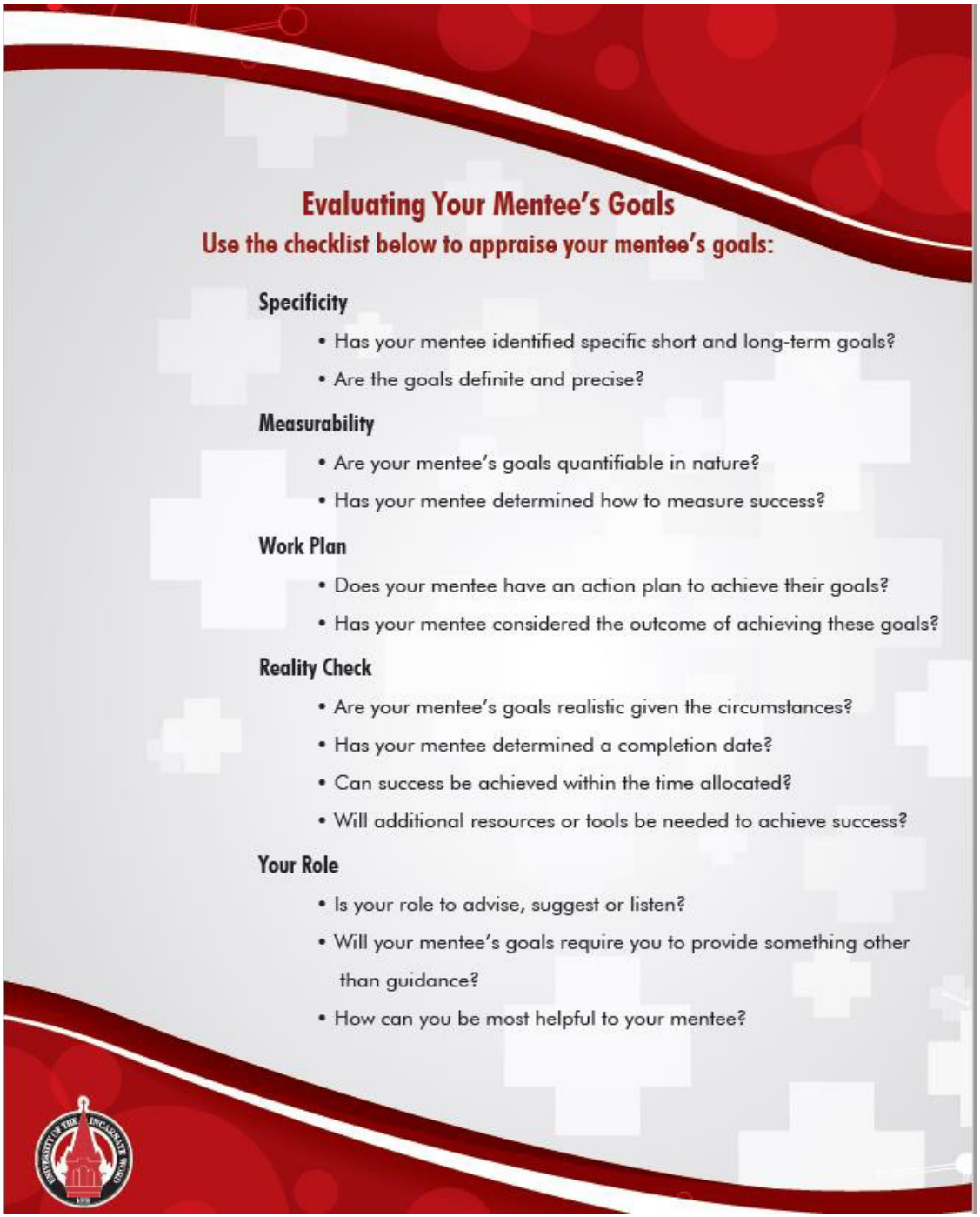
_____ Master's degree in Nursing

_____ Doctorate degree in Nursing

4. Length of nursing experience. _____**years** _____**months**

5. What department did you work prior to becoming APRN?

Evaluating Your Mentee's Goals



First Meeting Checklist

Appendix

Initiation: First Meeting Checklist

Get to Know Each Other

- Share information about your professional and personal life
- Learn something new about your mentee/mentor

Establish Guidelines

- When and where will we meet?
- How will we schedule meetings?
- How will we communicate between meetings?
- What agenda format will we use?
- Will there be any fixed agenda items to be discussed at every meeting?
- How will we exchange feedback?
- How will we measure success?

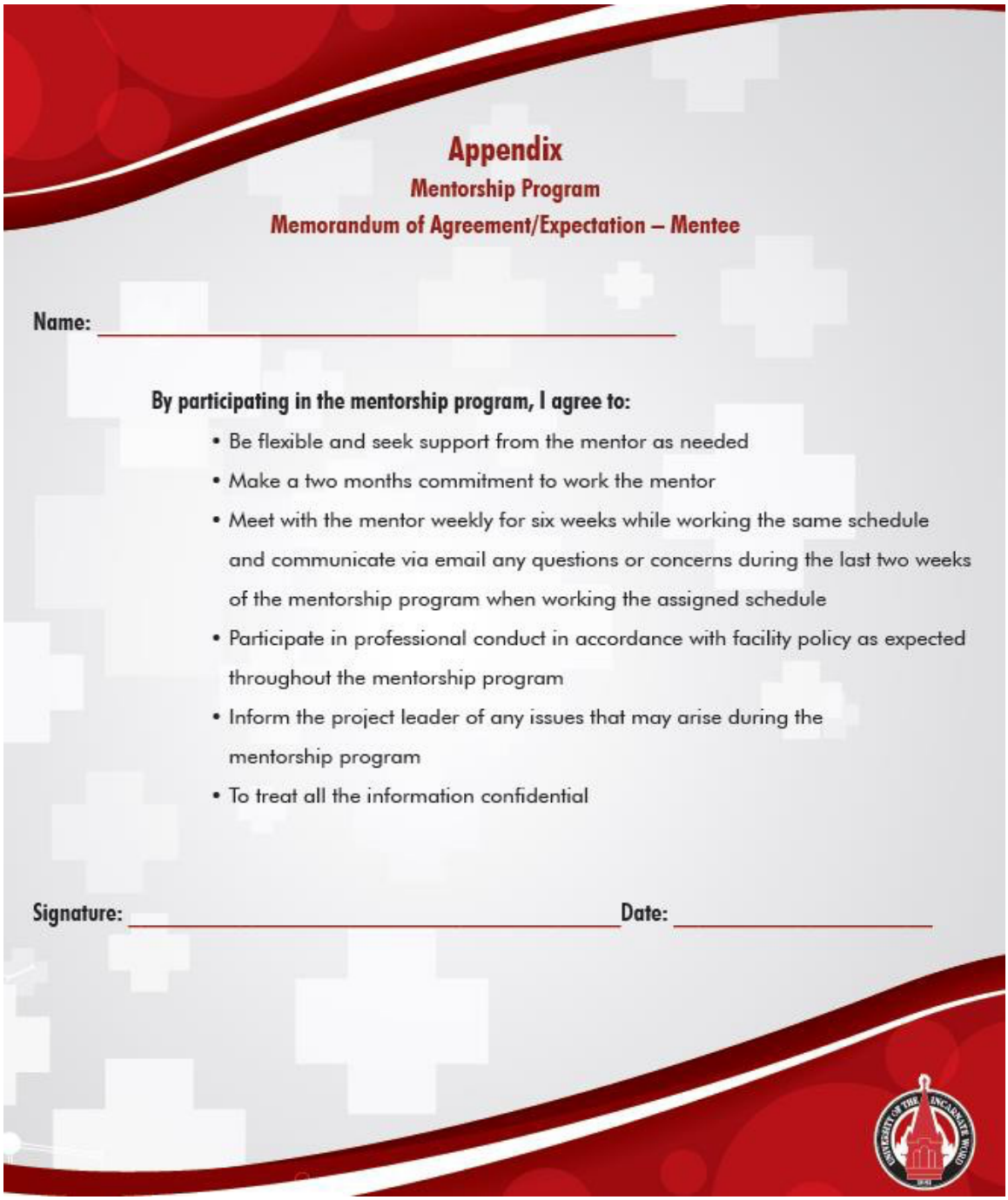
Partnership Agreement

- Review partnership agreement, modify if desired, sign and exchange
- Review goals for the mentoring relationship

Confirm Next Steps

- Schedule date, time and place of future meetings

Memorandum of Agreement/Expectations-Mentee



Appendix

Mentorship Program

Memorandum of Agreement/Expectation – Mentee

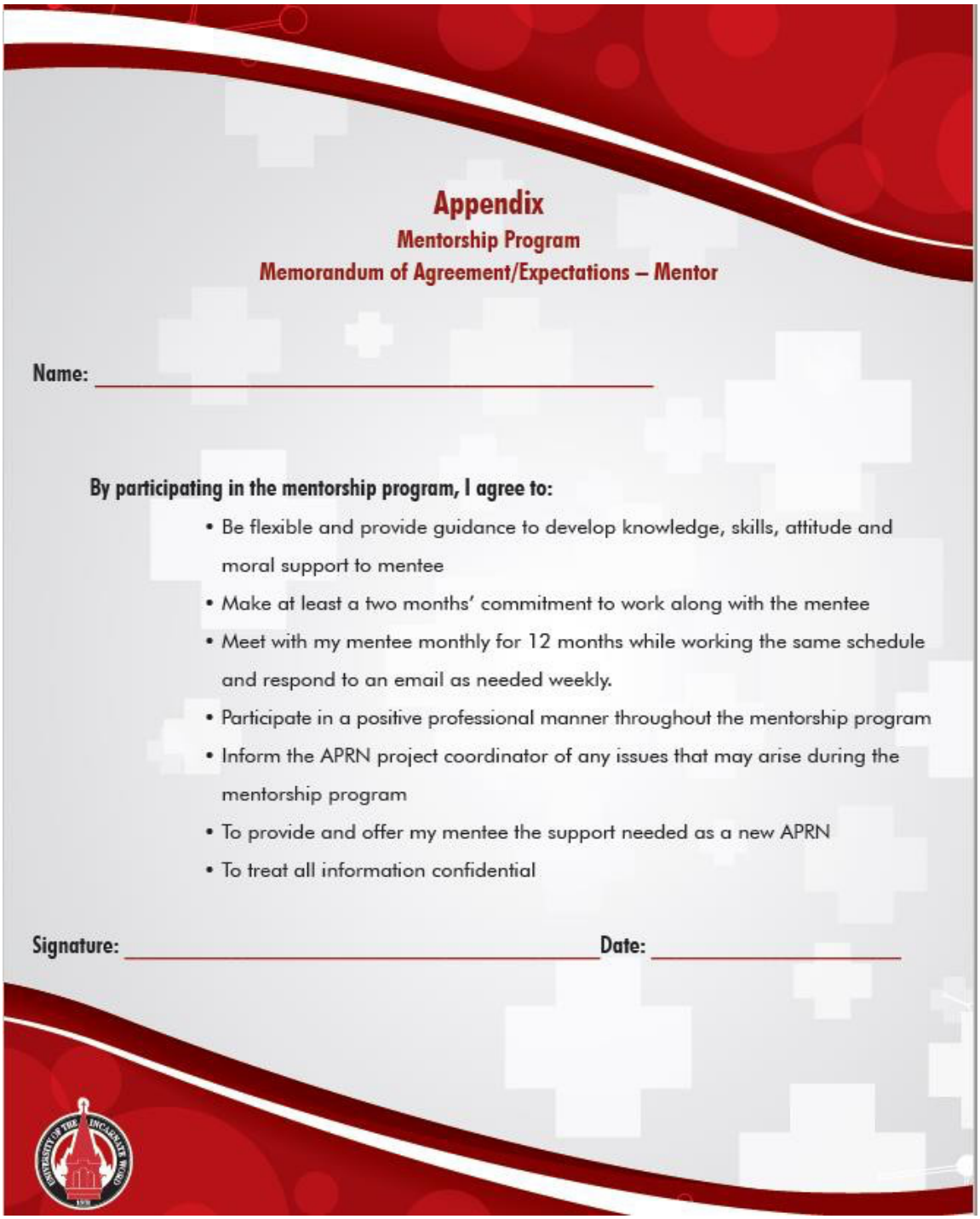
Name: _____

By participating in the mentorship program, I agree to:

- Be flexible and seek support from the mentor as needed
- Make a two months commitment to work the mentor
- Meet with the mentor weekly for six weeks while working the same schedule and communicate via email any questions or concerns during the last two weeks of the mentorship program when working the assigned schedule
- Participate in professional conduct in accordance with facility policy as expected throughout the mentorship program
- Inform the project leader of any issues that may arise during the mentorship program
- To treat all the information confidential

Signature: _____ **Date:** _____

Memorandum of Agreement/Expectations-Mentor



Appendix

Mentorship Program

Memorandum of Agreement/Expectations – Mentor

Name: _____

By participating in the mentorship program, I agree to:

- Be flexible and provide guidance to develop knowledge, skills, attitude and moral support to mentee
- Make at least a two months' commitment to work along with the mentee
- Meet with my mentee monthly for 12 months while working the same schedule and respond to an email as needed weekly.
- Participate in a positive professional manner throughout the mentorship program
- Inform the APRN project coordinator of any issues that may arise during the mentorship program
- To provide and offer my mentee the support needed as a new APRN
- To treat all information confidential

Signature: _____ **Date:** _____

CoEPCE—Clinical Competency in Planning and Managing Care

CoEPCE

Name of Trainee: _____ **Evaluation: 1 Month**

Name of Preceptor: _____

Date: _____ **Completed by: Perceptor/Mentor**

Please rate NP Trainee's level of skill, knowledge and abilities on the following PACT Nurse Practitioner professional activities:

To be completed by Nurse Practitioner Trainee and Preceptor/Mentor at 1, 6 and 12 months of training.

Scale:

1 = Observes task only
2 = Needs direct supervision
3 = Needs supervision periodically
4 = Able to perform without supervision
5 = Able to supervise others
NA = Not applicable, Not Observed or Not performed

Clinical Competency in Planning and Managing Care	1-5 or NA
Able to perform comprehensive history and physical exam	
Construct pertinent differential diagnosis	
Order appropriate screening and diagnostic tests	
Order appropriate consults	
Order appropriate medications	
Perform comprehensive medication review and reconciliation	
Present case to preceptor in clear, concise and organized fashion	
Able to assess for, diagnose, treat and manage over time common medical conditions experienced by patients in primary care:	
• Hypertension	
• Obesity	
• Diabetes Mellitus	
• Depression	
• Ischemic heart disease	
• Gastroesophageal reflux	

CoEPCE—Clinical Competency in Planning and Managing Care (Continued)

CoEPCE

Name of Trainee: _____ **Evaluation: 1 Month**

Name of Preceptor: _____

Date: _____ **Completed by: Perceptor/Mentor**

Clinical Competency in Planning and Managing Care Continued...	1-5 or NA
• PTSD	
• Enlarged prostate	
• COPD	
• Anemia	
• Chronic renal failure	
• Heart failure	
• Asthma	
• Peripheral arterial disease	
• Osteoarthritis	
• Substance abuse	
• Military Sexual Trauma	
• Suicidality	
• Traumatic brain Injury	
• Hepatitis C	
Care for acute illness, chronic disease and health maintenance needs using evidence based guidelines and other forms of decision support	

CoEPCE—Leadership

CoEPCE

Name of Trainee: _____ **Evaluation: 1 Month**

Name of Preceptor: _____

Date: _____ **Completed by: Perceptor/Mentor**

Leadership	1-5 or NA
Lead PACT team huddle	
Lead case conference	
Lead team meeting using conflict management/resolution as needed	
Lead group educational activities for patients/families, PACT team, peers	
Lead PACT team quality improvement project	
Lead shared/group medical appointments	
Apply leadership strategies that support collaborative practice and team effectiveness	
Interprofessional Team Collaboration	**1-5 or NA**
Develop own professional identity and clearly explains one's role and responsibilities to patients, families, and other professionals	
Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict	
Understand and appreciate contribution of other team members to the plan of care	
Function as a resource to other health professionals	
Maintain open communication with team members for quality and efficient care	
Safely transition patients among PACT team members and settings, including giving and receiving hand offs	
Seek feedback from faculty and team members	
Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families	
Engage in continuous professional and interprofessional development to enhance team performance	

CoEPCE—Patient-Centered Care and Shared Decision Making

CoEPCE

Name of Trainee: _____ **Evaluation: 1 Month**

Name of Preceptor: _____

Date: _____ **Completed by: Perceptor/Mentor**

Patient Centered-Care	1-5 or NA
Communicate with patient between office visits by telephone, secured email messages, MyhealtheVet	
Elicit patient's values, preferences, and cultural belief regarding care	
Identify, accommodate, and customize care for patients with language, cognitive, functional or cultural barriers	
Assess and provide education to empower the patients to self-manage their chronic conditions	
Track and coordinate care for patients ensuring follow-up on messages, tests, consults, and care at other facilities	
Engage other health professionals, appropriate to the specific care situation, in shared patient-centered problem-solving	
Use motivational interviewing to help patients change health related behaviors	
Shared Decision Making	**1-5 or NA**
Use active listening skills and open ended questions throughout each patient visit	
Counsel and support patients in their self-management of chronic diseases	
Facilitate patients participation in health care decisions using shared decision- making (or using formal decision-aids)	
Engage patients in advanced care planning	
Activate community resources to meet patients or populations needs	
Engage patients as care team members in tracking and coordinating care	
Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care	

CoEPCE—Sustained Relationships/Quality Improvement and Population Management

CoEPCE

Name of Trainee: _____ **Evaluation: 1 Month**

Name of Preceptor: _____

Date: _____ **Completed by: Perceptor/Mentor**

Sustained Relationships	1-5 or NA
Devise, follow, review, and adjust longitudinal care plan to meet assigned patient panel health care needs, including acute care, chronic disease management, modification of high risk behaviors and preventive care	
Develop and sustain respectful and trusting relationship with clinic faculty, preceptor and/or mentor	
Develop and sustain a respectful and trusting relationship with peer trainees	
Develop and sustain a respectful and trusting relationship with interprofessional PACT team (which includes all clinic staff)	
Develop and sustain a respectful and trusting relationship with patients and families	
Give timely, sensitive, instructive feedback to others about their performance on team, responding respectfully as a team member to feedback from others	
Use motivational interviewing to help patients change health related behaviors	
Quality Improvement and Population Management	**1-5 or NA**
Access and interpret performance data	
Improve care via Plan-Do-Study-Act cycles	
Perform root cause analyses and reflect upon critical incidents (medical error, near miss, preventable emergency room visit or readmission)	
Query registries to determine the health status and health care needs of entire practice and/or specific population of interest	
Reflect on individual and team performance and introduce strategies for improvement	

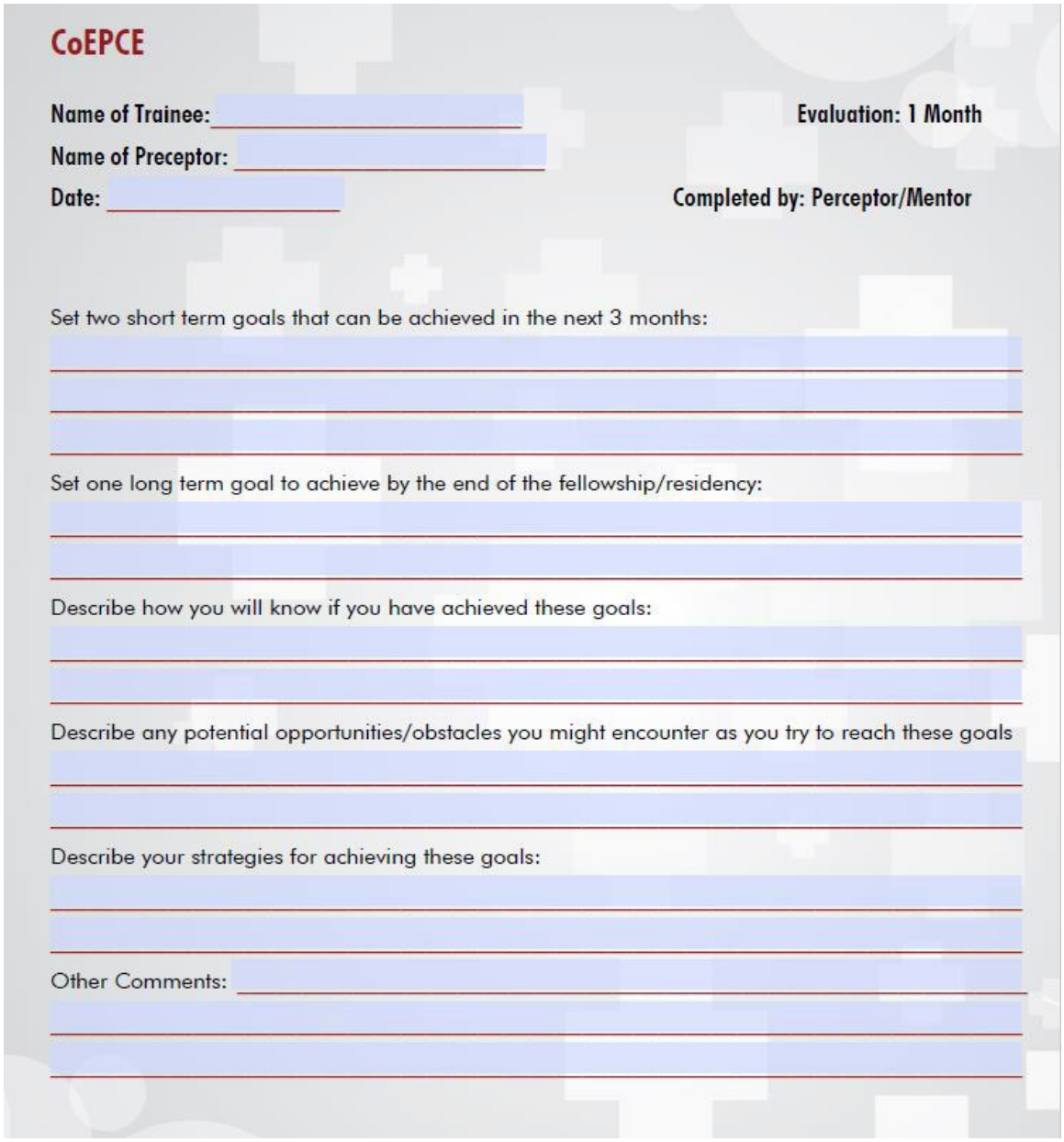
List two things that you do well: _____

_____

List two things you would like to improve: _____

_____

CoEPCE—Goals



CoEPCE

Name of Trainee: _____ Evaluation: 1 Month

Name of Preceptor: _____

Date: _____ Completed by: Perceptor/Mentor

Set two short term goals that can be achieved in the next 3 months:

Set one long term goal to achieve by the end of the fellowship/residency:

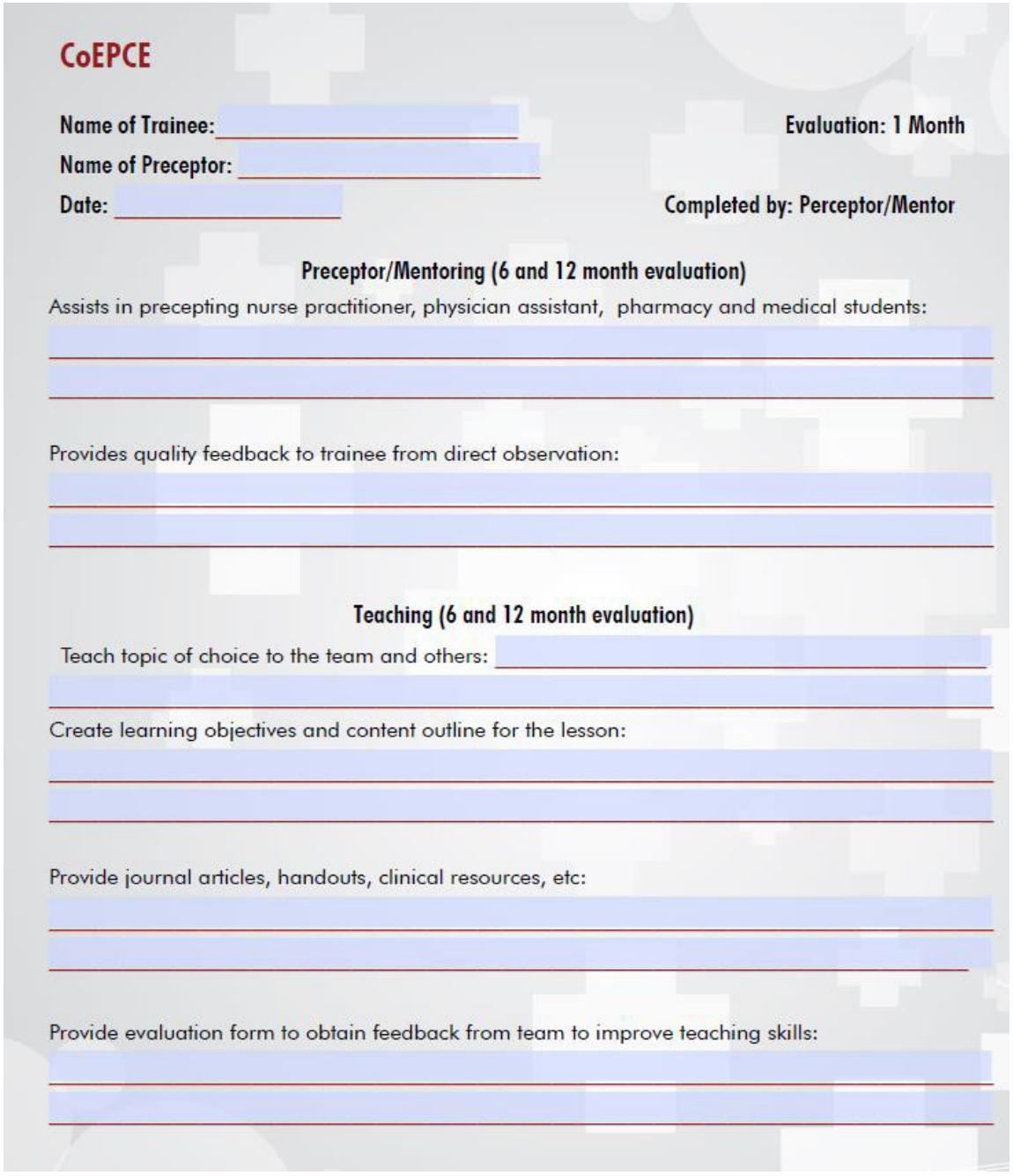
Describe how you will know if you have achieved these goals:

Describe any potential opportunities/obstacles you might encounter as you try to reach these goals

Describe your strategies for achieving these goals:

Other Comments: _____

CoEPCE—6 and 12–Month Evaluation



CoEPCE

Name of Trainee: _____ Evaluation: 1 Month

Name of Preceptor: _____

Date: _____ Completed by: Perceptor/Mentor

Preceptor/Mentoring (6 and 12 month evaluation)

Assists in precepting nurse practitioner, physician assistant, pharmacy and medical students:

Provides quality feedback to trainee from direct observation:

Teaching (6 and 12 month evaluation)

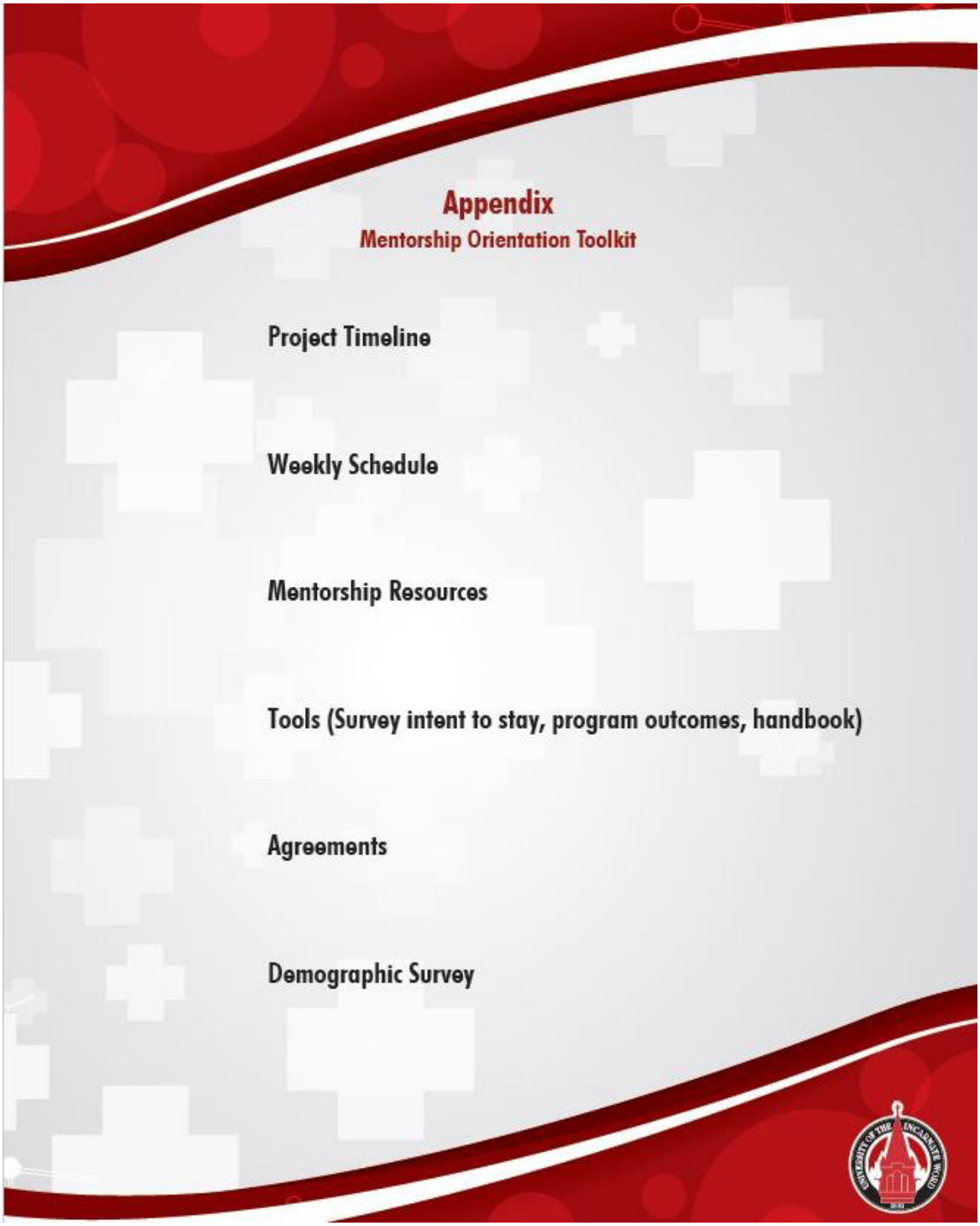
Teach topic of choice to the team and others: _____

Create learning objectives and content outline for the lesson:

Provide journal articles, handouts, clinical resources, etc:

Provide evaluation form to obtain feedback from team to improve teaching skills:

Mentorship Orientation Toolkit



Program Booklet: Certificate of Completion

Appendix

Certificate of Completion

This is to certify that

_____

had successfully completed the XXX hours of the Advance Nurse Practitioner mentorship program at Central Texas Veterans Health Care System, Temple, Texas.

Given this _____ day of _____.

_____

Catherine Davis– ADPCS

_____

XXX XXXX XXXX– Chief APRN

_____

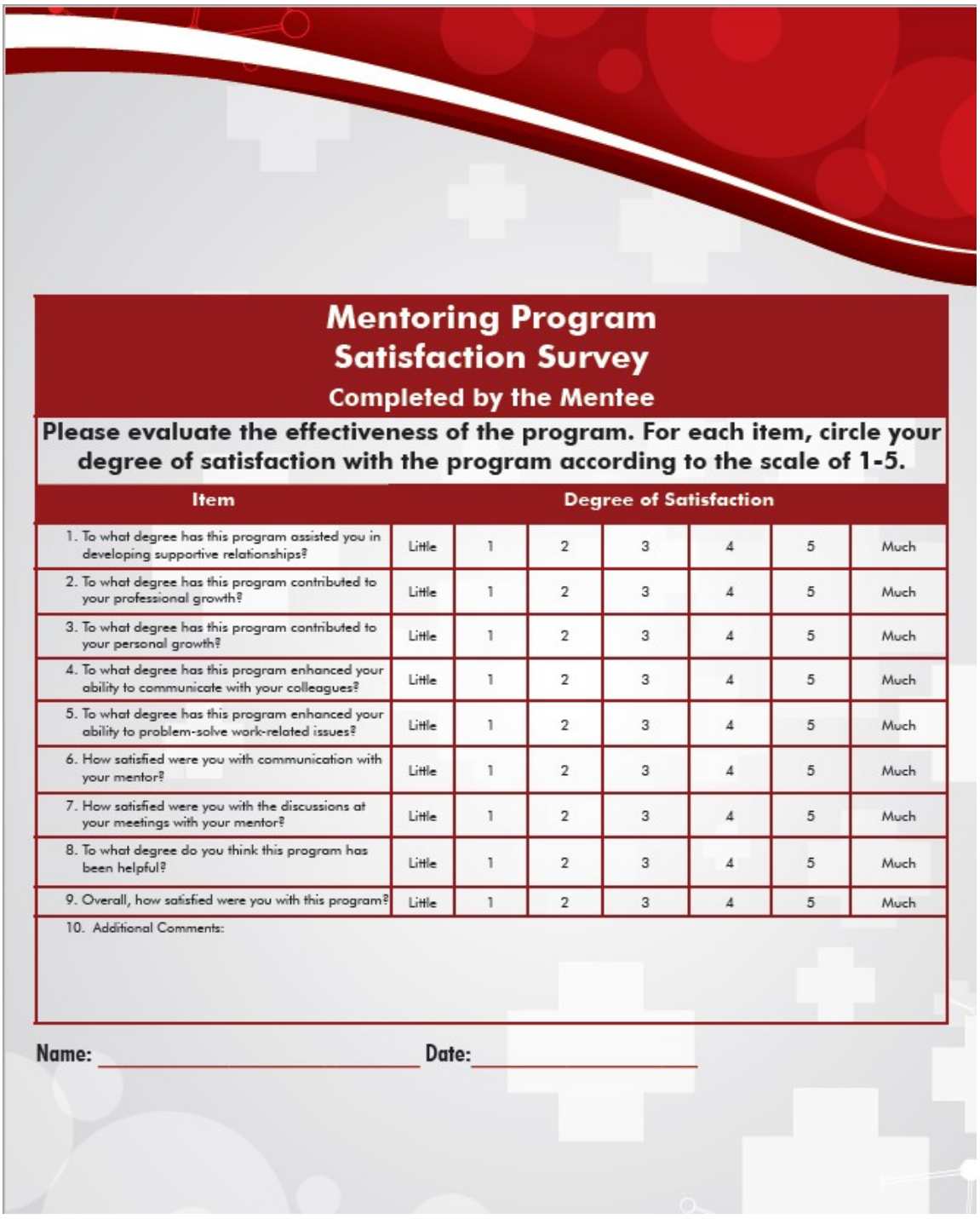
May Tanay FNP – Mentor Project Coordinator

_____

LeVeeta Springer MSN, RN – Nursing Excellence Coordinator

Appendix B

Mentoring Program Satisfaction Survey



Mentoring Program Satisfaction Survey

Completed by the Mentee

Please evaluate the effectiveness of the program. For each item, circle your degree of satisfaction with the program according to the scale of 1-5.

Item	Degree of Satisfaction						
1. To what degree has this program assisted you in developing supportive relationships?	Little	1	2	3	4	5	Much
2. To what degree has this program contributed to your professional growth?	Little	1	2	3	4	5	Much
3. To what degree has this program contributed to your personal growth?	Little	1	2	3	4	5	Much
4. To what degree has this program enhanced your ability to communicate with your colleagues?	Little	1	2	3	4	5	Much
5. To what degree has this program enhanced your ability to problem-solve work-related issues?	Little	1	2	3	4	5	Much
6. How satisfied were you with communication with your mentor?	Little	1	2	3	4	5	Much
7. How satisfied were you with the discussions at your meetings with your mentor?	Little	1	2	3	4	5	Much
8. To what degree do you think this program has been helpful?	Little	1	2	3	4	5	Much
9. Overall, how satisfied were you with this program?	Little	1	2	3	4	5	Much
10. Additional Comments:							

Name: _____ **Date:** _____

Appendix C
Letter of Support

DEPARTMENT OF VETERANS AFFAIRS
Central Texas Veterans Health Care System
1901 Veterans Memorial Drive
Temple, Texas 76504

November 26, 2019

University of the Incarnate Word
4301 Broadway Street
San Antonio, Texas 78209

RE: Performance Improvement Project Letter of Support for Rodney L. Duckett

Dear University of the Incarnate Word Chair, Faculty and Members:

I am writing this letter of support for Rodney L. Duckett. We intend to support the Rodney L. Duckett performance improvement project (described below).

Performance Improvement Project Overview

1. Project Purpose:

The purpose of this Doctor of Nurse Practice project is to assess advanced practice registered nurses (APRNs) mentorship program for novice nurse practitioners who are transitioning to practice.

2. Background & Rationale:

There are an estimated 270,000 APRNs licensed to practice in the U.S. in addition to nearly 30,000 more graduating annually. APRNs are a growing profession in healthcare and significant piece to the answer for the decreasing shortage of primary care providers and other critically low specialties in the United States. The transition into practice for a novice APRN can be extremely challenging without a dedicated training program to support the growth of the APRN. Importantly, our United States Veterans being a different population, is suffering from the effects of the shortage. In May 2019, The Central Texas Veterans Health Care System (CTVHCS), a small committee of masters prepared nurses and APRNs, proposed an NP residency coupled with mentorship to provide well-rounded clinical assimilation to better prepare novice and experienced APRNs within the CTVHCS. Currently, The Central Texas Veteran Health Care System (CTVHCS) lacks a formalized structured mentorship program for novice APRNs entering the VA System. The impact of this DNP project will increase participation and enrollment of APRN mentees and mentors in addition to an overall improvement of patient outcomes with a smoother transition into practice and CTVHCS.

Sincerely,

May Tanay, MSN, APRN, FNP-C
DNP Project Mentor
Geriatric and Extended Care
Central Texas Veterans Health Care System
1901 Veterans Memorial Drive
Temple, TX 76504
Tel: 254-743-2491
Email: may.tanay@va.gov

Appendix D
Institutional Review Board (IRB)

12/20/2019

Project Lead: Rodney Duckett
Project title: Mentorship

Rodney:

Your project titled Mentorship was deemed to be **Not Regulated Research**.

Your proposed project was reviewed and found to not meet federal regulatory requirements for human subject research and does not require approval via the IRB process. Please use the IRB number **NRR [19-067** when inquiring about or referencing this determination.

No further review of the project as proposed is required. Should you determine at any point you wish to add additional elements to the project, please contact us before initiating those components, as this may impact the determination.

For information regarding the IRB or the review process, please contact me at (210) 805-5885.

Sincerely,

Ana Hagendorf, PhD, CPRA

Ana Hagendorf, PhD, CPRA
Director, Office of Research and Sponsored Projects Operations
Office of Research and Graduate Studies
University of the Incarnate Word
4301 Broadway, CPO 1216
San Antonio, Texas 78209
(210) 805-3036
wandless@uiwtx.edu

Appendix E

Mentoring Competency Assessment (MCA)

Appendix

Mentoring Competency Assessment (MCA) (Fleming, M. et al., 2013)

Mentoring Skills

Please rate how skilled you feel your mentor is in each of the following areas. [We understand that you can only speak from your personal experience. Please try to rate a skill whenever possible, reserving the 'not observed' category for cases where you have no basis for assessment.]

	Not at all			Moderately			Extremely	Not Observed
	1	2	3	4	5	6	7	
1. Active listening								
2. Providing you constructive feedback								
3. Establishing a relationship based on trust with you								
4. Identifying and accommodating different communication styles								
5. Employing strategies to improve communication with you								
6. Coordinating effectively with other mentors with whom you work								
7. Working with you to set clear expectations of the mentoring relationship								
8. Aligning his or her expectations with your own								
9. Considering how personal and professional differences may impact expectations								
10. Working with you to set research goals								
11. Helping you develop strategies to meet research goals								
12. Accurately estimating your level of scientific knowledge								
13. Accurately estimating your ability to conduct research								
14. Employing strategies to enhance your understanding of the research								
15. Motivating you								
16. Building your confidence								
17. Stimulating your creativity								
18. Acknowledging your professional contribution								
19. Negotiating a path to professional independence with you								
20. Taking into account the biases and prejudices he/she brings to your mentor/mentee relationship								
21. Working effectively with mentees whose personal background is different from his/her own (age, race, gender, region, culture, religion, family composition, etc.)								
22. Helping you network effectively								
23. Helping you set career goals								
24. Helping you balance work with your personal life								
25. Understanding his/her impact as a role model for you								
26. Helping you acquire resources (e.g. grants, etc.)								

Appendix F

Permission to Use the Centers of Excellence in Primary Care Education Evaluation Tool

From: Michael F Fleming <m-fleming@northwestern.edu>
Sent: Thursday, April 9, 2020 7:41 PM
To: Duckett, Rodney L. <Rodney.Duckett@va.gov>
Subject: [EXTERNAL] Re: Permission to Use MCA Instrument

Yes you have my permission to use the MCA

Good luck with your work on mentoring

Sent from my iPhone

On Apr 9, 2020, at 12:05 PM, Duckett, Rodney L. <Rodney.Duckett@va.gov> wrote:

Dear Dr. Michael Flemings

I am a VA employee and doctoral student from University of the Incarnate Word in San Antonio, Texas. I am writing my Doctor of Nursing Practice (DNP) project tentatively titled *"Establishing a Formalized Structured Mentorship Program for Newly Hired Nurse Practitioners within the Veterans Affairs (VA)"* under the direction of my DNP committee advisor Dr. Holly DiLeo, May Tanay FNP, and LeVeeta Springer MSN/MBA.

I would like your permission to reproduce Centers of Excellence in Primary Care Education (CoEPCE) evaluation tool in my DNP project. I would like to use and print the CoEPCE evaluation tool under the following conditions:

1. I will use this evaluation tool only for my DNP project and will not sell or use it with any compensated or curriculum development activities.
2. I will include the copyright statement on all copies of the instrument.
3. I will send my research study and one copy of reports, articles, and the like that make use of these evaluation tool data promptly to your attention.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it through email: rodney.duckett@va.gov; rodney.duckett@gmail.com or email permission confirmation.

Sincerely,

Rodney L. Duckett

Rodney L. Duckett, BSN, RN
Doctor Nurse of Nurse Practice, Student
University of the Incarnate Word
4301 Broadway St,
San Antonio, TX 78209

Appendix G

Permission for Mentor Satisfaction Survey

Duckett, Rodney L.

From: Regina Donohue <regina.donohue@amsn.org>
Sent: Thursday, May 14, 2020 10:52 AM
To: Duckett, Rodney L.
Subject: [EXTERNAL] Re: Permission to Use Mentoring Program Satisfaction Survey

Good morning Rodney,

Thank you for inquiring about AMSN Mentoring Program. The AMSN Mentoring Program is provided as a service to the industry.

Our website contains the following statement: "You may use and customize the information and tools provided in any manner you deem appropriate for your agency or yourself."

The pdf contains the following statement: "Copyright (c) 2012 by the Academy of Medical-Surgical Nurses. All rights reserved.
Authorization to duplicate and personalize items for internal agency and personal use is granted by AMSN."

Reference would need to acknowledge AMSN as their Mentoring Program.

Here is a copy of the article where I believe the validity scores were discussed.
These guides were a result of the research completed by Cece Grindel many years ago (about 12 years ago) so the article looks pretty old, but because the topic is not clinical and facilities tell us it is still an effective program we have not updated it! It was a 5 year study during 2003 - 2007. Article published in 2009.

If you need to refer others here, use this link. https://www.amsn.org/professional-development/mentoring
The article is listed near the bottom of the page under its title - Nurses Nurturing Nurses: Outcomes and Lessons Learned

We hope you find it useful also. Thank you for thinking of AMSN as a valuable resource.

Regina Donohue
Customer Service Specialist
866.877.2676
regina.donohue@amsn.org
www.amsn.org
PO Box 56
Pitman, NJ 08071-0056