The Workforce Rx:
Scaling Nursing and Allied Health Talent in Idaho through Preceptorships and Apprenticeships

Developed by the Idaho Healthcare Workforce Solutions Collaborative

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Acknowledgments

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We are especially thankful to the members of the statewide 2025 Working Group—representing postsecondary institutions, healthcare employers, regulatory bodies, and state agencies—whose time, expertise, and thoughtful dialogue shaped every stage of this process. Their perspectives were critical in grounding this plan in on-the-ground realities and ensuring that proposed solutions are actionable and aligned with Idaho's long-term workforce goals.

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This work builds on previous research completed by the Idaho Healthcare Workforce Collaborative in 2024 supported by its Leadership Group, institutional leaders of post-secondary healthcare programs in Idaho. Collective input from this group surfaced the broad strokes of effective solutions in healthcare education & training in Idaho, which formed the foundation for this business plan. The members of the 2025 Working Group participated in interviews, completed surveys, reviewed drafts, and contributed data and case studies. Their collective input enriched the plan and reflected a shared commitment to building a stronger, more resilient healthcare workforce for all Idaho communities.

The extensive research and cross-sector coordination underlying this business plan was conducted by Tyton Partners, *a national strategy consultancy focused on the education and workforce sectors based in Boston, MA.*

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Introduction and investment case

This business plan presents a coordinated strategy to address Idaho's pressing shortage of healthcare workers by investing in a statewide education and training solution. The plan builds on two years of stakeholder engagement and research and is informed by leaders from Idaho's educational institutions, healthcare employers, and state agencies. With project leadership from the Idaho State Board of Education (SBOE), the Blue Cross of Idaho Foundation for Health (BCIFH), and the Idaho Workforce Development Council (WDC), and technical guidance from Tyton Partners, the plan represents a comprehensive and collaborative response to the bottlenecks that limit Idaho's ability to train and retain healthcare professionals.

Underlying this initiative are two critical interventions for unlocking Idaho's healthcare training capacity: preceptorship flexibility and registered apprenticeships. Preceptorship flexibility models enhance adaptability around who can train students and where clinical training can happen, while registered apprenticeships combine paid on-the-job training with related technical instruction to offer students a practical education. These approaches address the specific needs of the nursing pathway from Certified Nursing Assistant (CNA) to Licensed Practical Nurse (LPN) to Registered Nurse (RN) and selected high-demand allied health technician roles such as surgical technicians and radiologic technicians. The business plan outlines a phased approach for implementing these models statewide, beginning with rural pilot regions that demonstrate both high need and strong stakeholder readiness, and scaling over a five-year period from 2026 to 2030.

This plan proposes building on an existing intermediary with the potential for strategic expansion, leveraging statewide and partner resources to drive impact. This intermediary will coordinate with partners on the development of a statewide preceptorship database, recruitment and support for preceptors, design apprenticeship programs, and serve as a central liaison among key stakeholders. This intermediary could receive oversight from the State Board of Education and maintain close alignment with Idaho's Division of Career Technical Education and Workforce Development Council. Staffing, expenses, and activities will scale over time, with a deliberate emphasis on piloting in rural regions and gradually expanding reach statewide.

The investment required to support this initiative is justified by the magnitude and urgency of Idaho's healthcare workforce crisis. With more than 850 vacant nursing roles and persistent shortages in critical allied health professions, particularly in rural areas, targeted investment can yield sustained returns in workforce supply and healthcare access. The proposed intermediary will enable the expansion of these solutions that will ultimately close approximately 14% of RN vacancies (with a strengthened pathway to close more vacancies over time), 67% of LPN vacancies, and 10-20% of the total shortfalls across high-need allied health technician roles. It will also provide a platform for tracking progress, adapting strategies, and coordinating public

and private resources. This business plan serves as a call to action for funders, policymakers, and system leaders to invest in Idaho's future with a model that is grounded in best practices from other states, aligned with local needs, and ready to scale.

Context: Idaho's healthcare workforce shortage

Like the rest of the nation, Idaho is facing a sustained and intensifying shortage of healthcare workers[1], particularly in the nursing and allied health sectors. This shortage poses a significant threat to patient access, hospital and clinic operations, and the long-term resilience of healthcare delivery systems, especially in the state's rural and remote regions[2].

In the nursing field, the most acute employer needs are in registered nursing (RN) and licensed practical nursing (LPN). As of 2024, Idaho reported approximately 700 unfilled RN positions and 150 unfilled LPN roles, with vacancies heavily concentrated in long-term care, critical access hospitals, and rural clinics[3]. These shortages are the result of several intersecting factors[4]. A wave of early retirements during and following the COVID-19 pandemic significantly reduced the state's experienced nursing workforce. Meanwhile, efforts to replenish the pipeline have been hampered by weak visibility into career pathways for early-stage learners, particularly those beginning as Certified Nursing Assistants (CNAs) or Medical Assistants (MAs), and by limited access to LPN and RN programs in both urban and rural areas.

A major structural barrier to expanding nursing program capacity is the shortage of clinical placements and preceptors[2]. Although Idaho's regulatory environment permits a range of preceptorship arrangements, including flexible preceptor credentials and alternate clinical settings[4], higher education institutions have struggled to recruit and retain enough preceptors to support growing student demand. Without sufficient preceptors, many programs are forced to cap enrollment or extend completion timelines, creating bottlenecks for students seeking to progress from entry-level certifications into licensed practice.

In the allied health sector, the challenges are similarly acute but span a different set of roles[3]. Healthcare leaders across the state report significant difficulty hiring and retaining surgical

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[1] Idaho Behavioral Health Alliance 2022 Report

[2] Idaho Center for Nursing. (2024). *2024 Idaho nursing workforce report*. https://s3.amazonaws.com/nursing-network/production/attachments/272550/original/2024_Idaho_Nursing_Workforce_Report_Final.pdf; Clinical placements are defined as any arrangements where students are present, for educational purposes, in environments that provide healthcare or related services to patients or the public (General Medical Council); Preceptorship is defined as an approach to teaching and learning within the context of the practice setting which allows students to develop self-confidence while increasing their competence as they become socialized within the profession (Nurse Education in Practice)

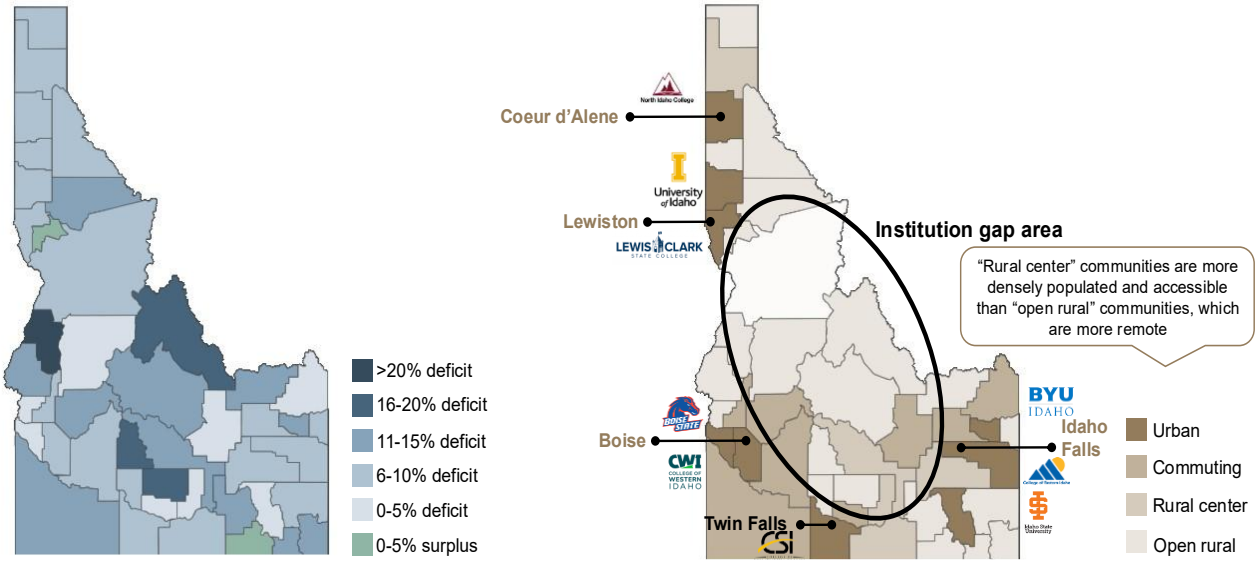
[3] Tyton Partners analysis, Lightcast employment data

[4] Idaho Legislature. (2025). *Title 54, Chapter 14, Section 54-1411A: Renewal and reinstatement of licenses*. https://legislature.idaho.gov/statutesrules/idstat/Title54/T54CH14/SECT54-1411A/

technicians and radiologic technologists in particular. These roles require specialized, high-touch clinical education that is both resource-intensive and difficult to scale. Training programs often rely on adjunct faculty or working professionals to deliver instruction, but many institutions struggle to offer competitive compensation for these instructors—further limiting their ability to meet employer demand.

These workforce shortages are most severe[3] in Idaho's rural and remote communities. Many of these areas—particularly counties classified as "open rural" or "rural centers" by the Idaho Department of Health and Welfare—report persistent vacancy rates of 15% or more in key healthcare roles. These regions face a triple constraint: they are often far from higher education institutions that offer healthcare training, they lack sufficient clinical infrastructure to support student placements locally, and they experience long-standing challenges with workforce retention, as students trained in urban centers often do not return to practice in their home communities.

Map of Idaho counties by priority healthcare role deficit[5]; map of Idaho colleges offering healthcare programs & counties by urbanicity[6].



[5] Priority healthcare roles identified as Nursing assts., orderlies, & psychiatric aides, Registered nurses, LPNs & LVNs, Home health & personal care aides, Health practitioner support techs, Therapists, Misc. healthcare diagnosing or treating practitioners, Clinical laboratory techs, Diagnostic related techs, and Physical therapist assts. & aides; Deficit % calculated as the difference between 2025 hires and separations plus the number of open roles in 2025, divided by total ideal employment (2025 jobs plus number of open roles in 2025)

[6] As designated by the Idaho Department of Health and Welfare

Taken together, these challenges reveal a deeply rooted and multi-tiered pipeline breakdown. Entry into healthcare careers is limited by poor pathway visibility and student advising. Progression through the system is slowed by shortages in clinical training capacity, faculty, and flexible preceptorship options. And even when students graduate, rural communities struggle to retain them, deepening regional disparities in healthcare access and outcomes.

Addressing Idaho's healthcare workforce shortage will require coordinated interventions that simultaneously expand program capacity, improve access to high-quality clinical training, and strengthen local placement and retention, particularly in rural and underserved communities. This initiative is designed to do exactly that: to remove key barriers across the education-to-employment continuum and ensure that the state can develop, deploy, and sustain a workforce that meets its growing and geographically distinct healthcare needs.

A stakeholder-informed approach to addressing workforce gaps

In response to growing concerns about Idaho's healthcare workforce shortages, the Idaho Healthcare Workforce Collaborative, a coalition of statewide employer, institutional, and government leaders, has been convening regularly since 2023. With financial support and leadership from the Blue Cross of Idaho Foundation for Health (BCIFH) and additional leadership by the Idaho State Board of Education (SBOE) and the Idaho Workforce Development Council (WDC), this group coalesced around a shared goal: to design an initiative capable of addressing critical education and training bottlenecks contributing to the healthcare workforce shortage in Idaho through innovative, scalable approaches to preceptorship and apprenticeship.

Tyton Partners, a national strategy consultancy focused on the education and workforce sectors, was engaged to guide the design and planning process of this effort in 2024 and 2025. Tyton Partners led a structured, research-based effort, incorporating broad stakeholder engagement and national best practices to ensure that the resulting strategy would be deeply informed by Idaho's local realities and positioned for sustainable implementation.

The foundational research phase included:

- Primary interviews with Idaho-based healthcare employers, postsecondary institutions, and clinical training providers to understand pain points and capacity constraints;
- A statewide employer survey, designed to surface regional variations in staffing needs, training infrastructure, and hiring trends; and
- A review of case studies from peer states, examining effective models for clinical training expansion, rural healthcare pipeline development, and public-private collaboration.

At the center of this work was a three-part design workshop series held during spring and summer 2025. These sessions convened a Working Group of 12 senior leaders from Idaho's colleges and universities, hospital systems, and state agencies. Each session focused on a distinct objective in the planning arc:

1. Vision Setting – Aligning on shared goals, design principles, and workforce priorities;
2. Model Refinement – Evaluating program structures, implementation scenarios, and institutional readiness; and
3. Governance and Sustainability Planning – Clarifying roles and responsibilities, decision-making protocols, and long-term funding pathways.

To supplement the group dialogue, Tyton also conducted individual interviews with each Working Group participant. These conversations helped test assumptions, refine emerging ideas, and ensure that all key stakeholders had a voice in shaping the final design.

The outcome of this collaborative, multi-stakeholder process is this comprehensive business plan for a statewide initiative that reflects Idaho's unique healthcare education and delivery landscape. The approach outlined in this plan is rooted in local data, practitioner insight, and operational feasibility, and shaped directly by the institutions and individuals responsible for educating, training, and employing Idaho's healthcare workforce[7].

Vision, mission, and goals

This plan envisions an Idaho in which every community—urban, rural, and remote—has access to a resilient, responsive healthcare workforce capable of meeting its evolving needs. The focus is to reduce the persistent barriers that prevent students from entering, advancing through, and completing healthcare training programs, particularly in regions where health systems are under the greatest strain.

Over the five-year period from 2026 to 2030, this initiative will work to:

- **Expand access to high-quality, flexible clinical education and apprenticeship opportunities;**
- **Support Idaho's public higher education institutions and healthcare employers in delivering more career-aligned, scalable training models; and**

[7] Tyton Partners was engaged to produce this business plan and while it broadly articulates the consensus of the working group, it may not fully reflect the opinions of all the individual members.

- **Strengthen workforce pipelines in nursing and allied health, with a focus on roles that are difficult to fill yet critical to delivering care, especially in underserved areas.**

While attracting and retaining healthcare professionals and aligning public policies with best practices in healthcare are recognized needs to improve Idaho's healthcare workforce, pursuing those particular strategies are the work of other groups within Idaho's Healthcare Workforce Collaborative.

This business plan recommends the funding and establishment of an intermediary organization whose responsibility will be to coordinate across higher education institutions, employers, and government agencies towards success of the activities outlined for this initiative. This intermediary organization will draw on existing expertise and program structures while receiving support and oversight from Idaho's State Board of Education, Division of Career Technical Education, and Workforce Development Council.

At the heart of this work is a focus on two high-need domains: the nursing pathway and a select group of allied health technician roles.

The nursing strategy supports a full continuum of preparation from entry-level certifications such as Certified Nursing Assistant (CNA) and Medical Assistant (MA), through Licensed Practical Nurse (LPN) credentials, and into Registered Nurse (RN) licensure. Within this pathway, particular emphasis will be placed on improving access to LPN-to-RN transition programs, which is a known bottleneck in Idaho's current pipeline that limits progression and reduces overall system capacity. By addressing this constraint directly, the initiative aims to create a more stable, upwardly mobile nursing workforce across the state.

In parallel, the initiative will focus on expanding access to training in priority allied health roles, including surgical technicians and radiologic technologists. These professions have been identified by Idaho healthcare leaders as both urgently needed and particularly difficult to hire, due in part to the prohibitive cost and complexity of training. Their inclusion reflects a deliberate focus on occupations with outsized impact in rural settings, where each clinical team member often plays a pivotal role in service delivery. Though these are the current recommended allied health roles to support, they may evolve over time as new workforce needs emerge and additional data becomes available.

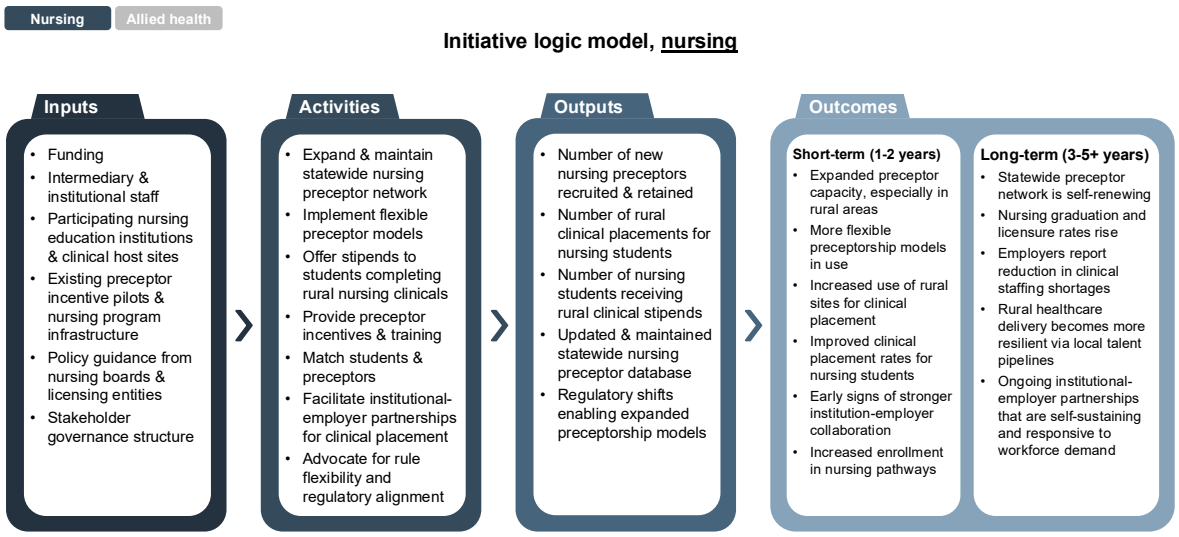
By targeting these two sectors, nursing and allied health, the initiative seeks to unlock local training capacity, expand access to hands-on clinical experiences, and strengthen the long-term viability of healthcare career pathways in the communities that need them most. This dual focus is designed not only to increase the supply of job-ready healthcare professionals, but also to ensure that Idaho's most vulnerable regions are better equipped to attract, train, and retain the talent they need to provide high-quality care.

Nursing solution overview

Idaho's acute nursing workforce shortage remains one of the state's most urgent healthcare challenges. Persistent vacancies across Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN), and Registered Nurse (RN) roles strain care delivery systems statewide, particularly in rural and remote areas. While employers continue to face difficulty hiring and retaining qualified nurses, students pursuing nursing careers encounter barriers at key transition points, such as advancing from CNA or Medical Assistant roles into LPN programs, or from LPN programs into RN licensure. These bottlenecks are often exacerbated by limited clinical placement infrastructure and a chronic shortage of preceptors, making it difficult for students to complete required clinical hours without extensive travel, long waitlists, or delayed program completion.

To address these systemic challenges, this initiative is centered on expanding and modernizing Idaho's clinical education infrastructure, with a focus on preceptorship reform, scale, and accessibility.

Logic model, nursing program



The solution includes three strategies designed to unlock latent capacity, promote institutional innovation, and ensure shared accountability across the education-to-employment continuum.

1. Unlocking preceptorship flexibility

Idaho's regulatory framework allows for a degree of flexibility in how preceptorships are structured both in terms of who can serve as a preceptor and where clinical education can occur. For example, preceptors are permitted to supervise students training for a role they have experience in but do not need to be credentialed at a higher level, and clinical placements are

allowed in assisted living facilities as well as hospitals and more traditional settings. However, this flexibility is not currently being taken advantage of to its fullest extent.

This initiative will capitalize on those regulatory flexibilities by:

- Training stakeholders on how to implement flexible preceptorship models without compromising quality or compliance; and
- Disseminating best practices and model policies to institutions and employers.

Leveraging these practices will expand the pool of eligible preceptors and offer preceptors more support and training to maximize their potential impact on student trainees. Similar practices have been successfully employed to decrease preceptor shortages in other contexts, such as Arizona's Rural Health Professions Program (RHPP), which created new training programs in nontraditional locations like poison control centers.

Together, these efforts aim to reduce clinical placement bottlenecks and ensure that more students can progress through their training in a timely and supported manner.

2. Advancing statewide coordination and infrastructure

To streamline clinical education and expand access across the state, the intermediary leading this initiative will establish a centralized infrastructure to support the coordination of preceptor and clinical site placements. Key activities will include:

- Developing and maintaining a statewide preceptor and clinical site database, improving visibility into available training opportunities, reducing duplication of effort, and enabling more equivalent placement of students in rural and urban Idaho;
- Recruiting, vetting, and credentialing new preceptors, with a particular focus on expanding access in rural and underserved communities;
- Implementing financial incentives (e.g., stipends or preceptor tax credit supports) to recognize the time and effort involved and to strengthen the preceptor pipeline; and
- Providing technical assistance to postsecondary institutions, supporting the adoption of more flexible clinical education models, and helping programs design clear, stackable pathways that guide students from entry-level certifications through to RN licensure.

Similar centralized preceptorship and mentorship database construction efforts supported Montana's highly successful Rural Allied Health Professions Training Program (MRAHPTP), which helped drive a 900% increase in Medical Lab Technician program enrollment over three years[8].

[8] Montana State University; MRAHPTP was a Montana AHEC program and was operated out of Montana State University's AHEC office

Together, these efforts will increase placement transparency, reduce administrative burden on both institutions and employers, and foster stronger, more coordinated partnerships between the education and healthcare sectors.

3. Establishing a partnership model with shared responsibility and shared benefit

Effective implementation relies on a coordinated model that clearly defines the roles and mutual benefits for higher education institutions and healthcare employers. Each partner brings essential contributions to the clinical training ecosystem:

- Higher education institutions are responsible for adapting and delivering flexible clinical education models, managing student placements, and tracking learner progression;
- Healthcare employers provide access to clinical sites, contribute qualified preceptors, and benefit directly from a more robust, localized talent pipeline.

In return, institutions receive customized technical assistance, access to implementation best practices, and support for enrollment growth. Employers benefit from early engagement with job-ready students, workforce insights aligned with their hiring needs, and streamlined support in hosting clinical placements.

All participating partners will engage in shared data reporting and continuous improvement efforts, including regular check-ins and feedback loops to ensure the model remains responsive, effective, and respectful of student privacy.

Nursing outcomes and impact timeline

This initiative is structured to deliver both near-term gains and long-term transformation to Idaho's nursing workforce pipeline. By building momentum early and investing in scalable infrastructure, the intermediary organization leading this work will lay the foundation for durable, statewide impact.

Intended short & long-term outcomes, nursing program

Short-term outcomes (1-2 years post launch)	Longer-term outcomes (3-5+ years post launch)
• Expand preceptor participation, particularly in rural and remote communities, by offering financial incentives, technical assistance, and streamlined credentialing processes; • Increase adoption of flexible preceptorship models, empowering institutions and employers to maximize existing clinical training resources without compromising quality or regulatory compliance; • Improve clinical placement rates and nursing program enrollment, especially in LPN and LPN-to-RN transition programs, by alleviating bottlenecks tied to limited clinical capacity; • Strengthen collaboration between higher education institutions and healthcare employers, through structured partnerships, shared accountability, and routine data sharing.	• Establishing a durable, statewide preceptor network, with strong rural representation and an active pipeline of new preceptors; • Increasing nursing program completion and licensure rates, driven by smoother student progression, reduced time-to-credential, and greater placement support; • Achieving measurable reductions in nurse vacancy rates, especially in high-need geographies and care settings; • Contributing to the development of a more equitable rural healthcare delivery system, where local talent is trained, supported, and retained to meet community needs.

In pursuing these outcomes, this initiative will create a better understanding of nursing supply and demand in Idaho and strengthen pathways to roles with critical staffing shortages (i.e., Registered Nurses).

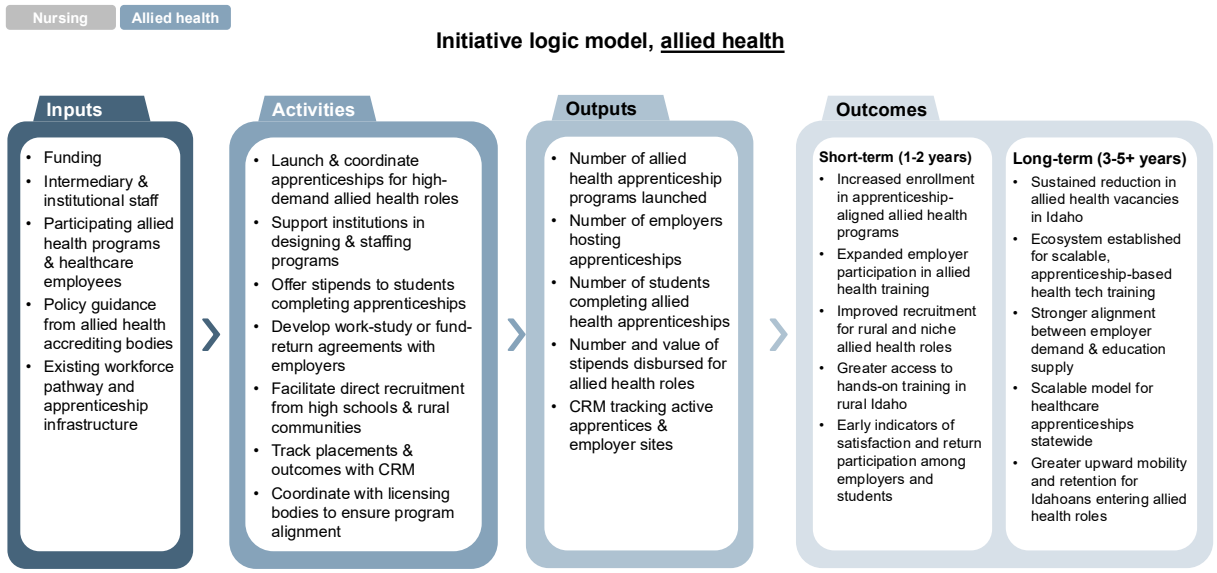
Allied health solution overview

Within Idaho's broader healthcare workforce shortage, deficits in critical allied health technician roles have emerged as a major barrier to both care access and quality, particularly in rural and remote areas. Positions such as surgical technicians and radiologic technicians are especially difficult to fill. This is due in part to the absence of local training programs, which often rely on in-person, hands-on learning opportunities that are not widely available outside of major population centers.

Employers and education providers have flagged several persistent challenges: the prohibitive cost of launching new programs, limited faculty availability, and low visibility of these career paths among students, which depress enrollment even where training is available. These obstacles have contributed to a cycle in which employer demand outpaces institutional capacity, especially in high-need geographies.

To address these gaps, this initiative will prioritize the development and scale of registered apprenticeship models that offer students structured, hands-on learning while directly aligning with employer needs. This approach provides a viable, scalable alternative to traditional programs, particularly in regions where brick-and-mortar expansion is not feasible.

Logic model, allied health program



The initiative will be supported by three coordinated strategies:

1. Codifying apprenticeship program best practices

The intermediary organization will lead the development of a comprehensive design framework for allied health apprenticeships, drawing from successful models in Idaho and peer states. Registered apprenticeships are defined as educational experiences that combine paid on-the-job training and mentorship with related technical instruction and culminate in the earning of a credential. This work will build on existing registered apprenticeship programs already coordinated by the Apprenticeship Idaho Coalition. Disseminated resources will include:

- Program design templates;
- Competency-based curriculum frameworks;
- Supervision and mentorship requirements; and
- Clear pathways to certification or licensure, where applicable.

By providing clear, standardized guidance and implementation tools, the initiative aims to lower the barriers to entry for institutions and employers interested in launching or scaling apprenticeship programs, while ensuring quality and statewide consistency.

2. Offering targeted technical assistance

To support adoption at scale, the intermediary will offer direct technical assistance to both education providers and healthcare employers.

For higher education institutions, support will include:

- Embedding apprenticeship structures within existing allied health curricula;
- Developing dual-enrollment pathways to engage high school students and offering advice on how to leverage existing LAUNCH funding; and
- Integrating hybrid and simulation-based learning models to reduce reliance on scarce clinical sites.

For employers, the intermediary will:

- Support the design of recruitment and selection strategies;
- Assist in clarifying supervision expectations and mentorship roles; and
- Recommend incentive structures that make participation both feasible and attractive.

This dual-pronged approach ensures that apprenticeship models are integrated into the broader talent pipeline, rather than functioning as isolated or ad hoc efforts.

3. Coordinating innovative staffing models

A central element of the allied health strategy will be the development of staff-sharing agreements between healthcare employers and educational institutions. Under these agreements, healthcare employers may designate experienced practitioners to serve as adjunct faculty or clinical instructors, with shared funding or cost-reimbursement mechanisms to offset the financial impact.

This model, which is already used successfully in Idaho on a limited basis and proven in other states, offers a cost-effective way to expand training capacity without requiring institutions to invest in new full-time faculty. It also reinforces alignment between classroom training and workforce needs by embedding industry expertise directly into instruction.

Allied health outcomes and impact timeline

This initiative is designed to support short-term wins and long-term improvement to Idaho's allied health education and training ecosystem. Effective resourcing and staffing can support an intermediary organization to quickly gain momentum in Idaho.

Intended short and long-term outcomes, allied health program

Short-term outcomes (1-2 years post launch)	Longer-term outcomes (3-5+ years post launch)
• Increased enrollment in allied health apprenticeship programs, particularly in high-need technician roles; • Expanded access to rural and hands-on training opportunities, through simulation, hybrid delivery, and localized apprenticeship placements; • Improved participation in workforce-aligned training pathways, with a growing number of students entering and advancing through structured programs; • Greater employer satisfaction with apprenticeship pipelines, based on early evidence of job readiness and training alignment.	• Increased student placement into high-demand allied health roles, supported by strong recruitment, mentorship, and on-the-job learning; • Reductions in regional and statewide allied health workforce shortages, especially in rural and remote communities; • A durable ecosystem for apprenticeship-driven workforce development, with scalable models adopted across institutions and employer networks; • Improved alignment between talent supply and employer demand, supported by shared data systems, feedback loops, and targeted technical assistance.

Through these outcomes, Idaho will be positioned to build a more agile and responsive allied health workforce pipeline, one that can grow and adapt alongside the state's evolving healthcare needs, with a special focus on rural Idaho.

Strategic governance and delivery structure

Establishing a well-positioned and capable intermediary entity is critical to the success of this initiative. Idaho's healthcare education and workforce landscape is geographically dispersed, with multiple institutions, employers, and agencies operating independently. While each plays an essential role, the absence of centralized coordination has limited the state's ability to address persistent workforce gaps at scale.

A lighter-touch approach such as offering only coordination or advisory support would lack the authority, resources, and hands-on capabilities needed to implement statewide reforms in preceptorship and apprenticeship. Similarly, a modestly resourced intermediary would struggle to provide the direct technical assistance, stakeholder engagement, and performance monitoring required to achieve system-wide impact. To succeed, the initiative requires a strong, neutral intermediary with a clear mandate, cross-sector credibility, sufficient resources, and operational capacity.

Housing the intermediary

Several options for housing an intermediary were evaluated to determine where this function should reside:

- A new, standalone nonprofit. This option would offer maximum independence and operational flexibility, potentially positioning the initiative to attract philanthropic investment and adapt quickly to stakeholder needs. However, a new entity could face

credibility challenges, delay momentum, and require substantial early-stage capacity building to gain traction with state leaders and institutional partners.

- An embedded function within an existing organization, such as the Idaho State Board of Education (SBOE), Idaho Division of Career Technical Education, or another workforce-aligned body such as the Idaho Healthcare Institute. This model would offer stronger alignment with public funding streams, policy priorities, and existing infrastructure. It could also enhance legitimacy, facilitate inter-agency collaboration, and reduce duplication of efforts, which is especially important in a resource-constrained environment.

After weighing these trade-offs and examining successful models from other states, this plan **recommends establishing an intermediary organization that would have direct oversight from the Idaho State Board of Education, the Idaho Division of Career Technical Education, and the Idaho Workforce Development Council. The intermediary could and should maintain day-to-day operational and funding capacity through an experienced third-party, non-profit organization, e.g., an expanded version of the Idaho Healthcare Institute.**

The SBOE and CTE are already statewide conveners with oversight of healthcare education and have demonstrated consistent leadership on workforce issues across political administrations. Connecting the intermediary to the SBOE and CTE:

- Aligns the initiative with Idaho's long-term workforce development strategies;
- Leverages existing governance and fiscal infrastructure; and
- Enables stronger integration with public higher education systems and funding mechanisms.

To preserve neutrality and promote innovation, the operational functions of the intermediary could be assigned to a designated entity such as the Idaho Healthcare Institute (IHI), which would expand its scope to manage the initiative's implementation. Under this model:

The implementing intermediary would be responsible for:

- Coordinating statewide preceptorship and apprenticeship efforts;
- Developing and disseminating program design resources;
- Administering financial incentives and stipends; and
- Operating the initiative's central data infrastructure.

The SBOE and associated agencies would provide:

- Strategic oversight and accountability;
- Shared performance expectations across participating stakeholders; and
- Governance continuity aligned with Idaho's broader workforce development agenda.

To support these activities, the SBOE could onboard an experienced leader in the Idaho healthcare education and training ecosystem in a part-time or contracting capacity. This person, serving at a program manager or director level, would be responsible for supporting the intermediary organization and advocating for any necessary policy changes and could be compensated at roughly $40,000 per year per the Idaho Division of Human Resources pay grade chart. Going forward, the SBOE would need to evaluate how this staffing might grow and change as this initiative matures and the intermediary scales. Intermediary staffing recommendations are included in the Phased rollout and Expenses and staffing by phase sections below.

The goal of this recommendation is to provide the proposed intermediary with a level of legitimacy and structure while enabling it to operate nimbly and form close partnerships with employers and institutions across regions. Integration with the Workforce Development Council's Talent Pipeline Management (TPM®) initiative is critical. Many employers are already engaged in regional healthcare collaboratives and leveraging the expertise of the TPM® project managers will increase the speed of implementation.

This emulates a similar model seen in state-based Area Health Education Centers (AHECs), which are supported a strong source of federal funding and a federal mandate and maintained by small teams typically spun up within existing organizations that specialize in healthcare education and training (e.g., higher education institutions).

Governance

To ensure transparency and cross-sector alignment, the initiative will establish a multi-tiered governance structure:

- A Governing Board or Advisory Council, composed of representatives from the Idaho SBOE, Idaho Division of Career Technical Education, the Idaho Workforce Development Council, healthcare employers, and educational institutions will guide strategic direction and monitor statewide outcomes. The existing Healthcare Workforce Collaborative may evolve into this function or assign a committee to serve in this capacity.
- A dedicated management team within the intermediary and expanded from an experienced organization such as the Idaho Healthcare Institute will oversee day-to-day operations and stakeholder coordination.

Regular reporting and transparent data-sharing will provide public accountability and ensure sustained focus on measurable outcomes. Through this balanced structure grounded in strategic oversight, operational autonomy, and transparent reporting Idaho will be equipped to deliver a coordinated, durable solution to its healthcare workforce challenges.

Data infrastructure, measurement, and impact

A robust, transparent data infrastructure is foundational to this initiative's success. It will enable real-time tracking of progress, ensure accountability to stakeholders, and support continuous program improvement.

Data priorities and system design

The initiative will establish a centralized data system to collect, integrate, and report on key indicators across program domains. This system will:

- Monitor student participation and progression through nursing and allied health programs;
- Track preceptor and employer engagement, financial support, and geographic distribution;
- Measure student outcomes, including placement, credentialing, and post-program employment; and
- Flag disparities in access, performance, or geographic reach that require corrective action.

The infrastructure will also support routine collaboration with licensing and accreditation bodies, ensuring that the data align with regulatory reporting requirements and inform broader state workforce planning efforts.

Primary metrics

These are the core outcomes against which initiative success will be measured:

- Student Enrollment Growth: Net new enrollments in (1) nursing pathways (CNA → LPN → RN) and (2) allied health apprenticeship programs (surgical and radiologic technician roles);
- Preceptor Engagement: Number of preceptors onboarded and financially supported (e.g., through stipends or tax incentives) each year; and

- Institutional and Employer Participation: Percentage of Idaho's public postsecondary institutions and major healthcare employers engaged in one or more initiative components (e.g., hosting students, using shared tools, contributing data).

Supplemental Key Performance Indicators (KPIs)

To provide a fuller picture of program inclusivity, quality, and sustainability, the initiative will also track:

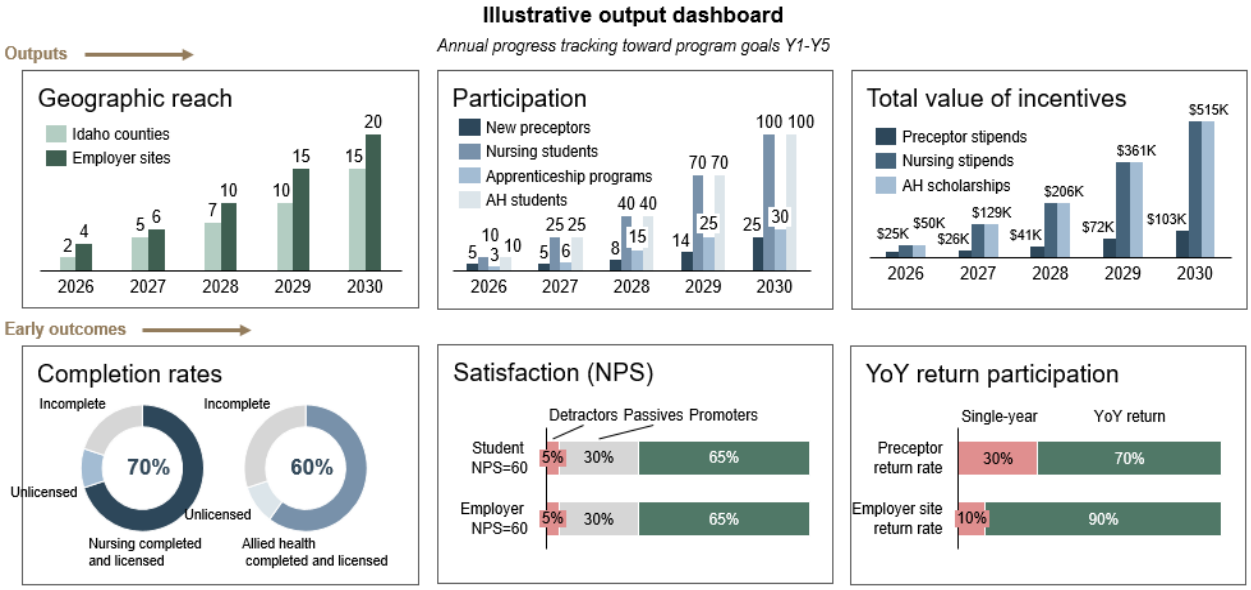
- Geographic Reach: Number of rural counties served; new clinical and apprenticeship sites launched in underserved areas;
- Student Experience: Scholarship delivery, satisfaction scores, participation in rural or hybrid training models, and program completion rates; and
- Employer Engagement: Use of the statewide preceptor database, employer satisfaction, and re-engagement in future student cohorts.

Where quantitative data may be insufficient, qualitative insights gathered through regular surveys and interviews will be used to assess stakeholder satisfaction and identify unmet needs.

Visualization and decision-making tools

All primary and supplemental data will be integrated into a live initiative dashboard like the mockup below.

Illustrative KPI tracking dashboard



This tool will:

- Provide intuitive visualizations of progress toward key milestones;
- Identify regional or programmatic gaps that require intervention; and
- Enable funders, policymakers, and program leaders to make informed, data-driven decisions about resource allocation, scaling, and course correction.

Public-facing elements of the dashboard will also enhance transparency and build trust across institutions, employers, students, and state agencies.

Long-term impact goals (by 2030)

By implementing this data-driven model and investing in high-need roles, the initiative aims to:

- Enroll 100 net new students in nursing pathway programs and 100 net new apprentices in allied health roles each year;
- Sustain financial support for 50 preceptors each year;
- Achieve full participation from Idaho's public postsecondary institutions and build durable partnerships with healthcare providers statewide;
- Reduce vacancy rates and workforce gaps in both urban and rural areas; and
- Contribute to the development of a more resilient healthcare delivery system that prepares and retains talent locally.

By linking real-time data with program delivery and policy, this initiative creates a feedback loop that allows Idaho to monitor, adapt, and scale its healthcare workforce strategy over time. The result will be a more efficient and responsive system—one that ensures Idaho's communities are served by well-trained, locally rooted healthcare professionals.

Phased rollout

This initiative will unfold through a five-year, phased implementation plan designed to build momentum, refine strategies in real-world conditions, and scale solutions that work. Beginning with targeted pilots in high-need rural areas, the initiative will gradually expand statewide delivering measurable workforce impact while strengthening Idaho's healthcare education and employment infrastructure.

Each phase builds on prior lessons, balances investment across systems and stakeholders, and sets clear benchmarks for student participation, employer engagement, and cross-sector alignment. The rollout also reflects a calibrated approach to resource allocation, scaling staff, technology, and financial support to match growing program complexity and geographic reach.

Summary of initiative phases and activities

Phase	Year	Total enrollment	Primary focus	Key activities
1 Infrastructure & Pilot Planning	2026	0 students	Foundation-building	• Hire core staff and launch intermediary • Refresh clinical/ apprenticeship database • Select rural pilot regions and partners • Confirm focus allied health roles
2 Pilot Launch & Early Implementation	2027	20 students	Pilot launch and testing	• Enroll first cohorts • Distribute incentives and scholarships • Match students to placements • Begin KPI tracking
3 Model Refinement & Expansion Prep	2028	80 students	Scale-up preparation	• Develop statewide implementation toolkit • Expand recruitment • Deepen institutional/ employer capacity
4 Statewide Expansion	2029	140 students	Full deployment	• Launch data platform • Scale financial incentives • Broaden institutional and employer engagement
5 Stabilization & Sustainability	2030	200 students	Institutionalization	• Implement Continuous Quality Improvement (CQI) system • Publish 5-year impact report • Launch long-term funding and replication strategy

A description of each phase including activities, staffing, and associated expenses is provided below.

Phase 1: Infrastructure & Pilot Planning (2026)

The first year of the initiative is dedicated to establishing a strong foundation for statewide implementation. Activities in this phase are focused on launching core operations, formalizing program governance, and preparing high-need regions for early pilot delivery. A successful Phase 1 sets the stage for long-term impact by securing critical buy-in, building necessary infrastructure, and aligning stakeholders on shared goals.

Key activities in this phase include the launch of intermediary operations, beginning with the hiring of initial staff including an Executive Director and Partnership Administrator and establishing a public-facing brand and communications presence to represent the initiative statewide. This includes building a digital platform and early marketing collateral that can help raise visibility and attract pilot participants.

To cement cross-sector collaboration and establish shared expectations, the intermediary will coordinate the development and signing of a Program Charter by core stakeholders. This document will serve as a foundational governance agreement, outlining roles, decision-making protocols, and priorities for implementation. Formal memoranda of understanding (MOUs) will also be executed with pilot-region partners, ensuring early alignment and operational readiness. During Phase 1, the intermediary should also explore cost-sharing opportunities with employers in particular, which could decrease stipend and scholarship costs while cementing employer participation in this initiative.

Initial pilot region(s) will be selected based on a combination of workforce demand, institutional readiness, and the opportunity to test models in rural and remote settings. Preliminary discussion with the Working Group uncovered that both the Magic Valley and North Idaho regions struggle with acute healthcare shortages in the primary roles selected, include rural and remote regions, and have existing employers and institutions that would be interested in partnering to support this work. They do, however, differ in important ways. Magic Valley offers a few large employer sites and so represents a more standard healthcare environment where the pilot can be tested and scaled quickly to other similar regions. North Idaho is more complex with a greater variety of satellite employer sites throughout the region that serve fewer patients. This would effectively establish the initiative's proof of concept in a variety of settings, but might take longer to scale. The below rubric could be leveraged to determine whether one or both of these sites could serve as the early testing ground for the initiative's preceptorship and apprenticeship strategies.

Regional prioritization rubric

Criteria	Definition	Low score	Medium score	High score
Healthcare ecosystem complexity	Ability for region's healthcare ecosystem to serve as an effective test site for statewide expansion	Region has too few healthcare providers to properly test solution model or too many to feasibly implement		Region has a manageable variety of healthcare providers with which partnerships can be formed
Higher education institution proximity	Closeness of region to major higher education institution	Region is not directly served by any major higher education institution		Region is directly served by at least one major higher education institution
Openness to partnership	Region's willingness to partner with an intermediary organization, as stated by key stakeholders and/or signaled through existing activities	Region does not employ many collaboration practices currently; region does not indicate openness to partnership		Region is highly collaborative in its existing practices; region indicates openness to partnership
Existing infrastructure	Ability to leverage existing resources and/or program structures in a region to expedite implementation	No resources or programs exist for an intermediary to build on		Existing resources and programs can be leveraged to expedite initiative implementation
Rurality dynamics	Existence of both rural and remote areas within the broader region	Region does not have both rural and remote areas		Region has both rural and remote areas in which a version of this initiative can be tested
Healthcare staffing need	Level of open priority roles in the region, as measured through workforce data analysis and anecdotal testimony	Region has a surplus or very small shortage of priority roles		Region has a distinct shortage of priority roles

Sector-specific planning will also begin in earnest:

- In nursing, the intermediary will assess the current state of Idaho's preceptorship and clinical placement database, identifying gaps and initiating a comprehensive refresh to improve visibility and matching capacity for students and institutions.
- In allied health, stakeholders will confirm the priority focus roles for the apprenticeship pilot, expected to include surgical technicians and radiologic technicians. These roles will be chosen based on demonstrated employer demand and feasibility of program delivery at pilot sites.

By the end of Phase 1, the initiative will have built the staffing, systems, partnerships, and early tools required to move into field-based pilot delivery in Phase 2. This work will also create the structural foundation (governance, branding, databases, and communications) on which future statewide scale will depend.

Phase 2: Pilot Launch and Early Implementation (2027)
In the second year, the initiative will transition from planning to implementation. Phase 2 centers on launching initial student cohorts, delivering early work-based learning experiences, and beginning to track program outcomes. It will also mark the expansion of the intermediary's operational capacity.

Student cohorts will be launched in pilot regions, with individuals matched to preceptors and apprenticeship placements. The program will also begin to financially incentivize a small cohort of preceptors to support growth in the nursing student population. New staff including a Program Director, Operations Manager, and Student Success Advisor could be hired and onboarded to manage delivery and support student and partner needs.

Stipend and scholarship disbursement protocols will be operationalized to ensure timely delivery of financial supports to students and preceptors. If cost-sharing agreements have been reached with employers, these practices will begin in Phase 2. Early tracking will measure uptake and assess impact. Technology onboarding will also begin, with institutions and students trained on the initiative's CRM and digital tools.

Sector-specific delivery targets include:

- Nursing: Enroll 10 students in pilot regions and expand the preceptor database into a second set of priority geographies.
- Allied health: Enroll 10 students and establish faculty-employer partnerships that enable co-delivery of apprenticeship programming.
- Preceptors: Award stipends to at least 5 preceptors in rural pilot regions to cover nursing enrollment increases; more stipends can be offered if budgets allow.

Regular KPI tracking and feedback collection will begin, supporting continuous improvement and positioning the program to scale.

Phase 3: Model Refinement and Expansion Prep (2028)
With early delivery underway and proof points emerging, Phase 3 focuses on statewide preparation. This includes formalizing implementation frameworks, broadening recruitment, and building the tools and partnerships needed for scale.

Additional staff including a Partnership Manager could be hired to manage statewide expansion and regulatory coordination. Learnings from pilot regions will be synthesized into standardized implementation guides, evaluation rubrics, and partnership protocols that can be adopted across Idaho.

Student recruitment efforts will expand through targeted outreach to high schools, adult learners, and underserved communities. Investments will also be made in upgrading the CRM system and adding a robust data visualization tool (e.g., Tableau or PowerBI) to support performance monitoring.

Sector-specific goals include:

- Nursing: Enroll 40 new students and broaden the preceptorship database to include statewide entries.
- Allied health: Enroll 40 new students across high-demand roles.
- Preceptors: Award stipends to at least 20 preceptors in rural pilot regions; more stipends to be offered if budget allows.

This phase ensures that the program is operationally and strategically ready for statewide delivery in the following year.

Phase 4: Statewide Expansion (2029)
In Phase 4, the initiative will scale across Idaho. Activities focus on deepening institutional and employer participation, expanding student enrollment, and integrating long-term sustainability supports. Ahead of this phase, the intermediary will have determined how it will expand its support to new regions beyond its initial pilot region.

A new Grants and Resource Development Officer could join the team to support funding diversification and the scaling of programs. Long-term governance mechanisms will be implemented to formalize statewide collaboration. A faculty development strategy will be launched to expand instructional capacity through adjunct and employer-affiliated roles.

A key deliverable in this phase is the launch of a statewide workforce data and placement platform, which will integrate with the CRM and dashboard to facilitate real-time decision-making. This platform will be developed during the intermediary's pilot years, and can be expanded statewide as its program reach expands statewide.

Enrollment and preceptorship goals include:

- Nursing: 70 students
- Allied health: 70 students

- Preceptors: At least 35 preceptors; more to be supported if budget allows

Financial incentives and rural training supports will also scale, positioning the program for its final phase.

Phase 5: Stabilization & Sustainability (2030)
The final phase of the initiative focuses on institutionalizing the work. This includes systematizing continuous improvement, embedding wraparound supports, and articulating a long-term sustainability strategy.

The initiative will introduce a continuous quality improvement (CQI) model to refine delivery across sites. Targeted outreach and learner supports will be scaled to boost retention among underserved populations.

A sustainability roadmap will be developed, exploring a blend of state, federal, philanthropic, and employer-based funding sources. The initiative will also produce a five-year impact report to share outcomes, support state policy development, and guide replication in other states.

Final annual enrollment and preceptorship targets include:

- Nursing: 100 students
- Allied health: 100 students
- Preceptors: At least 50 preceptors; more to be supported if budget allows

Over the five years, the initiative will have supported clinical completions for a total of 220 nursing students, apprenticeship program completions for 220 allied health students, and incentivized a total of 110 new preceptors to be part of the statewide database. By the end of Phase 5, Idaho will have a durable, data-driven, and inclusive statewide healthcare training infrastructure—positioned to evolve with the state's workforce needs.

Expenses and staffing by phase

Implementing a statewide solution to Idaho's healthcare workforce challenges requires a staged investment strategy aligned to the phased rollout. Costs will evolve from infrastructure-building in early years to scaled service delivery and sustainability planning in later phases. Each phase includes proposed staffing levels, administrative costs, and targeted funding for student and employer incentives. Importantly, all hiring decisions and technology scaling efforts should be carefully considered by the intermediary throughout its rollout. The recommendations below represent the heaviest possible staffing structure for an intermediary, and can be rolled back if desired.

Additionally, hiring for an intermediary can build off of its existing staffing structure. This could reduce costs, though it would require careful consideration of how existing staff members' roles would stretch to support a broader initiative.

Phased intermediary staffing plan

Role	Phase introduced	Core functions covered	Est. base salary (Idaho)*	Est. salary + benefits (+30%)
Executive Director	Phase 1	Leadership, fundraising, partnerships, policy advocacy, board engagement	$110,000	$143,000
Partnership Administrator	Phase 1	Public awareness, partnership development, and administrative & logistics support	$65,000	$84,500
Suggested roles for later-phase implementation				
Program Director	Phase 2	Clinical site & apprenticeship coordination, technical assistance to partners, ecosystem building	$90,000	$117,000
Operations & Data Support Manager	Phase 2	Budget, grant, compliance, data systems, & dashboard management	$75,000	$97,500
Student Success Advisor / Preceptor Liaison (part-time to full-time)	Phase 2	Student support; stipend, scholarship, & faculty-employer coordination	$70,000	$91,000
Partnership Development Manager	Phase 3	Institutional & employer partnership expansion	$80,000	$104,000
Grants & Resource Development Officer	Phase 4	Fundraising, reporting, & partnership development	$75,000	$97,500
		Total for first year hired	**$565,000**	**$734,500**

Phase 1: Infrastructure and Pilot Planning (2026)

This foundational year is focused on launching intermediary operations, confirming pilot regions, and beginning program design work. Staffing includes 2 core FTEs—a founding Executive Director and a Partnership Administrator—responsible for organizational setup, stakeholder coordination, and partner recruitment. Total expenses for Phase 1 are projected to be $267,500, largely for staff salaries. This amount for planning could feasibly be funded primarily by private sources, e.g., philanthropy and/or healthcare employer site subsidization of salaries.

Phase 2: Pilot Launch and Early Implementation (2027)

In this year, pilot programs go live in a rural region (potentially North Idaho or the Magic Valley). Student cohorts begin their training, incentive programs are launched, and technology platforms are onboarded. Staffing could expand to 5 FTEs to support program operations, data tracking, and student success. Total expenses for Phase 2 are estimated at $686,825 if all proposed roles are hired and begin to include stipends and scholarships as well as staff salaries. This amount for the pilot will likely require more public funding, such as federal and/or state grants, in addition to the prior committed private sources such as philanthropy and/or healthcare employer site subsidization of salaries.

Phase 3: Model Refinement and Expansion Prep (2028)

Building on rural pilot learnings, this phase involves scaling infrastructure statewide and expanding student recruitment pipelines. A sixth full-time role could be added, a partnership development manager. Technological enhancements and wider program participation drive moderate increases in administrative and incentive costs. Total expenses for Phase 3 are estimated at $1,124,120 if all proposed roles are hired, with increases primarily driven by increased student enrollment. This increase in expenses will require more substantial and sustained funding that is built into the state budget. A similar program in a similar state, Arizona's Rural Health Professions Program (RHPP) is a statewide initiative funded by the state legislature and connects healthcare students from the University of Arizona, Arizona State University, and Northern Arizona University with rural employers. The program is designed to provide rural training experiences and has been a model for leveraging public funds—such as lottery revenues—to support healthcare education in underserved areas.

Phase 4: Statewide Expansion (2029)

The initiative reaches full operational scale in year four. Staffing could grow to 7 FTEs to manage statewide engagement, partner onboarding, and data oversight. Institutional and employer partnerships deepen, and incentive programs scale to reach more students and preceptors in several regions across Idaho. Total expenses for Phase 4 are projected to be $1,558,625 if all proposed roles are hired to support staff salaries and a statewide cohort of students. As the initiative takes root across the state, it will need to continue to leverage reliable and significant amounts of federal and state dollars to make the intended impact with only a small emphasis on raising private funds.

Phase 5: Stabilization and Sustainability (2030)

The final phase focuses on quality assurance, wraparound support for underserved students, and long-term sustainability planning. The staff team remains steady, with full attention on program evaluation, impact reporting, and identifying blended public-private funding streams. Total expenses for Phase 5 are projected to be $1,899,260 if the full proposed team is hired and cover staff salaries and stipends and scholarships for a large cohort of preceptors and students.

Summary of expenses by phase, assuming full staffing allocation

	Phase 1: Infrastructure & Pilot Planning	Phase 2: Pilot Launch & Early Implementation	Phase 3: Model Refinement & Expansion Prep	Phase 4: Statewide Expansion	Phase 5: Stabilization and Sustainability
Total staff ***Staff category***	*(2) Executive director + Communications/Admin*	*(5) Program director + Data manager + Student liaison*	*(6) Partnerships manager*	*(7) Grants officer*	*(7) Full team*
Total salary expenses*	$227,500	$539,825	$660,020	$777,320	$800,640
Administrative* *CRM, recruitment, marketing*	$40,000	$42,000	$44,100	$46,305	$48,620
Nursing preceptors	*0*	*5*	*20*	*35*	*50*
Nursing preceptor incentives $1K	$0	$5,000	$8,000	$14,000	$25,000
Nursing students	*0*	*10*	*40*	*70*	*100*
Nursing rural clinical stipends $5K	$0	$50,000	$200,000	$350,000	$500,000
Allied health students	*0*	*10*	*40*	*70*	*100*
Allied health scholarships $5K	$0	$50,000	$200,000	$350,000	$500,000
Total preceptors	*0*	*5*	*20*	*35*	*50*
Total students	*0*	*20*	*80*	*140*	*200*
Total expenses	**$267,500**	**$686,825**	**$1,124,120**	**$1,558,625**	**$1,899,260**

Cost efficiency and return on investment

A core strength of this initiative lies in its ability to deliver growing impact at a declining cost per learner over time. By structuring the rollout in strategic phases—beginning with high-need pilot regions and building toward statewide expansion—the initiative leverages early infrastructure investments to drive long-term cost efficiency.

In 2027, the cost per student placement is projected at approximately $34,000, reflecting the upfront investment required to build statewide infrastructure, stand up pilot cohorts, and initiate programmatic systems. By 2030, as student participation grows and operations mature, that cost drops to below $10,000 per learner—a more than 70% reduction in cost per placement. This downward trend demonstrates a compelling return on foundational investments and establishes a sustainable cost structure for future expansion. It also mirrors cost per placement of Louisiana's Rural Health Scholars Program[9], which spends at least $8,000 per student on administrative, travel, and scholarship costs. If this initiative were only funded through state channels, the $1.9M increase to the state's higher education budget to support a steady-state version of this initiative in Year 5 would represent a $15 increase in the average cost per higher education student in Idaho.[10]

[9] Well-Ahead Louisiana representative interview conducted June 2025

[10] Based on Idaho's higher education budget (approved March 2025) and enrollment statistics from Education Data Initiative

Estimated cost per student placement by phase, assuming full staffing allocation

Phase	Year	Nursing enrollments	Allied health enrollments	Total enrollments	Total expenses	Estimated cost per placement
1 Infrastructure & Pilot Planning	2026	0	0	0	$267,500	*N/A (infrastructure only)*
2 Pilot Launch & Early Implementation	2027	10	10	20	$686,825	$34,341
3 Model Refinement & Expansion Prep	2028	40	40	80	$1,124,120	$14,052
4 Statewide Expansion	2029	70	70	140	$1,558,625	$11,133
5 Stabilization & Sustainability	2030	100	100	200	$1,899,260	$9,496

To strengthen the case for long-term investment, this initiative incorporates a clear return-on-investment (ROI) framework that quantifies both direct employer savings and broader economic benefits.

- For every $1 invested in clinical training and apprenticeship infrastructure, employers can expect to realize $5–$7 in savings through reduced vacancy durations, lower recruitment and onboarding costs, and decreased reliance on temporary or overtime staffing. These cost savings are particularly meaningful in rural and underserved areas, where persistent shortages disrupt care delivery and inflate hiring expenses.[11]
- Beyond direct employer benefits, the initiative delivers measurable economic value to Idaho communities. Using conservative, regionally adjusted economic multipliers, each additional healthcare worker retained locally generates an estimated $100,000 to

[11] Estimated ROI is based on aggregated cost savings associated with reducing vacancy durations, recruitment expenditures, onboarding expenses, and reliance on overtime or temporary staffing across both nursing and allied health roles. Registered nurse vacancies can cost employers $40,000–$60,000 annually per position, while allied health roles (e.g., surgical techs, radiologic techs) can carry annual vacancy costs of $25,000–$40,000 depending on setting. Recruitment and onboarding for clinical roles typically costs $10,000–$20,000 per hire, with additional costs incurred from staff burnout and temporary coverage. Apprenticeship and preceptorship models have demonstrated improved retention, lower recruitment churn, and reduced use of costly contract labor—resulting in an estimated return of $5–$7 for every $1 invested. These figures are conservative and do not include community-level economic multipliers such as retained local income, improved care access, or public health benefits in rural and frontier areas. Sources: NSI National Health Care Retention Report (2023), U.S. Department of Labor Apprenticeship ROI Toolkit, Idaho Hospital Association rural workforce analyses.

$150,000 in annual economic activity, including wages, local spending, and downstream benefits to health outcomes and workforce productivity.

By placing and retaining hundreds of new healthcare professionals across the state by 2030, this initiative will not only reduce critical workforce gaps but also serve as a powerful economic engine for rural Idaho.

In addition to cost efficiency and return on investment, the initiative will track its contribution to closing Idaho's healthcare workforce gaps. With a goal of placing 100 nursing students and 100 allied health students by 2030, the initiative would account for approximately:

- 14% of current RN vacancies (based on ~700 estimated open roles), with a strengthened pathway to support the closure of more vacancies over time
- 67% of current LPN vacancies (based on ~150 open roles)
- 10–20% of total shortfalls across high-need allied health technician roles

This level of gap reduction achieved through targeted role prioritization and strategic rural placement makes a meaningful dent in the state's most persistent shortages, particularly in regions where vacancies exceed 15%.

Together, the declining cost per placement, strong ROI potential, and measurable workforce gap closure form a compelling value proposition. This initiative doesn't just build a training pipeline - it delivers economic and healthcare system gains that far exceed the cost of implementation.

Funding sources

This initiative will be most successful if it is supported by diversified funding streams from state, private and philanthropic, and federal sources. Within Idaho, potential funding sources to be investigated include the Workforce Development Council, the State Board of Education, the Division of Career Technical Education, and the Department of Health and Welfare. These groups represent differing priorities and focuses, and may be able to partially fund specific aspects of the proposed initiative (e.g., the Division of Career Technical Education may be able to support apprenticeship infrastructure).

This initiative could also be supported by existing funding mechanisms if they are revisited to better support rural healthcare workforce training. An example of a potential existing mechanism is the County Liquor Fund distribution policy, where funds are currently allocated to counties with broad discretion, often for general public services. By updating the policy to allow — or even prioritize — investments in healthcare workforce development, especially in underserved rural areas, we could align this long-standing revenue stream with one of Idaho's

most pressing needs. This would not require the creation of a new funding source, just a modernized approach to an existing one.

The intermediary leading this initiative should also explore private and philanthropic funding sources within and beyond Idaho. The Blue Cross of Idaho Foundation for Health has already engaged in this work, but represents a potential funding source going forward. Other potential funding sources to explore include the Idaho Community Foundation, the Albertsons Foundation, and the charitable arms of major healthcare systems like St. Luke's and St. Alphonsus. Nationally, the Robert Wood Johnson Foundation, the Cambia Health Foundation, the Kresge Foundation, the JFF National Apprentice Fund, and the American Nurses Foundation should be investigated as potential funders.

A recent example of innovative funding from a private philanthropic source is Social Finance's partnership with Western Governors University (WGU) to offer a Pay It Forward Fund for nursing education. The fund, called the Reinvesting in Nursing Education and Workforce (ReNEW) Fund, offers students access to zero-interest loans and financial support with last-mile training costs associated with in-person labs and clinical placements. This initiative could seek to explore a similar arrangement with a private philanthropic funder, especially one that enables more direct financial support for more students.

Finally, an intermediary should seek out funding from federal sources that are aligned to this work. The Health Resources and Services Administration (HRSA) offers substantial funding to the nation's Area Health Education Centers for rural healthcare education and training development. Additionally, registering apprenticeship programs could enable institution partners to leverage US Department of Labor Registered Apprenticeship funds. Perkins V funding may also be a potential source to support technical education, especially for allied health roles.

Risks and mitigation strategies

The success of this initiative depends on proactively managing risks across five domains: stakeholder participation, funding stability, cross-sector coordination, measurable impact, and long-term sustainability. Each presents unique challenges, but all can be mitigated through targeted piloting, strong policy alignment, adaptive program design, and a data-informed approach.

1. Stakeholder participation

The initiative must address a range of participation-related risks that could limit its effectiveness and reach.

Key risks include:

- Limited student interest in the selected nursing or allied health roles, particularly those that are less visible or perceived as less desirable;
- Employer hesitation to participate due to ongoing staffing shortages, capacity limitations, or concerns about administrative complexity, especially in rural or under-resourced communities; and
- Insufficient supply of qualified preceptors, particularly in nursing, may constrain clinical training capacity and student progression.

Mitigation strategies:

The pilot phase will serve as critical proving ground, enabling the intermediary to track enrollment trends, assess employer engagement, and evaluate the feasibility of program implementation in real-world settings. To build localized trust and operational readiness, the intermediary will leverage regional liaisons who serve as direct points of contact for institutions and employers. These liaisons will help troubleshoot implementation barriers, coordinate partnerships, and ensure culturally and geographically responsive support.

In parallel, employer and preceptor engagement will be bolstered through:

- Streamlined onboarding processes that reduce administrative burden;
- Targeted financial incentives, such as stipends for preceptor participation or rural placement support; and
- Neutral convening and facilitation, designed to protect local interests and minimize friction during early implementation.

Together, these strategies are designed to build momentum, foster early buy-in, and lay the groundwork for broader participation as the initiative scales statewide.

2. Funding stability

Funding constraints present a significant risk to both the initial launch and long-term viability of the initiative.

Key risks include:

- Inadequate startup funding to support launch of pilot activities and intermediary operations; and
- Long-term operating costs outpacing available or sustainable funding sources.

Mitigation strategies

To ensure financial stability, the initiative will be anchored by a clear, multi-year funding strategy designed to attract diversified investment while demonstrating early value. This strategy includes:

- Designating a role to drive initial fundraising;
- Securing upfront capital for foundational systems that drive measurable progress, such as data infrastructure and preceptor and student support systems;
- Diversifying funding streams by blending state appropriations, federal grants, philanthropic contributions, and private sector co-investments;
- Establishing early proof points to build funder confidence and unlock sustained investment; and
- Using pilot data to refine cost models, assess return on investment, and adjust staffing and program delivery structures as needed over time.

This financial approach is designed not only to support a successful pilot but to lay the groundwork for long-term fiscal sustainability and scalable impact.

3. Cross-sector coordination

Given the initiative's reliance on collaboration across a wide array of stakeholders, the potential for coordination breakdown is a meaningful risk. Misalignment among these partners could slow implementation, create duplication, or limit regional impact.

Key risks include:

- The intermediary lacking sufficient authority or legitimacy to drive implementation, resulting in fragmented efforts or uneven progress across regions;
- Shifting stakeholder priorities over time that dilute strategic focus or disrupt momentum; and
- Regulatory or licensing constraints that limit flexibility and slow adoption, particularly those affecting preceptor eligibility or clinical training models.

Mitigation strategies

To ensure strong cross-sector coordination, the initiative will employ a deliberate and structured governance model. This includes:

- Formalizing roles and responsibilities through Memoranda of Understanding (MOUs) that clearly articulate expectations for each participating entity;

- Building cross-organizational coalitions that bring together stakeholders to ensure shared ownership and engagement; and
- Proactively engaging regulatory bodies to explore flexible preceptorship solutions while maintaining safety and quality standards.

Through these strategies, the initiative will promote transparency, minimize duplication, and create a durable structure for coordinated, statewide implementation.

4. Measurable impact

As the initiative matures, its credibility will hinge on its ability to demonstrate tangible, measurable outcomes, requiring it to have a robust infrastructure for data collection and performance monitoring.

Key risks include:

- Inadequate data systems that limit the intermediary's ability to make timely, data-informed decisions;
- Low student completion or licensure rates that undercut the program's effectiveness; and
- Weak retention of healthcare workers, particularly in rural placements.

Mitigation strategies

To ensure accountability and continuous improvement, the initiative will develop a centralized data infrastructure capable of capturing real-time performance metrics. These will include student enrollment and placement, preceptor participation, program completion, credentialing outcomes, and post-program employment.

The intermediary's Student Success Advisor will interpret this data and deploy responsive interventions as needed including:

- Academic advising and licensure preparation;
- Financial aid navigation; and
- Targeted retention supports for high-risk learners or regions.

Additionally, regular satisfaction surveys of both students and employers inform quality improvement efforts and enhance long-term retention and workforce alignment.

By embedding data-driven decision-making into its operating model, the initiative will ensure transparency, adaptability, and a clear demonstration of impact across Idaho's healthcare workforce system.

5. Long-term sustainability

Long-term sustainability presents a distinct set of risks that could undermine the durability and relevance of this initiative over time.

Key risks include:

- Preceptor burnout, leading to declining engagement and reduced capacity for student supervision;
- Political turnover or shifting leadership priorities that deprioritize healthcare workforce investment; and
- Evolving workforce demands and technological change that render program models or curricula outdated.

Mitigation strategies

To ensure preceptor retention, the initiative will promote ongoing recognition and support strategies at the institutional and employer levels. These include:

- Connecting with preceptors to identify and offer meaningful incentives and recognition;
- Flexible scheduling and workload accommodations; and
- Continued engagement through the statewide *Healthcare Workforce Collaborative*, fostering a peer learning and support network for educators and clinical mentors.

To safeguard against political and funding volatility, program activities will be explicitly aligned with enduring statewide priorities such as rural health access, economic mobility, and workforce resilience, reinforcing their relevance across administrations. The initiative should also be embedded into formal policy frameworks including workforce development legislation, employer advisory councils, and regulatory processes to ensure its model is adaptive.

Through these strategies, Idaho can build a future-ready healthcare workforce pipeline that is both resilient to disruption and responsive to the state's changing health and economic landscape.

Launch investment and enabling conditions

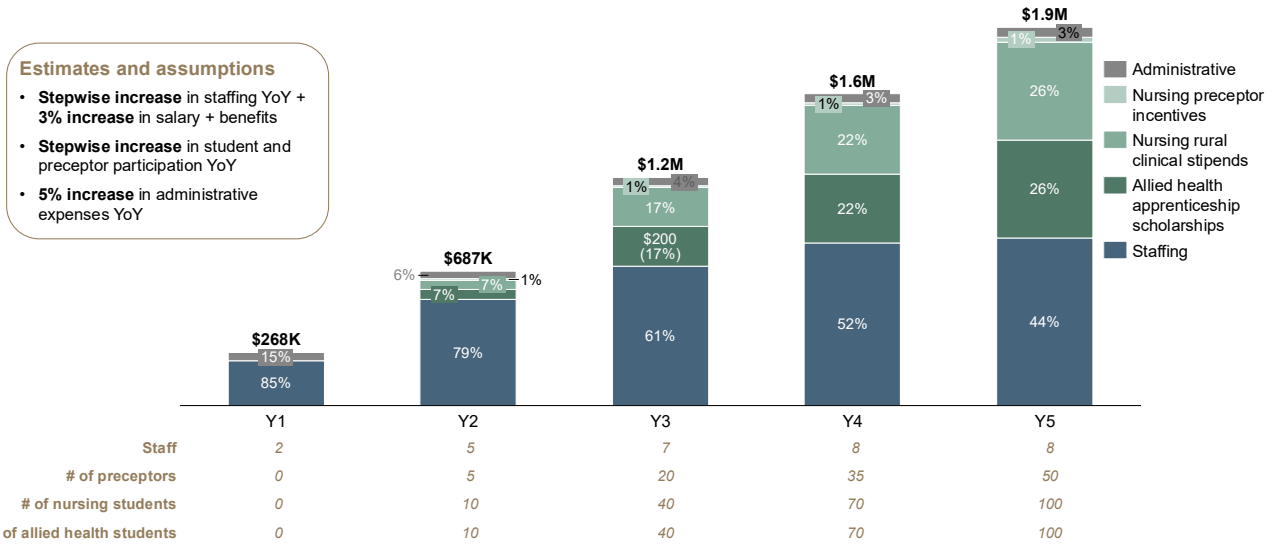
This initiative requires a five-year investment of approximately $5.64 million, a cost that reflects both its statewide scope and its targeted ambition to transform Idaho's healthcare workforce pipeline across nursing and allied health roles. While this investment exceeds the scale of legacy programs in Idaho, it is proportional to the initiative's goals: serving hundreds of students, expanding rural healthcare access, and improving health system resilience statewide.

To provide a comparative benchmark, the Idaho Area Health Education Center Program Office (IDAPO) has received $2.9 million in grant funding to support central administration, regional operations, and program delivery over five years. This funding supports approximately 9 staff across three regional AHECs, along with scholarships and other programming. By contrast, this initiative consolidates preceptorship, apprenticeship, technical assistance, and workforce coordination functions under a unified statewide model positioning it for broader reach and long-term system impact.

Initial costs are concentrated on early infrastructure and pilot development:

- Years 1–2 (Pilot Phase): Estimated investment of $954,325 to establish the intermediary, launch operations, engage rural pilot sites, and serve an initial cohort of 20 students (10 nursing, 10 allied health).
- Years 3–5 (Scaling Phase): Annual operating costs gradually increase to approximately $1.9 million as the initiative scales toward its recommended targets:
    - 100 nursing students enrolled in flexible clinical models;
    - 100 allied health apprentices supported through employer partnerships;
    - At least 50 preceptors incentivized annually with stipends and supports; and
    - Up to 7 full-time staff delivering program design, coordination, data, and technical assistance.

Initiative expense progression, assuming full staffing allocation



Several factors position this initiative for successful launch and impact:

- **Existing state commitment:** Idaho's ongoing efforts to address healthcare workforce shortages, including prior investments in education and clinical expansion, establish a strong foundation.
- **Stakeholder readiness:** Postsecondary institutions and healthcare employers have already expressed alignment and willingness to participate, particularly in rural areas where the need is greatest.
- **Comparative efficiency:** By centralizing coordination functions, this model reduces duplicative spending across regions and unlocks new economies of scale, especially in data management and clinical placement logistics.
- **Clear accountability:** A performance-driven structure backed by transparent data reporting and outcome tracking ensures public dollars are tied to measurable results in enrollment, employment, and retention.

Conclusion and call for support

Idaho's healthcare workforce shortages, particularly in nursing and high-demand allied health roles, present an urgent challenge with far-reaching implications for access and system stability. This business plan lays out a clear, evidence-based solution: expand statewide preceptorship capacity and launch registered apprenticeship pathways that deliver hands-on, career-aligned training in critical roles.

To ensure statewide coordination and scale, the initiative centers these strategies within a dedicated intermediary that will serve as the operational backbone of implementation. This organization will lead clinical site coordination, stakeholder engagement, incentive distribution, data reporting, and technical assistance to reduce redundancy and accelerate progress. A phased rollout, beginning with a rural pilot program in a region like the Magic Valley or North Idaho, will enable early impact while supporting continuous learning and refinement. Over five years, the intermediary will directly support education providers and employers while addressing key regulatory and infrastructural barriers.

Over the next five years, the initiative will:

- Support hundreds of new students across nursing and allied health;
- Incentivize and grow Idaho's preceptor network, with strong rural representation;
- Strengthen education-employer partnerships through shared infrastructure and governance; and

- Improve access to care by developing a resilient, community-rooted healthcare workforce.

Achieving this vision could require a $5.6 million investment over five years, with $1 million in startup funding needed in the first two years to establish the intermediary and activate the first pilot cohorts. These funds will unlock complementary resources from public institutions, employers, and philanthropy—and generate significant long-term value by producing more job-ready graduates and improving access to care, particularly in underserved communities.

This is a critical moment for Idaho to act. The solutions outlined here are grounded in stakeholder consensus and designed for measurable impact. With committed funding and cross-sector alignment, this initiative can catalyze a stronger, more sustainable healthcare workforce pipeline for communities across the state. We invite public and private funders, workforce champions, and system leaders to join us in bringing this effort to life. Together, we can build a future-ready healthcare workforce that is more responsive and resilient and ensure that every Idahoan has access to the care they need, close to home.