



By Eileen T. O'Grady

Dr. Eileen T. O'Grady is a certified adult nurse practitioner and Wellness Coach who has practiced in primary care for over 15 years.

She holds three graduate degrees from George Washington University and George Mason University in nursing as well as public health and a PhD in nursing. She currently serves as a visiting professor at Pace University in Manhattan where she teaches doctoral nursing students about health policy and ways of knowing and being to the next generation of nurse practitioners. Visit her website for upcoming presentations and recent publications or information on her coaching practice.

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 On Not Being Heard
 Stay Nonpartisan in a Partisan World
 The 5 NP Political Issues and the One Solution

From the Desk of Eileen T. O'Grady

Weighing the Pig Won't Fatten It

January 2011

As we inch toward 2014, the year that the Patient Protection and Affordable Care Act, the centerpiece of the healthcare overhaul, takes effect, it has become increasingly clear that the organization of US health care—or its “system”—is not designed to do what we want it to do. Its spiraling costs and uneven quality are certainly problems, but what is at the root of the myriad of delivery system problems is the lack of integration and coordination of care. As \$1 trillion is about to be invested in US health care, it must not be used to finance more of the same but rather must provide better care for patients. A study published in the *New England Journal of Medicine* last November found that almost no progress has been made in one state on patient safety,¹ despite the decade-old publication of the *Crossing the Quality Chasm* report's fervent call for a dramatic change and statewide efforts to improve preventable harm to patients in hospitals.² The study found that patient harm remains common in 10 North Carolina hospitals, and there was no significant reduction in harm, suggesting that the ambitious goal set by the Institute of Medicine (IOM) of a 50% reduction in preventable healthcare errors during a 5-year period has not been met and that there is little evidence of widespread improvement in patient safety. Looming workforce shortages present another thorny problem. As 32 million newly insured patients get swept into the system by 2014, a third of current physicians will retire over the next decade, and the physician scarcity will increase to 100,000 with shortages in all specialties, not just primary care.

The IOM Relies on Evidence and Gets Bold

Recall that Clara Barton neither asked for permission nor sought direction before she headed into the front lines of the Civil War. This experience inspired her to campaign fiercely and successfully to create the Red Cross. In the spirit of Clara Barton, 3 years ago, The Robert Wood Johnson Foundation (RWJF) and the IOM launched a 2-year initiative to re-conceptualize and transform the nursing profession. The IOM appointed a Committee on the Future of Nursing, which produced an evidence-based report that decisively recommends an action-oriented blueprint for the future of nursing. The report explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by healthcare reform and to advance improvements in America's increasingly complex health system.

Weighing the pig won't fatten it.

*If you are on the road to nowhere,
find another road.*

This small antelope can beat a big one.
—Gretchen Rubin

The report offers recommendations for a variety of stakeholders—from state legislators to Centers for Medicare & Medicaid Services (CMS) to the Congress—to ensure that nurses can practice to the full extent of their education and training. The federal government is particularly well suited to promote the reform of states' scope-of-practice laws by sharing and providing incentives for the adoption of best practices. One sub-recommendation is directed to the Federal Trade Commission, which has long targeted anticompetitive conduct in the healthcare market, including restrictions on the business practices of healthcare providers, as well as policies that could act as a barrier to entry for new competitors in the market.

High turnover rates among new nurses underscore the importance of transition-to-practice residency programs, which help manage the transition from nursing school to practice and help new graduates further develop the skills needed to deliver safe, quality care. While nurse residency programs are sometimes supported in hospitals and large health systems, they focus primarily on acute care. However, residency programs need to be developed and evaluated in community settings.

There are eight big, bold recommendations (see below) that in some form strengthen and improve advanced-practice-registered nurse (APRN) practice and make nursing more central to care delivery. This report had broken every record in the history of the IOM in regard to report sales, and the website has crashed due to such heavy usage. You can read the full evidence-based report at <http://thefutureofnursing.org/IOM-Report>; see the box for a brief summary of the eight recommendations from the IOM.

Helping Sisyphus: Accelerating the Modernization of the Nation's Outdated Nurse Practice Acts.

A sub-recommendation that is worthy of close APRN attention is the removal of scope-of-practice barriers. With nearly half of the 50 states needing to modernize their state practice act, it is expected that this process of modernizing and standardizing the state practice acts to comply with our professional standards in the APRN (LACE) Consensus framework (www.nacns.org/LinkClick.aspx?FileTicket=P6JBC2imjH=&tabid=36) may take decades. My experience testifying before a Virginia legislative body on the removal of physician collaboration showed me first-hand the challenges we face, i.e., a highly politicized environment, with little to no reliance on science, current realities, public input, or patient-centeredness that is led by a legislative committee that seemed wholly unqualified to adjudicate scope-of-practice challenges. Trying to modernize nurse practice acts in this environment is like Sisyphus rolling his immense boulder up a hill, only to watch it roll back down, and then to repeat the frustrating task over and over again. Imagine the federal government giving favorable funding preferences only to those states that have modernized their nurse practice acts. Just as states have long had highway funds linked to stringent drunk-driving laws and speed limits, those states with outdated practice acts could soon see their funding sources for nursing dry up. This financial loss to those outdated states would significantly expand the pool of stakeholders to advocate for modernization far beyond APRNs. University presidents, the public, hospital administrators, and many others would be joining our efforts. An audacious and compelling idea...

Making It Happen

To implement these recommendations, the RWJF is working with AARP and the states to advance recommendations from the IOM that would give APRNs greater roles and more control in health care. The initiative is encouraging states to partner with them to build regional action coalitions to expand leadership in nursing. If you would like to start or join a coalition or are seeking to modernize your state's nurse practice act, it would be expedient to work through one of these existing coalitions. For information, email futureofnursing@rwjf.org

Don Berwick's Message to Nurses

A national summit on advancing these IOM initiatives was held in Washington DC last December. CMS Administrator Don Berwick's keynote address began with his portrayal of the "majesty of nursing" and his enormous respect for nurse practitioners—he put his own children under their care. He describes the power of nursing as a force that understands patient safety and patient/family-centered care like no other discipline. Don Berwick heads the largest insurance company in the world, overseeing 4,500 people, and is currently implementing the largest health reform legislation since 1965, when Medicare was enacted. He described the reform legislation passed last March as "stunning" and "vastly under-estimated by the American public."

He sees it as a turning point for our country because it answers many questions on coverage, access, quality, and security for the chronically ill. A major concept he wants fully developed is "crafting journeys" for patients as they move through the healthcare system. The newly created CMS Center for Innovation is a place for forward-thinking ideas that foster the care integration required to create journeys of care. He stressed that this center will go a long way in addressing what works because, if we want different outcomes, we have to develop different systems. He insists that the focus must be on interdependency in order to respect the needs of patients and the traditions of human caring, which have always been core to nursing.

The Critic

The American Medical Association (AMA) has charged that the report overlooks the extensive education and training of physicians and ignores the importance of physician-led teams in ensuring patient safety. In its official statement, the AMA warns that "with a shortage of both nurses and physicians, increasing the responsibility of nurses is not the answer to the physician shortage." Suffice it to say that this "sto mentality" has defined our systems of care for decades and is widely understood to be a major factor in high-cost, poorly-coordinated care. Moreover, their quality concerns are not based on a foundation of evidence. Just as the Ghanaian proverb says that the pig won't fatten by weighing it, the AMA conviction that only physicians can provide safe care won't make it true.

References

1. Landrigan CP, Parry GJ, Bones KB, et al. Temporal trends in rates of patient harm resulting from medical care. *N Engl J Med*. 2010;363(22):2124-2134. Available at www.nejm.org/doi/pdf/10.1056/NEJMsa1004404. Accessed 12-10.
2. Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine, 2001.

The 8 Recommendations

Recommendation 1: Remove scope-of-practice barriers. APRNs should be able to practice to the full extent of their education and training. To achieve this goal, the committee recommends the following action.

For the Congress

- Expand the Medicare program to include coverage of APRN services that are within the scope of practice under applicable state law, just as physician services are now covered.
- Amend the Medicare program to authorize APRNs to perform admission assessments, as well as certification of patients for home healthcare services and for admission to hospice and skilled-nursing facilities.
- Extend the increase in Medicaid reimbursement rates for primary-care physicians included in the ACA to APRNs providing similar primary-care services.
- Limit federal funding for nursing education programs to programs in states that have adopted the National Council of State Boards of Nursing APRN model rules and regulations.

For state legislatures

- Reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing APRN-model rules and regulations.
- Require third-party payers that participate in fee-for-service payment arrangements to provide direct reimbursement to APRNs who are practicing within their scope of practice under state law.

For the CMS

- Amend or clarify the requirements for hospital participation in the Medicare program to ensure that APRNs are eligible for clinical privileges, admitting privileges, and membership on medical staff. For the Office of Personnel

Management

- Require insurers participating in the Federal Employees Health Benefits Program to include coverage of those services of APRNs that are within their scope of practice under applicable state law.

For the Federal Trade Commission and the Antitrust Division of the Department of Justice

Review existing and proposed state regulations concerning APRNs to identify those that have anticompetitive effects without contributing to the health and safety of the public. States with unduly restrictive regulations should be urged to amend them to allow APRNs to provide care to patients in all circumstances in which they are qualified to do so.

Recommendation 2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. Private and public funders, healthcare organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the healthcare team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.

Recommendation 3: Implement nurse residency programs. State boards of nursing, accrediting bodies, the federal government, and healthcare organizations should take actions to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed a pre-licensure or advanced-practice degree program or when they are transitioning into new clinical practice areas.

Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80% by 2020. Academic nurse leaders across all schools of nursing should work together to increase the proportion of nurses with a baccalaureate degree from 50 to 80% by 2020. These leaders should partner with education accrediting bodies, private and public funders, and employers to ensure funding, monitor progress, and increase the diversity of students to create a workforce prepared to meet the demands of diverse populations across the lifespan.

Recommendation 5: Double the number of nurses with a doctorate by 2020. Schools of nursing, with support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity.

Recommendation 6: Ensure that nurses engage in lifelong learning. Accrediting bodies, schools of nursing, healthcare organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.

Recommendation 7: Prepare and enable nurses to lead change to advance health. Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental healthcare decision makers should ensure that leadership positions are available to and filled by nurses.

Recommendation 8: Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data. The National Health Care Workforce Commission, with oversight from the Government Accountability Office and the Health Resources and Services Administration, should lead a collaborative effort to improve research and the collection and analysis of data on healthcare workforce requirements. The Workforce Commission and the Health Resources and Services Administration should collaborate with state licensing boards, state nursing workforce centers, and the Department of Labor in this effort to ensure that the data are timely and publicly accessible.

Office of Professional Regulation
Vermont Board of Nursing

Advanced Practice Registered Nurse
Attestation Form
Completion of Transition to Practice Requirement

* Fill out and submit one form for each certification you hold. On each form, indicate whether you have practiced the required number of hours to fulfill the transition to practice requirement (2400 hours and two years for primary credential; 1600 hours and 1 year for secondary credential)

Name: _____ DOB ____/____/____

License #: _____

Certification: _____
(eg: FNP, ANP, PNP, CNM, CRNA,
PMHNP (family, adult, child/adolescent);
Psychiatric CNS (family, adult, child/adolescent))

Date certification first issued: ____/____/____
(month / year)

Total Number of collaborative practice hours completed: _____

Dates of practice that led to completion of transition to practice hours:
____/____/____ to ____/____/____

***I certify under the pains and penalties of perjury, that all information I have provided in this document is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in action against me. (The maximum penalty for perjury is fifteen years in prison and/or \$10,000 fine. 3 V.S.A. §2901)**

Signed: _____
Signature Date

PRINT name of signature

Send completed form to: Vermont Board of Nursing
Office of Professional Regulation
National Life Building, North, Floor 2
Montpelier, VT 05620-3402

**APRN
FREQUENTLY ASKED QUESTIONS
ABOUT THE REVISED ADMINISTRATIVE RULES**

What is transition to practice?

- APRN graduates with fewer than 2400 hours and two years of practice are required to have a written collaborative agreement with a provider who will provide support and guidance in the clinical practice of the APRN.
- If you are an APRN and have practiced for more than 2,400 hours and 2 years with a written collaborative agreement, you must fill out a "Completion of Transition to Practice Requirement" form. Attach this form to your revised practice guidelines making sure your "new guidelines" meet the requirements of the new law and Rules. Once approved by the Board, you will no longer need to have a written collaborative agreement (See, Administrative Rule 15.14).

NOTE: Every APRN who has fulfilled the above transition to practice requirement is required to fill out a "Completion of Transition to Practice Requirement" form once to verify removal of their collaborative agreement, regardless of years of practice. Going forward, all new graduates, APRNs applying by endorsement and those APRNs adding new credentials will be required to complete the transition to practice form.

If I do not need a written collaborative agreement do I need to still need to send "Practice Guidelines" to the Board of Nursing?

- YES! You still need to have practice guidelines approved by the Board of Nursing prior to starting employment, at renewal or if you have a change of employment (See, Administrative Rule 15.9).
- You can use the "Template for APRN Practice Guidelines" to help you craft your practice guidelines. All elements in the template must be reflected in your practice guidelines (Template is on the Board of Nursing website).

Do I need to change my practice guidelines since the Administrative Rules have changed?

- You do not need to make any changes to your current practice guidelines if you continue to work at your current place of employment. At the next renewal cycle or if you change employment or clinical role, population focus or specialty you must update your guidelines to meet the new criteria.

What if I receive additional certifications?

- APRNs who obtain subsequent certification in an additional role or population focus are required to have a formal agreement with a collaborating provider for no fewer than 12 months and 1600 hours of practice in the area of the additional certification (See, Administrative Rule 15.14(b)).

If I have not completed the transition to practice hours, who can be my collaborator?

- You may have a written collaborative agreement with an APRN with the same role and population focus who has four (4) years of experience, or a licensed Physician, or Osteopathic Physician (See, Administrative Rule 15.17).



HISTORY OF AMERICA'S
FIRST NP RESIDENCY

CURRENT POLICY DEVELOPMENT

ABOUT THE COMMUNITY
HEALTH CENTER, INC

WHO WE ARE

Current Policy Development

Nurse practitioners, with their intensive graduate education and clinical training, enter practice ready to provide safe, high-quality care. The demanding role of primary care provider in community health centers calls for more: an intensive training bridge to support the transition from new Nurse Practitioner to primary care provider. Our goal is to provide new Nurse Practitioners with the training and support that will enable them to create and thrive in practice careers as primary care providers in community health centers.

- In the U.S., federal graduate medical education funds and legislation has supported residency training for doctors since Medicare legislation was enacted in 1965. There has been no funding or opportunity for Nurse Practitioner residency training. Considering the demands of practice at Federally Qualified Health Centers, we can't leave it to chance that new NPs will get the support they need.
- The literature suggests that the concept of a practice residency or fellowships has taken place in the acute care setting and in specialty areas across the nation, with many hospitals sponsoring training for novice NPs.
- Literature also provides evidence that new NPs experience a very difficult transition as they move from university to practice. At least one national survey documents that the majority of NPs would choose residency if one were available.
(Britt, A. M. and Maence, C. L. (2007). How well are nurse practitioners prepared for practice: Results of a 2004 questionnaire study. *Journal of the American Academy of Nurse Practitioners*, 19: 35-42.)
- The Patient Protection and Affordable Care Act (PPACA) calls for increasing the number of patients served in FQHCs from 20 million to 40 million. Section 5316 of the PPACA authorizes a demonstration project to replicate the NP residency model. NPs, with a focus on prevention, comprehensive care, and holistic approach are ideally suited for FQHC practice as primary care providers.
- The Institute of Medicine's two-year Initiative on the Future of Nursing, chaired by former HHS Secretary Donna Shalala, has released its report, called "The Future of Nursing: Leading Change, Advancing Health." The report concludes with eight key recommendations, including recommendation #3: Implement nurse residency programs. Recommendation #3 calls for action to support nurses' completion of transition-to-practice residency after they have completed a pre-licensure or an advanced practice degree program, as well as when transitioning into a new clinical area. Section 3 (pp3-1 through 3-53) of the report, titled "Transforming Practice," includes an elaboration on the need for residency training for new nurse practitioners and specifically references (p. 3-34) the testimony of Margaret Flinter, SVP and clinical director of Community Health Center, Inc. (CHC), on the need for residency training for new nurse practitioners and the model developed by CHC in establishing the country's first such residency training program for advanced practice registered nurses.

[Click here to view the PDF](#)

CHC's Family Nurse Practitioner Residency Training Program in Community Health and Primary Care is one of CHC's national initiatives. For more information about CHC, Inc. please visit www.chc1.com

***SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.**

"(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall establish a training demonstration program for family nurse practitioners (referred to in this section as the 'program') to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as 'FQHCs') and nurse-managed health clinics (referred to in this section as 'NMHCs').

"(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

"(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

"(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

"(3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

"(c) GRANTS.—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

"(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

"(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395i(aa)); or

"(B) be a nurse-managed health clinic, as defined in section 390A-1 of the Public Health Service Act (as added by section 5208 of this Act); and

"(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(e) PRIORITY IN AWARDED GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

"(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year, and to provide to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of such entity;

"(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics;

"(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women's health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas;

"(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

"(5) collaborate with other safety net providers, schools, colleges, and universities that provide health professions training.

(f) ELIGIBILITY OF NURSE PRACTITIONERS.—

"(1) IN GENERAL.—To be eligible for acceptance to a program funded through a grant awarded under this section, an individual shall—

"(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

"(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

"(2) PREFERENCE.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

"(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 22 days after the date of completion of the program.

"(g) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed \$600,000 per year. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

"(h) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

"(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014."

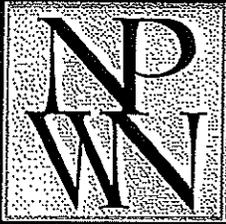
(f)(1) Section 399W of the Public Health Service Act, as added by section 5405, is redesignated as section 399V-1.

(2) Section 399V-1 of the Public Health Service Act, as so redesignated, is amended in subsection (b)(2)(A) by striking "and the departments of 1 or more health professions schools in the State that train providers in primary care" and inserting "and the departments that train providers in primary care in 1 or more health professions schools in the State".

(3) Section 394 of the Public Health Service Act, as added by section 3501, is amended by striking "399W" each place such term appears and inserting "399V-1".

(4) Section 395(b) of the Public Health Service Act, as added by section 3503, is amended by striking "399W" and inserting "399V-1".

(g) Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 10411, is amended by adding at the end the following:



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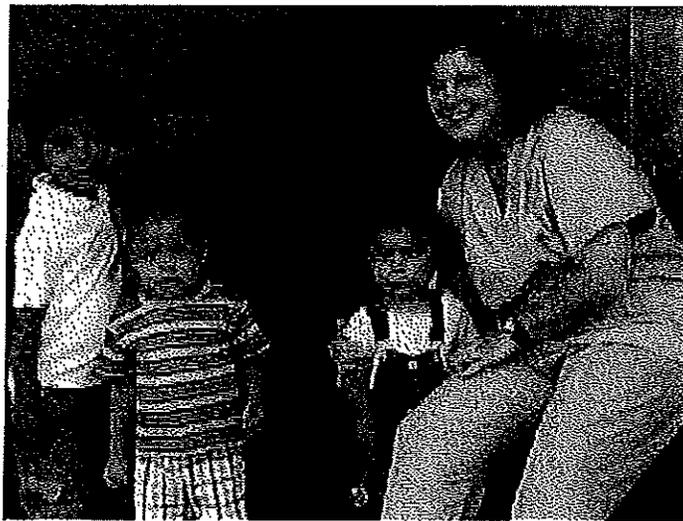
Medical Mission to Nicaragua

By Vicki Thiel, MSN, FNP

For 15 years the Trinity Episcopal Medical Mission from New Orleans has served the medical needs of residents of Central America. On May 11, 2007, I attended my second medical mission to Nicaragua with the Trinity mission. I was much more at ease this time, as I was now familiar with the mission team, the towns being served, and the overall routine. I had also learned more about Latin culture.

A Year in the Making

Coordinators of the Trinity mission are John Hevron, MD, an OB/GYN in Metairie, Louisiana, and Mamsie Maynard, RN, who works in the neonatal intensive care unit at Lakeview Regional Medical Center in Covington, Louisiana. They manage and organize the mission trip, with help from missionary team members. As soon as one mission arrives home, they begin planning the next one, getting funding and collecting and purchasing supplies and medications in mass quantities. The coordinators also make arrangements for the team's room and board, food, and transportation from the airport to the hotel and to the towns where clinics are set up for the day. Police escorts are arranged for the daily bus trips to the clinics, and an English-speaking bus driver is hired for the week.



Vicki Thiel with children outside the clinic

Local Peace Corps volunteers are recruited as translators.

Throughout the year, the mission team gathers at the home of one of the coordinators to pack supplies and medications for dispensing in the mission pharmacy. Each package contains an individual dose and is labeled with explicit instructions in Spanish, as well as a drawing of the instructions that depicts the time of day to take the medication. These "pill

packing parties" are a great way for past mission team members to reunite and for new members of the team to get acquainted with the culture of the mission.

The 2007 Mission Team Arrives

This year, the mission team had 45 members. I shared the women's health role on the mission with my collaborating physician and colleague, Dr. Hevron, one of the

Please see *Medical Mission to Nicaragua*, page 10

LET'S TALK MONEY

By Carolyn Buppert, JD, NP

20 Questions to Ask a Prospective Employer

This column offers 20 questions, the answers to which can give a nurse practitioner an idea of a prospective employer's expectations. It may be surprising that none of the questions asks about the employer's philosophy of patient care, whom the NP would be working with, office hours, what procedures the employer expects the NP to perform, or whether the NP will work in an office, hospital, or nursing home or conduct home visits. Those issues are important, and most NPs know how to address them in a job interview.



Carolyn Buppert

Nor do any of these questions directly ask the salary, hourly rate, or percentage of

Please see *Let's Talk Money*, page 7

Inside this Issue:

- House Calls: Home-Based Primary Care
- At the Abu Ghraib Prison Hospital
- Update on the National Nurse Movement

The First NP Residency Program

By Margaret Flinter, APRN, MSN

For more than 40 years, Medicare has been funding graduate medical education, which enables physician residents to earn a salary while they deepen their knowledge and skills under the structured guidance of more experienced colleagues. A similar opportunity for postgraduate residency training has not been available for nurse practitioners. It's time to change that.

The country's first family nurse practitioner residency program began last month. The 12-month residency was developed under the auspices of the Weitzman Center for Innovation in Community Health and Primary Care. The Weitzman Center is the research and development arm of Community Health Center (CHC), Inc, one of the largest



Margaret Flinter

Please see *First NP Residency Program*, page 18

Continued from page 1

The First NP Residency Program

Federally qualified health centers in the nation. The health care home for 70,000 patients, CHC provides a full range of primary care services in communities across Connecticut.

The inaugural class of the residency program is based in 2 of CHC's primary care sites, in the cities of New Britain and Meriden. These sites were chosen because of the volume and diversity of the patient population and the availability of enthusiastic clinical staff for faculty.

The residency program is designed for newly graduated and certified family nurse practitioners who intend to practice and lead in the complex environment of the more than 1,000 community health centers across the country. The NP residency emphasizes clinical skill building in the context of transformational health care, including population management, evidence-based health care, and true community engagement. In addition to carrying their own panel of patients, the residents will be assigned to intensive clinical rotations in areas important to family practice in a community health center, such as HIV/AIDS, orthopedics, behavioral health, and geriatrics.

Political Support

Support and encouragement for this project have come from many sources. In the Connecticut legislature, Representative Peggy Sayers, a registered nurse and cochair of the Public Health Committee, introduced House Bill 5751. This bill authorized creation of the pilot residency program and mandated a progress report to the legislature. Following its unanimous approval in the House and Senate, Governor M. Jodi Reil held a bill-signing ceremony on July 3, 2007.

Recognizing the benefit to Medicaid enrollees of additional training for NP primary care providers in the community health center setting, leaders in the state's Department of Social Services, which is responsible for the Medicaid program, are exploring possible funding mechanisms.

Support has come on the national level as well. Upon appeal from CHC, the National Health Service Corps agreed that participation in the residency program qualified newly graduated nurse practitioners who were

"obligated scholars" for a 1-year deferral of their service obligation.

The First Residents

After a limited recruitment campaign in the spring of 2007, 4 candidates were offered residency slots. Members of the inaugural residency class are:

- Rachel Gollnick
- Sarah Long
- Laura McDonald
- Monica O'Reilly

The residents appreciate the unique opportunity they have in this pioneer program. Below are a few words about what they anticipate gaining from the residency, as expressed in their applications.

"The program would provide for a supportive transition from graduate school to independent practice as a FNP."—*Sarah Long*

"With attentive and intentional mentorship, I intend to dramatically refine my clinical practice and emerge as a competent and highly trained family nurse practitioner."—*Monica O'Reilly*

"I think the beauty of a residency program for nurse practitioners is the opportunity to learn a great deal from every single patient encounter, rather than rushing through the day attempting to keep up with a schedule."—*Laura McDonald*

"I think that the residency will be a wonderful opportunity to learn together with fellow new graduates and help forge an emerging role for NP residencies in other community health centers."—*Rachel Gollnick*

The NP residency in family practice and community health at CHC is an innovative step in developing a cadre of expert, confident primary care providers for the challenging environment of community health centers. The 4 members of the inaugural class and the expert clinicians they are working with at CHC are pioneers in this endeavor.

Margaret Flinter is vice president and clinical director of Community Health Center, Inc., and director of the Weitzman Center. She acknowledges the Robert Wood Johnson Executive Nurse Fellows program for its support and encouragement in the development of the NP residency program.



The first 4 NP residents surround the vice president and clinical director of Community Health Center. Pictured left to right: Sarah Long, Monica O'Reilly, Margaret Flinter, Rachel Gollnick, and Laura McDonald.



The ceremonial bill signing on July 3, 2007. Standing behind Governor M. Jodi Reil are (left to right): Dr. Robert Galvin, Commissioner of the Department of Public Health; Rachel Gollnick, member of Inaugural residency class; Angela Anthony, board member of CHC; Margaret Flinter, vice president and clinical director of CHC; Daren Anderson, MD, chief medical officer of CHC; Mike Starkowski, Commissioner of the Department of Social Services; State Senator John Kissel; and State Representative Faith McMahon.

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Home ANA Periodicals OJIN Table of Contents Vol 17

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2012 No1 Jan 2012 Articles Previous Topics From New Nurse Practitioner to Primary Care Provider

From New Nurse Practitioner to Primary Care Provider: Bridging the Transition through FQHC-Based Residency Training

Margaret Flinter, PhD, APRN, C-FNP

Abstract

Community Health Center, Inc. (CHCI), a multi-site, federally qualified, health center (FQHC) in Connecticut, implemented a one-year-residency program for new nurse practitioners (NPs) in 2007. This residency program is specifically designed for family nurse practitioners intending to practice as primary care providers in federally qualified health centers. These centers comprise the nation's largest safety net setting; they are commonly referred to as community health centers. Supported in part by the Health Resources Service Administration, health centers are private nonprofit or public organizations serving populations with limited access to healthcare. They are located in designated, high need communities; governed by patient-majority boards of directors; and provide comprehensive, primary healthcare services. The author begins by reviewing the background and context for a nurse practitioner residency program, the importance of NP residency programs, and the recruitment and selection of NP residents. She explains how the residents are trained to a model of care and the content of care. She furthers the discussion by addressing program evaluation and outcomes and costs. Implications for national health policy, clinical practice, and nursing and areas for further research are presented. This article is timely in light of recent recommendations in the Institute of Medicine's 2010 report on the future of nursing recommending the development of residency programs for new, advanced practice registered nurses.

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Keywords: residency-training, transition, FQHC, nurse practitioners, primary care.

The United States (US) today faces a crisis in access to primary healthcare. Millions of newly insured people will soon seek additional healthcare.

The United States (US) today faces a crisis in access to primary healthcare. Millions of newly insured people will soon seek additional healthcare. They will confront the current and projected shortfall of primary care providers to deliver that care. This shortage is most apparent in the nation's largest primary care system, the network of more than 1,100 federally qualified health centers (FQHCs), also known as community health centers, or simply health centers. These centers are currently serving 18 million people in medically underserved and health-professional-shortage areas across the US. These numbers are expected to double by 2040.

underserved and health-professional-shortage areas across the US. These numbers are expected to double by 2040.

I will begin by reviewing the background and context for a nurse practitioner residency program, the importance of NP residency programs, and the recruitment and selection of NP residents. Next, I will explain how the residents are trained to a model of care and to the content of care. I will conclude by discussing the program evaluation and outcomes to date; implications for national health policy, clinical practice, and nursing; and areas

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Letter to the Editor

It takes a village of disciplines and health care personal to care for our patients today. As nurses we believe we are always open to collaboration and think we do it well.

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for further research.

In this article, I will focus on a particular FQHC, Connecticut's Community Health Center, Inc. (CHCI), a comprehensive, statewide, primary care system with 130,000 patients. Established in 1972 with a mission of healthcare as a right, not a privilege, the center focuses on improving health outcomes of special populations and building healthy communities. CHCI has three central drivers: clinical excellence; research and innovation; and training the next generation of healthcare providers. CHCI's Weitzman Center is its research, development, and innovation arm. In 2007 the Weitzman Center piloted the country's first formal, post-graduate residency training program for new family nurse practitioners. CHCI took this step after years of observing the difficult transition experience of new nurse practitioners (NPs). Their challenges included caring for a totally new panel of patients representing an enormous range of health conditions and needs that often included problems of behavioral health, substance abuse, low health literacy, and lack of access to specialists. These observations are supported in the literature (Bosch, 2000; Brown & Olshansky, 1997, 1998; Hart & Macnee, 2007; Huffstutler & Varnell, 2006; Kelly & Mathews, 2001). The NP residency program accepts four residents annually for the one-year, full-time program. As the Senior Vice President and Clinical Director of CHCI, and the Director of the Weitzman Center, the NP Residency is under my organizational leadership but has the strong, collaborative support of the entire executive team. CHCI anticipates that the NP residency graduates will develop careers as primary care providers in community health centers across the country; we have no implicit or explicit expectation that they will remain at CHCI.

Background and Context

The call for a blending of expertise in individual health, population health, and public health into the role of the primary care provider has never been louder.

The Patient Protection and Affordable Care Act (PL11-148) (An act, 2010) has made a significant investment in expanding the number and capacity of federally qualified health centers to deliver high quality, lower cost, primary care to underserved and special populations. The health reform debate now focuses on improving quality, increasing safety, and controlling cost while ensuring access to both health insurance and healthcare. Nationally we are seeing a new policy focus on prevention, care coordination, chronic disease management, health information technology, and patient-centered medical homes. The call for a blending of expertise in individual health, population health, and public health into the role of the primary care provider has never been louder.

...health centers might once have been perceived as the place of last resort for the nation's underserved, uninsured, and vulnerable populations, increasingly they are recognized as a model of first choice for the healthcare they provide.

Against this backdrop is the acute need for an expert primary care workforce that is prepared and motivated to practice a model of primary care appropriate to our 21st century healthcare system. We recognize the importance of asking not only "Why aren't more physicians choosing primary care?" but also "Who does want to be a primary care provider and what strategies are necessary to support them?" We believe post-graduate residency training for new nurse practitioners is a promising answer to the latter question.

The Health Resources Service Administration (HRSA) has reported that more than three thousand nurse practitioners deliver 9.7 million visits or 11% of all community health center visits (HRSA, 2009). Although health centers might once have been perceived as the place of last resort for

the nation's underserved, uninsured, and vulnerable populations, increasingly they are recognized as a model of first choice for the healthcare they provide. Evidence suggests that health centers are both clinically and cost effective as a primary care system addressing vulnerable populations (Hicks et al., 2006; Huang et al., 2007, 2008; Ku, Rosenbaum, & Shin, 2009; Landon et al., 2007; Rothkopf et al., 2011).

Importance of the FQHC-Based Residency for New Nurse Practitioners

Our FQHC organization recognizes and values the unique contributions of nurse practitioners serving as primary care providers. We recognize that they provide a nursing perspective to the challenges of a vulnerable population and nursing's commitment to health promotion, prevention, patient education, and community engagement. We also recognize that the current and future shortage of primary care providers demands that we think creatively and strategically about how to build on education, talent, and commitment in creating satisfying and long-term career opportunities for nurse practitioners within community health centers.

As a senior organizational leader across all clinical disciplines as well as a family nurse practitioner, I have observed over many years the difficulty of the transition from new NP

to primary care provider and the stress that the transition places on the new NP, the practice team, and the organization, I have seen a significantly less difficult transition of new physicians entering practice after a residency-training program in a primary care discipline. After testing various approaches for supporting this transition for the new NP's, including intensive orientations, assigned mentors, and very slow assumption of responsibilities, I have concluded that a structured, formal residency training program would be the approach most likely to support the transition from new NP to competent primary care provider.

In 2005 the CHCI executive team began the process of planning a residency program for new NPs. Our review of the literature and discussions with national colleagues within the FQHC community led to the publication of an article citing the need for FQHC-based residency training for nurse practitioners and discussing the desirability of basing such training in community health centers (Elinter, 2005). We accepted our first cohort of NP residents in 2007.

The NP residency program prioritizes both training to the complexity of clinical care and training to a model of primary care that is patient centered, team based, and comprehensive. The NP residents are assigned to 'pods,' a physical and staffing structure that groups primary care provider-led teams, with each team being responsible for a panel of patients. Each team consists of nurses, medical assistants, and shared personnel resources, including a dietitian, behavioralist, pharmacist, and diabetes educator. Each primary care provider (a physician or a nurse practitioner) is ultimately responsible for the care of all patients

in his/her panel. Key components of the NP residency program include precepted clinics, specialty rotations, independent clinics, and didactic sessions, supplemented by resident involvement in workgroups and data-driven quality initiatives of the organization. NP residents build their own panel of patients, derived from new patients registering for care at CHCI; they see each of these patients during 'continuity clinics' in which the NP resident has the exclusive attention of a CHCI staff NP or physician. Specialty rotations focus on areas that are high risk, high burden, and/or high volume in community health centers. Independent clinics provide an opportunity to focus on practicing independently, but with access to an identified PCP for consultation. A six week 'snapshot' of one NP resident's schedule is shown in Figure 1.

Key components of the NP residency program include precepted clinics, specialty rotations, independent clinics, and didactic sessions...

Weekly Resident Schedule

Resident	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Specialty Rotation	Precepted Clinic	Self Study
10/19	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/20	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/21	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/22	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/23	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/24	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/25	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/26	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/27	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/28	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/29	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/30	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study
10/31	Precepted Clinic	Independent Clinic	Block ED/Inpatient	Precepted Clinic	Precepted Clinic	Self Study

Figure 1. 'Snap Shot' of Resident Schedule (see full size [pdf])

Weekly didactic and experiential sessions that address specific content, skills, and procedures are shown in Figure 2.

The NP residency program collects on-going evaluation data using a commercial, medical-residency-evaluation program adapted for a NP residency. NP residents evaluate each element of the program weekly, monthly, or quarterly. Residents are evaluated in turn by their continuity clinic preceptors, specialty rotation preceptors, and the on-site medical director of their assigned site. We track visit volume, patient panel size and composition, diagnoses addressed, and procedures performed. Each week, NP residents must submit a reflective journal; these journals have provided rich insights into the transition from new nurse practitioner to competent primary care provider, and into the abundant challenges they encounter and overcome.

A multiple case study with cross-case synthesis of the inaugural 2007 class using Meleis' transition theory (Meleis, Sawyer, Messias, & Schumacher, 2000) as the theoretical foundation for studying the transition from new NP to competent primary care provider (Elinter, 2010) has been completed. A cross-case synthesis treats each individual case (NP student/graduate) as a separate study, thus examining the content of all of the data that is collected both during and following the residency (Yin, 2009). A full summary of the study is beyond the scope of this article. However, its findings are useful to consider when addressing policy and program development, as it provides a framework for examining the nature of the transition, facilitating and inhibiting factors, and process and outcome indicators of a successful transition. As Figure 3 illustrates, these indicators include developing confidence and coping, mastery, and the development of a fluid integrative identity.

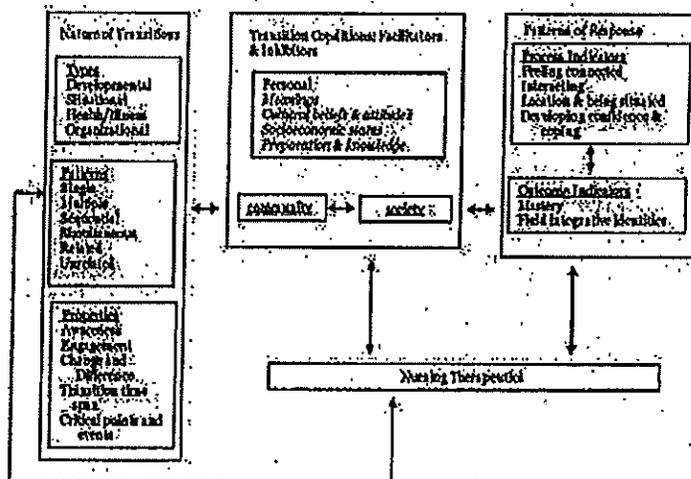


Figure 3, Meleis, A. Sawyer, L., Im, E., Messias, D., & Schumacher, K. (2000). Experiencing transitions: An emerging middle range theory. *Advances in Nursing Science*, 23(1), 17. Reprinted with permission. (See full size) [pdf]

Perhaps their most significant area of mastery is...the ability to pursue one's goals for prevention, health promotion, and health maintenance, no matter how ill the patient...

The cross-case synthesis of the inaugural class provided evidence that a healthy transition occurred, as described below in the responses given by the students. The NP residents allowed CHCI to use their responses for projects related to the residency program. This cross-case synthesis study was approved by CHCI's Institutional Review Board. One NP resident wrote towards the end of the residency, "As time went on, I hit a better stride and arrived at the end of the residency astounded at the difference between where I started and where I finished." She recalled the satisfaction of arriving on "day one" at her new job post-residency and feeling confident to handle her role and her patients. Another resident marked her

confidence in her skills by noting that her very complicated patients were getting better; their "A1Cs and BPs dropping, their asthma controlled." A year after completing the residency, each of the former NP residents identified that part of being a primary care provider means constantly confronting unknowns. They were sobered by the awareness of how sick patients seen by primary care providers in community health centers can be. As one resident noted, "not everyone with a cough has pulmonary emboli, but some of them do, and one of my patients did." Perhaps their most significant area of mastery is one that is well known and challenging for all primary care providers in community health centers, namely the ability to pursue one's goals for prevention, health promotion, and health maintenance, no matter how ill the patient, how numerous the chronic diseases, or how severe the socio-economic conditions.

Program Outcomes and Costs

All of the sixteen NP residents who have started the program since 2007 have completed the program. All but one are practicing as primary care providers in federally qualified health centers across the US.

To date, there is no federal source of financial support for residency training for nurse practitioners. Federal graduate medical education funding is not accessible for nurse practitioner residency training. CHCI considers the value of NP residency training of sufficient importance to invest internal resources, supplemented by sporadic external grant funding, while working vigorously to address the legislative and policy issues necessary to develop a structural, sustainable funding model for NP residency programs.

Federal graduate medical education funding is not accessible for nurse practitioner residency training...NP residents bill for clinical services they deliver, and this revenue is an offset to the expense of the program.

The costs of the NP residency program derive from four major areas: NP resident salary and benefits; compensation for the NP residency program coordinator; lost revenue when the CHCI preceptor is exclusively assigned to a precepting session with a resident versus being assigned to seeing the preceptor's own patients; and facility overhead and administrative expenses. Most external specialty preceptors have contributed their time without charge. As fully licensed and credentialed providers, NP residents bill for clinical services they deliver, and this revenue is an offset to the expense of the program.

Implications

This Residency Program has implications for national policy, clinical practice, and the nursing profession. Each of these will be discussed below.

National Health Policy

In 1986, Congress created the Council on Graduate Medical Education (Phillips, Dadoo, & Jaen, 2005). This Council is an advisory council. It issues reports and recommendations concerning physician workforce development and training and has made several strong recommendations to address the primary care physician shortage:

The 19th Council on Graduate Medical Education (COGME) report of September 2007 (COGME, 2007) called for aligning Graduate Medical Education (GME) with future workforce needs, broadening the definition of training venues, removing regulatory barriers to executing flexible GME programs, and making accountability for the public's health a driving force in GME. Unfortunately, residency training for nurse practitioners has not yet been addressed by COGME.

The Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine, in its landmark report, calls for residency training programs for new APRNs.

Since 2005, CHCI leaders have collaborated with other stakeholders with an interest in NP residencies and have worked to educate and inform congressional leaders of the need for and benefits of NP residency training. These efforts, and other efforts of many colleagues who have an interest in NP residency training, have led to the inclusion of Section 5316 in HR 3590 (the Patient Protection and Affordable Care Act of 2010), which authorized HRSA to create a three-year demonstration project funding training programs for family nurse practitioners in FQHCs and nurse managed health centers. The details of the amendment are quite specific in describing the elements of the CHCI NP Residency Model and the

standards that sponsoring organizations must meet. We continue to work towards securing an appropriation funding for this demonstration project.

The Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine, in its landmark report, calls for residency training programs for new APRNs (IOM, 2011). The final report, which references CHCI's model, establishes a strong basis for further support, evaluation, and development of the model across the country as nursing and other stakeholders move forward with strategic initiatives to implement the recommendations of the Committee.

Clinical Practice

The situations our NP residents have encountered have convinced us of the urgent need to prepare new nurse practitioners to

NP residents frequently

effectively care for the complex, multi-problem, and often undifferentiated (having had no prior evaluation/work-up) patients who are challenged by physical, social, and often behavioral health and substance abuse concerns. NP residents frequently describe the presentation of the unknown, the complex, and/or the undifferentiated patient concerns (a routine part of primary care practice) as the greatest challenge they face and discuss examples such as these:

describe the presentation of the unknown, the complex, and/or the undifferentiated patient concerns...as the greatest challenge they face...

- The 'brief' appointment for a chief complaint of 'bump on the leg' that proved to be an aggressive cancer in an uninsured migrant farm worker
- The 'late medication refill' for a new pediatric patient who presented with a list of multiple co-morbidities and medications initiated elsewhere.
- The crashing diabetic, newly homeless and contemplating suicide

These are the 'initial' patients that appear in the schedule of every primary care provider in the nation's federally qualified health centers, and who stand to reap enormous health benefits from the expert care of a nurse practitioner over time. Far from rare, these patients are in fact quite representative of the special populations served by health centers. All primary care providers must be ready, able, and trained to thoughtfully, completely, accurately, and compassionately establish a relationship; begin the process of differentiation, management, and treatment; work with a team to coordinate care; and assure that patients and families get the full benefit of prevention, health promotion, treatment, and management.

The Nursing Profession

CHCI's program has generated discussion in the nursing community about the need, desirability, and context for residency training, as well as whether the proper term for such a program should be 'fellowship' or 'residency.' Crabtree (2002) has described NP preparation as rigorous, thorough, and ensuring that new NPs meet the HRSA standards for entry-level competency in the primary care specialties. I stand in full respect of the educational preparation for NPs. In the FQHC setting, however, patients are most often not 'entry level' patients. Even the rigorous clinical training hours required for all NP programs is insufficient to begin practice with confidence and mastery as a primary care provider in these settings. Whether residency training is needed in all practice settings for new NPs is a question that requires further discussion, although the report on the future of nursing (IOM, 2011) includes residency training for all new APRNs as one of their final recommendations.

Areas for Further Research

...residency training for new NPs is successful in bridging the transition from new NP to confident and competent primary care provider.

Our CHCI experience to date supports our initial observation that residency training for new NPs is successful in bridging the transition from new NP to confident and competent primary care provider. However, more research is needed into the nature of the transition; facilitating and inhibiting factors; and indicators of outcomes for the NPs who complete the residency. It is essential that research be devoted to understanding primary care practice in community health centers; and specifically NP practice in these settings. Also important is the study of the longitudinal impact of NP residency training on retention, leadership, and clinical quality of NPs in FQHCs, along with the true costs and benefits to the sponsoring organization. A particularly interesting area for

research would be the study of possible differences in practice between those NPs who have completed a residency program and other primary care providers. Finally, the various elements of the NP residency, including the effectiveness of preceptors; the impact of the residency program on the organization; and the outcomes of various strategies to prepare new NPs to manage complexities, such as behavioral health disorders, trauma, substance abuse, and pain management as a primary care provider, require study.

Conclusion

Our CHCI has consulted with many organizations across the country who are now actively developing NP residency training Programs. From Maine to Alaska, FQHC leaders are questioning how to support the transition from new NPs to competent primary care providers. Our experience over the past five years has confirmed the value of NP residency training for new nurse practitioners in supporting the transition to primary care provider. We are committed both to continuing to support our 'first in the country' NP residency program for new family nurse practitioners and also to working with other community health centers and nurse leaders around the country in further developing the

model. Meleis et al. (2000) wrote of the 'wisdom' that may be seen at the end of a healthy transition. One of the members of the Inaugural class exemplified such wisdom in her remarks at a May 2009 Capitol Hill briefing:

After the residency, I moved to a health center in one of the poorest towns of my state. My transition to being an independent provider has been smooth. I have a certain level of confidence that enables me to keep my head above water. A list of twelve complaints in one visit no longer paralyzes me; instead I prioritize almost instinctively. I ask better questions. I put the pieces together just a little bit faster. And when I feel like I'm about to crumble from the demands of community health, I remember that there are thousands of primary care providers out there with varying levels of training and experience all facing similar challenges. I am grateful to know that this is the nature of the work, that this is simply what it requires and that I am well prepared to address the needs of the community. (Monica O'Reilly, Capitol Hill Briefing, May 20, 2009, Washington, DC)

Community health centers and nurse practitioners are two innovations, one organizational and one professional, that were born of the same era in American history, the 1960s, now more than forty years ago. Each represents the highest level of commitment to care, to quality, and to individuals and communities most in need of healthcare.

Author

Margaret Flinter, PhD, APRN, c-FNP
E-mail: Margaret@chci.com

Dr. Flinter is the Senior Vice President and Clinical Director of the Community Health Center (CHC), Incorporated, a statewide, federally qualified, health center serving 130,000 patients across Connecticut. Prepared as a family nurse practitioner, she has held progressive clinical and executive leadership positions in this organization since joining it as a National Health Service Corps Scholar in 1980. In 2005 Dr. Flinter established the Weitzman Center for Innovation in Community Health and Primary Care as the Research and Development arm of CHC, Inc. She received her Master's Degree from Yale University School of Nursing (New Haven, CT) and her BSN and PhD degrees from the University of Connecticut (Storrs, CT). She has also been a Robert Wood Johnson Executive Nurse Fellow. Dr. Flinter is a former President of the Connecticut Nurses Association; she was appointed by the Connecticut Legislature as Chair of both the HealthFirst Authority and the Statewide Primary Care Access Authority in 2007. She acknowledges the support of CHCI President and CEO, Mark Masselli, and Chief Medical Officer, Nwando Olayiwola, MD, MPH, for their support of CHCI's NP Residency in Community Health and Primary Care.

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WATCH OUR PROGRAM VIDEO

An overview of America's first Family Nurse Practitioner Residency Training Program, including background from Community Health Center, Inc. founders Mark Masselli and Margaret Flinter and insights from past residents.

 [Watch the Video](#)

FROM AN IDEA TO A PROGRAM TO PART OF THE FEDERAL HEALTH CARE REFORM BILL - AMENDMENT NO. 5316

Section 5316, of the Patient Protection and Affordable Care Act includes an amendment introduced by Senator Daniel Inouye of Hawaii. This amendment authorizes the establishment of a three-year demonstration project that will replicate Community Health Center's residency training program for family nurse practitioners in federally qualified health centers (FQHCs) and in nurse managed health centers (NMHCs).

Current effort is focused on the appropriation of funding to go along with the authorization.

Thank you Senator Inouye for your support!

 [Download the PDF](#)

THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH

The Institute of Medicine's two-year Initiative on the Future of Nursing, chaired by former IHS Secretary Donna Shalala, has released its report, called "The Future of Nursing: Leading Change, Advancing Health." The report concludes with eight key recommendations, including recommendation #3: Implement nurse residency programs. Recommendation #3 calls for action to support nurses' completion of transition-to-practice residency after they have completed a pre-licensure or an advanced practice degree program, as well as when transitioning into a new clinical area. Section 3 (pp3-1 through 3-53) of the report, titled "Transforming Practice," includes an elaboration on the need for residency training for new nurse practitioners and specifically references (p. 3-34) the testimony of Margaret Flinter, SVP and clinical director of Community Health Center, Inc. (CHC), on the need for residency training for new nurse practitioners and the model developed by CHC in establishing the country's first such residency training program for advanced practice registered nurses.



Capitol Hill Gets Briefed on NPs in FQHCs

By Eileen T. O'Grady, PhD, RN, NP

With economic stimulus funds working their way through federal agencies for disbursement, a group of inspirational NPs held a briefing on Capitol Hill on May 28 to tell congressional staff about unique workforce issues in Federally Qualified Health Centers (FQHCs) and steps they have taken to address these issues. FQHCs receive Medicare and Medicaid reimbursement for care for uninsured individuals. Margaret Flinter, APRN, vice president and clinical director of the Community Health Center, Inc., in Connecticut, and other executives from that organization led the NPs as they shared their stories.

Margaret's organization is an exemplar of community health centers, serving 70,000 patients in 160 locations across Connecticut. This FQHC is a model of a comprehensive, fully electronic, primary health care system.

Nationwide, there are 6,000 vacancies for primary care positions in community health centers. The turnover rate is very high. The NPs at the congressional briefing presented compelling cases about unique challenges that providers at these health centers face. The Capitol Hill visitors spoke of the need for NPs committed to the underserved to have support in their first year of practice.

To address these needs, the Connecticut Community Health Center developed and implemented a model for a one-year residency training program to prepare new NPs for practice in any FQHC in the nation. New NP graduates (either MSN or DNP) receive a full salary and intensive, structured support while they develop competency and confidence as primary care providers in this challenging setting.

Two NPs, one just entering the residency training program (Kandree Hicks) and a graduate from the inaugural group of 2007-2008 (Monica O'Reilly) spoke of their journeys into nursing and their commitment to the underserved. They described how their classmates avoided community health centers or left after short stints because they felt overwhelmed and unprepared to serve such complex patients.

Monica told how the NP residency program smoothed her transition from NP graduate to provider. All elements of the residency, from precepted clinics to additional training in specialty areas, prepared her to thrive in her new position as a primary care provider in another FQHC. The speakers eloquently shared powerful stories of the work of well-prepared NPs in this difficult setting.



Margaret Flinter, APRN, vice president and clinical director of the Community Health Center, Inc., speaks at the congressional briefing. Seated at the table are Mark Masselli, president and CEO of the organization, and Monica O'Reilly, APRN, a graduate of the inaugural class of the residency program who now works at Holyoke Health Center in Holyoke, Massachusetts.



Monica O'Reilly, APRN, a graduate of the inaugural class of the Community Health Center residency program, shares her experiences. Seated at the table are (left) Kandree Hicks, MSN, an incoming resident in the program, and Nvando Olaylowola, MD, chief medical officer of the Community Health Center.

The goal of the NP-led briefing was to educate congressional staff about the value of FQHC-based residency training and to propose a model for replication across the country. A proposal developed by the Connecticut Community Health Center was put forward to target specific Health Resources and Services Administration funds for this purpose.