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RESIDENCY PROGRAMS FOR PRIMARY CARE NURSE PRACTITIONERS IN FEDERALLY QUALIFIED HEALTH CENTERS: A SERVICE PERSPECTIVE

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ABSTRACT

A number of social forces are converging to shape the coming health care and professional practice environment for nurse practitioners (NPs) and the public they serve. Two major innovations of the 1960s, NPs and community health centers, have reached their fourth decade since their inception. These forces have traveled parallel and overlapping paths in their mission to provide high quality health care. Today the current federally qualified community health centers (FQHCs) are a major component of the nation's safety net for the medically underserved, special populations, and the uninsured throughout the United States. Nurse practitioners in the FQHC settings are responsible for highly complex care across lifecycles, with a focus on the treatment and management of disease along with prevention and health promotion. The author suggests that FQHC-based formal residency programs in primary care at either the post-master's or post-doctoral level are the next step in the evolution of both FQHCs and NP preparation. Possible funding mechanisms through changes in federal graduate medical education legislation are explored.

Key words: doctorate of nursing practice, federally qualified community health centers, primary care nurse practitioners, residency programs

The literature suggests that the concept of a practice residency has taken hold in the acute care setting, with many hospitals now sponsoring such programs for entry to practice nurses ([Goode & Williams, 2004](#); [Olson et al., 2001](#); [Rosenfeld, Iervolino, & Bowar-Ferres, 2004](#); [Williams, Burkhead, & Ward, 2002](#)). These residencies are primarily at the post-baccalaureate, early-employment stage of a nurse's career, with the residency serving as the first leg of the nurse's employment by the sponsoring institution. Although both Hollinger-Smith and Murphy ([1998](#)) and also Donley et al.'s discussion of the Nurse Reinvestment Act ([2002/03](#)) address the need for internships and residency programs in various settings, including community health centers, the funding for such programs is not yet available for nurse practitioners.

In contrast, the completion of a primary care residency is mandatory for physicians seeking specialization in this area. The desire to ensure that there would be a supply of adequately prepared physicians to take care of the newly insured elderly of America drove the development of graduate medical education funding when Medicare was enacted in 1965 (Thies & Harper, 2004). The physician residency is a salaried position in which the sponsoring organization must devote reimbursed clinical faculty time and attention exclusively to the educational needs of the physician resident. Such a residency is the accepted standard for preparation for primary care medical practice, leading to board certification and serving to assure the public that the physician has the necessary training, education, and competencies for the independent practice he/she will choose to enter upon completion of the residency. There is no equivalent program available to nurse practitioners. I contend that the lack of residency programs places nurse practitioners (NPs) at a severe disadvantage as they enter practice in the highly complex, clinical environment of a federally qualified health center (FQHC). My observation is based upon two decades in clinical and executive roles, which has included recruiting and mentoring generations of physicians and NPs in one of the country's largest community health centers. The new NP entering FQHC practice requires up to a full year of mentorship by another clinician employee before the NP is fully "up to speed," confident, independent, and able to manage a full panel of patients. Brown and Olshansky (1997), too, have described the difficulty of the NP's "transitional" year and the need for employers to expect lower volume in that first year. They acknowledged the potentially devastating effects of a practice environment that does not provide the support needed by new NPs.

During this critical first year of practice, the new NP's development is largely tied to the skills and scope of a colleague whose primary responsibility is not mentorship, but his/her own practice, and who may or may not have the skill, patience, interest, and/or time to devote to intensive training and mentoring. This first year of experience is in contrast to the entry-to-practice physician who has completed a residency in a primary care specialty. The discrepancy in entry to practice risks placing the new NP in a mid-level, apprentice-type position from which it is very difficult to move to full professional status.

I suggest that the very basis of the nurse practitioner role—a full range of clinical competency, which goes well beyond the medical model to include a holistic approach to patients and the communities in which they live—argues the case for their central practice and leadership role in FQHCs. Dr. Mary Munding, in stating the case for the doctor of nursing practice model, challenged nurse educators to assure quality and access in advanced practice nursing by preparing these nurses for full scope of practice in primary care (Munding et al., 2000). This new academic degree has the potential to significantly enhance nurse practitioner preparation. However, from my FQHC perspective, the practice-based residency is still needed to prepare for the wide range of clinical and social challenges which occur daily in a community health center setting. In this article I will review the convergence of the NP and FQHC movements, describe the benefits of a NP residency in a FQHC, and address possible funding sources for NP residency programs.

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The Development and Convergence of the Nurse Practitioner and the Community Health Center Movements

Both the NP role and the community health centers (CHCs) emerged in the 1960s and have developed in separate, but in many ways philosophically and pragmatically parallel paths. One can argue that both movements began from a single point: the conception of an idea that increased access to quality health care was desirable. The CHCs focused on developing a structure for creating access and providing care in a community context; the NPs focused on the development of an expanded role for nursing to deliver that care. Both innovations, early on, valued the social good and created tangible innovations to address it. Both have been extraordinarily successful in their growth and impact. It is possible that these paths might yet converge in a closer trajectory.

CHCs grew out of an even earlier social medicine model known as community-oriented primary care, first developed in South Africa (Susser, 1999) and later carried into the intellectual, legislative, and structural development of the federally funded program originally known as neighborhood health centers and now known as FQHCs (Geiger, 2005; Lefkowitz & Todd, 1999, Strelnick, 1999). The CHC movement, starting with projects in Mississippi and Boston, was inspired by the concept of community-oriented primary care and was founded within the context of the civil rights movements, President Lyndon Johnson's War on Poverty, and the inspiring leadership of a young generation of activists.

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From the start, this movement focused on the critical need for a different kind of health care organization, one that was of the community and for the community, one in which financial barriers could be eliminated and the goals of equality in health care could be realized. From its earlier days as a demonstration project of the Office of Economic Opportunity, the community health center movement has grown into a national safety net which catches and cares for 15,000,000 Americans in multiple sites in every state (Bureau of Primary Health Care, n.d.). By definition and by statute, FQHCs are consumer-controlled health care entities that focus on prevention as well as treatment, and target underserved and high need populations and communities

without regard to individuals' ability to pay. Federally qualified health centers are built upon the radical social idea that health care is a right and not a privilege and that no one should be denied care because of inability to pay. Further, in contrast to the obligations of hospitals and universities, FQHC designation mandates a host of commitments from guaranteed access by low income and uninsured persons to an independent, consumer-controlled board of directors who exert control over the system in which they receive care. These legislative requirements are detailed in Policy Information Notice 2003-21, (<ftp://ftp.hrsa.gov/bphc/docs/2003pins/2003-21.pdf>).

The nurse practitioner movement was birthed among a similar set of social changes, recognizing the need for a different kind of health care provider, and the ability of nurses to play previously unrealized independent roles in primary care. The nurse practitioner movement was first described by Loretta Ford and Henry Silver (1967) in their landmark article. Today, the American Academy of Nurse Practitioners (AANP) 2004 survey numbers NPs at 106,000 (AANP, n.d.).

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Although the two movements pursued separate paths, both were, and continue to be, focused on making access to quality health care a priority. Both are innovative social models that have stood the test of time and continue to adapt to changing conditions with each decade.

and achieve full professional recognition.

During these past forty years, NPs have made enormous contributions to CHCs and their patients. Structurally, however, it is not clear that there has ever been transcendence of the mid-level provider designation of the NP. We arrive in the 21st century with both community health centers and NPs enjoying considerable success. Yet the specter of uninsured patients, health disparities, rising costs, an aging population, and an increasing burden of chronic disease remain in spite of existing scientific, organizational, and patient-driven approaches to deal with these problems. In discussions of the future of health care, NPs are rarely cited as part of the solution, and CHCs are cited only as politically expedient. I propose that a NP residency program would enable NPs to transcend their mid-level provider status and achieve full professional recognition.

Nurse Practitioner Residency Programs in Community Health Centers

The time is right for the parallel paths of CHCs and NPs to come together in a new way. The opportunity exists for NPs to assume leadership for assuring that all people have access to primary care that is expert and effective in meeting the needs of patients across all settings, and throughout the lifespan. They provide care in multi-cultural settings, in which the dominant language may not be English and the dominant demographic descriptor is poverty. Nurse practitioners bring a commitment to working in partnership with patients and the community. NPs contribute expertise in multiple areas considered sub-specialties in other settings, including obstetrics, psychiatry/behavioral health, multi-chronic disease management, pediatrics, geriatrics, and prevention. The demands of this practice require an entry-level residency program as explained below. Nurse practitioners should enter FQHC practice prepared for independent practice as a full peer with other members of an interdisciplinary team. To do this, NPs need practice-based training of a scope, duration, and focus that is better obtained in institutions in which care is delivered than in the educational institution in which the academic degree is earned. In short, one must go where the patients are for the final phase of preparation for entry to advanced practice in primary care across the lifecycles.

Why a residency model? My premise is that residency is the training that follows education and allows that education to be translated into the broad and specific competencies in practice that are fundamental to safe, quality practice. One could argue that the diploma nursing schools were in fact residencies without the university education. Perhaps in reaction to diploma nursing programs, we have developed a professional bias against institution-based training in favor of preparation provided in institutions of higher education. Advanced practice primary care requires both.

Currently it is expected that the employing organization will provide a mentor for the NP, either physician or NP, who will provide an intensive level of clinical decision-making support throughout the first year of practice. However, FQHCs are not structured to meet this expectation. Rather NPs in a FQHC enter practice dependent on the patience, skills, experience, and time of a clinical mentor whose primary responsibility is to his/her own practice and performance. One might argue that "new" NPs should "get their experience" in

a less challenging setting. But failure to prepare them to master the skills they need in the "acute" FQHC setting is precisely what leads to turn-over and retention issues among new NPs. No other setting can supply equivalent training and experience.

The establishment of a formal, FQHC-residency program, with a concomitant change in the federal legislation that determines funding for graduate medical education to allow support of nurse residency programs, has the potential to prepare a cadre of advanced practice nurses for full accountability and autonomy within the multi-disciplinary team structure of primary care. The full benefit of this intervention would ultimately accrue to the patients of these centers who are disproportionately low income, uninsured, publicly insured, minority, and/or non English speaking. In addition to meeting the needs of the population using health centers, the FQHC residency has the potential to greatly expand the health center model in new and entrepreneurial ways relying increasingly on NPs as the clinical foundation of the system.

At this point in time the medical residency model is unique to medicine. In medicine, there is a clear differentiation between medical school education and the subsequent residency. Medical school is university-based and focused on didactic education. It provides supervised, experiential exposure to patients in hospitals and ambulatory settings. Upon graduation, one chooses a specialty area and a residency program to prepare for that specialty. The residency is based in a practice-focused institution (hospital) which is chosen for its strength in the specialty of interest and which has sufficient size, depth, quality, and resources to provide the required training. The resident, now a salaried employee and a licensed clinician, is carefully nurtured through a series of intensive, increasingly autonomous opportunities and challenges to master all components of care for which he/she will be expected to assume responsibility/competency in practice following the residency. Of key concern is the exclusive assignment of the attending clinical faculty to training of the resident. The structure, content, and documentation of both experience and competency are clearly charted. It is expected that the "finished product," while of course still at the beginning of the path to expert practice that only experience can provide, will be fully and wholly competent to practice independently as outlined by the residency program. The notion of "needing a mentor" to enter practice does not exist. This residency model would offer many benefits as a model for advanced practice nursing.

Where Will the Funding Come From?

Where will the funding to support nurse practitioner residencies in FQHCs come from? In answering this question it is important to look at who will gain from these residencies. The country today is more focused on health care and its twin issues of cost and coverage than at any time in recent history, with a renewed interest in Medicare and Medicaid program innovations. Patients of FQHCs are overwhelmingly Medicare, Medicaid, or uninsured. FQHCs derive the majority of their revenues directly or indirectly through the governmental entities in the form of publicly funded insurance or grants. Thus, the federal government may have the most to gain from further improvement in the FQHC model of care delivery.

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First this section will examine the current legislation related to Medicare funding for physician residency programs and the benefits of a comparable residency program for NPs. Next it will consider the possibilities of modifying this legislation in support of nurse practitioner residency programs in primary care. Finally it will suggest that some funding for NP residency programs could come from Medicaid GME.

Current Funding for Graduate Medical Education

Nursing has begun to focus on the history and legislative underpinnings of Graduate medical Education (GME) as it seeks to explain past funding for nursing education and to prepare for the future (Fulcher, 2000;). Graduate medical education rules dictate compensation to the institution sponsoring the physician residency in reimbursement for direct and indirect expenses. There is no allowance within the legislation for a corollary support for nurse practitioner residency programs. Unlike nurse practitioner clinical training sites, where there is no formalized payment or reimbursement structure either to institution or to preceptor, GME rules dictate that the residency sites include faculty time dedicated specifically to the education of the residents. During these periods of dedicated time the preceptor has no clinical responsibility other than the education of the resident(s). In contrast, practitioners and administrators in the community health center setting struggle with the competing desires to both participate in the education and training of the future NP workforce and to meet the productivity levels needed to keep the organization financially solvent. Revenue losses associated with time spent educating others can be high.

A redesign of GME funding to allow the creation of CHC-based nurse practitioner residency programs would accomplish several goals. It would provide appropriate compensation to FQHCs for sponsoring and developing formal residency training for NPs. It would provide the salaried support to new graduates of NP programs which would allow them to devote this additional period of time to preparation for what hopefully would be a long-term career in the delivery of excellent health care to people most in need of such care. It would enable them to develop a specialty in areas such as chronic disease management, prevention, cultural competency, self management, or care across the life span. One would hope that an FQHC-based residency program for NPs would influence NPs to make FQHC practice their career specialty, and exert even greater influence in the future as the leaders of such organizations.

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It should be noted that another parallel of the NP residency program to medical residency programs is the intent of the institution to train the resident, without a concomitant commitment to hiring the resident after the completion of the program. One of the most exciting consequences of an NP residency program is that the larger, more developed FQHCs would serve as training sites capable of sending forth graduates to other FQHCS, rural or urban, fully prepared for independent practice.

Is every FQHC a potential site for an NP residency programs? No. Clearly, only those FQHCs of a certain size, scope, and infrastructure would be prepared for this undertaking. As a yet untested model, standards and requirements would need to be developed. A first step in this direction would be the clarification of these standards and requirements to determine which FQHCs qualify

as sites of residency programs. Given the wide distribution of FQHCs across the country, and the preferential funding for new FQHC development in rural, frontier, and urban communities of greatest need, it is reasonable to presume that most NPs seeking such a residency program would have geographic access without relocation.

Ideas for Funding Nurse Residency Programs and Steps to Achieve this Funding

The two most likely sources of funding for FQHC-based residency programs include Medicare GME and Medicaid GME. Given its standing as the oldest and best established funding source, the most obvious and rational starting point is to change existing Medicare GME legislation that currently funds both the institutions sponsoring residencies and the residents themselves. As part of laying the foundational strategy for this proposed change, this author requested a legal analysis of the statutory and regulatory barriers to federal graduate medical education financing for non-physician providers. A very brief overview of the current status of the GME reimbursement legislation is presented below to deepen our understanding of what a coalition seeking to effect this change for nurses might confront.

The purpose of direct GME reimbursement (DGME) is to reimburse institutions on a cost basis for the direct training costs incurred by institutions involved in medical residency training programs. Allowable DGME includes the salary and fringe benefits of the residents and that portion of the cost of teaching physicians' salaries and fringe benefits attributable to teaching activities. Indirect GME (IGME), generally the larger portion of GME support, is meant to reimburse a hospital for the generally higher operating costs experienced by hospitals that sponsor/house residency training programs. These higher operating costs typically arise from increased resource utilization and clinical inefficiency due to the inclusion of an additional layer of less experienced staff involved in the delivery of patient care. In 1998, substantive changes to the GME legislation were made which make the pathway to creating NP residencies in FQHCs easier. Section 1886(K) was added to the Social Security Act (42 U.S.C. 1395ww(k) and expanded the number and types of institutions eligible to receive DME reimbursement, regardless of whether or not the institution is the sponsoring institution of the residency program, provided that such institutions incur all or substantially all of the direct training costs at the institution's site(s). This section includes payment to non-hospital providers and includes FQHCs as eligible providers, along with rural health clinics, Medicare + Choice organizations, and other such providers as the Secretary determines to be appropriate.

Having cleared the hurdle of recognizing in-patient (hospital) settings as the only site for a residency program, the next real challenge in obtaining Medicare GME funding would be qualifying non-physician residency training programs. An amendment to the Social Security Act to create an appropriate expansion (or new) definition of "approved medical residency training program" which covers nursing would be needed, along with corresponding amendments to the definitions of "resident" and "primary care resident" to include appropriate non-physician providers. At the same time, given the historically much lower profile of Medicare patients in the FQHC setting than is typical for in-patient institutions, the funding formulas would require revision or the simpler, and possibly more politically palatable, approach of creating a new section in

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Section 1886(h) specifically addressing how GME for FQHCs would be calculated.

Medicare's indirect GME (IGME) is statutorily authorized in Section 1886(d) (5) of the Social Security Act. As such, it would require fundamental amendments that either (a) insert the phrase "Federally Qualified Community Health Centers" after the word "hospitals" throughout or replace the term "hospitals" with a broader term which effectively includes FQHCs, and (b) address necessary changes in definitions, such as resident, primary care resident, and approved medical residency training program. A new mechanism also would be needed to address how IGME for non-hospital providers would be calculated. Section 4004(b) of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) requires the Department of Health and Human Services to reimburse hospitals (or institutions controlled by the hospitals) for reasonable costs incurred for clinical training conducted on hospital premises under approved nursing or allied health education programs. In order for non-hospital providers to receive access to such reimbursement directly, a statutory directive requiring DHHS to reimburse them for reasonable costs incurred for comparable clinical training conducted on non-hospital premises would be necessary. Evidence that such changes may be within the realm of the possible is found in the report of the Council on Graduate Medical Education (COGME), "Financing Graduate Medical Education in a Changing Health Care Environment" ([Bureau of Health Professions, 2000](#)) and the subsequent COGME Resource Paper "State and Managed Care Support for Graduate Medical Education: Innovations and Implications for Federal Policy" ([COGME, 2004](#)). These reports identify the contradictions inherent in current funding methodology restrictions, pointing to the vital role that the states play and identifying the need for changes in regulations.

One could argue that Medicaid, which insures a more significant percentage of patients in FQHCs than does Medicare, also has a vested interest in the training and preparation of the health care workforce that will care for its enrollees. Such funding could be accomplished by allowing FQHCs to build the costs associated with nurse practitioner residency program into the Medicaid per encounter rate.

Conclusion

Federally qualified health centers and primary care NPs are natural partners. They share a commitment to the highest quality of care for underserved and special populations in a consumer-dominated, community setting. The establishment of FQHC-based, formal residency programs, modeled in many ways after physician primary care residency programs, is a timely and needed intervention to achieve fully independent NP practice in this setting. Although this article has chosen to focus specifically on the development of FQHC-based residencies for NPs in primary care to the exclusion of nursing residency needs for other APN roles and/or other NP specialties, further discussion on the merits of residency programs across other specialties and in other settings is invited.

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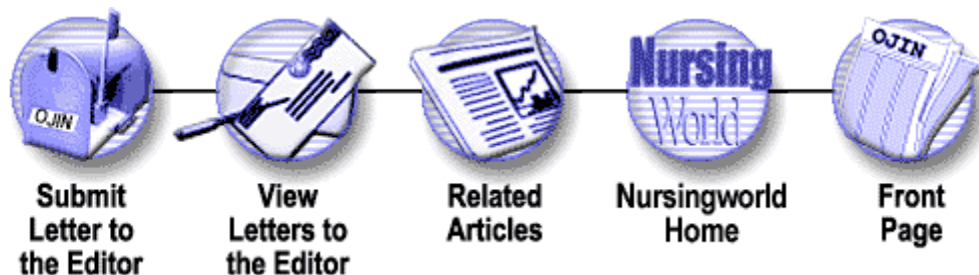
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