Recruiting, retaining, and training new NPs to **THRIVE** as PCPs in Health Centers

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CHC Inc., est. 1972 - Service Delivery

173 Community and School Based Sites

Patients come from almost every town to see our clinicians

- Towns where CHC patients come from
- Towns with no CHC patients
CHC Model of Primary Care

- Patient-centered healthcare home
- Advanced Access—timely and efficient care
- Data driven; outcome focused
- Expanded hours—evenings, weekends
- Team-based: integration of all services
- Planned Care and Chronic Care Model
- Integrated E.M.R. and HIE
- Training the next generation of healthcare providers to the FQHC model of care
Transformational Care

1. Clinical Excellence
2. Research & Development
3. Training the Next Generation
Recruit, retain, and thrive
Factors in Recruitment of PCPs

- Local ties—family, community, school
- Competitive (or better) salary and benefits
- Dedicated clinical recruiter
- Consistent messaging on organization
- Positive, high-vitality team-mates
- Opportunity for research, teaching, or other assignments beyond patient care
- Quality of facility and technology (EMR)
Factors in Retention of PCPs

- Competitive (or better) compensation
- Reasonable on call schedule
- Strong on-site clinical leader
- Strong central clinical leader
- 4-day, 10 hr (full time) option
- Support for complex patients, particularly pain management, substance abuse, BH
- Positive, high vitality team mates
- (Financial) Incentive program for both quality and productivity
- Facilities and technology

Recruit, retain, and thrive
Clinical Leadership of PCPs in Multi-Site Health Centers

- Clinical mentoring of new providers
- Translates policy and practice
- Mentor, Buffer, Coach, Sage, Leader
- Peer Review and Performance Assessment
- Quality and safety oversight
- Recruitment champion for site
- Resolution of problems and issues, including poorly performing providers

Recruit, retain, and thrive
Nurse Practitioners and FQHCs

- NPs and FQHCs born of same era: 1960s
- 2009 UDS: almost 3,000 NPs in FQHCs
- Master’s degree or DNP; board certification
- Initial NP focus on primary care, health promotion, prevention now expanded to specialty care as well
- Scope of practice varies by state statute from:
  - fully independent or
  - requires collaborative agreement or
  - requires supervision
  Some states mandate recognition of NPs as PCPs by insurers.
Now 147,295 NPs in practice (Pearson Report 2009)

65% of NPs choose primary care practice
(America Association of Colleges of Nursing 2009)

NPs deliver one in 11 visits in FQHCs

Increasing competition for new NPs from other sectors: acute care, long term care, specialties, retail clinics

MGMA reports median compensation of $85,706, with larger rates of increase in past five years than MDs or PAs
Recruitment and Retention of NPs

- Critical issue for FQHCs: recruit and retain best and brightest

- NPs, with focus on prevention, holistic and comprehensive care and are well suited for practice as PCP in FQHCs

- Entry to practice as NP can be a shock: how does an NP student prepare for the complexity of FQHC practice?

- R&R issues similar to those identified for all providers (compensation, high vitality team, clinical support, flexibility, strong clinical leadership, opportunity for research and teaching)
What Do NPs Want?

- NPs want to serve as primary care provider with identified panel of patients
- Now by NCQA as medical home leaders
- Recognized and privileged as member of medical & nursing staff
- Recognized as distinct professional: Nurse practitioner and PCP, not “mid-level”
- Opportunities for clinical and administrative leadership; teaching and research involvement similar to other providers
- Compensation commensurate with responsibilities
- Support staffing commensurate as well
Commonly Seen Factors that Discourage NP Retention

- Disparities in key benefits: PTO, CME time and allowance, participation in productivity bonus plans
- Disparities in support staffing such as medical assistant, RN support
- Barriers to progressive professional development and leadership in the FQHC organization
- Language inconsistent with professional role (mid-level, physician extender)
- Some frustrations are beyond the FQHC’s control (specialist refusing to accept referrals, HomeCare orders that must be signed by MD, etc.)
Why NP Residency?

- NPs transition from university to practice without residency
- Clinical training may or may not include FQHC setting

Evidence of challenging transition from new NP to primary care provider:
- Brown & Olshansky: “from limbo to legitimacy”,
- Bosch: “more than I bargained for”
- Huffstutler & Varnell: “imposter phenomenon”
- Matthews and Kelly: “guilt and uncertainty”
- GME legislation currently precludes NP residency
What Does Primary Care Look Like In FQHC?

Recruit, retain, and thrive
Why has it worked as well as it has to date?

- Academic preparation does prepare new NPs for safe entry level practice
- FQHC providers have served as mentor and support, and often titrated up the difficulty of patient panel
- We only have data on the NPs that stay, not the ones we lose, maybe forever to primary care
- *Can we do better?*
- As FQHCs expand in number and size, we MUST do better and…
- Hart and McNee: 87% of respondents (>500) would have done residency if available
Hallmarks Of Residency Training

• Service-institution based; historically hospitals, now moving to community
• Residents are typically employees, salaried, with benefits
• Preceptors are assigned *exclusively* to the teaching and supervision of residents during precepted sessions
• Residents have **continuity clinics** with panel of assigned patients over time
• Mix of additional **didactic and specialty** experiences
• Clear learning **objectives and evaluation** plan
• **Fully integrated** into the organization
CHC’s Goals In Establishing Residency

- Provide new nurse practitioners with a depth, breadth, volume, and intensity of clinical training necessary to serve as primary care providers in the complex setting of the country’s FQHCs.
- Train new nurse practitioners to a model of primary care consistent with the IOM principles of health care and the needs of vulnerable populations.
- Create a nationally replicable model of FQHC-based Residency training for nurse practitioners.
- Prepare new NPs for practice in an setting—rural, urban, large or small.
Required FNP-certification, Spanish-speaking preferred, stated commitment to PCP career in FQHC

• Full time, salaried employment x 12 months

• Core elements of residency:
  – Precepted continuity clinics, with CHC faculty 40%
  – Specialty rotations (in and out of CHC) 30%
  – Independent clinics 20%
  – Didactic lectures 5%
  – Integrated participation in life of the organization (on-call, task forces)
  – Training to a specific model of high performance primary care
Where our NP Residents Come From

• Sept. 2007 - admitted 1st class of four residents
  - 3 from Yale University School of Nursing
  - 1 from Boston College School of Nursing

• Sept. 2008 - 2nd class of four residents
  - 1 from Yale University School of Nursing
  - 1 from Boston College School of Nursing
  - 2 from John Hopkins School of Nursing

• Sept. 2009 – 3rd class of four residents
  - 1 from Yale University School of Nursing
  - 1 from University of Pennsylvania
  - 1 from University of Illinois at Chicago
  - 1 from the University of Virginia

• Sept. 2010 – 4th class of four residents will start
  - 2 from Yale University School of Nursing
  - 1 from University of Illinois at Chicago
  - 1 from the University of South Carolina

• Home States: Our residents have come from
  California, Connecticut, Illinois, Maine, Massachusetts, Michigan, New York, Pennsylvania, South Carolina, Vermont, Virginia
Outcomes To Date

- Former NP residents are practicing as primary care providers in FQHCs across the country
  - Connecticut (3), Massachusetts, North Carolina, Washington state, Washington DC, Oregon, Pennsylvania

At end of residency, each resident has averaged a continuity of 350-450 patients with full age/severity mix

Evaluations, reflective journals, and narratives indicate tremendous progress in confidence and competence at end of residency, but the transition is not complete until well into the 2nd year post-graduation/1st year of practice post residency

Cost per resident/program is a combination of both fixed costs (resident salary and overhead) and diminished revenue of preceptors during sessions.
Questions To Be Answered

• How does a formal post graduate residency training program affect the transition from new NP to competent and confident PCP?
• How do the individual elements of a residency program affect this transition?
• How is the experience of the first year of practice post-residency different from expectations developed during the residency?
• What are the inhibiting and facilitating factors associated with the transition to PCP?
• What are the process and outcome measures of a successful transition from new NP to PCP?
Findings of a Multiple Case Study (unpublished)

- Applicants are universally committed to caring for patients comprehensively, in families & communities
- Seek mastery in areas they associate with caring for special populations, esp. caring for complex patients with multiple problems
- They undergo a transition: “I no longer feel like an imposter in a white coat.” “I feel in awe of how far I’ve come”, develop absolute confidence in knowing their limits and feel “ready and able” to take on their first PCP job post-residency
Facilitating Factors

- Preceptors and precepted clinics: “they were the ones guiding us the whole way
- Specialty clinics: especially psychiatry (adult and child)
- Didactics: addressing the specific clinical issues seen in health centers
- Being on-call (“I hated it! but really valuable); Being the person someone calls at 2 am and having them trust you
- Being part of the staff, team, provider meetings: the life of the organization
Unexpected Challenges

• “The psych piece surprised me. There were just so many patients with co-dominant mental illness”
• “I do not think I ever could have been prepared for the complexity of the patients”
• “I did not expect the amount of drug use and mental illness”
• “Muddiness” of the role of a resident, particularly in relationships with other staff at site
• “The productivity push: is it like this in all health centers?”
Unprecedented investment in and support for FQHCs
Major expansion in National Health Service Corps
Significant increases in funding for academic preparation of NPs
Funding for Nurse Managed Health Centers
Authorization of 3-yr demonstration project to replicate NP residency model along model developed by CHC, Inc.
Nurse Managed Health Centers

- Currently 250 NMHCs across county
- 12 are also FQHCs per Association
- PPACA/H R 3590 authorizes $50 for new NMHCs; first round of funding pending
- Definition: Majority of care provided by nurses. At least one APRN must hold executive position in organizational structure. Comprehensive primary care, consumer-majority board, sliding fees
- Applicants must demonstrate how they will move towards becoming FQHC
Section 5316: Secretary shall establish a training demonstration program for family nurse practitioners....to train for careers as primary care providers in FQHCs and Nurse Managed Health Centers...to provide new NPs with clinical training...consistent with IOM and needs of vulnerable populations...to create a nationally replicable model.

“no more than $600,000 per year per program; no less than 3 residents per year
• 2\textsuperscript{nd} NP residency created in 2009 by Lana Sargent at Worcester Family Health Center
• NP residencies authorized but not funded in legislation; working on next appropriation
• Current “best path” may be state by state appropriations
• Teaching Health Centers program offers natural partnership, but no funding was targeted specifically for NPs
• CHC, Inc. is ready and available to support other FQHCs in developing NP residency
In 2004, AACN recommended the development of a practice doctorate as a terminal degree in nursing.

Response to multiple drivers and needs.

Doctor of Nursing Practice programs found in most states now.

Implications for FQHCs:
- Will see increased requests for more extensive clinical placements (generally unfunded).
- Current NPs may want/need to seek DNP degree—time and financial implications.
- Advanced preparation for leadership and practice.
In the quest to provide the most expert care to a most vulnerable and complex patient population, the focus on prevention, health promotion, supporting families, and building healthy communities remains a fundamental goal of nurse practitioners and hopefully, our entire clinical teams and organizations.
Community Health Center Week at CHC New Britain
Recess Rocks!!!!

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Enter our contest make a video win prizes open to kids in grades 2-8

Help stop childhood obesity

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Recess Rocks

Make a Video in 2 Minutes or Less

Solve a Problem & Enter to Win

Great Prizes

Enter Our Video Contest to Win One of These Great Prizes!

Individual Entry

Free Prize

Encourage kids to be physically active

Encourage students to be responsible for their environment

Group Entry

Free Prize

Dance Move

Encourage students to be literate

Get Kids to Think

Encourage students to be environmentally conscious

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