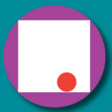


FHEA News

NP "Firsts"

Recognizing nurse practitioners who are pioneers in their profession.

Margaret Flinter, PhD, FNP-BC, FAANP, Founder of America's First NP Residency Program
by Jaclyn Fitzgerald, Editor

The 2010-2011 CHC NP Residency class at their graduation ceremony. From left to right, Martha Trevey, MSN, FNP-BC; Anna Olivier, MSN, FNP-BC; Margaret Flinter, PhD, FNP-BC, FAANP; Kristie Quarles, MSN, FNP-BC; Hao Pham, MSN, FNP-BC.

Since becoming a family nurse practitioner (FNP) more than 32 years ago, Margaret Flinter, PhD, FNP-BC, FAANP, has been a prime example of an NP leader within a federally qualified health center (FQHC) practice setting. In 1980, Dr. Flinter became the first NP to work for Community Health Center, Inc. (CHC), a FQHC with 13 locations in Connecticut. She is currently the senior vice president and clinical director for CHC and is also the founder and director of the clinic's center for research and development, the Weitzman Center for Innovation in Community Health and Primary Care. Five years ago, she established the first primary care NP residency program in the nation, which operates out of CHC and has paved the way for similar programs. The latter accomplishment has resulted in national recognition for Dr. Flinter and her NP residency program model.

In September 2007, Dr. Flinter and her colleagues at CHC welcomed four NP residents to the first NP residency program in the United States (US). The program, which is 12 months full-time, is open to board certified FNPs who are licensed to practice and prescribe in Connecticut and have completed their graduate education at the master's or doctoral level within 18 months of applying. Residents in pairs of two join a team comprised of NPs, medical doctors (MD), medical assistants, and primary care nurses at one of four CHC locations qualified to host the program.

The CHC residency program model begins with a 4-week orientation. The overall program structure includes four main elements: precepted clinics, specialty rotations, didactic sessions, and independent clinics. Residents spend 40% of each week practicing alongside an NP or MD preceptor at CHC, during which time they amass a patient panel that consists of those who are new to the clinic. Each resident spends 12 hours a week in a 10-month specialty rotation, which is intended to provide knowledge of areas of practice that would often be referred out of primary care. Once a week, residents partake in a didactic session on clinical challenges that are encountered in FQHCs. Case studies are presented by residents as part of these sessions. Twice a week, they practice with patients of their primary care provider colleagues to increase their understanding of episodic and acute care problems. Other elements include an on-call rotation with back-up, participation in quality improvement initiatives and in clinic and community events and meetings.

The effort that Dr. Flinter has put into CHC's NP residency program has not gone unnoticed. Section 5316 of the Patient Protection and Affordable Care Act (PPACA) authorized the US Health Resources and Services Administration to create a 3-year demonstration program for NP residencies in FQHCs and nurse-managed health clinics. Today, eight organizations in six states offer NP residency programs based on Dr. Flinter's model (See Figure 1 below). These organizations have incorporated an orientation, precepted clinic and didactic sessions into their program. All but one has included specialty rotations and all but two have included specialty clinics.

(NP Firsts: Continued on page 6)

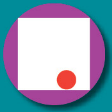
NP Residency Program Replicability

CHC Model	Didactic Education	Independent Clinics	Precepted Continuity Clinics	Specialty Rotations
Worcester	x	x	x	x
Philadelphia	x		x	x
Austin	x	x	x	x
Bangor	x	x	x	x
Los Angeles	x		x	x
San Francisco	x		x	
Santa Rosa	x	x	x	x
Tacoma	x	x	x	x
	100%	62.5%	100%	88%

Data provided by NP Residency Program Coordinators

- ✓ All residency programs are twelve months in length
- ✓ All comprise elements of a precepted clinical experience and didactic education
- ✓ All include some form of orientation

Figure 1: Courtesy of Amber Richert and Nicole Seagriff, CHC FNP Residents



FHEA News

(NP Firsts: Continued from page 4)

The number of residents practicing at one time varies from one to four for each organization as does the length of the orientation. (See Figure 2) By December 2012, a total of 12 organizations will have implemented residency programs based on Dr. Flinter's model.

Since its inception, the most significant change that the CHC residency program has undergone has been in terms of growth. This year will mark the first time that CHC will accept eight residents, rather than four. Dr. Flinter's future goals include continuing to support the adoption of her residency model, further researching the impact of the program and securing long-term funding and authorization for NP residency programs.

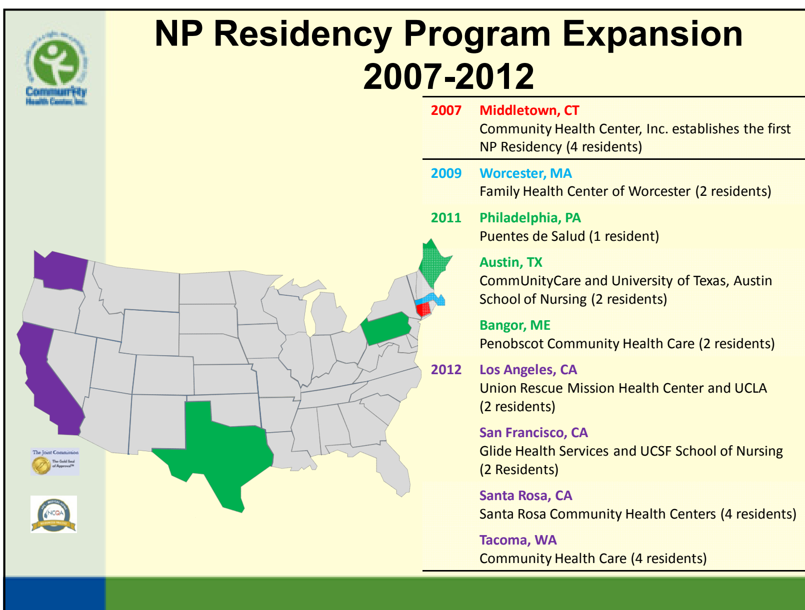


Figure 2: Courtesy of Amber Richert and Nicole Seagriff, CHC FNP Residents

The following is a question and answer session with Margaret Flinter, PhD, FNP-BC, FAANP.

Question: How do you feel NPs will benefit from a residency program?
Answer: I think we have conclusive evidence based on 5 years of qualitative and quantitative data that the original goals—the development of confidence and competence by the new NP as a primary care provider in the challenging setting of a community health center—have been achieved. This is confirmed both by our graduates who have gone on to practice as primary care providers in health centers across the country, and by their clinical and organizational leaders in those health centers.

Question: What do you hope to accomplish through the creation of your residency model?
Answer: We have an immediate and long-term need for primary care providers in the United States; primary care providers who are expertly educated and trained to the full spectrum from prevention and health promotion to chronic disease management and acute care, and who understand how to do this in the context of managing a panel and a population while engaging with the neighborhood and community in which their patients and families live, work and study. This is how we are going to improve health outcomes and transform communities in America. The national policy debate continues to place enormous emphasis on creating incentives and strategies to entice physicians to choose primary care. While I support those efforts, I also insist that we ask the question: "Who wants to be a primary care provider? What resources and strategies do we need to put in place to support them?" NPs overwhelmingly express a preference for primary care as their practice specialty area, and my goal in creating the residency is to give them the support and training they need to enter practice successfully and build vibrant careers as primary care providers, particularly in the nation's safety net [FQHCs]. And while I haven't discussed the Affordable Care Act yet, of course this becomes ever more urgent as millions of Americans become insured for the first time and seek previously deferred primary care and a primary care provider.

Question: What are your thoughts on Amendment 5316 of the PPACA? How do you think it will impact NP practice?
Answer: Section 5316 of the ACA is a brilliant amendment in search of the funding to make it happen! The quick story behind it is that my colleagues at CHC and I have worked very hard since 2007 to educate Congress about these issues we have discussed here, and the need for and benefits of developing residency training for NPs. We were invited to do a Capitol Hill briefing in 2009, and a Health Policy Fellow, Dr. Jacqueline Rychnovsky, also an NP, was inspired to take this issue up. She was instrumental in getting support from key members of Congress, particularly Senator Chris Dodd and Senator Daniel Inouye. It was passed as part of the ACA but without a specific funding authorization, and we have continued to fight for funding for the past 2 years. The obvious benefit of funding Amendment 5316 would be to allow a number of community health centers as well as nurse-managed health centers to get programs up and running, in a fairly consistent and standardized way. That's how we are going to move forward as a national model that ultimately secures a sustainable funding stream whether through GME [graduate medical education], Medicaid GME, or some other funding vehicle.

(NP Firsts: Continued on page 7)

(NP Firsts: Continued from page 6)

Question: Do you believe that NP residency programs should be mandatory? Why or why not?
Answer: NPs practice in an enormous variety of settings. I don't presume to have the answer for the entire field. I look to my colleagues in all the other areas to share their thoughts on the need for residency training. However, in the area in which I do consider myself an expert, I would say every new primary care NP should have access to a formal post-graduate residency training program in an organization that offers training to a high performance model of care. This is a point I would like to stress. When we accept NP residents, we are not doing this as "pre-employment" training or preparation for employment at CHC. There is no commitment on our part to hire them or on their part to remain, though I am delighted if they do! An organization has to have the size, scope and capability and obviously not all settings will. Our vision is that the new NP picks a residency in such an institution, and then can go forth from there to practice in any organization, regardless of size and capability and make a huge contribution in that setting.

Question: What are your future goals with regards to NP residency programs nationally and at CHC?
Answer: Our goals center on refinement, scalability, replication, and sustainability. We have completed one formal research study (case study) but are ready for a full-scale evaluation of the past 5 years, expanding to include the new NP residency programs now operating. As we move forward, we are thinking about the issue of accreditation or certification as we begin to reach a critical mass—we aren't there yet, but that is likely coming in the future and of course, sustainability and funding remains the biggest obstacle to widespread development of NP residency programs. On that front, I continue to work through the legislative process on funding Section 5316, to dialogue with my national colleagues in community health centers about expanding the Teaching Health Center initiative to include NP residency, and to urge state Medicaid leaders to consider using the option of Medicaid GME funding as a vehicle for development and sustainability, as Medicaid is perhaps the most direct payor beneficiary of the benefits of an expert primary care provider workforce in community health centers. In all of this, I am deeply grateful for the support of so many individuals and organizations, from Capitol Hill to national, state, and local organizations, to my own incredible team of colleagues at CHC and of course, to that initial class of residents in 2007 and the subsequent classes that have followed. They are the ones who inspire us to continue this exciting and innovative work.

For more information on the CHC NP residency program, please visit: www.npresidency.com.

New and Updated Products

Antimicrobial Update: The basics and beyond

What is the mechanism of action of the most commonly used antibiotics? How are these antibiotics most effectively prescribed? How do certain patient characteristics increase the risk of infection with a resistant pathogen? When should you prescribe a first-line product? When is more aggressive therapy indicated? What should be prescribed if first-line therapy fails? Find out about the "basics and beyond" in this case-based session designed to help demystify antimicrobial prescribing in common bacterial infections including community-acquired pneumonia, COPD exacerbation, acute bacterial sinusitis, and urinary tract infection. This program, presented by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC, is available **on-line** or on **audio CD**.

Worst Case Scenario: Uncommon outcomes in common diseases, volume 2

Nurse practitioners face the challenge of sorting out a confusing "worst case scenario." This session will focus on applying sound diagnostic principles to the puzzling clinical situation, helping you to hone your clinical decision-making skills when a patient has an uncommon outcome in a common disease. This program, presented by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC, is available **on-line** or on **audio CD**.

FHEA Raffle Winners

Fitzgerald Health Education Associates, Inc., recently held a raffle drawing at the 24th Annual Texas Nurse Practitioner Conference in Austin, Texas. We would like to congratulate Gail Messner for winning *Nurse Practitioner Certification Examination and Practice Preparation, 3rd edition*, by Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. We would also like to congratulate Michelle Butaud for winning the boxed book set of four *Cherry Ames Nursing Stories,* by Helen Wells. Raffles are held at all of our exhibit locations.